Global ties and local enclosures: Reflections on global health territory

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Starting points

- Geographical theories of the remaking of region and city spaces in the context of globalization (glocalization)
- Experience as director of the *UW Department of Global Health* undergraduate program
- Involvement in the *Biological Futures in a Globalized World* research cluster with the Fred Hutch Cancer Research Center

From ties to enclosures

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2961854-5/fulltext

Washington Global Health Alliance

WASHINGTON'S GLOBAL HEALTH SECTOR HAS WORLDWIDE REACH AND IMPACT

THE STATE'S GLOBAL HEALTH ORGANIZATIONS ARE GROWING – BRINGING THE BENEFITS OF INNOVATIVE RESEARCH, EDUCATION, TRAINING, AND PROGRAM DELIVERY TO PEOPLE ACROSS THE WORLD

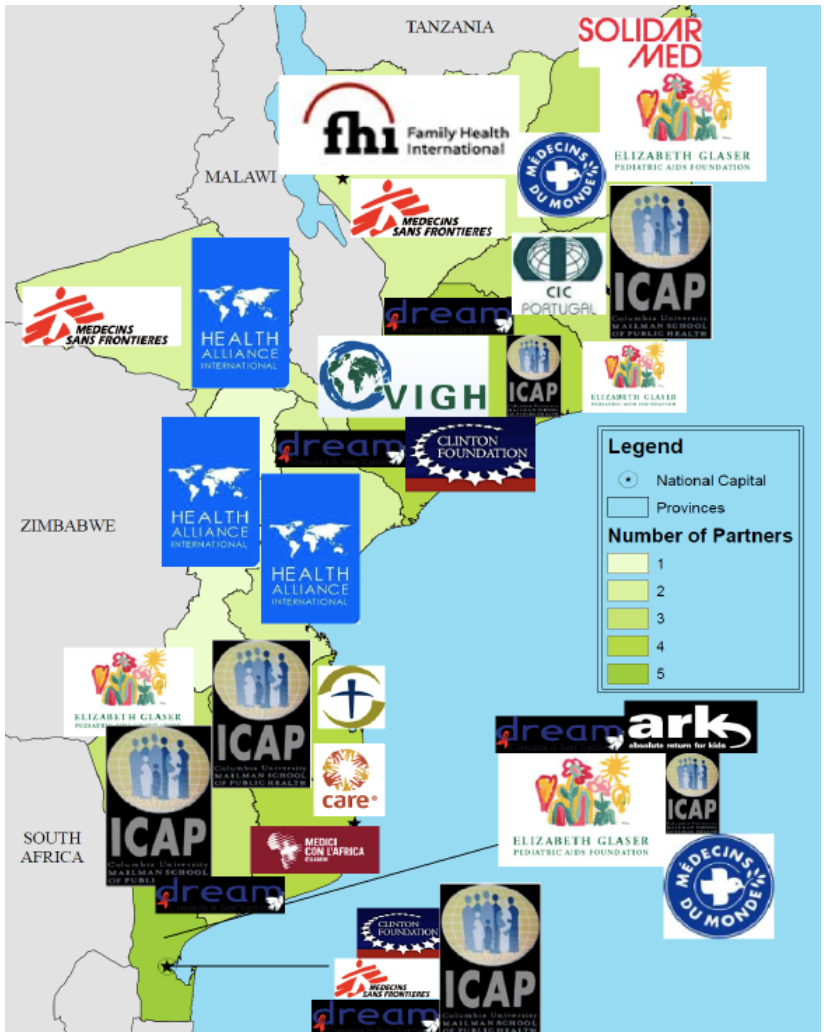
WGHA organizations have a global presence. The map below shows the international locations of WGHA organizations' offices and facilities. WGHA organizations operate offices and lab facilities in 29 countries and 58 cities worldwide. This does not include the hundreds of project sites and the use of partner facilities.

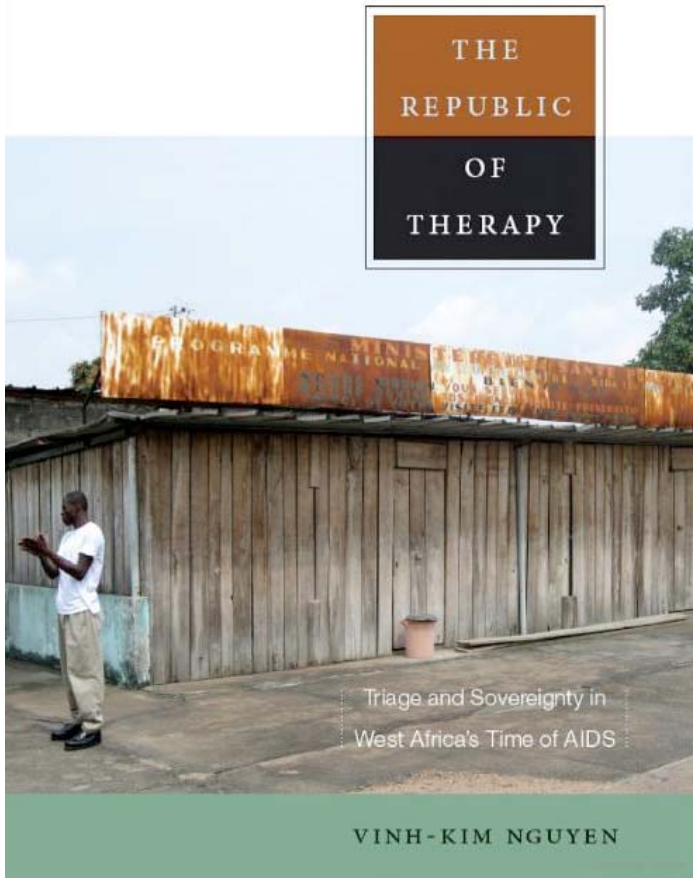
FULL-TIME EQUIVALENTS, IN WASHINGTON	2,324
FULL-TIME EQUIVALENTS, OUTSIDE OF WASHINGTON	2,150
FULL-TIME EQUIVALENTS, TOTAL	4,474

Four forms of enclosure

1. Enclosure of intervention in global south clinical compounds & NGO ‘turf’
2. Enclosure of research in global city research enclaves
3. Enclosure of molecular science in public-private-philanthro partnerships
4. Enclosure of global health policy-making debate in part-privatized conferences and data hubs

Enclosure of global health in clinical compounds and NGO ‘turf’





Enclosure of global health in clinical compounds and NGO ‘turf’

a) Epidemiological enclaving through disease specific targeting and cost-effetiveness treatment

b) NGO ‘turf’ and the temporary sovereignty of health emergencies

c) Value extraction from the enclave through brain-drain & research

Enclosure of global health in global city research enclaves

a) Clustering expertise in bio-tech technopoles

b) Seeking inward investment by both government & pharma

c) Making novel biopolitical appeals for biocapital

Examples:

1. Singapore's Biopolis
2. London's Crick Institute / UKCMRI
3. Seattle's South Lake Union

Enclosure of global health in global city research enclaves - Biopolis

Biopolis is a site which brings together local and imported scientific expertise with the biological productivity of the multiethnic Singaporean population, who are understood as surrogates for the SE Asian population more generally. The ultimate aim of Biopolis is to recalibrate the relationships between the biological and political life of the Singaporean population, and secure the economic future of the city-state, through the advanced research and development of Asia-specific medical biotechnology.

Cathy Waldby, 2009

Enclosure of global health in global city research enclaves – Crick Institute

Large, isolated pharmaceutical laboratories have fallen from fashion as drug companies face up to the poor productivity of most in-house labs. Instead, they are rapidly outsourcing research, particularly the early discovery stages, to universities and small biotechnology companies.

Now everyone wants to be in a “cluster” offering a wide range of scientific and medical activities. UKCMRI will be a multidisciplinary cluster in its own right, with 1,250 scientists and 300 support staff. It will also work in partnership with London’s worldclass academic resources and hospitals.

“UKCMRI is close not only to universities but also to a huge hub of high-quality medical delivery,” says Sir David Cooksey, its chairman, who is a leader of Britain’s venture capital industry. “London is one of the most ethnically diverse cities in the world, giving us a base to understand the effect of any new therapy on a broadly diverse patient population.”

Financial Times, 2011

Enclosure of global health in global city research enclaves – Seattle

"There's been a lot of buzz about the region's growing global health industry over the last two years, and for good reason: with the largest philanthropic investor in this industry in the world (Gates Foundation) here in our backyard, combined with leading research institutions in global health (University of Washington's School of Global Health, Seattle Biomedical Research Institute) and internationally recognized service delivery organizations (PATH), we're pretty well situated to become THE epicenter for this industry in the world. But a lot of people are still confused as to how a cluster that's focused on helping the world's poorest people survive the world's most widespread diseases translates into economic prosperity for our region."

The enclosures of public private partnerships

1. Enclosure of molecular science in public-private-philanthro partnerships
   - E.g. ‘data exclusivity’ and ’global access pricing agreements’
2. Enclosure of global health policy-making debate in part-privatized conferences and data hubs
   - E.g. Pacific Health Summit & Global Health Metrics complaints

Enclosure of molecular science in public-private-philanthro partnerships

A Healthy Dose of Skepticism

Global health is big business in Seattle—which means it may be in danger of forgetting the billions of people it set out to help.

By Tom Paulson

Photo: John Stamos / agoodson.com

BACK IN THE GLORY DAYS of the British Empire, it was called "tropical medicine." As the sun dipped on the imperial Brits, it became "international health," the province of health activists, religious do-gooders, Peace Corps types, and scruffy scientists studying obscure diseases. Now it is "global health," and Seattle, the home of the Bill and Melinda Gates Foundation, is one of its epicenters, on par with Geneva (home of the World Health Organization) and Atlanta (the U.S. Centers for Disease Control and Prevention, or CDC).

As a consequence, global health is now widely hailed as a local growth business. Last October participants at the Greater Seattle Chamber of Commerce's annual leadership conference celebrated it as an important "emerging industry" with huge growth potential for the Puget Sound region. In 2007 a University of Washington economic analysis found that global health already supported 44,000 jobs at nearly 200 organizations and brought more than $4 billion in "business activities" to the region. At the annual meeting of the Washington, DC–based Global Health Council in May, Seattle's leadership role was as visible as Microsoft's presence is at a consumer electronics conference.

Enclosure of global health policy-making debate in part-privatized conferences and data hubs

- Pacific Health Summit
- Consortium of Universities for Global Health (CUGH)

Why do population health targets become spatial targets of vertical intervention?

Global Health Target Talk

- Millennium Development Goals

- President's Emergency Fund for AIDS Relief (PEPFAR)

- The Global Fund to Fight AIDS, Tuberculosis and Malaria

"The Global Fund aspires to contribute substantially to international goals by saving 10 million lives and preventing 140-180 million new infections from HIV/AIDS, tuberculosis and malaria between 2012 and 2016. These goals are complemented by disease-specific **targets** aligned with the global targets set by UNAIDS, the World Health Organization, and the Stop TB and Roll Back Malaria partnerships."

The Global Fund Strategy 2012-2016: Investing for Impact

The Global Fund Strategy Framework 2012-2016: "Investing for impact"

Vision	A world free of the burden of HIV/AIDS, tuberculosis and malaria with better health for all		
Mission	To attract, manage and disburse additional resources to make a sustainable and significant contribution in the fight against AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the MDGs		
Guiding principles	• Being a financing instrument • Additionality • Sustainability • Country ownership	• Multi-sectoral engagement • Partnership • Integrated, balanced approach • Promoting human right to health	• Performance-based funding • Good value for money • Effectiveness and efficiency • Transparency and accountability
Goals	**10 million lives saved[1] over 2012-2016** **140-180 million new infections prevented over 2012-2016**		

		Global plan	Global Fund leading targets for 2016	Indicators for other selected services
Targets[2] (2016)	**HIV / AIDS**	UNAIDS 2011-2015 Strategy, 2011 Investment Framework, and UNGASS June 2011 Declaration	7.3 million people alive on ARTs	• PMTCT: ARV prophylaxis and/or treatment • HIV testing and counseling • Prevention services for MARPs • Male circumcision
	TB	Global Plan to Stop TB 2011-2015	4.6 million DOTS treatments (annual) 21 million DOTS treatments over 2012-2016	• HIV co-infected TB patients enrolled on ARTs • MDR-TB treatments
	Malaria	RBM Global Malaria Action Plan 2008 and May 2011 updated goals and targets	90 million LLINs distributed (annual) 390 million LLINs distributed over 2012-2016	• Houses sprayed with IRS • Diagnoses with RDTs • Courses of ACT administered to confirmed malaria cases

1. Based on impact of provision of ART, DOTS and LLINs using methodology agreed with partners. 2. Targets refer to service levels to be achieved in low- and middle-income countries.
Note: Goals and targets are based on results from Global Fund-supported programs which may also be funded by other sources; targets are dependent on resource levels

Why do population health targets become spatial targets of vertical intervention?

http://portfolio.theglobalfund.org/en/Home/Index

The High- Level Panel stated that *"To be effective, the Global Fund should be more targeted… [It] must be much more assertive about **where and how** its money is deployed; it should take a more global look at the disease burden and better determine who needs the money most."*

So to achieve its targets, the Global Fund will "invest for impact", based on five **strategic objectives**:

1) Invest more strategically in areas with high potential for impact and strong value for money, and fund based on countries' national strategies;

2) Evolve the funding model to provide funding in a more proactive, flexible, predictable and effective way;

3) Actively support grant implementation success through more active grant management and better engagement with partners;

4) Promote and protect human rights in the context of the three diseases;

5) Sustains the gains, mobilize resources – by increasing the sustainability of supported programs and attracting additional funding from current and new sources.

The Global Fund Strategy 2012-2016: Investing for Impact

Why do population health targets become spatial targets of vertical intervention?

- Two sets of factors:

1. Deterritorialization

   Undermining the national-state as a provider of 'health for all' across all the national territory.

2. Reterritorialization

   Creating new enclaves of targeted 'high-impact' biomedical intervention in particular places.

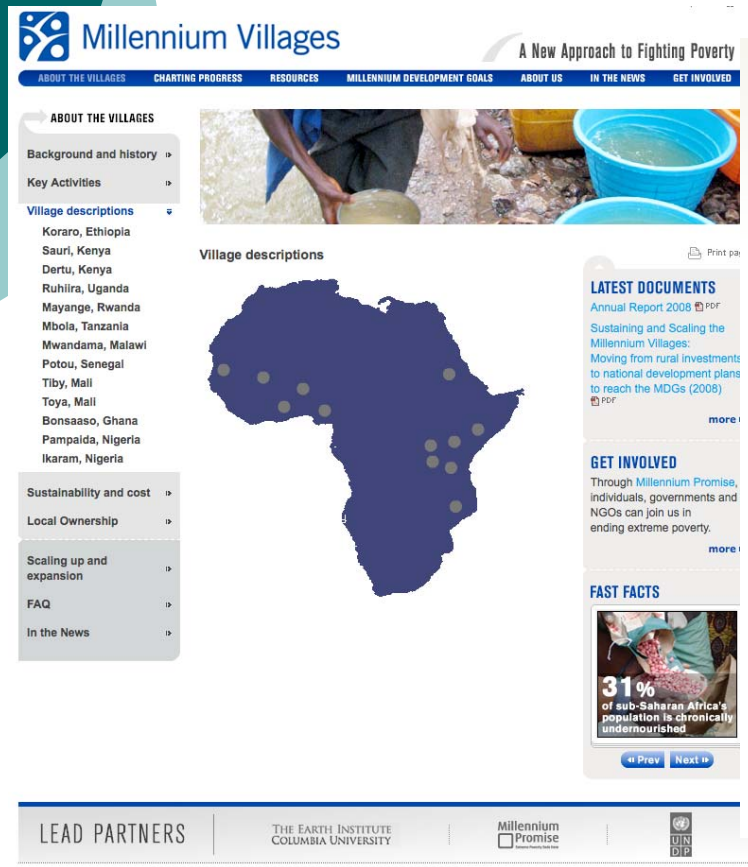
Deterritorialization: The impact of Washington Consensus neoliberalism on health systems

1. Material legacies of structural adjustment programs and ongoing impacts of PRSP conditionalities on health services
2. The structural violence of increasing in-country inequalities that lead to poor health outcomes
3. The problems of global brain-drain migration
4. The constraints created by TRIPS and other trade agreements that expand IP rights and curtail public services
5. Distrust and defunding of horizontal systems managed by governments and MOHs

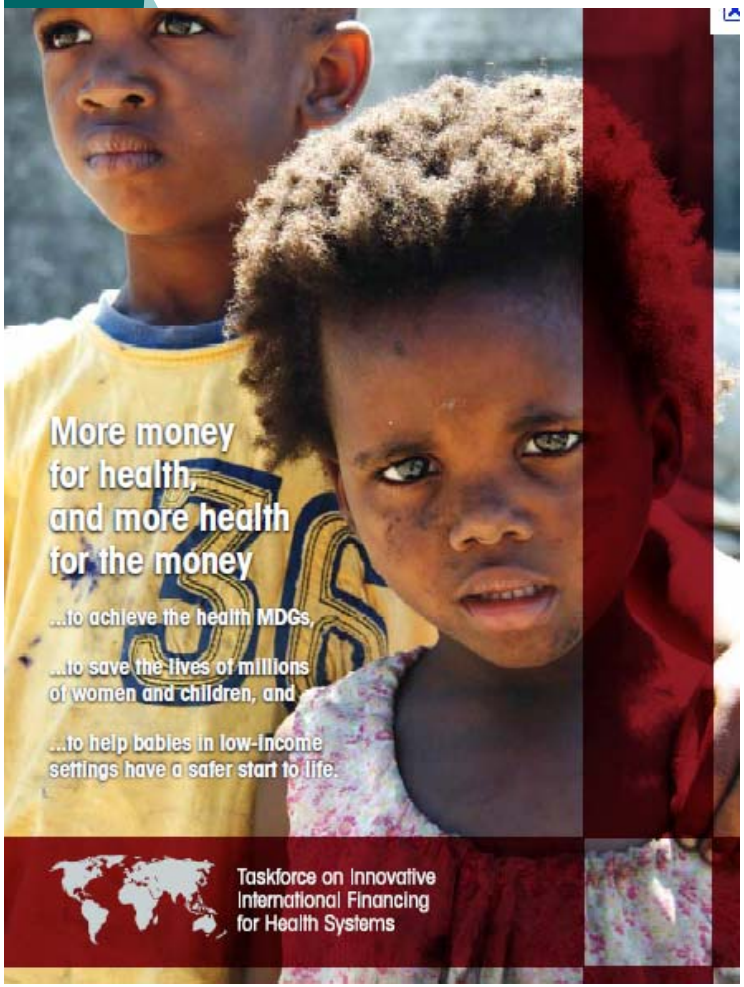
Reterritorialization: The push towards a post-Washington consensus on neoliberal targeting

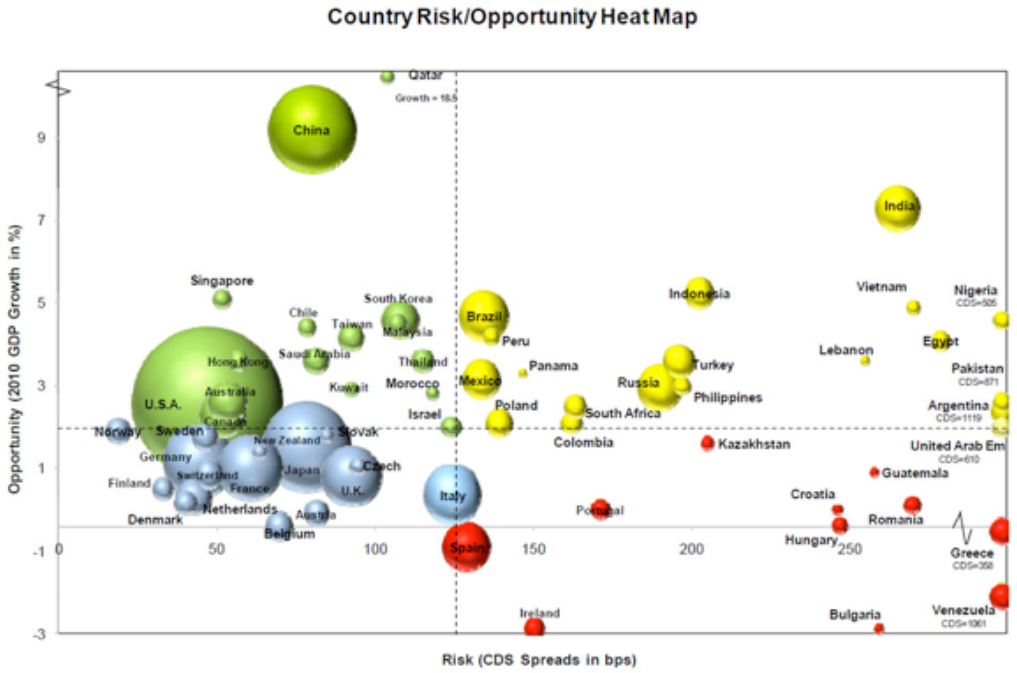
1. Identification of pathological places for treatment for global re-integration
2. Cost-effectiveness investment imperatives for funders, philanthropies and NGOs
3. Accountability protocols that turn target counts for treatment into spatial targets
4. Dynamic demonstration effects for fast policy and fundraising
5. Ethical enclaving associated with human subjects risk management

1) Identification of pathological places for treatment for global re-integration



2) Cost-effectiveness investment imperatives for funders, philanthropies and NGOs





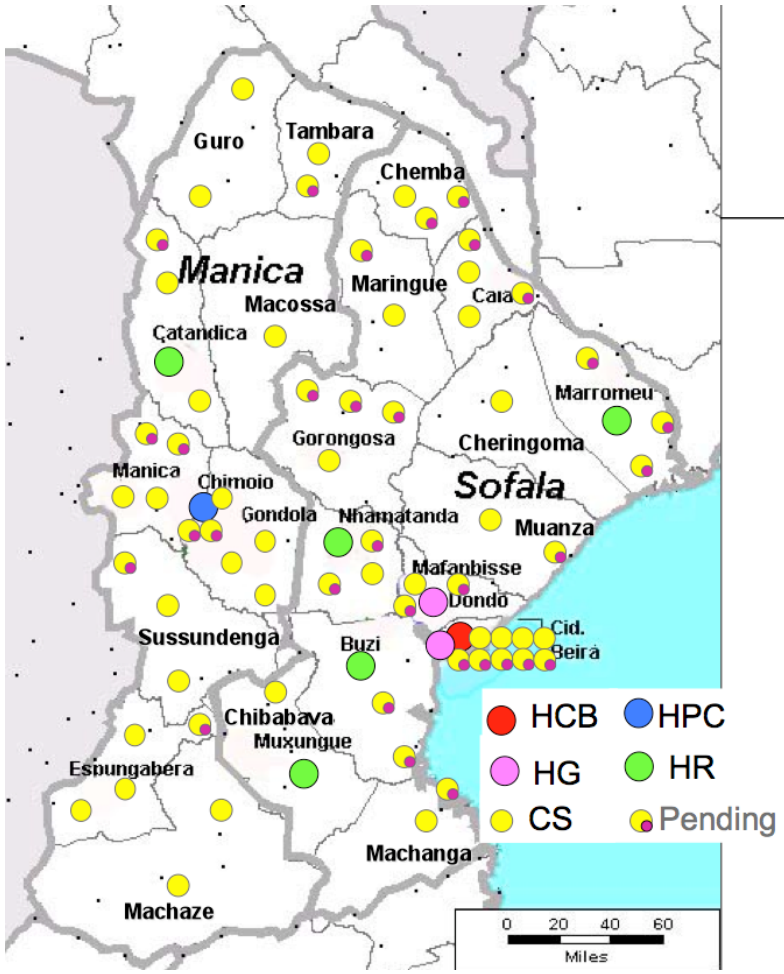
DOW JONES INDEXES AND THE GLOBAL FUND LAUNCH THE DOW JONES GLOBAL FUND 50 INDEX

NEW YORK/GENEVA (December 13, 2010) – Dow Jones Indexes is launching a new index, in collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria, which will help generate resources for the Global Fund's work.

The Dow Jones Global Fund 50 Index measures the performance of the largest companies that support the mission of the Global Fund. A portion of revenues generated through the licensing of the index will go to the Global Fund.

The Dow Jones Global Fund 50 Index is the flagship of a new index series, which will include indexes with overlaying strategies and additional themes. The index has been licensed to db X-trackers, the leading ETF platform of Deutsche Bank, to serve as a basis for a financial product, the db x-trackers Global Fund Supporters ETF. The ETF begins trading today on the

3) Accountability protocols that turn target counts for treatment into spatial targets



HIV Treatment Expansion Plan 2008-09

Facilities providing HAART
53 at end FY07
87 by FY 09

HIV+ Registered 180,000

Eligible in HAART
45,000

Children <15 y in HAART
5,000

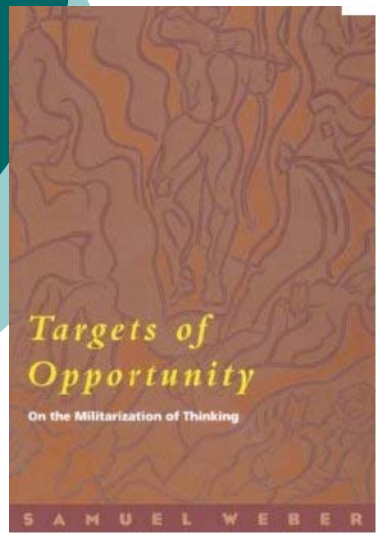
All TB treatment sites in Sofala and Manica testing for HIV; improved TB diagnosis for PLWHA

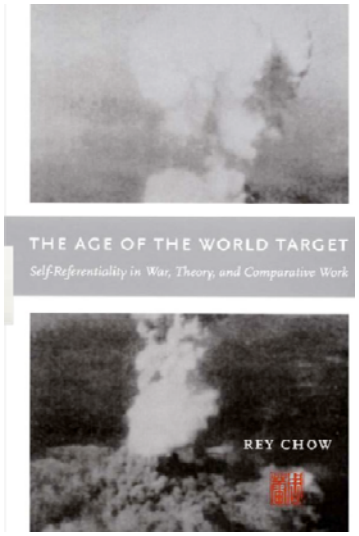
202 facilities with pMTCT (2007)

4) Dynamic demonstration effects for fast policy and fundraising

5) Ethical enclaving of humanitarian hope

Other influences? The conjunction of militarized turned medical thinking





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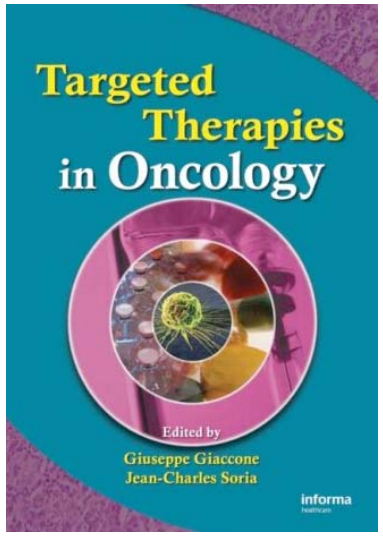
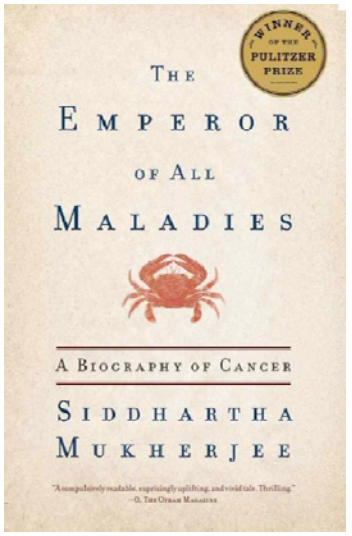




MDGs **GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES**

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

"It seemed as if we had entered a brave new world of precisely targeted, less toxic, more effective combined therapies."

Breast Cancer Action Newsletter, 2004

So why does targeting matter?

- Why might the new geographies of global health be a problem?

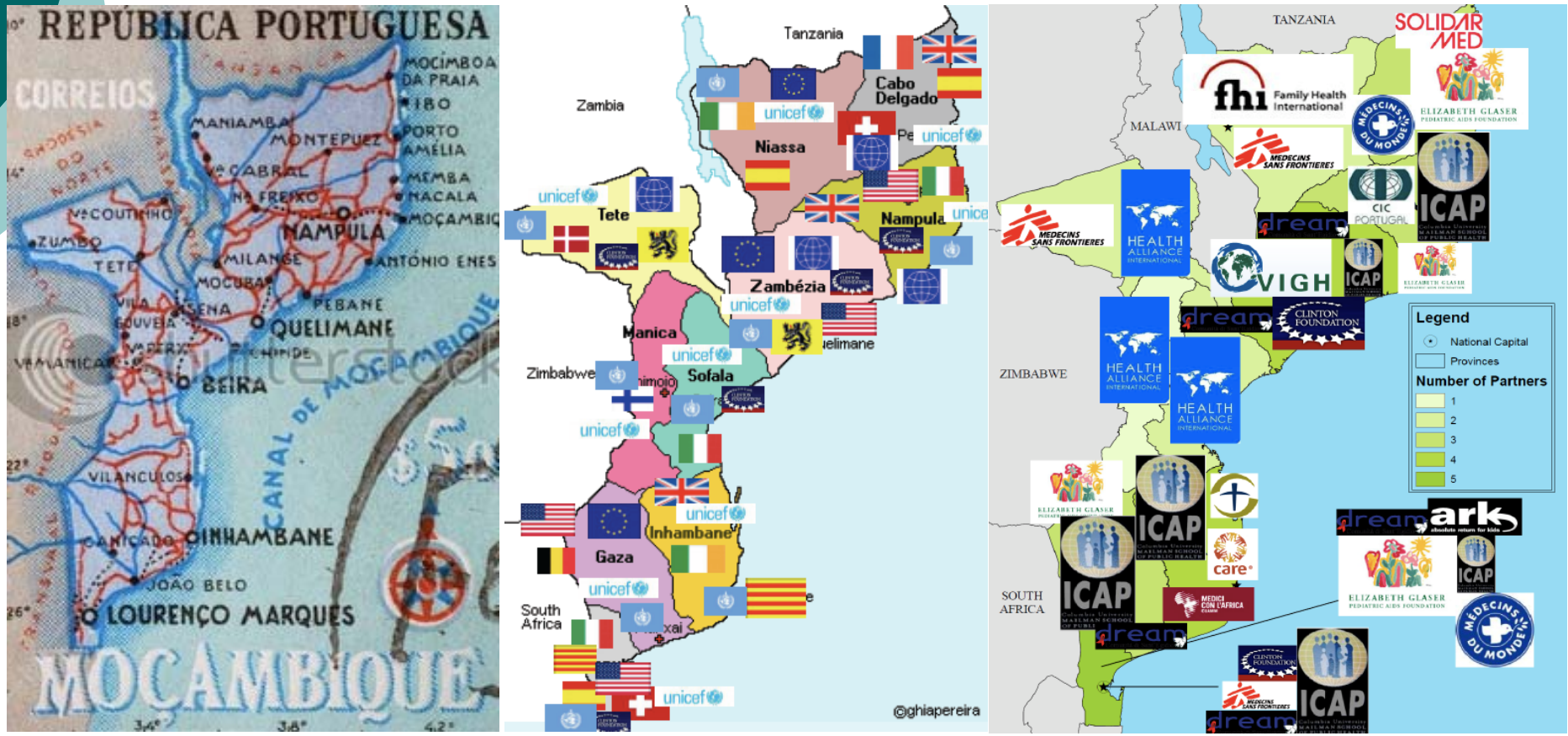
1. The spatial shadow of colonial medicine
2. The problems of NGO scrambling for turf
3. The problems of therapeutic sovereignty
4. The problems of privilege & exclusion
5. The problems of biomedical research extraction
6. The problems of internal brain-drain
7. The problems of non-sustainability and waste

The shadow of colonial medicine

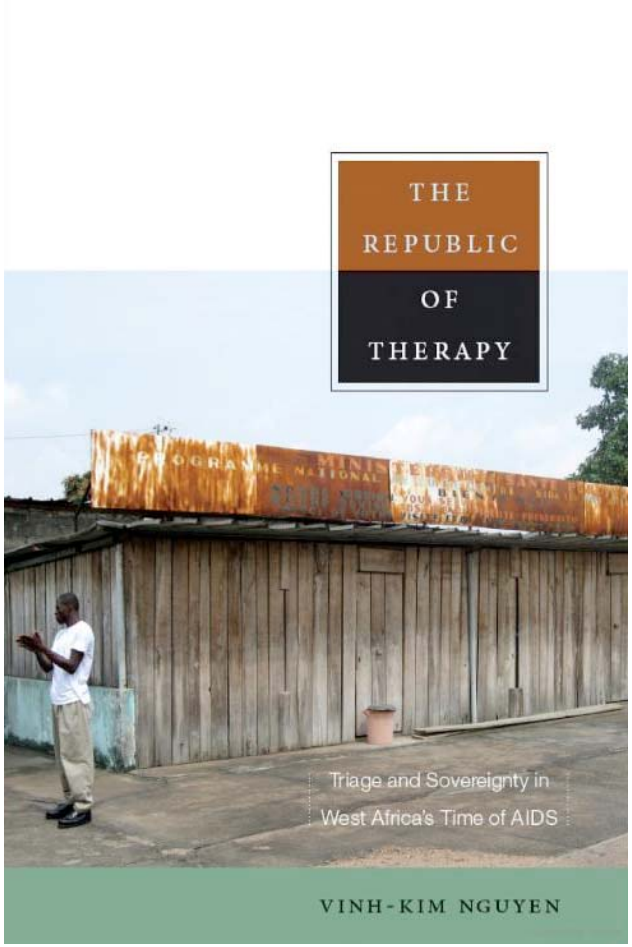
"Tropical medicine was only concerned with the health of colonized subjects to the extend that their ill health threatened colonial economic enterprises and the health of Europeans. [... As] a result] health services for native populations were located near areas of European settlement and sites of production, and thus in or near urban areas. Colonial medical services tended to be narrowly technical in their design and implementation. Health was defined as the absence of disease and could be achieved by understanding and developing methods for attacking diseases, one at a time."

Randall Packard

Global health turf as a new ‘scramble for Africa’



Global health clinics as therapeutic sovereignty



"Relief efforts are thus political in the strongest sense, projecting the power of life and death, and doing so through an apparatus that has linked truth-telling to a vast epidemiological machinery for sorting out people. May not a kind of republic of therapy emerge from its shadow?"
Vinh-Kim Nguyen, 2010

"Today it is not the city but rather the camp that is the fundamental biopolitical paradigm."
Giorgio Agamben, 1998

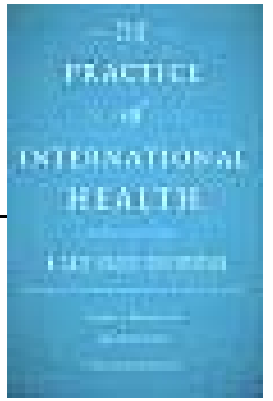
Clinical sovereignty as emergency biopolitics

MSF defines itself around a concern for life in crisis on a global scale, in which survival in perceived settings of social rupture or political failure is put in question. Yet the group's action is not simply an analog to that of a state agency insofar as it avoids wider governance and its inherent mobility produces only partial and limited effects of sovereignty and citizenship….

One can both act and know by being somewhere at just the right moment. But if disaster becomes circumscribed through limited governance (as exemplified by the model refugee camp) then one enters another mode of time, one of incomplete history and abeyance. It is in the extension of this mode of time that crisis becomes truly a state in which humanitarian action can preserve existence while deferring the very dignity or redemption it seeks. And it is the expansion of the geographic scope of this state that threatens the emergence of a new configuration of old inequalities.

Peter Redfield

Expat enclaves compounding privilege



"I was paid a salary of $23K…the Nigerian project manager … was paid less than $400 a month…the watchmen as little as $50 a month. Further I was provided free housing…, and because my project provided house was inside the NGO compound, the office generator supplied my fully furnished house with electricity…and the project's compound supervisor doubled as my steward helping me with shopping, cooking, cleaning my house and washing my laundry. Compared with the palatial quarters of expatriates working for bigger agencies like USAID or UNICEF, my house was relatively humble. Many expatriates' houses are far more luxurious than anything they could afford in their own countries….I remember feeling particularly empowered controlling a fleet of vehicles, … and I was especially fond of our white Toyota Land Cruiser."

Daniel Jordan Smith, 2009

Expat enclaves compounding privilege

"The NGOs bore the brunt of the anger at reconstruction because they were intensely visible, slapping their logos on every available surface along the coast, while the World Bank, USAID and government officials dreaming up Bali plans rarely left their urban offices. It was ironic, since the aid organizations were the only ones offering any kind of help at all – but also inevitable, because what they offered was so inadequate. Part of the was that the aid complex had become so large and so cut off from the people it was serving that the lifestyles of the staffers became … a national obsession. Almost everyone I met commented on what priest called the "NGO wild life": high-end hotels, beachfront villas and the ultimate lightening rod for popular rage, the brand new white sport utility vehicles. All the aid organizations had them, monstrous things that were far too wide and powerful for the country's narrow dirt roads. All day long they went roaring past the camps, forcing everyone to eat their dust, their logos billowing on flags in the breeze – Oxfam, World Vision, Save the Children – as if they were visitors from a far-off NGO World. In a country this hot, these cars with their tinted windows and blasting air conditioners were more than modes of transportation; they were rolling microclimates." Naomi Klein, 2008

Research enclaves as parasites?

"Today, someone who walks from the northwest toward the Malawi hospital ward where I watched a young woman die long ago may still pass the herbalists selling their medicines. Those approaching from the east or south must make their way between the gleaming buildings of the transnational research projects. Gates, Wellcome, the CDC, Johns Hopkins are all represented: all the big guns in international research, plus many smaller guns. The studies conducted within have been carefully vetted, stamped, and approved as ethical; there will be no more research on second-best therapies, though this restriction sometimes means the projects are not very relevant to the local clinical world. Climate controlled, well equipped, stuffed with staff and microscopes and laboratory reagents and automated specimen processors, the research buildings make for a striking contrast with the hospital they surround. It is sometimes hard not to see them as parasites feeding on an emaciated host."

Claire Wendland, 2008

Internal brain-drain

- Legislatures in the major donor nations should consider how the current targeting requirements they place on their funding may have adverse outcomes. For example, the U.S. Congress and its counterparts in Europe and Canada have mandated hiv/aids programs that set specific **targets** for the number of people who should receive arvs, be placed in orphan-care centers, obtain condoms, and the like. If these **targets** are achievable only by robbing local health-care workers from pediatric and general health programs, they may well do more harm than good, and should be changed or eliminated.

  Laurie Garrett, 2007

http://zmtalib.wordpress.com/2012/01/17/too-many-african-doctors-lost-to-local-ngos-we-need-to-fix-the-internal-brain-drain/

Non-sustainability and waste

Thanks to [philanthropic] efforts, there are now billions of dollars being made available for health spending—and thousands of NGOs and humanitarian groups vying to spend it. But much more than money is required. It takes states, health-care systems, and at least passable local infrastructure to improve public health in the developing world. And because decades of neglect there have rendered local hospitals, clinics, laboratories, medical schools, and health talent dangerously deficient, much of the cash now flooding the field is leaking away without result. Moreover, in all too many cases, aid is tied to short-term numerical **targets** such as increasing the number of people receiving specific drugs, decreasing the number of pregnant women diagnosed with HIV, or increasing the quantity of bed nets handed out to children to block disease-carrying mosquitoes. Few donors seem to understand that it will take at least a full generation to substantially improve public health—and that efforts should focus less on particular diseases than on broad measures that affect populations' general well-being.

Laurie Garrett, 2007

Responses to the problems

- Collaboration with ministries of health (MOH) & poor country governments
- Policy-making beyond and between vertical silos of action on specific diseases
- Diagonalization

Collaboration with ministries of health (MOH) & poor country governments

Farmer's frame-breakers

1) ***Collaboration*** **with the local community breaks the standard professional frame of the isolated doctor-patient relationship**

2) ***Transnationalization*** **of diagnosis breaks the spatial frame that obscures local-global ties and associated structural violence**

3) ***Depathologization*** **of treatment breaks the isolating ethical frame that blames the victim and excuses poor treatment for the poor**

Farmer forces us to reframe sickness in terms of wider contexts beyond the medicalized human body

Examples in *Mountains Beyond Mountains*

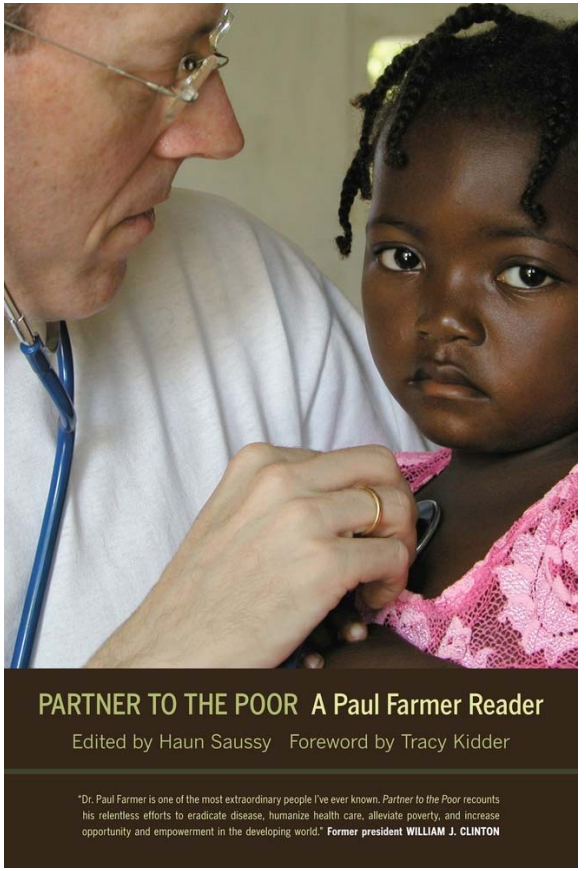
1) **Practical collaboration (*e.g.* with Père Lafontant to build the clinics in Cange) combined with ethnographic collaboration (*e.g.* Farmer's commitment to learning from the poor themselves) (pp. 65 & 91).**

2) **Farmer's care to make connections: "He saw intimate, inescapable connections between the gleaming corporate offices of Paris and New York and a legless man lying on the mud floor of a hut in the remotest part of remote Haiti" (p. 219).**

3) **Farmer's critique of double standards: "A powerful rebuke to the hiding away of poverty," (p. 78). "The only noncompliant people are physicians. If the patient doesn't get better, it's your fault. Fix it….Beyond mountains there are mountains" (p. 36).**

The Diagonal Approach? Paul Farmer's pragmatism

"The arguments have always been multivocal. We've been trying to do several things at once: argue for health care not as a commodity but as a right; **advance the use of disease-specific funding and interventions as a way of strengthening health systems**; advocate making health care accessible to the poor and those in need; and propose adopting other health care models, such as investment in health care as a way of bringing countries out of poverty. But as pragmatists, we'll try anything, we'll go anywhere, if it will help the poor majority." Paul Farmer, 2010, page 567



Policy-making beyond and between vertical silos of action on specific diseases

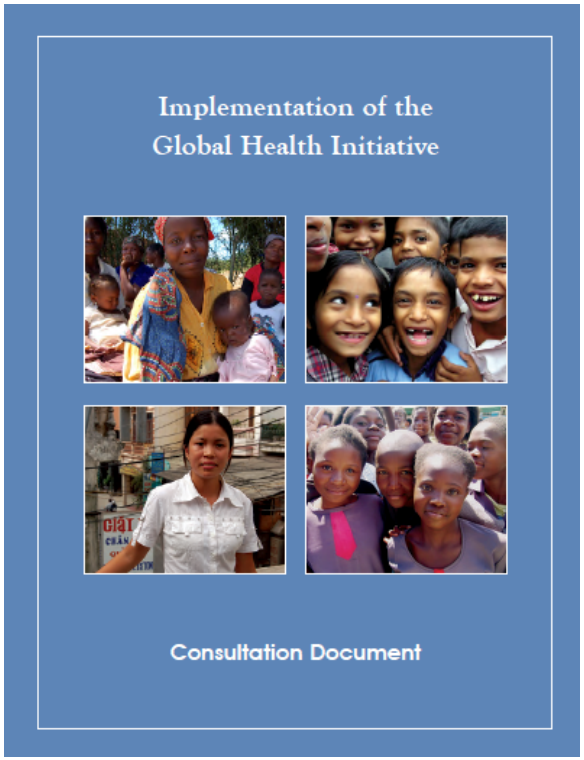
President Obama's 'Global Health Initiative'

"In the 21st century, disease flows freely across borders and oceans, and, in recent days, the 2009 H1N1 virus has reminded us of the urgent need for action. We cannot wall ourselves off from the world and hope for the best, nor ignore the public health challenges beyond our borders. …We cannot simply confront individual preventable illnesses in isolation. The world is interconnected, and that demands an integrated approach to global health."

http://www.ghi.gov/about/index.htm

The Diagonal Approach? The US Global Health Initiative

"The initiative adopts a more integrated approach to fighting diseases, improving health, and strengthening health systems." http://www.whitehouse.gov/the_press_office/Statement-by-the-President-on-Global-Health-Initiative/



Global Health Initiative Principles:

- Implement a woman- and girl-centered approach
- Increase impact through strategic coordination and integration
- Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement
- Encourage country ownership and invest in country-led plans
- Build sustainability through health systems strengthening
- Improve metrics, monitoring and evaluation
- Promote research and innovation

The Diagonal Approach? The US Global Health Initiative

THE NEED

The growing health needs in the developing world are well-documented. What these reports do not typically capture is the experience of individuals served by the programs and systems currently in place.

Consider an HIV-positive pregnant woman who lives in drought-stricken rural Africa. She has walked several miles with a child on her back to arrive at the nearest health post. Here, her child will receive immunizations and basic primary care. Because this facility is small and provides only limited services, the woman will be unable to receive either antenatal care or basic obstetric care at this post when she is ready to deliver her next child.

To receive these services, she must travel to a different clinic in a separate village, where she will spend hours or days waiting outside, as there is no reliable transportation between her village and the clinic. This clinic can provide the treatment necessary to prevent transmission of HIV to her unborn child. It is not equipped, however, to address the many complications of delivery that result in maternal death or disability. Those services would require a much longer journey – and money she does not have – so the woman takes her chances at the site that offers some promise of assistance.

Her baby is born HIV-free, thanks to assistance provided through the President's Emergency Plan for AIDS Relief (PEPFAR). Once back home, the mother tries to feed her family in a year when crop yields are low. Her children will not receive the Vitamin A supplements needed to thrive, and she herself will suffer from anemia. Friends and relatives have told her of health workers that can help monitor the baby's progress and provide medicine, guidance and family planning, but no workers serve the rural village in which she lives, and once again the journey is too long.

The Diagonal Approach? The US Global Health Initiative

THE VISION

The all-too-common conditions faced by this woman and her children illustrate how health programs and weak systems in many developing countries are not meeting the needs of their population. While health services may be available, too often they exist in an uncoordinated or *ad hoc* manner – aligned around funding sources or diseases – rather than the broader needs of the populations they seek to serve.

President Obama's Global Health Initiative addresses the challenges faced by this woman and her family – and millions of others in similar circumstances. The GHI will help partner countries improve health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns and children through programs including infectious disease, nutrition, maternal and child health, and safe water. Achieving major improvements in health outcomes is the paramount objective of the Initiative. To that end, the GHI supports the following goals and targets:

Diagramming diagonalization after Ooms *et al*

Rather than preserving its vertical financing approach, and rather than shifting overnight to a horizontal financing approach, the Global Fund should adopt a diagonal financing approach to support increased diagonal programming. But if the Global Fund's diagonal intentions were undertaken without additional resources and without preserving long-term, sustained foreign assistance and if a diagonal approach could not continue to bypass IMF policies, the Global Fund could be sucked into the swamp of past failed health development efforts.

“Diagonalization” of vertical programs

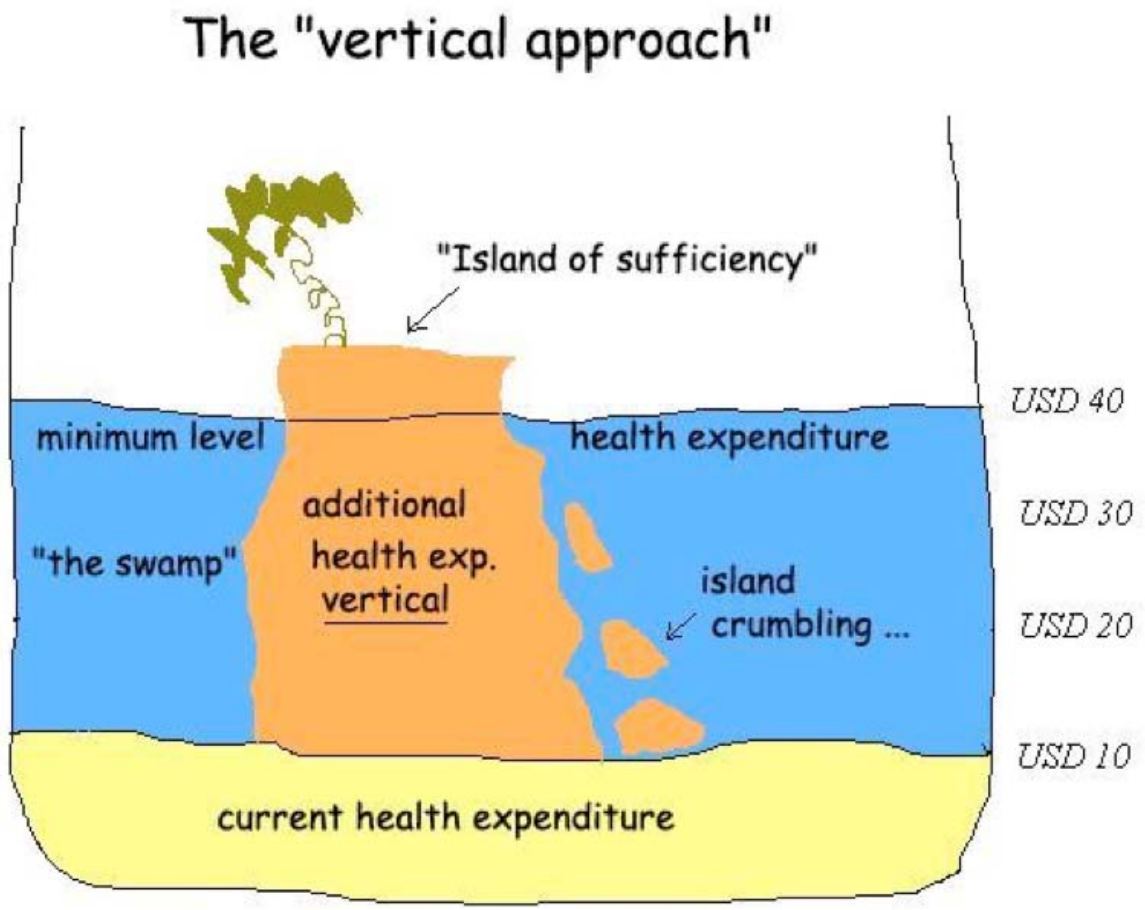
- HIV & TB treatment both require national level laboratories, pharmacies, referral systems
- NGOs can create centers of excellence, but depend on lab and drug systems
- Workforce inadequacy limits scale up
- Vertical HIV & TB funding have been used to strengthen national lab, drug, HR systems

Diagramming diagonalization after Ooms *et al*

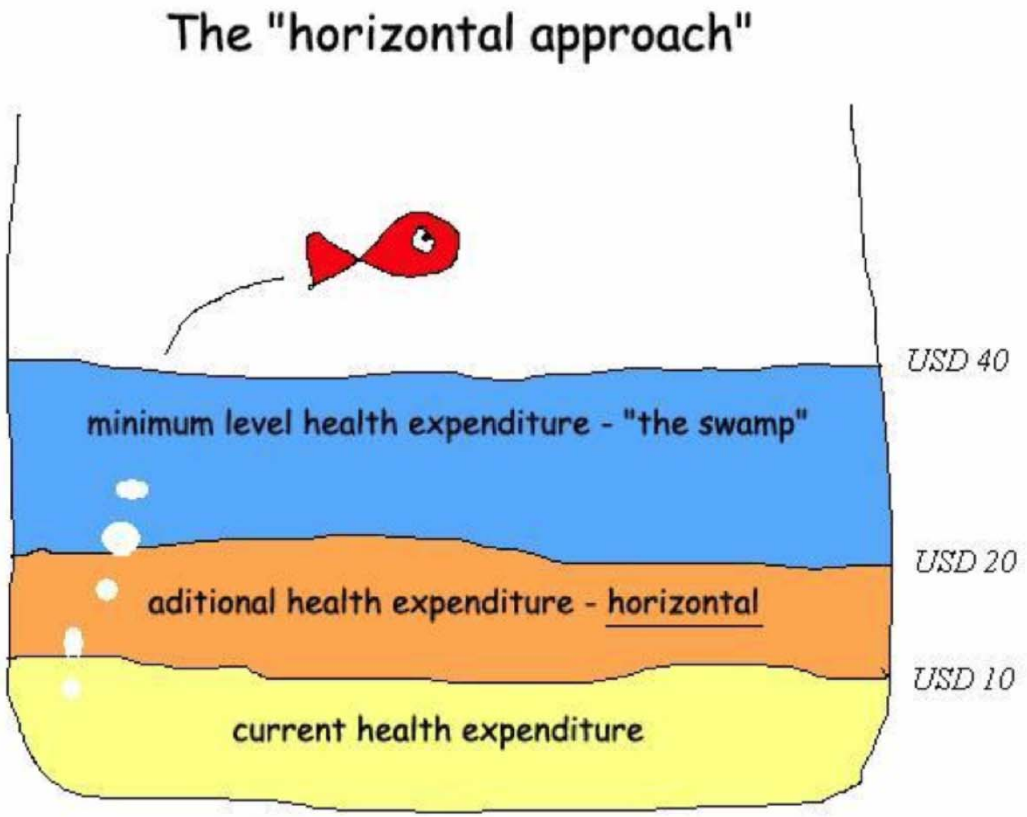
The limits of the vertical approach

Buse and Waxman warned in 2001 that the vertical approach adopted by Public-Private Partnerships might create "islands of excellence in seas of under provision."[13] AIDS treatment services in low-income countries do not deserve the label 'excellence', as they often serve less than a third of the people needing treatment; they are merely islands of sufficiency. Furthermore, 'seas of under provision' sound like depths that will never be filled, while in fact it would take relatively modest resources (on a global scale) to fill them; 'swamps' might be a more appropriate image.

The Vertical Approach from Gorik Ooms & Marc Bestgen



The Horizontal Approach from Gorik Ooms & Marc Bestgen



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