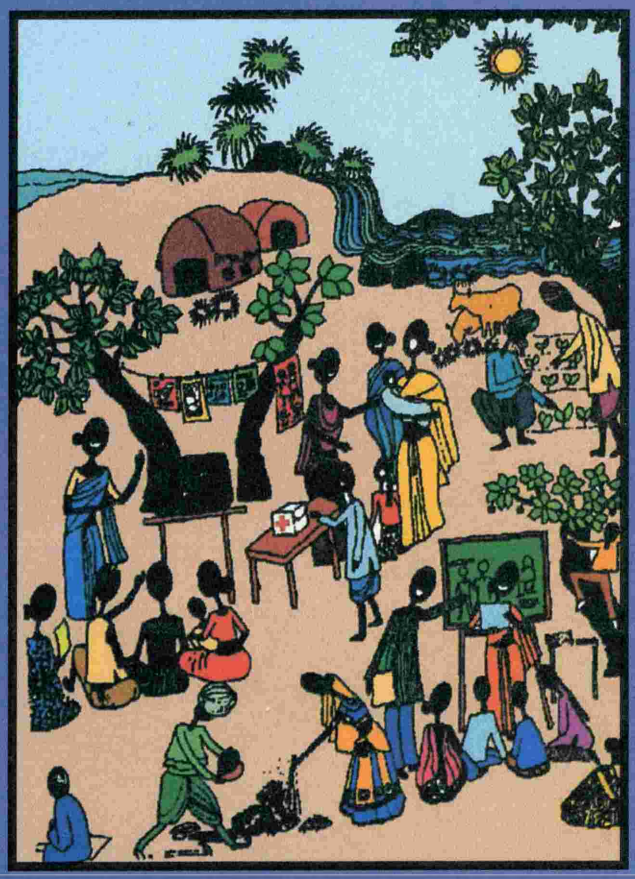
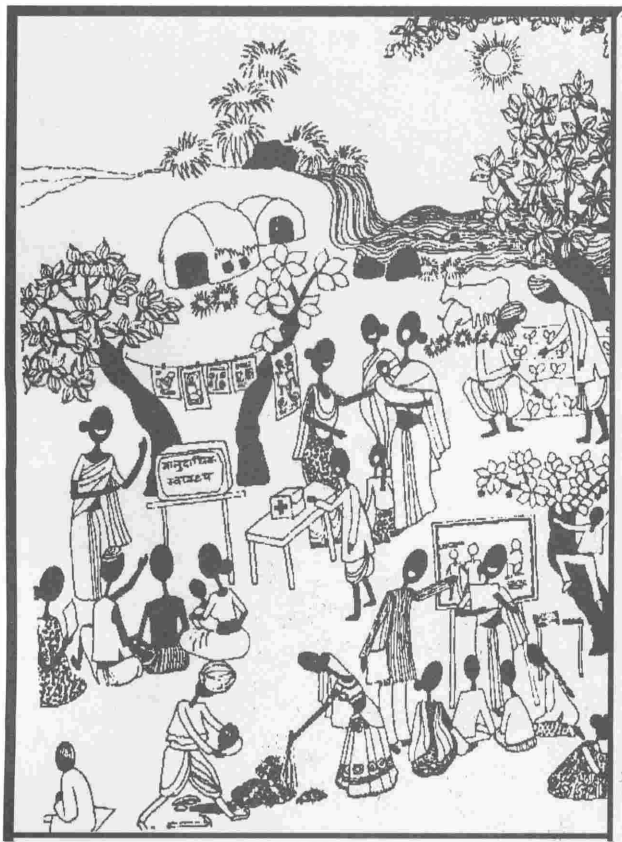
People's Health Assembly

discussion papers



Discussion papers
prepared by the
PHA drafting group



Cover picture taken from *Health for the Millions, Sept-Oct, Nov-Dec 1997*

Layout and design by *Janet-Maychin*

Contents

PHA DISCUSSION PAPERS

These are five discussion papers for the People's Health Assembly. The papers are draft versions. We would like you to discuss the papers, suggest additions or changes, and identify points where you may disagree. We would also like you to use the papers as a starting point for the identification of your own stories and case studies that you think illustrate some of the issues brought up (or others that you come to think about!).

At the end of the paper you will find a list of action points. Please add to this list, which we will use as an input for the *People's Charter for Health* which is currently being formulated.

Please submit your comments, stories and suggestions for action to the drafting group coordinator,
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If you have acccess to the internet, you should be able to find other PHA papers and the People's Charter for Health primer on the address www.pha2000.org

For more information on the People's Health Assembly, please contact:
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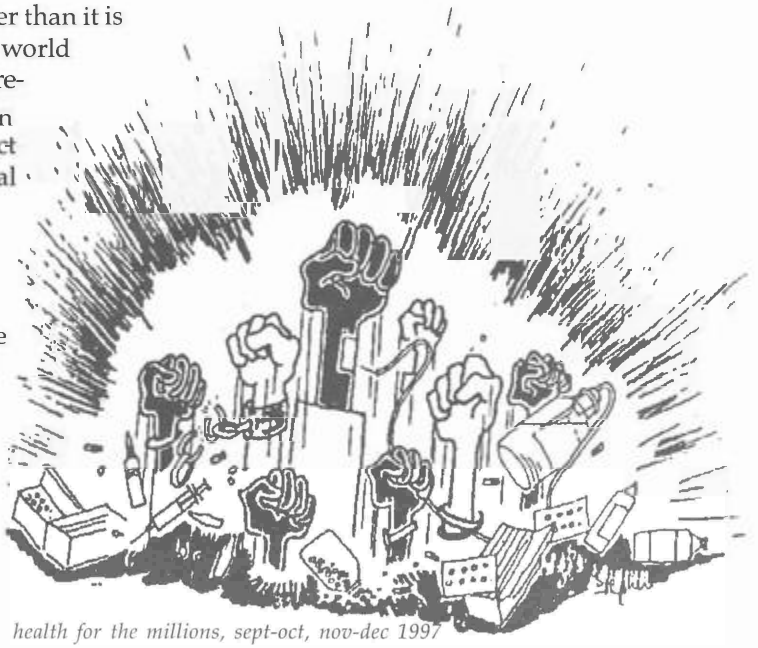
1 The Political Economy of the Assault on

by Mohan Rao and Rene Loewenson

Executive Summary

The world has never before been richer than it is today. Yet large populations of the world find themselves without adequate resources to provide for basic needs to remain healthy. While health indicators like life expectancy has increased, and mortality in general and infantmortality rates in particular have decreased on average, the rates of improvement in these indices have declined in the last two decades. Indeed in many countries across the globe, there have been increases in levels of infant and child mortality even as life expectancy has declined.



health for the millions, sept-oct, nov-dec 1997

Inequalities between and within countries have widened sharply. While a small proportion of the world's population is becoming increasingly wealthier, unemployment, loss of assets and deprivation are increasing in a widening share of the world's communities, including the poor in rich countries.

These changes, moulding health and guiding health policy, are consequences of the manner in which structures of ownership, production and distribution of the world's wealth have been systematically changed over the last two decades. This paper traces some of the influences and factors which together have shaped policies across the world, drawing attention to the manner in which they impinge upon health and affect health services.

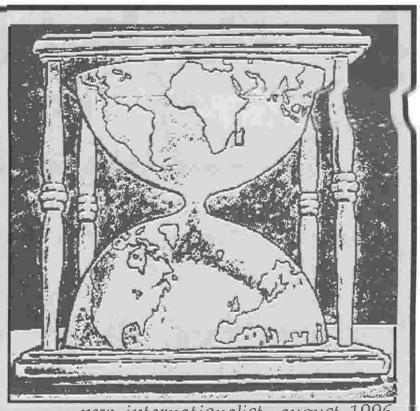
Economic policies around the world are being shaped by international financial institutions, in particular the International Monetary Fund (IMF) and the World Bank (WB). These neo-liberal policies are characterised by reducing the role of the state and increasing that of market forces. Globalistion, privatisation and liberalisation form the heart of this package of policies.

Third World countries indebted to international financial institutions are pressurised to implement the set of policies under the Structural Adjustment Programme (SAP). SAP policies applied in a uniform manner across the globe has increased indebtedness of these countries and accelerated the transfer of resources from poor communities and nations to rich ones. They have also had profound social consequences. They have led to the collapse of weak and under-funded systems of public health even as they increased levels of hunger and poverty, and thus diseases.

These SAP policies have also had profound political consequences as nation states implementing these policies have been weakened. At the same time multinational corporations (MNCs) have become increasingly powerful, controlling an increasing share of global resources. The free flow of speculative finance across borders in search of quick profits, have left a trail of devastation in people's lives.

In order to reclaim people's health it is necessary to address these wider issues of disempowerment, address issues of equity and participatory democracy, and for rebuilding national priorities with a focus on the needs of the majority of the population.

In 1960, the 20% of the world's people living in the richest countries had 30 times the income of the poorest 20%. Now they command 74 times more. The richest 20% of the world's population command 86% of the world GDP while the poorest 20% command merely 1%. More than 80 countries now have per capita incomes lower than they had a decade ago; 55 countries, mostly in sub-Saharan Africa, Eastern Europe and the Commonwealth of Independent States (CIS), have had declining per capita incomes.



new internationalist, august 1996

Although the world today is richer than ever before, nearly 1.3 billion people live on less than a dollar a day and close to 1 billion cannot meet their basic consumption requirements. More than 800 million people lack access to health services, and 2.6 billion to basic sanitation. Although people are living much longer today, around 1.5 billion are not expected to survive to age 60. Indeed life expectancy in some countries of sub-Saharan Africa is only around 40 years.

Despite population growth, per capita food production increased by nearly 25% between 1990 and 1997. But the overall consumption of the richest fifth of the world's people is 160 times that of the poorest fifth. 840 million people are undernourished, including 160 million children. Close to 340 million women are not expected to survive to age 40.

Introduction

The world has never before been richer than it is today. Yet large populations of the world find themselves without adequate resources to ensure good health. Despite the unprecedented advances in medical technology, around 800 million people lack access to appropriate and affordable health services. While life expectancy has increased—and mortality in general and infant mortality rates in particular—have decreased in most countries, the rates of improvement in these indices have declined in the last two decades. Indeed, in some countries, there has been an increase in levels of infant and child mortality. In other words, the increased opportunities for health have been distributed highly unequally around the world.

Inequalities between and within countries have been widening to levels seldom before witnessed. Unemployment, landlessness, loss of assets, and deprivation are increasing in a widening share of the world's communities. At the same time poverty has spread even within rich countries. Together, these factors profoundly affect the health of large sections of the population of the world.

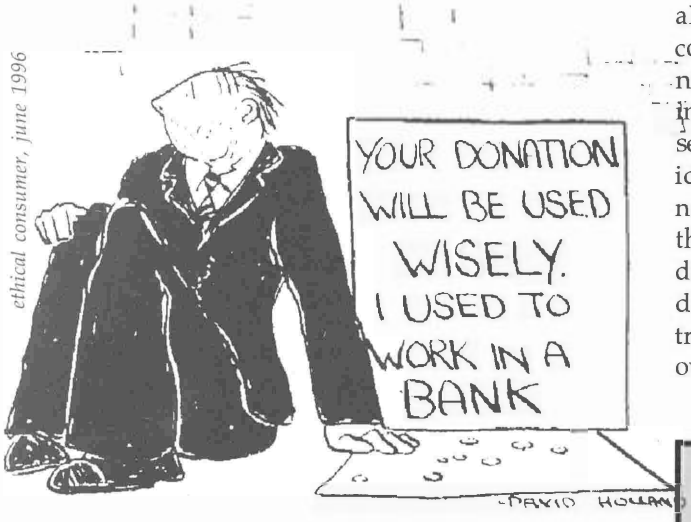
Such factors are not an accident, but the consequence of the way in which structures of ownership, production and distribution of the world's wealth have been systematically changed over the last two decades. This paper briefly attempts to delineate some of these changes while drawing attention to the manner in which they impinge upon health and influence health services organisation.

A recent history of economic policies

Towards the end of the 1970s the long boom of post-war economic growth ground to a halt. Economists hesitated to use the term 'depression' to describe this phenomenon since it brought back memories of the 1930s, a period that had plunged the world into the horrors of fascism and the 2nd World War, but the 'recession' of the 1980s was similarly widespread and deep. These changes took place together with the collapse of the Soviet Union and the state-controlled economies of the socialist world. They also led to a reshaping of the capitalist world, particularly the pursuit of market policies and the opening of countries to transnational corporations (TNCs) through a complex of changes known as globalisation, privatisation and liberalisation.

The debt crisis

In the 1970s—and particularly following the rush of deposits in the wake of the oil-price increase—private Western banks encouraged countries in the Third World to borrow extensively to finance large-scale development projects. Indeed, so acute were the problems of uninvested capital that the banks resorted to bribing politicians and influential officials in the Third World to make commitments towards these projects, many of which were otherwise unviable. The projected returns failed to materialise, however, interest rates rose sharply. By the early 1980s, large num-



bers of now heavily indebted countries were unable to pay back their loans.

It was at this point that the International Monetary Fund (IMF) stepped in to bail out the Northern banks by offering loans to the indebted countries. The loans were primarily aimed at preventing the collapse of the private banks; they also served to involve the borrowing countries in a new framework of regulations in the economy, ostensibly aimed at improving their efficiency and competitiveness in the world market.[1] Thus the restructuring of Third World economies to ensure debt repayment began to drive economic policy.

Neoliberalism

Over the same period, right-wing economic policies took centre-stage in the USA and the UK. These policies, described variously as Reagonomics, Thatcherism or monetarism, reflected an ideological commitment to unbridled market principles, ignoring the remarkable role in these countries of state-directed economies. One of the significant lessons of post-war economic growth had been the singular role that the state could play, and indeed needed to play, in capitalist countries in order to avoid recurrent periods of crisis due to falling demand. For instance, state involvement in public health had been at the heart of the strategy to stabilise the economies, in a move to help capital growth and technological change. In the new environment of the 1980s, these policies (Keynesian) came under systematic attack from neo-liberal economists.

Reducing the role of the state and increasing that of market forces, irrespective of their social and long-term economic costs, were at the centre of the new model of economic growth. This was accompanied by the triumph of the ideology of individualism, competitive wealth-seeking and conspicuous consumption. Along with the decrease of community values has become the undermining of public initiatives and institutions, especially those that serve and protect the interests of the poor. In this ideology, public intervention and institutions are necessarily inefficient and wasteful, and markets the best way to both economic growth and overall development. Economic growth, it was maintained despite extensive evidence to the contrary, would trickle down to the less fortunate and thus result in overall development.

The contradiction between the prescription to the third world and the economic success stories

'The great post-war economic success stories of capitalist countries, with the rarest exceptions (Hong Kong), are stories of industrialisation-backed, supervised, steered, and sometimes planned processes managed by governments: from France and Spain in Europe to Japan, Singapore and South Korea. At the same time, the political commitment of governments to full employment and—to a lesser extent—to the lessening of economic inequality through. a commitment to welfare and social security explains part of the success[4]

'The greatest of neo-liberal regimes, President Reagan's in the USA, though officially devoted to fiscal conservatism and "monetarism", in fact used Keynesian methods to spend its way out of the depression of 1979–82 by running up a gigantic deficit and engaging in equally gigantic armaments build-up. So far from leaving the value of the dollar entirely to monetary rectitude and the market, Washington after 1984 returned to deliberate management.' [5]

Structural Adjustment Programmes (SAP)

At the height of her economic and political power in the new unipolar world, the USA— assisted by the Bretton Woods institutions (World Bank and International Monetary Fund)—found a way out of the impasse of falling rates of profit and increasing unemployment by opening-up potential markets in Third World countries.

The debt situation of these countries became the vehicle for introducing a set of policies brought together under the rubric of structural adjustment programmes (SAPs). Future loans from international financial institutions and access to other donor funds and to markets, became henceforth linked to accepting this broad package of macro-economic policies.

The structural adjustment programme (SAP) package comprises essentially the following measures:

- trade liberalisation removing the protection to local industry;
- reduction of import-export-tariffs;
- deregulation of the economy with fewer or no controls on foreign investments;
- abolition of price controls;
- removing the protective barriers to outflow of funds;
- cuts in government spending including funding of social sectors;
- devaluation of currencies to achieve export competitiveness;
- deregulation of labour laws and retrenchment of workers;
- cuts or removal of social subsidies; and
- public sector enterprise 'reform' typically through privatisation

It was believed that by adopting this package of policies, indebted countries would not only attract foreign investments but would also be in a position to pay for them by increasing their exports of primary commodities. The free flow of funds across borders, it was believed, would facilitate this process. At the same time, removing public subsidies and cutting public spending would enable indebted countries to mobilise larger funds for investment. Providing a stimulus to the private sector by loosening regulations and controls would provide the necessary stimulus to this sector to act as the engine of economic growth.

SAP, liberalisation and privatisation measures were applied in a uniform manner across three continents, beginning with Latin America and Africa in the early 1980s and in Asia in the late 1980s.

In the agricultural sector this led to a reinforcement of colonial patterns of agricultural production, stimulating the growth of export-oriented crops and reducing the production of food crops. The problem at the heart of this pattern of production was that it reinforced the pre-existing international division of labour and that it was implemented when the prices of primary commodities exported by Third World countries were low as never before. The more successful the countries were in increasing the volume of exports, in competition with other Third World countries exporting similar products, the less successful they were in raising foreign exchange to finance their imports. Thus many countries shifted backwards into being exporters of unprocessed raw materials and importers of manufactured goods, in keeping with the saying 'produce what you don't consume and consume what you don't produce'. Indeed as the range of products consumed by households in the South shrank, the acronym SAP increasingly came to be given new meanings: 'See And Pass' or 'Suffer And Perish'.

In the industrial sector, where the countries had been striving to break out of colonial patterns of dependent development, the withdrawal of state support plunged many enterprises into crisis. Such units were then allowed to close or were privatised or handed over to TNCs, typically with significant losses in employment. Just as the state reduced its commitment to critical sectors such as education and health, so also the free flow of capital across borders in search of labour, raw materials and markets weakened the state. Further, over this period, capital across the globe was increasingly being concentrated in fewer and fewer hands with an explosion of mergers and acquisitions.

Together these policies and processes increased indebtedness, increased the rate of exploitation of low-income communities across all countries; and shifted wealth from productive to speculative financial sectors where boom and bust became the order of the day. Many countries opened export-processing zones (EPZs) to attract foreign investment, driving down their own labour costs and forgoing tax revenues. Usually exempt from national labour laws, EPZs employed women in low-paid jobs, while tax concessions made it difficult for national governments to meet the long-term social costs of production incurred in these zones. Thus these policies also led to a significant increase in casual, poorly-paid and insecure forms of employment, and led to the collapse of already weak and underfunded systems of health, education and food security. They increased poverty in already poor countries even as a few people became richer and the middle and upper classes obtained access to

consumer products manufactured in the rich countries.

One consequence of these processes has been commonly described as the feminisation of poverty, as females increasingly had to strive to hold families together in various ways. More women entered the paid labour force, typically at lower wages and with inferior working conditions than men. Simultaneously, the extent of unpaid labour in households (predominantly performed by women) increased as public provision of basic goods and services declined. Young children, especially girls, were increasingly withdrawn from school to join the vast and underpaid labour market or to assist in running the household. The involvement of children and adolescents in crime and delinquency increased under these circumstances. Rising food prices meant that an increasing proportion of families were pushed under the poverty line, and women and girl children were disproportionately affected. Morbidity levels increased even as poor people were increasingly unable to access health institutions, which, under the reform measures, typically introduced payment for services. Given increasing levels of malnutrition, it is not surprising that infant and child mortality rates, which had hitherto shown a decline, either stagnated or in fact increased in a number of poor communities.

The growth promised by the initiation of SAP measures was particularly not achieved in Africa, which has shown reduced economic growth for more than two decades now. Per capita income for sub-Saharan Africa as a whole is lower than it was in 1960. It is thus not surprising that these last two decades are often described as lost decades for these countries.

Changes in food prices induced by SAP: Bolivia 1975 and 1984		
Food item	Hours worked to purchase 1,000 calories in	
	1975	1984
Barley	0.07	0.59
Sugar	0.16	0.40
Corn	0.17	0.64
Wheat flour	0.21	0.52
Dried beans	0.22	3.47
Rice	0.22	0.48
Bread	0.28	0.51
Oil	0.28	0.51
Dried peas	0.29	1.38
Potatoes	0.76	2.35
Onions	1.02	3.22
Powdered milk	1.05	3.95

Source: Susan George, A Fate Worse Than Debt : The World Financial Crisis and the Poor , PIRG, New Delhi, 1990, p.152

Concentration of power

Globalchanges in production technologies and in the organisation of production have also taken place, with fewer and fewer corporations controlling such critical sectors as information, energy, transport and communication; this process has been described as transnationalisation. Multinational corporations were increasingly becoming transnational in their operations, spreading different components of their manufacturing processes to different countries where resources and conditions for their operations were optimal. Thus, around 100 TNCs control 33% of the world's productive assets, account for one- third of world production and employ only 5% of the global workforce. At the same time, the state sector in Third World countries, which was the only sector large enough to enable investment for wider development, has been pushed into a much less significant role. Such measures as the sale of public assets (often to TNCs), and fiscal policies that combined decreasing taxation of the richer segments of the population with decreasing subsidies to weaker segments, essentially meant a widening of income disparities. It is not surprising that income inequalities within countries have significantly increased.

Reduced public sector spending to enable debt repayment also meant that states could no longer play a critical role in maintaining measures for equitable development that they had in many cases initiated. Thus the package of SAP measures led to the collapse of the models of self-sufficient import-substituting industrialisation that many of them had established in the immediate postcolonial years. The essential feature of this past was that socio-economic development in these countries was based on their being ex-

d.werner

porters of cheap primary commodities and importers of finished manufacturedg goods.

Many SAP-implementing countries fell from their initial debt into the debt trap wherein they had to take increasing loans merely to pay back the interest on their earlier loans. Since they now received less for the raw materials they exported, they were forced to undertake repeated devaluation and thus paid more for imported products. They became caught in a vicious cycle of low capital for initiating development, borrowing, devaluation, and less capital. Furthermore, the net flow of resources from the countries of the South to those of the North substantially increased. UNICEF, for instance, estimates that this outflow now amounts to 60 billion dollars annually. In other words, the SAP measures have been successful in increasing the rates of exploitation of the poor by the rich. Liberalised capital markets meant that trillions of dollars could flow in and out of a country within a single day. As the crises in East Asia have indicated, the free flow of capital in search of quick profits has left in its wake devastating poverty and social disruption.

As noted by the UNDP, free market expansion has outpaced systems to protect the social well-being of people and human development. Recent UNDP *Human Development Reports* note that more progress has been made in norms, standards, policies and institutions for open global markets than for people and their rights. They note that when economic growth through the market is left uncontrolled, it inevitably concentrates wealth and power in the hands of a select group of already powerful people, nations and corporations, while marginalising others.

International organisations and national elites

It is equally true that several global institutions of the United Nations have themselves been a part of this process. The World Health Organization (WHO), for instance, has increasingly forfeited its leadership role in health to the World Bank; indeed the total budget of the WHO is less than the health spending of the WB. It has also been suggested that the interests represented by the advanced capitalist countries have themselves increasingly influenced such institutions. Policy prescriptions such as the endorsement of the concept of Disability adjusted life years (DALYs) in health means an approach to health services development that increases the role of the private health sector and the pharmaceutical industry. The World Trade Organization (WTO) has become a forum of debate and struggle over the extent to which trade and industry, including the pharmaceutical industry, should have rights over governments to meaningfully protect resources and public health. Rapidly changing trade regulations demand capacities and negotiating abilities that many developing countries do not have.

The dominance of neoliberal policies across the globe was also linked to the collapse of the socialist economies. The ideological vacuum of alternatives to free-market promises at the global level led to the demoralisation of social movements that rejected first colonial and later neocolonial policies of development.

Although these neoliberal policies have often been described as a neocolonialization, influential sectors in Third World countries have expressed their support for them. These sectors, which benefited disproportionately from postcolonial development in the 1950s and 1960s, have given up ideas of national self-sufficiency, independence and sovereignty, which guided them before. They now intent to reap the benefits as junior partners to foreign capital in search of quick profits, or the purchase of public assets at a low price through privatisation, these classes have lent open support to the policies of the World Bank and the IMF. Aiding this process has been the role of the global media, which transmits messages glorifying consumerism. Not to be underplayed is the role of illicit sources of money from trade in drugs, and rewards to politicians in the Third World for protecting these practices.

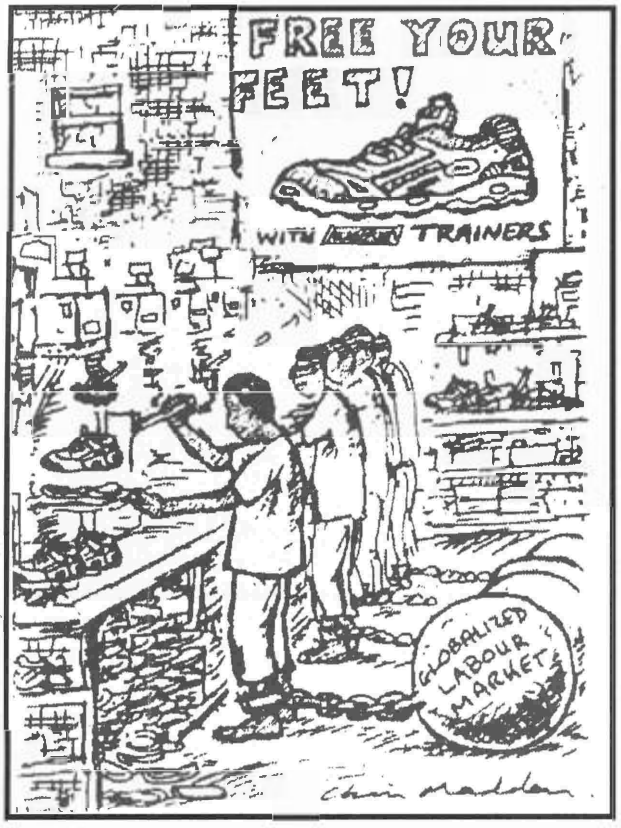
There have been two significant political ramifications of this process. First, international financial institutions and TNCs consolidated their position through institutional measures. Under the new world trading order, which emerged with the completion of

the Uruguay Round of talks in Marrakech, the role of the Bretton Woods institutions and national governments was redefined. It was envisaged that in the articles of the new World Trade Organisation (which was to have been endorsed in Seattle), many aspects of SAP would become legally enforceable articles in international law. Third World countries would thus be at an increasing disadvantage, and less and less the owners of their own indigenous biological materials and knowledge.

The WTO has been criticised for its lack of transparency and democracy in decision-making, but the problem runs even deeper. In the profoundly uneven playing field on which the process of global economic change is taking place, even a transparent WTO would not pursue the values or principles that would enable the vast share of the world's population to access resources or enhance their productive capacities.

The second ramification is that national governments in many Third World countries, after losing support from the former socialist countries, failed to build stronger South to South links with neighbouring countries or with those producing similar primary commodities; instead they embarked on a competitive race to integrate into the global economy, thus pushing primary commodity and labour prices lower.

When populations in Third World countries resisted—and these sites of resistance are legion—their governments used severe measures to suppress them. Indeed, in many countries, scarce public resources were often typically directed to military and security expenditures. Thus, paradoxically, 'liberal' pro-market policies in much of the developing world have been associated with repressive politics.



There have been many sites of resistance to these policies in many parts of the Third World. The Caracas anti-IMF riots in 1989 were sparked off by a 200% increase in the price of bread. Unofficial reports indicate that in January 1984 more than 1000 people were killed by the police firing in Tunis when protesting adjustment measures. Bread riots have also occurred in Nigeria in 1989. In 1990 anti-SAP riots took place in Morocco. The 1994 uprising in Chiapas, Mexico were also sparked off by SAP measures.[6]

Movement for change: setbacks and hopes

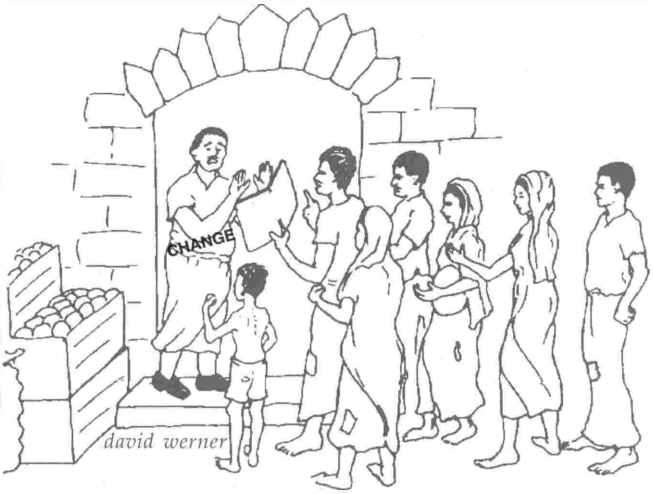
The last decade of the 20th century has seen the weakening of democratic movements and aspirations. This has occurred partly because of the preoccupation with survival among larger sections of the population and the weakening of trade unions in the face of privatisation and layoffs. It is also partly due to the increasing centralisation of decision-making at national and often international levels. Indeed decisions affecting large sections of the population in poor countries are often made at distant capitals in the West, with the national government mandated merely to implement such decisions.

It is in this situation that poor people fallback on their sectarian identities and turn on their equally poor neighbours in ethnic and religious conflicts. At the same time, increasing conflicts over scarce resources at the local level are breaking out in a number of places. In other cases a withdrawal into the family occurrs, with women bearing the brunt of this rise in violence.

While these are mechanisms for coping with an increasingly hostile world where people are marginalised and disempowered, they do not confront the sources of alienation and disempowerment. A political culture of dependence, withdrawal or passivity, even as governments have acted against the interests of their own poor people, strengthens the same forces of authority.

The situation is not, however, completely bleak. There are significant positive developments that indicate confrontation with this unacceptable social

and economic order. These are leading to organisation for change at many levels: local, national and international. Powerlessness is being addressed through a range of movements that organise in a representative and accountable manner, giving voice to the voiceless. Those movements that make links with others, pressurising governments for participatory democracy and to rebuild national priorities with a focus on the needs and aspirations of the majority of the population, must inevitably confront the wider sources of disempowerment. It is from this dimension of social movements confronting the current global political economy that there is hope for a more humane and human-centred type of development based on sustainability and equity. Within this larger struggle must be located the struggle for health for the people of the world.



Guyana in South America is the poorest country in the Western hemisphere. Since 1988, 80% of the government's revenues have gone on servicing foreign debt. Through the 1980s and 1990s, malnutrition, child death rates, unemployment and poverty rose dramatically as a result of the implementation of the SAP package. In 1992, following the election of a new President, the citizens of Guyana joined forces with the Bretton Woods Reform Organisation (BWRO) to create the first Alternative Structural Adjustment Programme, which envisaged a comprehensive economic policy to meet the basic needs of the entire population. The ASAP was based on the principle that a healthy economy does not rely on exports for income and imports for daily needs. The supporters of the ASAP also rejected the IMF freeze on social sector spending, and the President declared that raising the standard of living of the majority was the first objective.

Notes

[1] George, Susan, *A Fate Worse Than Debt: The World Financial Crisis and the Poor*, PIRG, New Delhi, 1990.
[2] Hobsbawm, Eric, *The Age of Extremes: The Short Twentieth Century 1914–1991*, Viking, New Delhi, 1994, p.269.
[3] Ibid, p.412.
[4] Hobsbawm, Eric, *The Age of Extremes: The Short Twentieth Century 1914–1991*, Viking, New Delhi, 1994, p.269.
[5] Ibid, p.412.
[6] Information from Chossudovsky, Michel, 'The Globalisation of Poverty and Ill Health' in *Lighten the Burden of Third World Health*, Health Systems Trust, Durban, 1999.

Questions:

- What has happened to the lives of ordinary people in your country or community in the last two decades? How similar are the experiences of different countries? Who have been the winners and losers?
- Why is 'free trade' a slogan primarily of the rich and influential countries?
- What has happened to the profile of health and disease in poor communities? What has caused these changes in health and ill-health?
- What actions have ordinary people taken to protect their rights to food, housing, jobs, health and health care? How far have these actions been coping mechanisms? How far have they confronted the causes of their problems collectively? What has been the response of the state?
- In what ways have countries acted together to improve their trade advantage in your region? In what way have they competed with each other? Which is more effective?
- What do ordinary people know about the international banks, financial institutions, world trade rules and markets that affect their lives?
- Have you ever thought of the range of products available in a typical supermarket in the West? How many of them emanate from the Third World? How is it that these are available to the middle class Westerner but not to large populations within the countries they come from?

2 EQUITY and inequity today

some contributing social factors

by Nadine Grasman and Maxine Hart

INTRODUCTION

The 1999 United Nations Human Development report begins: 'The real wealth of a nation is its people. And the purpose of development is to create an enabling environment for people to enjoy long, healthy and creative lives. This simple but powerful truth is too often forgotten in the pursuit of material and financial wealth.'[1]

The current trend of globalisation has contradictory implications. While the last 50 years have witnessed developments that augur better for the future of humanity—child death rates have fallen by half since 1965, and a child born today can expect to live a decade longer than a child born 20 years ago; the combined primary and secondary school enrolment ratio in developing countries has more than doubled—the world faces huge amounts of deprivation and inequality. ***Poverty is everywhere***. Measured on the human poverty index—more than a quarter of the 4.5 billion people in developing countries still do not enjoy some of life's basic rights—survival beyond the age of 40, access to knowledge and adequate private and public services.

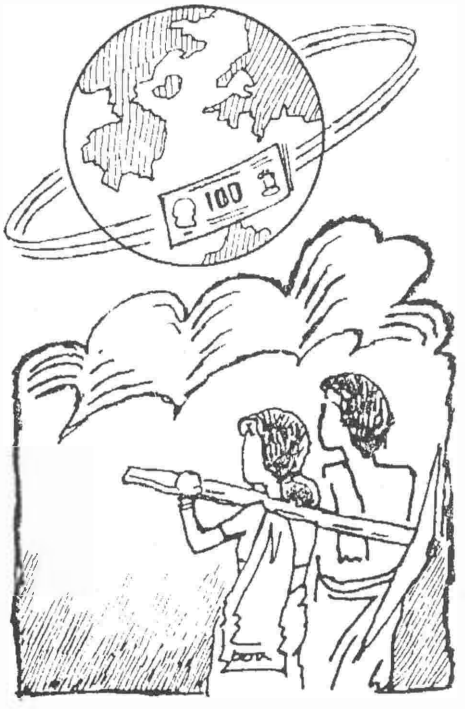
The quickening pace of globalisation has generated enormous social tensions that development policies have failed to tackle. The underlying assumption has been that once economic fundamentals are corrected, social issues will resolve themselves of their own accord, and that well-functioning markets will not just create wealth, but will also resolve problems of human welfare.[2]

Current events reveal with awful clarity the depth of this fallacy. Millions of people are poorer than ever before, with growing indices of inequality between countries and within countries. Most countries report erosion of their social fabric, with social unrest, more crime, and more violence in the home.

Neoliberal advisors in the 1980s developed a vision of the ideal country: its economy would be largely self-regulating through open competition between private firms; its public sector would be relatively passive—providing the minimum services necessary to conduct private business efficiently and to protect society's weakest members.

This dogmatic economic prescription, concludes the United Nations Research Institute in Social Development (UNRISD), has not only had limited value, but has been dangerous. Even those countries that have been held up as economic success stories have been social failures. Most people in highly indebted African and Latin American countries have suffered a sharp drop in living standards.

Between 1980 and 1990 the per capita income declined markedly in developing countries. An International Labour Organization study of 28 African countries showed that the real minimum wage fell by 20% and more than half of Africa's people now live in absolute poverty. In most Latin American countries the real minimum wage fell by 50% or more. Coupled with this, people have suffered from severe cuts in public services—affecting nutrition, health, education and transport.



The UN Human Development Report of 1999 goes further: a comparison between the size of income of the fifth of the world's people living in the richest countries and that of the fifth in the poorest showed a ratio of 74 to 1 in 1997, up from 60 to 1 in 1990 and 30 to 1 in 1960.

The advocates of adjustment had hoped for a trade-off: long-term economic gain in return for short-term social cost. What they did not foresee was that the

social impact could itself frustrate the desired economic effect. This temporary sacrifice for the poor is beginning to look like a permanent intensification of poverty.

UNRISD explains: 'When the market goes too far in dominating social and political outcomes, the opportunities for and rewards of globalisation spread unequally and inequitably—concentrating power and wealth in a select group of people, nations and corporations, marginalising others. Globalisation in this era seeks to promote economic efficiency, generate growth and yield profits. But it fails on the goals of equity, poverty eradication and enhanced human security.'

Economic growth, an important input for human development, can only translate into human development if the expansion of private income is equitable, and only if growth generates public provisioning that is invested in human development—in schools and health centres rather than arms. Reduced public spending weakens institutions of redistribution—leading to inequalities.

FACTORS SHAPING inequality

Below are some of the major factors shaping inequality in a globalised environment:

Institutions

Institutions matter for development. In 1997, the World Bank warned: 'Without adequate institutions, the potential benefits of globalisation in terms of higher growth and investment rates will either not happen, or be too concentrated, thereby increasing, rather than decreasing inequalities and social tensions'. It adds further that 'good institutions are critical for macroeconomic stability in today's world of global financial integration'.[3]

UNRISD states: 'Social institutions have not just been ignored but they have been considered obstacles to progress and have been ruthlessly dismantled. This has happened at every level. At national level, many state institutions have been eroded and eliminated. And at local level, the imperatives of market forces have been undermining communities and families.'

The formal or semi-formal ties between states and society are increasingly unravelling, and being replaced by more diffuse arrangements. *States are growing weaker*, and state institutions are less able to fulfil basic responsibilities in areas that encourage personal development such as education, health, nutrition, land redistribution and welfare.

As states weaken, power is being transferred to institutions that ignore the social implications of their actions, while at the same time responsibility for absorbing the damage is being passed to non-governmental agencies or to communities and families that have themselves been so weakened that they are in no position to respond.

Political parties have become more diffuse and fragmented, particularly in the former Eastern Bloc countries where institutional chaos is common.

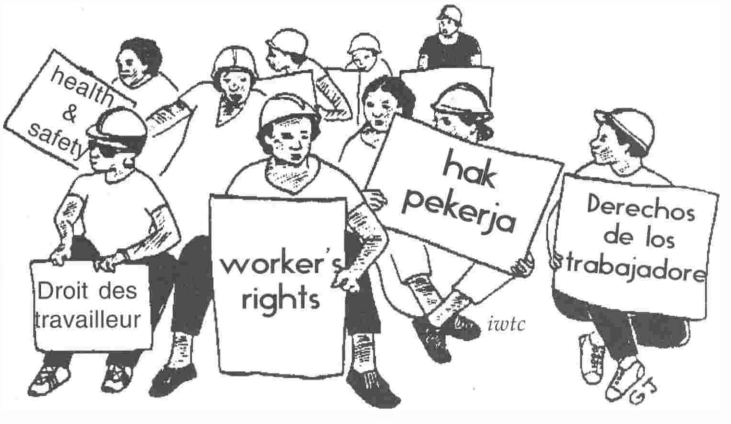
Trade Unions are being eroded—suffering from changes in working patterns. In countries with high unemployment, employers are finding it easier to avoid dealing with trade unions and are dealing directly with individual workers.

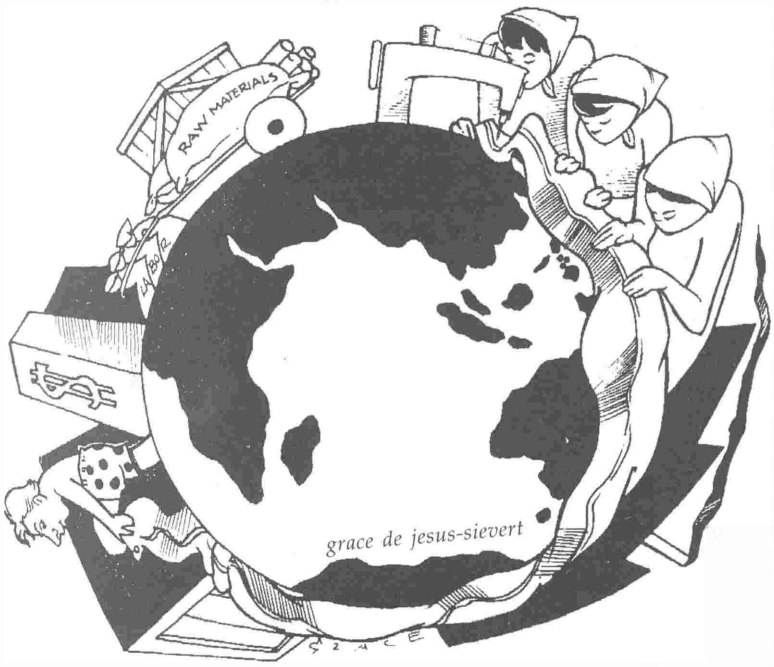
NGOs are increasing their influence and have been used to deliver services in many developing countries where governments are incapable of providing services. Accountability is thus undermined.

While many national institutions are being weakened, forcing communities and families to take on added burdens, other institutions are enjoying much greater freedom—without any commensurate increase in responsibility. This is especially true for *Transnational corporations (TNCs)*, which now control 33% of the world's productive assets, but only employ directly or indirectly 5% of the global workforce. TNCs are accused of exploiting cheap labour in developing countries, marketing dangerous products, avoiding taxation and causing serious environmental damage. Despite this, they remain untouched by any form of international regulation. In cases where national governments try to exert pressure on them, the companies move elsewhere.

Education

Persistent inequality and low quality characterise basic education systems in developing countries. Education inequalities in access to school, attend-





ance, quality of teaching and learning outcomes—perpetuates income and social inequalities. Poor children attend poor schools, have less opportunity to complete their basic education, and perform below their counterparts in private schools.

Misallocation of resources, inefficiencies and lack of accountability are prominent attributes of the organisational structure of education in most countries. According to the report by the UNHDP, one in seven children of primary school age is out of school.

Corruption

Corruption seriously weakens the ability of nations to ensure wealth is distributed fairly. Corrupt officials siphon off wealth from public and private sources, and discourage investment by those who fear profits will be stolen.

Weak governments allow *tax evasion* to flourish, undermining one of the key government tools for wealth redistribution by denying governments adequate resources to alleviate poverty and assist development.

Underground or informal economies have grown, further reducing national tax bases and feeding criminal organisations that grow up around the informal economies.

Employment and unemployment

Expansion of trade does not always mean more employment and better wages. In the OECD countries, employment creation has lagged behind GDP growth and the expansion of trade and investment. More than 35 million people are unemployed, and another 10 million are not taken into account in the statistics since they have given up looking for a job. Among youth, one in five is unemployed.

In both poor and rich countries, dislocations from economic and corporate restructuring and dismantled social protection have meant heavy job losses and worsening employment conditions. Jobs and incomes have become more precarious. The pressures of global competition have led countries and employers to adopt more flexible labour policies and work arrangements with no long-term commitment between employer and employee.

Dislocation of populations

Migration is now a major global preoccupation, although it represents nothing new. In today's globalising world, migration is marked by uneven human opportunities and uneven human impacts. Whilst global employment opportunities are opening for some, they are closing for most others. For high-skilled labour, the market is more integrated, but the market for unskilled labour is highly restricted by national barriers.

While most migrants have some choice over when and how to leave, millions of others become refugees—driven from their homes and countries by famine, drought, floods, war, civil conflict, mass persecution, environmental degradation or misguided development programmes.

Dislocation of populations through wars and economic crises prevents stable growth in the sending countries and leaves them dependent on uncertain remittances from migrants. In Lesotho, 60% of households send labourers to work in South African mines, leaving females to cope with managing families. People who leave are often the youngest and most enterprising—predominantly male—leaving communities with high proportions of elderly people, women and young children.

An alarming outbreak of *national conflicts* based on race, religion or ethnic identity has fed social tensions and conflicts—especially when there are extremes of inequality between the marginal and the powerful. Inequalities are reflected in incomes, political participation, economic assets and social conditions—education, housing and employment. Apart from killing or maiming millions of people, these wars weaken or destroy societies, devastate infrastructure and the environment, and bring

public services to a standstill—undoing decades of development.

Global crime

Crime is a growth industry that is likely to intensify as a result of globalisation. Modern means of transportation, advanced communications and relaxed border controls have created opportunities for transnational crime. Organised crime is now estimated to gross US$1.5 trillion a year. Illicit trade in drugs, women, weapons and laundered money is contributing to the violence and crime that threaten neighbourhoods around the world.

A high proportion of modern-day criminal activity is associated with narcotic drugs. *Illicit drugs* have a corrosive effect in both consuming and producing countries. Drug syndicates, gangs and smugglers use any means necessary to protect their trade—whether it be murder, or bribery and corruption—undermining institutions and social systems such as traditional agricultural communities. The illegal drug trade in 1995 was estimated at about 8% of world trade.

All these factors have a direct effect on families, but especially on women and children. Around the world one in every three women has experienced violence in an intimate relationships, and about 1.2 million women and girls under 18 are trafficked for prostitution each year. About 300 000 children were soldiers in the 1990s, and 6 million were injured in armed conflicts[4].

Families and women

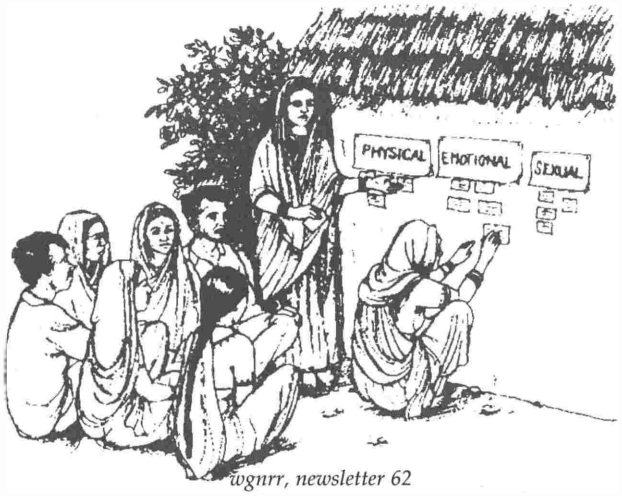
The weakening of families: The family has always offered the most basic form of security. When all else fails, people have assumed that they can rely on their family members for support. This has become especially important during the current era of economic restructuring that has seriously weakened the capacity of the state to provide for those in greatest need. Unfortunately, this is happening at a time when the family itself is coming under the greatest pressure it has known. In industrialised countries, around one third of marriages end in divorce, and 20% of children are born outside marriage. Many of the current social ills are blamed on the family—from high crime to teenage pregnancies, to drug taking.

One of the most widely discussed changes in the structure of the family is the rising proportion of *single-parent families*—generally women. Female-headed households are disadvantaged, not because women lacking a sense of responsibility towards their families, but rather because social and economic factors are stacked against them—women face discrimination in property, land, income and credit. Social and economic changes in recent years have made family life even harder for women. Many more women are working outside the home—in industrial countries women make up 40% of the official labour force. The economic crisis in many countries has increased women's workload in other ways. It has been found that women suffer more from cuts in public services—health cuts mean that women take care of sick relatives, and cuts in education mean that women spend more time supervising children, which UNRISD calls 'invisible adjustment'. Further, women spend more time growing their own food—and this has been transferred to their daughters at the expense of attending school.

A current problem, which is reaching unprecedented proportions, is the number of orphans as a result of the AIDS epidemic. Since the beginning of the epidemic there have been 13.2 million orphan in the world, most of them are in Sub-Saharan Africa. These children are taken care by their extended families or emerging institutions that have not only to ensure their survival but address the psychological, health and social needs. This increasing problem can only be expected to get worse in thefuture.

Children

The same pressures that have taken their toll of parents have also taken their toll of children. In the industrialised countries, the period 1950–1975 saw remarkable progress for children—whether measured by health, growth rates or education. These rates of progress are being brought to a halt. There is a steady rise in school drop-out rates, more cases of physical and sexual abuse, and rises in teenage violence and suicide. Children in developing countries come under even greater pressure. Whilst child survival rates have improved



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enormously over the last 30 years—infant and under-five mortality rates more than halved—those who survive live under greater stress.

In developing countries there are some 250 million child labourers –140 million are boys and 110 million girls[4]. Poverty and low wages are the underlying reasons for *child labour*: parents earn so little that their children have to work and employers are happy to take children as they will work for even lower wages. (children's wages may pay for their own schooling as well as keep the family together as a unit)

THE FUTURE

We face the challenge of setting up rules and institutions for stronger govern ance—local, national, regional and global—that put the health and well-being of each individual, community and nation at the centre. We need to create enough space for human, community and environmental resources to ensure that development works for people and not just for profit.

Globalisation expands the opportunities for unprecedented human advance for some, but shrinks those opportunities for others and erodes human security. It is integrating economies, culture and governance, but is fragmenting societies and ignoring the goals of equity, poverty eradication and human development.

Overcoming poverty must be seen as the main ethical and political challenge. Experience shows that the most appropriate programmes are long-term initiatives of a comprehensive/ multi-dimensional and multi-sectoral nature, aimed at breaking down the mechanisms that perpetuate poverty from one generation to another.

Development patterns need to be oriented to make ***equity***—that is, the reduction of social inequality—the central pillar. This should be the basic yardstick against which we measure development. ***Education*** and ***employment*** present two master keys for development. Education has an impact on equity, development and citizenship, and therefore needs to be assigned top priority in terms of social policy and public spending, especially important is education of girls. Latin American studies have indicated that 11–12 years of schooling (completed secondary education) are required if people are to have a chance of escaping poverty. At the same time, a high-quality job- creation process needs to be put in place.

Questions?

- What are the social factors that influence the health situation in your community or countries?
- Is violence a problem in your community?
- What is the status of Women and children?
- Is government responding to the people's needs?Why?

Notes

[1] UNDP. "United Nations Human Development Report". 1999. Geneva.

[2] United Nations Research Institute in Social Development. "States of disarray. The social effects of globalization". 1995. Geneva.

[3] Report Institutions Matter– World Bank Latin American and Caribbean studies 1998

[4] UNDP. "Human Development Report 2000. New York, USA.

3 the Medicalization of and the challenge of Health Care for all

by David Sanders

The Global Health Situation

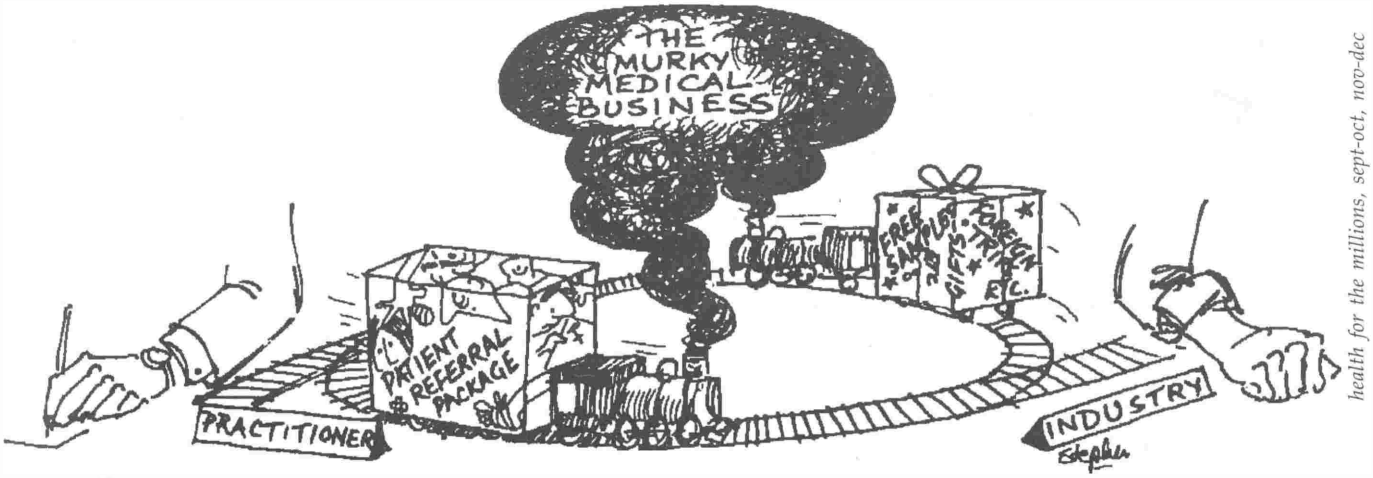
Over the past 50 years, considerable gains in health status have been made. Globally, life expectancy at birth has increased from 46 years in the 1950s to approximately 66 years in 1999 and the total number of young children dying has fallen to approximately 12.5 million instead of a projected 17.5 million. Substantial control of certain communicable diseases, notably poliomyelitis, diphtheria, measles, onchocerciasis (river blindness) and dracunculiasis (guinea worm) has been achieved through immunisation and specific disease-control programmes, and cardiovascular diseases have decreased in males in developed countries, partly because of a decline in smoking.

Despite these gains, there have been setbacks. In step with the widening disparities in socio-economic status, disparities in health have also increased between poor and rich countries and within both. Although child mortality and life expectancy have improved in aggregate terms, a breakdown of the numbers reveals that the gap in mortality rates between rich and poor countries has widened significantly for certain age groups: the relative probability of dying for under-five-year-olds in developing countries compared to European countries increased from a ratio of 3.4 in 1950 to 8.8 in 1990. Furthermore, in a number of sub-Saharan African (SSA) countries, infant mortality rates (IMR) actually increased in the 1980s under the impact of economic recession, structural adjustment, drought, wars and civil unrest and HIV/AIDS. In countries that did experience major health gains, health care interventions cannot be credited as the only or the main factor; these improvements could be mainly or at least partly due to a general improvement in living standards as a result of social and economic development.

It is recognised that health care services worldwide are often **inaccessible, unaffordable, inequitably distributed** and **inappropriate** in their emphasis and approach. Indeed, these problems have, in many situations, worsened over the past decade, with erosion of many of the gains of the 1970s and early 1980s.

While government expenditure on the health sector as a percentage of the GNP had increased in most countries by the early 1990s, the percentage devoted to local health services has been increasing in developed countries, been stagnant in developing countries, and has decreased in the least developed countries. This has resulted in the recent deterioration of services in the latter group.

health for the millions, sept-oct, nov-dec 1997



In the poorest 37 countries, public per capita spending on health was reduced by 50% in the 1980s. In some third world countries, cutbacks in spending on health and education have been even more drastic. For example, in 1991, Peru spent roughly US$12 per capita on health and education, one-fourth of what it had spent a decade before—and half the amount it was spending on debt payments to Western banks.

This situation has resulted from a number of related problems, which in turn have underlying causes ultimately rooted in a complex of political and economic factors (see background paper on "The Political Economy of the Assault on Health").

> ***The health care sector has not been given sufficient importance in national planning. Public services in general, and health services in particular, have become increasingly starved of national resources, resulting in deterioration and even collapse of these services at all levels.***

These problems are rooted in a complex of factors, which result from particular fiscal policies including inadequate financial allocations for capital and recurrent costs. This has led to a decline in the quality of health care facilities and shortages of equipment, drugs and transport. The deteriorating conditions of service have further resulted in a decrease in the performance of health personnel.

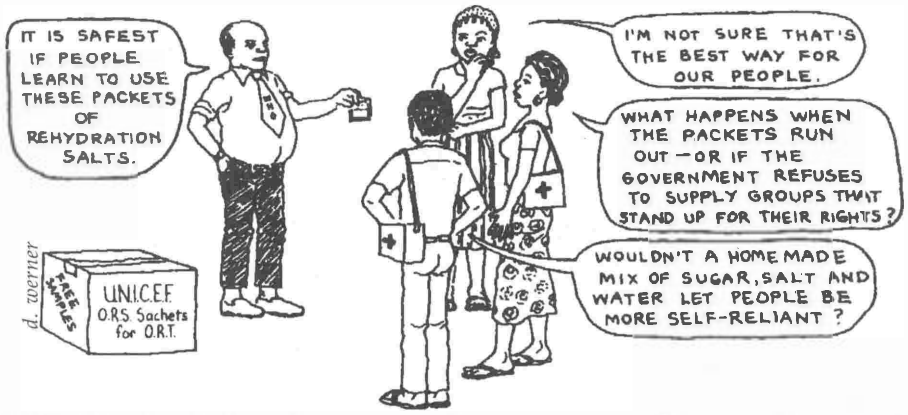
The underlying causes of these problems are both economic and political. Neoliberal economic policies, dominant internationally over the past decade or two, have reduced state funding of health and social services, and resulted in its increased privatisation. This decline in political commitment to social provisioning reflects, in many cases, reduced accountability of governments to their populations. The 1960s and 70s were a period characterised by optimism and popular mobilisation, reflected in Third World countries in a basic needs approach to social development of which the Comprehensive Primary Health Care (PHC) approach was part. This has been replaced by apathy and fragmentation of popular initiatives as a result of growing disillusionment with conservative and corrupt governments and the dismantling or absence of structures for genuine political participation.

> ***Health care services have become more inequitably distributed in relation to need.***

Historically, health services—both private and public—have been concentrated in urban centres and often in better-off areas: this has been summarised in the "Inverse Care Law", coined for Britain in the 1970s by Tudor Hart but shown to have universal application.

Health sector reforms, which are introducing radical management change into fragile district systems, often make the situation worse. In developing countries, reform strategies are being directed at inefficient use of scarce public funds on inappropriate and cost-ineffective services with poorly functioning systems; poor coverage by inadequately planned and managed services; and low quality services rendered by unmotivated, poorly trained staff in poorly equipped facilities.

Although its aims appear rational in their conception, the reform process has evolved at different rates and to different extents in different countries, and it is difficult to generalise about the success of its implementation. It appears that in many, especially developing, countries the rhetoric of implementation often masks the truth that fundamental change has not occurred. Policy-makers have tended to concentrate on 'quick fix' solutions rather than on the sustainable development of public health services and improvements in quality of care. There is all too often a major separation between policy formulation and implementation, with little focus on the realities of putting policies into practice, and an eagerness to shift and redefine policies frequently.



While decentralisation of management, a common feature of health sector reform, has the potential for being a mechanism to improve the efficiency and accountability of health services, it has often meant decentralisation of responsibility without real decentralisation of power or resources. It has, in effect, frequently become a mechanism for further withdrawal of central government from financial responsibility, and a means to decentralise conflict and criticism of services to an under-resourced and disempowered local level.

Alternative approaches to health financing, another common component of reform programmes, have also promoted privatisation, which instead of serving as an instrument for change has frequently become an end in itself. Growth in private health care has often resulted in: the shifting of costs to households by increasing cost sharing; in priority setting decisions about the choice of services (or packages of care) to be publicly funded; and in the creation of competing private insurance schemes and informal payment mechanisms. Because of differential ability to pay, all these new financing approaches undermine equity-oriented health policies. This suggests that privatisation is based on ideological commitment rather than sound evidence of its effectiveness.

These initiatives, together with the lack of human and other resources from an under funded public sector, have led to the rapid growth of private health care and have further aggravated inequity in the distribution of public services, leaving increasing numbers of poor people with little or no access to health care. For example, in Latin America there is an increased tendency to develop managed care organisations. This has become an important investment area for the main multinational insurance companies such as Aetna, Cigna, American International Group (AIG), International Medical Group (IMG), Prudential, International Managed Care Advisors (IMCA) and Blue Cross Blue Shield.

Health care is becoming increasingly inappropriate in its emphasis and organisation.

The definition and control of health care by medical professionals has resulted in its commodification—its configuration as a product, which can be sold or exchanged for profit. The commodity nature of health care has resulted in an overwhelming emphasis on the curative aspects and a stunting of the preventive and especially the promotive aspects, since the former are more likely to be purchased in the face of acute illness and the latter are perceived as less needed due to the less direct and less immediate impact on current health problems.

The dominance of the curative aspects has been reinforced by a number of factors. These include, most importantly, the health care industry, the education of health professionals and new and influential approaches to developing cost-effective health interventions.

Over the past decades, the health care industry—pharmaceutical, medical equipment, baby food—has developed dramatically and has significantly increased its influence. Many studies have shown that research investment into diseases dominant in developing countries is minuscule when compared to that allocated to health problems predominating in the industrialised world. Additionally, investment in researching and developing preventive interventions is dwarfed by that allocated to developing pharmaceuticals and cosmetics for middle class consumption.

The medical equipment industry has experienced massive expansion with the advent of computer technology. Although this has increased the efficacy of diagnosis and treatment of some conditions, it has also significantly raised the costs of medical care worldwide and has aggravated the predominance of (often inappropriate) curative approaches and of disparities in access.

The agreements of the World Trade Organization, especially those concerning Trade-related Intellectual Property Rights (TRIPS) threaten the economic sovereignty of poorer nations and are likely to undermine their already fragile food security situation, as well as their ability to undertake indigenous technological development, including in the area of essential pharmaceuticals.

Curative, biomedical approaches are still the focus of health professionals' education. Notwithstanding innovations in a number of educational institu-

tions internationally, most health sciences curricula have not integrated the principles of public health and PHC into their core subjects. PHC has often remained separated off as a small component of a marginalized public health course, rather than informing the whole curriculum. Attempts to educate health science teachers about PHC and its relevance and application to their own disciplines have been limited.

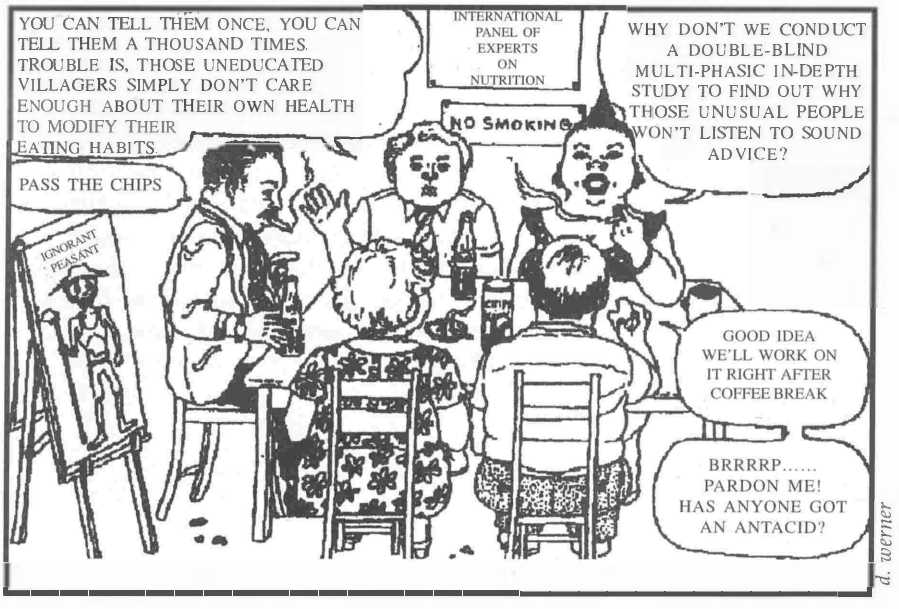
The tendency of the PHC approach to be restricted to, or focus overwhelmingly on, the medical technical interventions such as in the Child Survival Initiative that promoted UNICEF's GOBI package, has been reinforced recently by new methodologies designed to promote cost-effectiveness in health. Furthermore, the focus on cost-effective and efficient 'delivery' of 'health care packages' reinforces the excessively technical emphasis seen in selective PHC and to result in further neglect of the process of health development. In the economically conservative climate of the 1980s, GOBI, an acronym for growth monitoring, oral rehydration therapy, breastfeeding and immunisation, was adopted as a streamlined, cheaper, more feasible set of interventions in primary health care. While superficially a compelling idea, GOBI ended up being a way for governments and health workers to avoid tackling the social, economic and political causes of poor health. Health interventions remained resolutely within medical control where simple evidence-based results could be observed. There was little appreciation of the myriad roots through which a social intervention, as opposed to a strictly medical one, could improve health.

Similarly today, the development of the DALYs (disability adjusted life years) as an index to quantify the burden of disease, and to cost the effectiveness of certain interventions, inevitably results in a focus on selected medical technologies at the expense of broader social interventions. Hence, oral rehydration therapy for diarrhoea management is proposed as an essential component of a core health package while water and sanitation, which have an indirect and less easily quantifiable impact on diarrhoea, are deemed 'cost-ineffective' and therefore not recommended as an area for public sector investment. The DALYs approach, promoted by the World Bank and enthusiastically embraced by WHO, also has the effect of devaluing important aspects of health care, such as caring, which cannot be easily evaluated for their cost-effectiveness.

The institutional mechanisms to implement comprehensive PHC have been relatively neglected.

In addition to inadequate attention to the reform of health personnel education and its institutions, insufficient thought, resources and activity have been allocated to important aspects of PHC such as the development of intersectoral action and community involvement, and the incorporation of lessons learned from innovative experiences in a multitude of community-based health projects. It is also clear that the dominant technical approach described above inevitably results in medically driven, vertical and top-down initiatives, which discourage intersectoral collaboration and community involvement.

These vertical programmes may be effective in specific situations and in the short term, but are ultimately ineffective at providing steady and consistent care. For example, the Expanded Programme of Immunisation (EPI) launched in Togo, Senegal, Ivory Coast and Congo only sporadically increased the number of children vaccinated because the immunisations were not an integrated component of the health services. In contrast, significant reductions in infant and child mortality were achieved in Zimbabwe, Botswana and Cape Verde when immunisation and maternal and child health services became the responsibilities of the permanent health services.



This emphasis on medically-driven programmes is reflected in the internal organisational structure of many ministries of health and WHO itself: such arrangements reinforce the tendency towards vertical technical approaches and militate against implementation of comprehensive PHC.

Health care continues to be an instrument of social control.

Overtly unethical behaviour and human rights violations by health personnel are, unfortunately, not only a disgraceful part of health history, but persist, particularly in situations of war and political oppression. However, health care as an instrument of social control is much more subtle and widespread. Central to this is the mystification by the health professions of the real causes of illness, which is often attributed to ill-considered individual behaviour and natural misfortune, rather than to social injustice, economic inequality and oppressive political systems. Examples of such individualised and conservative approaches range from the promotion of family planning, in isolation from social development, as a means of population control, to oppressive forms of health education that neglect the social determinants of certain 'lifestyle' factors linked to ill-health.

d. werner

Guiding values and suggested action

The vision of the Peoples' Health Assembly is of an accessible, affordable, equitably distributed, appropriate and sustainable health system, based on the principles of comprehensive PHC and responsive to its users. Mechanisms for popular participation in the health system should ensure its accountability and also contribute to the movement for participatory democracy in society at large.

In order to achieve such a vision the following broad types of action are suggested:

Advocate at national and international levels for prioritisation of and investment in health.

There is accumulating evidence that investment in the social sectors has not only contributed to social development but has also often led to economic development. The 'Good Health at Low Cost' examples of Cuba, Sri Lanka, China, Costa Rica and Kerala State in India demonstrate that a commitment to broad-based, equitable development, with investment in women's education, health and welfare, has a significant and sustainable impact on the health and social indicators of the whole population. To realise the equity essential for a healthy society, evidence suggests that a strong, organised demand for government responsiveness and accountability to social needs is crucial. Recognition of this important challenge informed the Alma Ata call for stronger community participation. To achieve and sustain the political will to meet all people's basic needs, and to regulate the activities of the private sector, a process of participatory democracy—or at least a well-informed movement of civil society—is essential: analysts have noted that such political commitment was achieved in Costa Rica through a long history of egalitarian principles and democracy, in Kerala through agitation by disadvantaged political groups, and in Cuba and China through social revolution. 'Strong' community participation is important not only in securing greater government responsiveness to social needs, but also to mobilize an active, conscious and organised population critical to the design, implementation and sustainability of comprehensive health systems.

Good Health at Low Cost

Despite the dismal living conditions and health situation in many poor countries, a few poor states have succeeded in making impressive strides in improving their people's health. In 1985, the Rockefeller Foundation sponsored the 'Good Health at Low Cost' study to explore why certain poor countries with low national incomes managed to achieve acceptable health statistics. More specifically, they asked how China, the state of Kerala in India, Sri Lanka, and Costa Rica attained life expectancies of 65–70 years with GNPs per capita of only US$300–1,300.

Upon completing the study, the authors determined that the increased life expectancies were due to a reduction in child and infant mortality rates (IMR) in the four states and were accompanied by declines in malnutrition and, in some cases, in the incidence of disease. These remarkable improvements in health were attributed to four key factors:

- political and social commitment to equity (i.e. to meeting all people's basic needs);
- education for all, with an emphasis on the primary level;
- equitable distribution throughout the urban and rural populations of public health measures and primary health care;
- an assurance of adequate caloric intake at all levels of society in a manner that does not replace indigenous agricultural activity.

The importance of factor one, a strong political and social commitment to equity, cannot be overemphasised. While the course of action may vary, equitable access to health services necessitates breaking down the social and economic barriers that exist between disadvantaged subgroups and medical services.

Of the four regions investigated, China was the most exceptional in terms of equality. Whereas in the other three states, the decline in IMR was largely due to better social services (improved health care coverage, immunisation, water and sanitation, food subsidies and education), China's improvements were rooted in fairer distribution of land use and food production. The population was encouraged to become more self-sufficient, rather than to become dependent on government assistance.

While all four regions developed cooperative, community-oriented approaches to resolving problems and meeting basic needs, in the 15 years since the Rockefeller study, China has had the most success in maintaining its advances towards 'good health at low cost'.

Source: Werner, D. and Sanders, D. (1997) Questioning the Solution: The Politics of Primary Heath Care and Child Survival. Palo Alto: HealthWrights, p.115.

Concerted action should be taken to persuade individual governments to invest in health. WHO needs to be lobbied to assume a stronger advocacy role. It should take the lead in analysing and publicising the negative impact that globalisation and neoliberal policies are having on vulnerable groups. It should spearhead moves to limit health hazards aggravated by globalisation, including trade in dangerous substances such as tobacco and narcotics. It needs to strongly assert health as a Human Right and publicise and promote the benefits of equitable development and investment in health. The extent to which WHO and governments play such roles will depend on the extent to which popular mobilisation around health occurs. Communities have to be active and organised in demanding these changes.

Demystify the causes of ill-health and promote an understanding of its social determinants.

Since 'health' and 'medicine' have become virtually synonymous in the popular consciousness, it is important to communicate the evidence for the fact that ill-health results from unhealthy living and working conditions, from the failure of governments to provide health-promoting conditions through policies that ensure greater equity. It then becomes obvious that health problems are the result of structural factors and political choices and that their solution cannot lie in health care alone, but requires substantial economic reform as well as comprehensive and intersectoral health action. Mechanisms to disseminate this message, including the use of the mass media, must be identified and exploited.

Advocate and promote policies and projects that emphasise intersectoral action for health.

Government health ministries and international health agencies need to be pressed to engage as partners with the sectors, agencies and social groups critical to the achievement of better health. Policy development must be transparent and inclusive to secure broader understanding and wider ownership of health policies. Structures involving the different partners need to be created at different levels from local to national, or within such settings as schools and workplaces. The priority should be to focus on geographical areas with the greatest health needs and involve communities and their representatives at local level. Subgroups with responsibility for health, within local, provincial or national government (e.g. health committees of local government councils) should be promoted and should have links to the above structures. This has occurred in some of the Healthy Cities projects in both industrialised and developing countries. Currently the Brazilian law requires different groups to discuss the health policies to be promoted, and includes community and consumer participation.[1]

Intersectoral action to reduce traffic accidents

In the early 1970s, Denmark had the highest rate of child mortality from traffic accidents in Western Europe. A pilot study was started in Odense. Forty-five schools participated in an exercise carried out with accident specialists, planning officials, the police, hospitals and road authorities, to identify the specific road dangers that needed to be addressed. A network of traffic-free foot and cycle paths were created as well as a parallel policy of traffic speed reduction, road narrowing and traffic islands. Following the success of the pilot study, the Danish Safe Routes to Schools Programme has been implemented in 65 out of 185 proposed localities and the number of accidents has fallen by 85%. Accidents can, and must, be avoided. It is the responsibility of each one of us, but many initiatives can and should come from local authorities.

Source: Walking and Cycling in the City. WHO, 1998E, p. 64

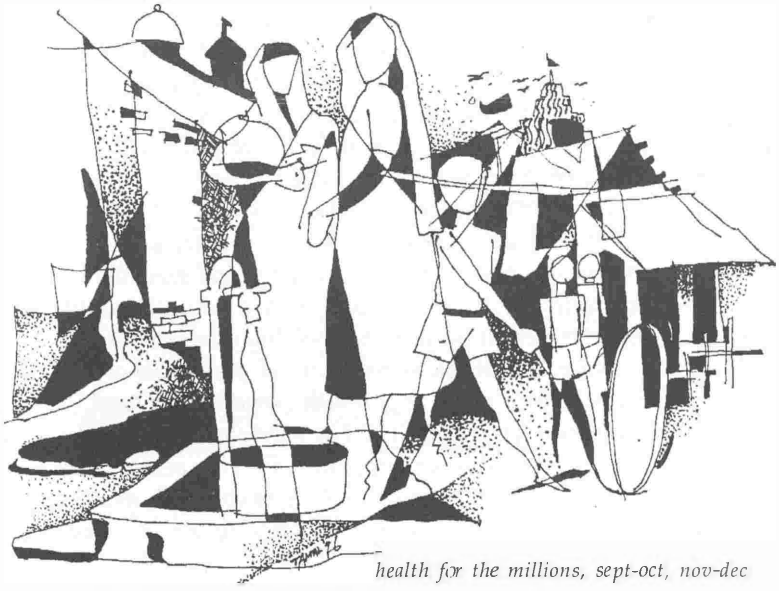
A process of engaging the public in a dialogue about public health problems and in setting goals for their control can both popularise health issues and become a rallying-point around which civil society can mobilise and demand accountability. It can also create the basis for popular involvement in implementation of health initiatives.

Actively develop comprehensive, community-based programmes.

Most programmes addressing priority health problems start from a health care or services perspective. While curative, personal preventive and caring actions are very important and still constitute the core of medical care, comprehensive PHC demands that they be accompanied by rehabilitative and promotive actions. In addressing priority health problems comprehensively, by defining and implementing promotive, preventive, curative and rehabilitative actions, a set of activities common to a number of health programmes will be developed as well as a horizontal infrastructure.

The principles of programme development apply equally to all types of health problems, from diarrhoea to heart attacks to domestic violence. After the priority health problems in a community have been identified, the first step in programme development is the conducting of a situation analysis. This should identify the prevalence and distribution of the problem, its causes, the potential resources to address them,, including community capacities and strengths that can be mobilised and actions that can be undertaken to address the problems. The more effective programmes have taken the above approach, involving health workers, other sectors' workers and the community in the three phases of programme development, namely, assessment of the nature and extent of the problems, analysis of their multi-level causation and priority actions to address the identified causes. Here, partnerships with NGOs with expertise in various aspects of community development are crucial.

Clearly, the specific combination of actions making up a comprehensive programme will vary from situation to situation. However, there are certain principles that should inform programme design, one of which is the deliberate linking of actions that address determinants operating at different levels. So, for example, in a nutrition programme any intervention around dietary inadequacy (immediate cause) should also address household food insecurity (underlying cause). Clearly the principle of linking curative or rehabilitative (feeding), preventive (nutrition education) and promotive actions (improved household food security) should be applied to health programmes other than nutrition, together with addressing basic causes in the political and economic realm.



health for the millions, sept-oct, nov-dec

A Comprehensive Approach to Under Nutrition in Zimbabwe: The Children's Supplementary Feeding Programme (CSFP)

The existing community-based popular infrastructure that had developed during the war permitted a more rapid and better-organised implementation of the nutrition programme than would otherwise have been possible. Mothers evaluated the children's nutritional status by measuring and recording their upper arm circumferences. Those with mid-upper-arm circumferences less than 13 cms were included in the programme. The reasons for this cut-off point were explained to all parents, both those of children admitted to the programme, as well as those considered not at risk. They then established locations for supplementary feeding (which the mothers preferred to be located close to their homes and fields), and themselves cooked the food and fed the underweight children.

The design of the programme was informed, on the one hand, by an understanding of the most important factors underlying rural child undernutrition in Zimbabwe and, on the other, by knowledge of rational dietary measures and identification of locally used and cultivable food sources (analysis). By deliberately selecting for use in the programme foods that were highly nutritious, traditionally used in weaning and commonly cultivated, and by reinforcing their value with a very specific message in the form of a widely distributed poster asserting the importance of groundnuts and beans in addition to the staple, it was possible to shift the focus of the intervention from supplementary feeding towards small-scale agricultural production programme. This was aimed at reinstating the cultivation of groundnuts— culturally a 'women's crop'—which had been largely displaced as a food crop in Zimbabwe by the commercialisation of maize. The provision by the local and the national government of communal land, agricultural inputs and extension assistance, together with the policy of collective production on these groundnut plots, contributed to improving poor households' food security. The joint involvement of ministries of health and agriculture in this project led to the development of intersectoral Food and Nutrition Committees at sub-district, district and provincial levels.

The programme design therefore allowed the linking of a rehabilitative measure (supplementary feeding) to preventive and promotive interventions (nutrition education and food production), thereby displaying the features of a comprehensive primary health care programme. This comprehensive approach to child undernutritiongreatly influenced the management of this problem within the health sector. It resulted in a changed approach of health staffto the dietary management of the sick child and to nutritional rehabilitation. It also created a community-level infrastructure of feeding points and food production plots/child care centres to which recuperating undernourished children could be sent. Thus the sequenced addressing of immediate (dietary) and underlying causes (household food insecurity, inadequate young child care and inaccessible health services) by the feeding,the communal plots and pre-school centres respectively, was made possible by both careful design based on a prior analysis and by the presence of a well-organised and motivated population. Intersectoral action and structures for nutrition and food security developed around the project, from the bottom-up. and were supported at higher levels of government.

health for the millions, sept-oct, nov-dec 1997

Source: Sanders in Werner, D & Sanders, D. (1997). Questioning the Solution: The Politics of Primary Health Care and Child Survival. Palo Alto: HealthWrights.

In other health programmes – such as the Safe Motherhood Initiative, the programme for Integrated Management of Childhood Illness and Tuberculosis management (DOTS)– as also in technical guidelines for the management of common non-communicable diseases, similar minimum or core service components can be identified. Standardising and replicating these core activities in health facilities is helpful in reinforcing their practice throughout the health system, but does not guarantee the implementation of a comprehensive PHC programme, which must involve other sectors as well as communities in promotive actions.

Promote the use and dissemination of appropriate health technologies

The use of appropriate health technologies can have a number of positive effects, which include spreading health care more widely and increasing its cost-effectiveness. One of the less obvious, but

very important effects of appropriate technology is in demystifying health care by giving lower-level health workers and, through them, community members better understanding, skills and effective technologies forhealth care. Thus the medical professions' monopoly of knowledge and expertise can be challenged. A good example is the use of homemade cereal gruels, which have been shown to be very effective in rehydration during diarrhoea.

Similarly, if certain appropriate health technologies become widely incorporated into standard health practice, their use can stimulate a critical approach to the expanding range of inappropriate, sophisticated and expensive technologies. A good example is that of pharmaceuticals. Encouragement of the use of a standardised, short list of inexpensive drugs (essential drugs lists) known by their own name (generics), not a trade name, can reduce bad prescribing practices and begin to undermine the operations of the pharmaceutical industry. Evidence that such an initiative has succeeded in challenging the forces that historically have dominated health care has been the extent of the opposition by the pharmaceutical industry to WHO's essential drugs programme.

Increasing the visibility and role of community-based health workers.

In the early years of the PHC movement an important and effective role was played by community health workers (CHWs) in the implementation of PHC. One of the strongest features of CHWs is that they are predominantly women who can often identify and gain access to those households and individuals with the greatest health needs. Indeed, many of the 'model' PHC initiatives relied extensively on CHWs for their successful operation. Further, the role of CHWs was seen not merely as a technical one of extending basic health care to peripheral communities and households: it was also, importantly, frequently an advocacy and social mobilising role, enlisting the conscious involvement of communities and other sectors in health development.

The conservative economic and political environment of the late 1980s and 1990s has contributed to the demise of many CHWs programmes: policy-makers seldom advocate the retention of this cadre, and communities are economically unable to support them.

Given the very positive past experiences of CHW programmes in diverse situations, and the increasing need for community-based workers given the international health crisis, aggravated in many countries by the HIV pandemic, it is urgent that the progressive health movement advocate and campaign for the reintroduction of this cadre and look for innovative ways to care for their communities.

Advocate for equity in health and health care.

Equity is core to the policy of Health for All. Socio-economic inequalities are growing everywhere, at a more rapid rate than ever before. Together with reductions in public health and social services in many countries, this is leading to growing inequities in health. To advocate equity in health and health care more successfully amongst international organisations, governments, donors and professional organisations, we have to demonstrate the social differentials in access to health resources and in health outcomes. The progressive health movement needs to press for the monitoring of equity in health through advocacy and information dissemination.

Promote more appropriate health personnel education and better management.

The primary health care approach needs much more strongly to inform the content of health sciences curricula as well as the learning process and choice of venues for learning. The aim is to equip learners with competencies spanning a broader range than has traditionally been the case. There is accumulating evidence that problem-oriented and practice-based approaches result in more relevant learning, and in the acquisition of problem-solving skills, both necessary attributes for the successful development of the PHC approach. If health workers are to contribute to a health system that enables people to assume more responsibility for their own health through an emphasis on preventive and promotive measures

Table: Key indicators for monitoring equity in health and health care

Indicator categories	Indicators measuring differences between population groups
Health determinants indicators	Prevalence and level of poverty Income distrivution Educational levels Adequate sanitation and safe water coverage
Health status indicators	Under 5-year child mortality rate Prevalence of child stunting [Recommended additional indicators: maternal mortality ratio; life expectancy at birth; incidence/prevalence of relevant infectious diseases; infant mortality rate and 1–4 year old mortality rate expressed separately]
Health care resource allocation indicators	Per capita distribution of *qualified* personnel in selected categories Per capita distribution of service facilities at primary, secondary, tertiary and quaternary levels Per capita distribution of total health expenditures on personnel and supplies, as well as facilities
Health care utilisation indicators	Immunisation coverage Antenatal care coverage % of births attended by a qualified attendant Current use of contraception, percentage

Source: World Health Organization (1998). Final report of meeting on policy-orientated monitoring of equity in health and health care. 29 September–3 October 1997. Geneva: WHO, page ii.

integrated with curative and rehabilitative measures, then their training must expose them to good practice at district level and to the social issues at community level. There is also an urgent need for teaching staff in the health sciences to upgrade their skills to carry out such a reorientation of the curricula.

The above suggestions for education reform apply equally to all categories of health personnel, as well as to undergraduate and post-graduate training. It has long been acknowledged that nurses play a pivotal role in the PHC team; in addition, they constitute the largest category of health personnel in many countries. Endorsement of such educational reforms and their fuller implementation and promotion by the nursing leadership within individual countries is critically important for progress towards Health for All.

In most countries, health education institutions have not carried out curriculum reform along the lines described above. Although there are indications that some have embarked or will embark on such a course, there will probably still be a significant delay before sufficient 'new' graduates are available to work in and transform the health system. Clearly, if the implementation of comprehensive PHC is to be achieved during the next decades, the process of curriculum reform in the educational institutions needs to be accelerated and accompanied by a massive programme of capacity development of personnel already working in the health system. In short, the current Health for All imperative demands the rapid expansion of continuing education activities in most countries. Some of this in-service learning should take place in multi-disciplinary teams to promote better teamwork.

Similarly, education in PHC needs to involve personnel from other health-related sectors as well as community members: capacity development for these constituencies has generally been neglected and has weakened the growth of both community participation and intersectoral involvement in health development.

Health personnel management also needs to be greatly strengthened through the development of incentives, appropriate regulations and improved support and supervision. The technocratisation of health care that has been a feature of the past decade has resulted in increasing inequities in service provision and reduced accountability of service providers. The progressive health movement needs to lobby strongly for greater investment in human resources for health, since people are the key to more appropriate and accountable health services.

CONCLUSIONS

- Itis clear that progress towards Health for All has been uneven and is increasingly compromised. Gains already achieved are under threat from a complex and accelerating process of globalisation and neoliberal economic policies, which are negatively impacting on the livelihoods and health of an increasing percentage of the world's population and the large majority in developing countries. Although the global PHC initiative has been successful in disseminating a number of effective technologies and programmes, which have reduced substantially the impact of certain (mostly infectious) diseases, its intersectoral focus and social mobilising roles – which are the keys to its sustainability – have been neglected, not only in the discourse but also in implementation.
- Government health ministries need to be pressed to enter into partnerships with other sectors, agencies and communities to develop intersectoral policies that address the determinants of inequities and ill-health. The policy-development process needs to be inclusive, dynamic, transparent and supported by legislation and financial commitments.
- The time is long overdue for more forcefully translating policies into actions. The main actions should centre around the development of well-managed and comprehensive programmes involving communities, the health sector and other sectors. The process needs to be structured in well-managed district systems, which need to be considerably strengthened, particularly to effectively reach the household, community and primary levels. Here, PCH centres and their personnel have to focus onthe reinstatement of community health worker schemes.
- The successful implementation of decentralised health systems will require targeted investment in infrastructure, personnel, management and information systems. A key primary step is a new capacity development of district personnel through training on the job practice and health systems research. Such human resources development must be practice-based, problem and community oriented and come after we reorient, educational institutions and professional bodies.
- Clearly, the implementation and sustenance of comprehensive PHC requires inputs and skills that demand resources, expertise and experience not sufficiently present in the health sector in many countries. Here partnerships with NGOs and their expertise in various aspects of community development is crucial. The engagement of communities in health development needs to be pursued with much more commitment and focus. The identification of well-functioning organs of people's organisations , whether or not they are presently active in the health sector, needs to be urgently pursued to make the necessary alliances that can multiply our efforts.
- In promoting the above move from policy to action, WHO needs to be pressed to play a much bolder role in: advocating equity and legislation needed for its achievement; pointing out the dangers of globalisation poses to health; stressing the importance of partnerships between the health sector and other sectors; integrating its own internal structures and activities to ensure that comprehensive PHC programmes are developed; entering into partnerships with and influencing other multilateral and bilateral agencies and donors, as well as NGOs and professional bodies, towards a common Alma Ata rooted vision of PHC; and advocating for major needed investments in health, especially in human resource development, without which Health for All will remain a mere statement of intent.

Suggested reading list

Sanders, D. (1985). The Struggle for Health. Hampshire, UK: Macmilliian Education.

Sanders, D. (2000) 'Primary Health Care 21 - Everybody's Business' in Primary Health Care 21 - Everybody's Business: An international meeting to celebrate 20 years after Alma Ata. Geneva: WHO.

Werner, D. and Sanders, D. (1997) Questioning the Solution: The Politics of Primary Heath Care and Child Survival. Palo Alto: HealthWrights, p.115.

World Bank (1994) Better Health in Africa: Experience and Lessons Learned. Washington DC: World Bank.

4 the Environmental crisis threats to HEALTH and ways forward

by Niclas Hallstrom

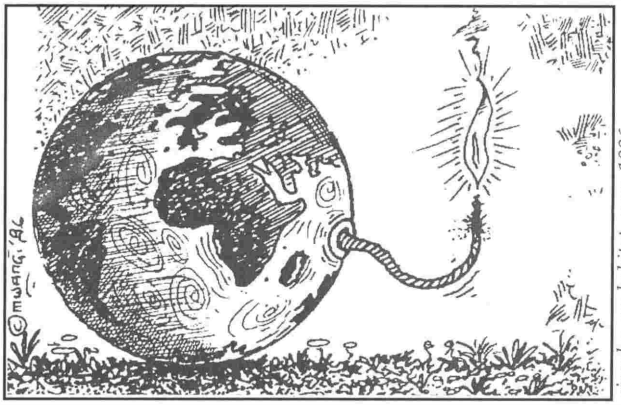
INTRODUCTION

The world is currently facing an unprec edented health and environmental crisis. Despite progress in both the health and the environment fields, the situation is approaching the brink of global disaster. So extensive and far-reaching are the problems that the future well-being of humanity, together with that of many other life forms on the planet, is in jeopardy. On one level, individuals and communities—especially those who are poorest, most marginalised and suffering the most discrimination—are facing the direct consequences of *local* environmental destruction, which often result from exploitative business practices and destructive development projects. Those who are worst-off pay with their health for the destruction of their local environment.

On another level, people all over the world are beginning to be affected by *regional* and *global* environmental changes. These drastic environmental problems, e.g. the changing climate and the depletion of the ozone layer, are mainly the result of unsustainable lifestyles, overconsumption and unhealthy patterns of development. Also these environmental problems are likely to hit the poor and marginalised first—and with the most drastic consequences—but will sooner or later also affect the privileged. Unless curbed (through wide-ranging, structural changes) these global environmental trends threaten to cause havoc to whole ecosystems and essential life-supporting systems. This may in turn lead to an immense, unprecedented crisis for the whole of humanity.

It is thus of utmost relevance for everyone involved in the People's Health Assembly to understand the links and interconnections between health, the environment as well as underlying factors such as social, political and economic structures which determine the current patterns of development. Ultimately, the health and environment crisis relates to issues of social justice.

Analysing health in an ecological and environmental framework calls for a broad, intersectoral, holistic understanding of health. It shows how



circular on habitat, may 1996

many of the pressing health and environmental problems of today share the same root causes and the same barriers to being effectively tackled and solved. It encourages a long-term perspective on health and its future challenges. And it provides, through the experiences of the environmental movement, exciting examples of how people—or 'civil society'—can successfully influence current thinking and policies.

To achieve environmentally sustainable societies will require drastic changes in the current world order and the formulation of alternative ways of thinking. Within the environmental movement there is a huge wealth of ideas, experience and visions of what an alternative—just, environmentally sustainable and people-oriented—society would look like. The health movement can draw on this experience while, on the other hand, influencing the environmental movement to incorporate human health into their analyses and actions. A closer integration of the health and environmental movements is essential to counter the present environmentally destructive and exploitative course of development. In order to solve the current crisis, *both* humans and the environment must be taken into full account.

the ENVIRONMENT and **health**

Evolution and characteristics of environmental problems

The destruction of the environment has always been part of the human story. Throughout time, environmental problems have been some of the most important factors affecting people's health, both on the individual and the community level. Floods, plagues and the environmental consequences of war have continuously led to ill health and premature death.*

However, as the scale of human societies has steadily increased and technology has developed ever faster, the pressure on the environment has likewise increased enormously. Fuelled, by a runaway global economic system—which has created both unprecedented affluence (overconsumption) and enormous levels of poverty—environmental deterioration now threaten to increase inequalities and cause irreversible harm to ecosystems on a *global* scale.

While many environmental problems remain *immediate*, local problems whose causes may be relatively easy to understand and for which solutions can be identified (although not necessarily easy to implement), many others are incredibly complex and difficult to handle. These involve much uncertainty, affect whole continents or even the whole earth, and are the combined result of millions or billions of people's behaviours. They are often deeply embedded in societal structures maintained by powerful interests. Even worse, many of the current problems cause *irreversible* damage, so we cannot afford to make certain mistakes even once! Moreover, there may be a considerable time lag between the harmful action and the visible effects.

The history of the environment is partly a story of unpredictable, unexpected problems. Often, environmental abuses are absorbed until a threshold is crossed and a catastrophe results. At this stage it may be too late, or more costly, to reverse the damage. There is no reason to believe that the future does not have new unpleasant surprises in store

Environmental threats to health

Degradation of the environment threatens health both directly and indirectly; and both immediately and in the long term.

The environmental problems we most easily observe are those with ***immediate*** and ***direct*** effects. People—and mostly the poorest and the marginalised—get sick from drinking polluted water, eat contaminated food, suffer from exposure to polluted air and poisonous chemicals, and spend much of their time in harmful working conditions.

People's health suffers in ***immediate*** and ***indirect*** ways from, for example, food shortages caused by the environmental degradation of both farmland and forests. Environmental refugees—people who have been forced to leave their homes because of the destruction of their local environment—often suffer severe hardships and are prone to ill health. Many people are also being killed or maimed in wars fought over scarce natural resources. Accidents resulting from environmentally induced natural disasters, such as floods caused by the destruction of forests, are another example of the immediate and indirect effects of environmental degradation.

Many environmental threats to health have ***direct, long-term (delayed)*** effects about which awareness may be slow to develop For example, cancer is increasing rapidly in all areas of the world, largely as a result of exposure to pesticides, carcinogenic chemical substances included in the goods we consume, and increased exposure to various forms of radiation. These threats concern every person on the planet, although we might not even know what is making us sick and where it is coming from. Toxic substances accumulate in our bodies and are mixed in new and potentially lethal ways. Ill health may result several decades after exposure.

Yet, the possible ***indirect*** effects of environmental change in the ***long term*** may pose some of the most alarming threats to human health. The disturbance of the world's climate due to enhanced global warming is already underway, and may cause severe damage to health. Droughts and floods could kill millions of people and introduce

* Indeed, since the beginning of agriculture many human societies seem to have perished as a result of overwhelming environmental problems caused by over-use and pollution of natural resources. For example, 4,000 years ago the early civilisation of Mesopotamia may have collapsed because people over-irrigated their fields (making the soil excessively salty), while 1,000 years ago the Mayan civilisation may have perished due to deforestation and soil erosion.[1]

new epidemics. New scarcity of valuable resources might increase tensions and lead to drastic increases in wars and violent conflicts. Perhaps worst of all, whole regions may lose much of their capacity to grow food. Furthermore, global environmental change ultimately threatens to destabilise our social and economic systems, which in turn play important roles for people's health—through society's ability to provide employment, a healthy social environment and appropriate health services.

Some food for thought

Natural history tells us that 99% of all the species ever to have evolved on earth are now extinct. What guarantees that *homo sapiens* will be one of those few evolutionary successful species that survives? Are we in fact rushing to ensure we join the other 99%? And if so, what can we do to turn the tide?

Table 1: Possible health effects of environmental degradation

			Type (direct, indirect) and timing (early, late) of adverse health effects			
Root/underlying Causes	**Env'l change**	**Manifestation**	**Direct, early**	**Direct, late**	**Indirect, early**	**Indirect, late**
Exploitation of people and nature; egoistic behaviour and self-interest Underlying views on nature, progress and development Growth-centred development Over-consumption/ Affluence Failure of neo-classical economic theory to account for true environmental costs Corporate concentration/ Profit maximisation Impaired long-term vision Scale; no direct feedback between cause and effect	*Enhanced greenhouse effect*	Global warming and other climatic change	Heatwave-related illness and death		Extension of vector-borne infections	Altered viability of (edible) fish in warmed oceans
		Sea-level rise	Natural disasters: cyclones, floods, landslides, fires		Food shortages due to impaired agriculture	
			Increased risk of flash floods and surges	Inundation→ social disorder, impaired sanitation, farmland loss	Consequences of damage to foreshore facilities, roads etc.	Destruction of wetlands→ decline in fish stocks
	Stratospheric ozone depletion	Increased UV-B flux at Earth's surface	Sunburn, conjunctivitis Suppression of immune system→ increased risk of infection	Skin cancer Ocular effects: cataracts, pterygium		Impaired growth of food crops and of marine micro-organisms base of aquatic food web)
	Acid aerosols (from burning of sulphurous fossil fuels)	Acid rain	respiratory system		Aquatic damage (reduced fish) Impaired growth of crops	Impaired forest growth → reduced ecosystem productivity
	Land degradation: intensive agriculture, overgrazing	Erosion, sterility, nutrient loss, salinity, desertification	Decline in agricultural productivity	Rural sector depression → migration to fringes of cities (see bottom row)	Exposure to pesticides and fertilisers (may also cause algal blooms)	Consequences of silting up of dams and rivers
		Depletion of underground aquifers	Lack of water for drinking and hygiene	Decline in agricultural productivity		
	Loss of biodiversity	Destruction of habitat	Deforestation → disruption of local culture	Loss of potentially edible species		Deforestation → greenhouse enhancement
		Loss of genetic diversity; weakening of ecosystems			Loss of medicinals, and other health-supporting materials	Greater vulnerability of crops and livestock. Reduced vitality of ecosystems
	Effects of poverty and crowded living conditions	Crowded urban slums	Infections Malnutrition Homelessness Antisocial behaviours	Social disorder Chronic toxic effects of environmental pollutants		Consequences of overload of local ecosystems

Table adapted from the table "Possible adverse effects upon human health caused by global environmental changes" in McMichael, A.J. 1993. Planetary Overload: Global Environmental Change and the Health of the Human Species. Cambridge: Cambridge University Press (p. 4-5).

Root causes of the Environment and health crisis

Like so many other aspects of the health crisis, many of the root causes behind environment and health problems can be traced to the current dominant development model, the global economic system, and the grave injustices associated with these.* Several factors can be identified.

View of development and progress

The notion of 'progress' underlies much of what has became mainstream Western development thinking, which dominates views among the elites as well as many ordinary people around the world. The idea of progress, which emerged in the 18th century in Europe during the Enlightenment, introduced the view that history was a staircase of constant improvements and increasingly advanced stages. Not surprisingly, Europe placed its own culture at the top, and the European experience came to be seen as the norm which all other—'backward'—societies would eventually follow. The uniqueness of each culture was ignored.

The Enlightenment also drastically altered the existing views on nature and the relationship between human beings and nature. The metaphor of nature as a mechanical, clockwork construction, which could be fully understood by dividing it into minuscule pieces, and the view of nature (except humans) as inert, and existing only to be exploited maximally by humans, gained acceptance and legitimised 300 years of large-scale extraction and abuse of the environment.

It is from this tradition that the mainstream understanding of 'development' and 'globalisation' stems: the view of a universal, linear, predetermined pattern of societal change where different societies all take part in the same race towards industrialisation and ever-increasing wealth. And it is from this very same tradition that today's dominant economic theories emerge.

Outdated economic thinking

Unfortunately, all dominant economic theories fail to take into account the environmental concerns and long-term sustainability of society. The established economic theories—which guide decision-makers from all over the world and from most kinds of ideological backgrounds—regard the economic system in isolation from ecosystems. As ecological services are not owned, their degradation and abuse are not accounted for and consequently neither show up in GDP nor function as disincentives to continued exploitation. In fact, environmental destruction usually *improves* the look of the national accounts, since all economic activity (destructive, as well as constructive) add to the gross domestic product while none of the reduced carrying capacity of the ecosystem is taken into account. Thus, the economic activity following both the Bhopal gas accident and the Chernobyl nuclear disaster improved the national accounting in India and the USSR respectively, although considerable real natural wealth and human lives were destroyed. The dominant economic theory has explicitly encouraged excessive extraction, consumption and waste—all in the exalted cause of expanding the. The failure of mainstream economics to consider environmental constraints is clearly one of the most serious causes of the present environment and health crisis.

Excessive focus on economic growth

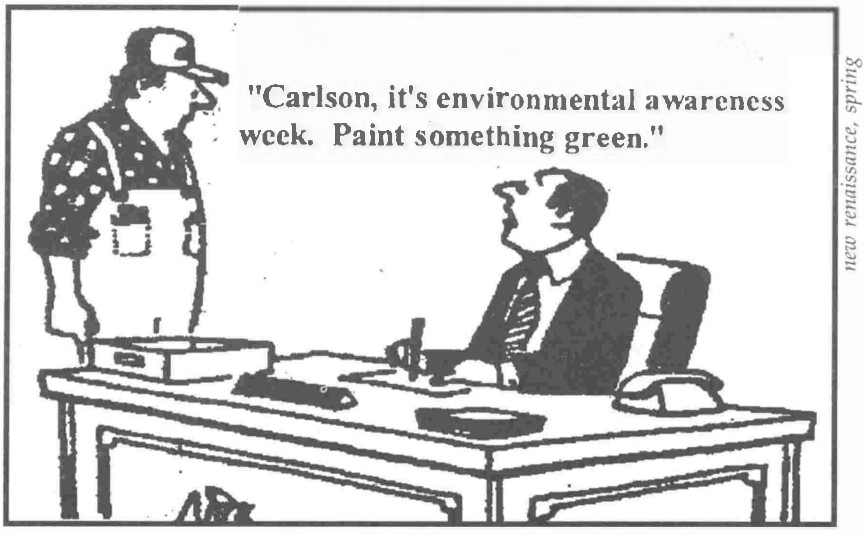
Built into the established economic theories is a supposition that unending economic growth is both possible and desirable. In fact, growth and increasing consumption are two of the main objectives of capitalism. Yet, from an environmental perspective, this excessive focus on economic growth is both undesirable and unrealistic, especially in the rich, industrialised countries. It is impossible for the world economy to grow its way out of poverty and environmental degradation. Instead, wealth must be redistributed and the world's economic systems be kept at a sustainable level. Exponential growth is impossible in the long run.

Rather than hoping for everlasting economic growth—which will unavoidably lead to increasing burdens on the earth's already strained ecosys-

david werner

* (This is also discussed in the PHA analytical background paper "The Political Economy of the Assault on Health")

tems—there is a need to find the optimal scale of the economy and then develop sustainable economies. Such economies would not be static or stagnant: 'An economy in sustainable development adapts and improves in knowledge, organisation, technical efficiency, and wisdom; and it does this without assimilating or accreting, beyond some point, an ever greater percentage of the matter-energy of the ecosystem itself....'[2] Yet, in the short and medium term, environmentalists agree on the need for economic growth in the South. Few people would dispute the need for economic growth and industrial development in the economically poorer countries. However, unless these processes are based on environmental regeneration rather than continued environmental degradation, they will not be sustainable and will undermine the South's populations' conditions of survival. The eradication of both poverty and excessive affluence needs to be put firmly on the long-term agenda of humanity.



From a policy point of view, such economic thinking are totally absent from current decision-making. The power of growth-centred economic thinking is pervasive, and it is not difficult to understand why. Reliance on growth means many unpleasant decisions can be avoided. Dividing a growing pie is easier than redistributing what there already is. And the notion of growth is deeply ingrained in concepts such as progress and development. Yet, to come to grips with the environment and health crisis one needs the courage to question established truths, which may in the end turn out to be 'lies'. The excessive focus on economic growth is likely to be just that.

Neoliberalism and trade—as if the market could solve everything

Since the early 1980s, neoliberalism has become the dominant economic policy of our time. In countries of the North and the South, governments are aggressively pursuing the neoliberal prescription of letting the market solve all problems while reducing the role of the state to a minimum. The same ideology is firmly rooted in the world's most powerful intergovernmental economic institutions: the World Bank, the International Monetary Fund (IMF) and the World Trade Organization (WTO). As a result, privatisation and the promotion of free trade have been aggressively pursued on both regional and global scales. In the early 1990s the North American Free Trade Agreement (NAFTA) was signed, despite massive protests, and in 1995 the WTO eventually came into existence—with more powerful mandates than any other international organisation. These institutions are making efforts to open every country's market to the rest of the world. In 1998, a Multilateral Agreement on Investments (MAI) was on the verge of being instituted, which would in essence have granted foreign companies the right to 'sue' a government for denying them the right to outcompete local firms. Altogether, these policies have had direct negative consequences on people's health, which is further discussed in several other PHA analytical background papers ('for example, 'The Political Economy of the Assault on Health' and 'Health and the Health sector').

Neoliberal policies have also had serious negative consequences for the environment. Poverty, leading to overuse of marginal lands, malnutrition and ill health; the selling of land and natural resources; privatising of the common resources; reluctance to regulate large corporations; pursuit of free trade in opening up new markets; the emergence of free-trade zones with weakening worker safety and lax environmental regulations: all these stem (at least in part) from neoliberal policies and impact negatively on the environment and on people's health.

Case study or story

Do you have an example that illustrates any of the points made above? For example, do you have stories to tell about the environmental effects on health in the 'Special Economic Zones'?

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opportunities—those already in powerful positions—thereby perpetuating unjust and environmentally inappropriate practices. International organisations such as the WTO, the World Bank and the IMF are all consolidating power. Ideals and societal norms emphasising policies and conduct for the common good have suddenly been dismissed as naïve and unrealistic dreams and are quickly being placed on the ideological waste dump. People are feeling more and more alienated and increasingly mistrust their political systems. These disturbing transformations are further analysed in other PHA background papers on the political economy of health, and social action for health.

Globalisation: Corporate concentration and lack of participation

The growth-oriented, neoliberal economic system is concentrating power in the hands of a minority and weakening participation in decision-making by the majority. Over the last few decades, inequalities have increased tremendously, with the richest 20% income group now having 74 times the income of the poorest 20%.[3] Transnational corporations (TNCs) are taking advantage of the liberalised global economy by establishing themselves in new markets and consolidating their positions through giant mergers, which are now happening at a frantic pace. The value of mergers between TNCs exploded from USD 0.9 trillion in 1996 to USD 3.4 trillion in 1999.[4] In 1974, the annual value of US acquisitions was less then USD 12 billion, which rose to USD 330 billion in 1988, and in 1999 exceeded USD 1,7 trillion.[5]

In short, the already powerful are becoming more powerful. Through their activities on a global scale, countries are forced to compete with each other by offering the most favourable business conditions—often in the form of weak environmental standards and policies that keep wages low and hamper workers' ability to organise. Thus, as governments are gradually handing over much of their power to the market, it is becoming increasingly difficult to regulate against environmentally destructive behaviour, both at the national and international level. National policies that discriminate against environmentally harmful products or production processes may be challenged as constituting trade barriers.

In the name of 'free markets' and 'efficiency', economic orthodoxy is rapidly opening up the global economy for those with the best ability to take advantage of new

Case study or story

Are you familiar with any story that illustrates how globalisation and corporate concentration affect the environment and the health situation in your community or country? Please submit these to the PHA process!

Scale

Environmental destruction is not new. However, never before has it taken place on such a large scale, at such a rate and with such disastrous consequences as today. Why is this? Coupled with the underlying economic factors discussed earlier, the sheer size of human society may play an important role. Today, almost all societies are interconnected, and it has become increasingly easy to get away with activities in one place that cause harm at some other, distant place.

In today's globalised society, the consequences of most of our actions are hidden. We cannot directly see—or choose not to see—the Costa Rican farmer who is suffering from cancer after having sprayed the bananas we eat with pesticides. We are not exposed to the radioactive rivers and the deformed children born in communities where uranium is mined for the nuclear-powered electricity we use in our homes. In fact, the norms and ethics of conducting business and economics are based on the acceptance that costs and suffering passed onto others are fine as long as they are not visible. In a world economy driven by stock markets and international trade, the distance between those who benefit and those who suffer from the costs is steadily increasing. This is the true face of globalisation.

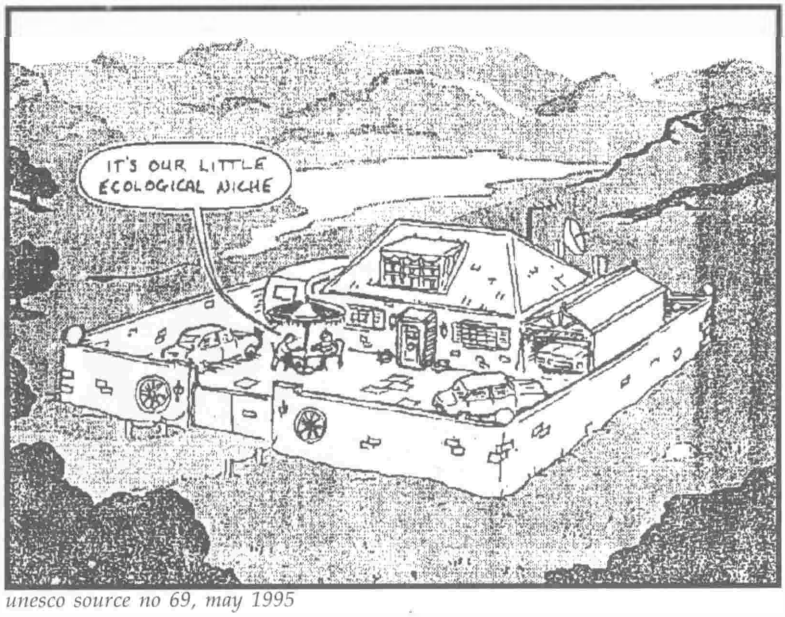
Poverty, over-consumption, the environment and population

The relation between consumption, poverty, environmental destruction and population has long been one of the most controversial issues in the environmental debate. Some environmentalists argue that the growing population of the world (especially in the South) is a root cause to the global environmental destruction and one of the most serious threats. They say that the world is rapidly reaching the maximum number of people that it can feed. Every additional person will mean increased environmental destruction and overuse of natural resources. They see the Third World population growth as a ticking bomb, and argue that it must be curbed by drastic means.

Although it is true that there is a limit to how many people the earth can sustain, the above reasoning has some fundamental flaws.

First, looking at the number of people without also taking into account each person's consumption gives the wrong message. In fact, overconsmption and affluence in the rich world and among the world's elites is a more serious problem than the number of children that poor people have. Currently the richer fifth of the world consumes four fifths of the world's resources and is responsible for the majority of the pollution and waste. On average, a child born in the United States will be a 50-100 times larger burden to the Earth's ecosystems than a child born in the Third World. Therefore, population should be as much of a Northern concern as a Southern concern. With their current lifestyles, most of the Northern countries are already 'over-populated'.

Second, concentrating on numbers is to focus too much on symptoms of much larger, underlying problems. Those worried about the rapidly growing human population have too often seen 'technical' approaches such as family planning and coercive population control measures as solutions. Yet, it is clear that the most important factors behind the reduction of population growth are the improvement of social conditions, women's status, education and reproductive rights, and overall equity in society. Availability of contraceptives is just a necessary condition, but far from the solution. Even if one focuses on numbers, the best way to reduce population growth is to fight for social justice.



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The Way Forward

In order to successfully move towards lasting solutions to the health and environment crisis, we need to be aware of future challenges, the conceptual barriers that need to be overcome and various forms of social action for change.

Future challenges

New technologies: possibilities and threats

Consideration of the environmental problems we have experienced to date shows clearly that many of them stem from the introduction of new technologies. These were initially thought to be harmless and then, at a later stage, when their use had become widespread, they were found to be destructive. DDT was initially seen as a miracle chemical; the emission of CO_2 from cars was not regarded as a problem at first; and no one thought that cadmium used in batteries would eventually show up in the blood of all living beings.

What, then, are the emerging and potential environmental and health hazards from which we may suffer in the future? What new technologies are under development? What trends needs to be scrutinised now in order to anticipate and preempt future problems? These are important questions for PHA activists to consider.

In the field of genetics and biotechnology, development of new methods and technologies is taking place so rapidly that there is very little chance to scrutinise it all carefully. Despite the many promises claimed by its proponents, there are a number of biotechnology applications that

may have direct negative effects on people's health. Some molecular biologists point out, for example, that very little is known about 'gene ecology', the spontaneous interaction between genes within a manipulated organism or what the effect on humans may be of eating genetically manipulated food.[6] As long as there is so much uncertainty surrounding the technology there should be very tight restrictions on its application outside the laboratory. Likewise, much controversy surrounds the introduction of genetically modified plants in farmers' fields. Critics fear that the genetically modified organisms may interfere with the natural populations and at worst cause considerable ecological disruption or even epidemics. Several countries are also using genetic engineering to develop new forms of weapons that could have disastrous consequences for both people and nature. For example, in at least a dozen countries there is research on the use of biological weapons targeted for certain ethnic groups of a population.[7]

However, it is important for health activists to also look beyond biotechnology. Today, several new technologies with potentially huge implications on health and the environment are under development. Nano-technology and its merging with micro-electronics and genetic engineering, the development of micro-robots and the field of 'psycho-engineering' all present serious concerns from both a health and environment point of view. Discussions on both the threats and possibilities of these technologies must urgently be brought into the public debate.

The introduction of new technologies in unjust societies always benefits those in power and shifts the harmful effects onto those with little influence or power. One of the foremost challenges for the future is thus to handle better the development and introduction of new inventions. Mechanisms are needed to stimulate the development of relevant, environmentally and socially appropriate technologies. Procedures and regulations must be put in place within universities as well as in the private sector to prevent the development of destructive technologies.

Implementing the precautionary principle

One useful principle to guide the way forward is the 'precautionary principle'. This principle calls for prudence and restraint in cases of uncertainty, to ensure that even the suspicion of a technology or policy having potentially negative consequences leads to caution, and shifts the burden of proof to those in favour of the technology. A strict application of this principle would be likely to mean slower decision-making in society.

Environmental Impact Assessments (EIAs) constitute one precautionary method that has been widely used by both public and private actors around the world. In many countries, an EIA must be conducted before any major project can be considered. Health activists can build on these experiences and develop methods for prior assessment that would also include social justice and health concerns.

Overcoming short-sightedness and developing distance vision

Environmental changes are often slow when measured against the course of an individual human lifetime. These changes, therefore, do not evoke strong, immediate reactions, although they may be as much a survival issue as any other immediate dangers that we encounter and instinctively try to escape from. Biological evolution has programmed us, like all other species, to react most strongly to current, immediate problems rather than to possible future threats.

Local environmental destruction, therefore, is often much easier to detect and connect with one's own health and well-being than are distant global problems. People working at or living close to waste-dumps, polluting factories, highways and pesticide-sprayed fields are often acutely aware of how their health is affected and understand the causes and effects. It is also in these situations that people react most forcefully. The struggle for a cleaner environment and improved health become an immediate struggle for survival, with the power to mobilise people to take action, demonstrate, engage in civil disobedience and form grassroots activist organisations.

The challenge now is to strengthen these local struggles while also evoking a similar strong sense of urgency and seriousness when it comes to long-term, global environmental change. Here, it is much more difficult to see the direct causes and

new internationalist

effects, and it may be more difficult to identify who benefits in the short run and who pays the price in the long run. Often, present beneficiaries may also suffer in the long term. In short, it requires a *qualitatively* different type of understanding to see why and how long-term ecosystem disruption will endanger health and our very survival. Although the international panel of climate researchers have unanimously concluded that global emissions of greenhouse gases must be curbed to a fraction of current levels within a few decades in order to avoid a catastrophic climate changes, the world's governments are still negotiating on the margin, agreeing on a few per cent reductions for the coming decades. The powers-that-be seem to believe that the life-supporting capacity of the natural systems is open to negotiation: that it will somehow be possible to get away with abusing the Earth—or perhaps that it is simply not worth giving up some of the short-term individual benefits for the sake of the long-term survival of future generations and the planet itself. This tendency is both shortsighted and cynical, and must be countered by networks of people who take responsibility also for the future.

As governments and business have not yet shown that they can abandon short-term agendas, most of the hope falls on people's movements and civil society organisations (CSOs) being able to take the lead.

Introducing alternative indicators of progress

Most societies are today preoccupied with monetary indicators. Countries struggle to obtain growth in Gross Domestic Product (GDP), but often ignore whether it was acheived through heavy environmental or social costs. People measure suceess and personal status according to salary levels. And decisions are based on Cost-Benefit Analyses where all pros and cons are translated into money value to estimate whether a certain project is favorable or not. Environmentalists are increasingly rebelling against this way of looking at the world. Instead, alternative indicators of progress must be developed and introduced in policy-making. Several interesting concepts are currently being discussed and tested.

Community indicators of environmental and social progress are being developed at several locations around the world. Through broad-based participation, a community can agree on certain non-monetary goals (e.g. being able to eat the fish in the local river; decreasing poverty by X%; achieving improved child survival by Y% etc.) that are then continuously monitored and given as much importance as ordinary economic reports.

In many countries, goods and products are now **labled** if they meet certain environmental criteria. Consumers are thus presented a clear choice and can prioritise (if they can afford it) food that has been grown without pesticides, energy-efficient machines and products without toxic chemicals. In most cases, these environmental labeling systems were initiated by civil society organisations or volutary associations of producers, without the involvement of government. In some countries, the labeling has recently been expanded to also take into account the working conditions of those producing the goods. Such 'social justice' labeling could expanded to also explicitly include health concerns.

The concept of **equitable environmental space** has been developed as a method for estimating a morally acceptable level of consumption and pollution. A maximally accepable level of resource use and pollution is estimated for the whole earth, and these figures are then divided by the number of people on the planet (with some adaptations for specific local/regional factors). The result is a set of indicators that shows that most Northern countries need drastically to reduce consumption,

while there is room for the poorest countries to grow and increase their consumption levels significantly. The average industrialised country needs to reduce its natural resource use and pollution levels to a tenth of current levels. This **'Factor ten'** reduction can be achieved without negatively affecting the quality of life. Through careful planning, altered lifestyles and improved efficiency, most of the required reduction can easily be achieved.

Private corporations are also introducing alternative indicators. Several **environmental management systems** now exist internationally. These require companies to set environmenal goals and systems for monitoring, training and follow-up activities. Many corporations are also producing annual environmental reports as a complement to their annual financial reports. Yet, human rights, health and social justice concerns are seldom taken into account. Health activists could lobby for the expansion of these practices to incorporate these additional concerns.

Reshaping the economy and development as if people and the planet mattered—the need for a new vision

The environment and health crisis cries out for new, alternative visions of development. People everywhere share 'gut feelings' that some things are fundamentally wrong; that the wrong priorities are being set and that their well-being is slowly being undermined. The articulation of visions that put both ordinary people and the environment at the centre are needed and will provide meaning and help to mobilise actions for change.

The formulation of such alternative development visions is taking place among people's organisations and movements in all continents. Despite their diversity, many common threads stand out: the need to increase public participation and counter corporate concentration of power; the need to re-create healthy communities; the necessity to reshape the global economic system so that it is based on a recognition of environmental constraints and equity; the call for a closer and more spiritual relationship with nature; and the attraction of collective solutions and responsibilities while maintaining considerable individual freedom. Some of the alternative visions are the result of new ideas, while there is also a huge wealth of experiences and models to learn from traditional societies.

There is a growing sense of unity and empowerment among people around the world involved in health and environmental activism. Through the People's Health Assembly, the struggle towards a just and ecologically sustainable society will be taken yet another step forward.

Movements for change

Throughout human history, structural changes in society have started with the convictions and dedicated struggles of a minority. Today, there are tremendous opportunities for widespread, co-ordinated action. Groups and networks that are eagerly hoping to link up with a larger, global movement can be found all over the world. Although the opposing interests are enormously powerful, it must not be forgotten that people's power, when well organised, is often more influential than anyone could dream of. It is this, in essence, that the People's Health Assembly is all about.

In the PHA analytical background paper "Communication as if people mattered" the strategies used by the world's ruling classes to keep the majority of humanity disempowered and complacent, and the methods and resources whereby enough people can become sufficiently aware and empowered collectively to transform our current unfair social order, are thoroughly examined. These discussions are not repeated here in any detail; instead some points with particular environmental relevance are mentioned.

Learning from the environmental movement

What can PHA affiliated organisations and networks learn from the environmental movement? Maybe a great deal. Over the last few decades environmentally oriented networks and CSOs have grown considerably in both number and influence. Their organising and political skills are becoming ever more sophisticated and they are rapidly learning how to organise effective global networks. In recent years, for example, many environmental CSOs have begun to use the internet in sophisticated ways—both as an effective campaigning tool and as a way to coordinate work, share information, and form and maintain networks.

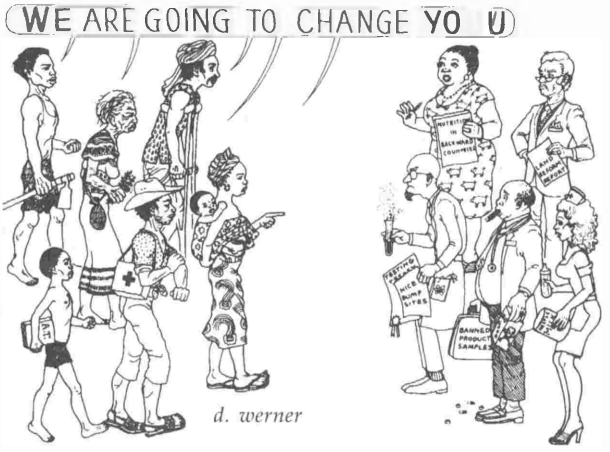
In certain fora, environmental CSOs have been particularly influencial as lobbyists at the international level. In the area of genetic resources and biodiversity, as just one example, CSOs such as the Rural Advancement Foundation International (RAFI) have succeeded in significantly influencing the international negotiations on the Convention on Biological Diversity and in UN Food and Agriculture Organisation (FAO) fora. Maybe there is scope for the progressive health movement to develop its capacity and resources to participate more forcefully in the various fora of international policy-making. This is one pracical aim of the People's Health Assembly.

Another strength of the environmental movement is its huge diversity. Within the movement there is room for service-providing, 'watchdog' activities, campaigning and think-tank/research-oriented CSOs. The more effectively these organisations are able to draw on each other's strengths and experiences, the more influential they will become.

The environmental justice movement

Traditionally, those who are most prosperous have also been those who are most effective in preventing hazardous and other dangerous operations from taking place in their neighbourhoods. Through this 'not-in-my-backyard' mentality they have passed the problem on to disempowered and marginalised communities. However, increasingly around the world, people who have ended up with the most hazardous and polluting industries in their backyards are protesting and mobilising. Thousands of grassroots movements claiming 'environmental justice' have emerged around the world. They forcefully cry out against the unacceptable fact that their children, family members and friends get sick and even die from environmental hazards. Interestingly, women often tend to take leadership in these struggles, perhaps reflecting that the very survival of their families is at stake.

In many areas, those grassroots environmental movements that are also oriented towards social justice are also beginning to form alliances and networks, thereby bringing the struggle to the next level and conscientising their members on the underlying, root causes of their problems. In South Africa, for example, the Environmental Justice Networking Forum, formed in the early 1990s, now has more than 400 member groups and organisations. Through such networks, the struggle can be directed towards the goal of 'not-in-anyone's-backyard', thus shifting attention to the deeper, more long-term problems of our societies' power structures, lifestyles and injustices.



Environment and health—a common struggle

After all, the health and the environmental movements are both part of the common, overriding struggle for a just, healthy and sustainable society. It is surprising, however, how little interaction there seems to be between activists of the environmental movements and health activists. One explanation for this may be that many mainstream environmental organisations are concerned almost exclusively with nature conservation and have not traditionally seen issues of social justice and people's well-being as part of their agenda.

The environmental movements need therefore to place their environmental struggles much more clearly within an overall context of health and social justice for all. This would also be strategically wise as people are usually deeply concerned with their own and their families' health. It is to be hoped that environmentalists will increasingly regard the struggles for health as an integral part of their own struggles. Likewise, as this paper argues, the struggle for health must also join with the struggle against environmental destruction and social injustice.

Notes

[1] McMichael, A.J. 1993. *Planetary Overload: Global Environmental Change and the Health of the Human Species.* Cambridge: Cambridge University Press. (p. 85-6).

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[3] *Human Development Report*, UNDP 1999.

[4] Coorigan, Tracy. 'Cross-border M&A deals at record levels". *Financial Times*, April 5, 1999. (p.16)

[5] Mooney, Pat. 'The ETC Century'. *Development Dialogue.* Forthcoming.

[6] Ho, Mae-Wan et al. 1998. 'Gene Technology and Gene Ecology of Infectious Diseases'. Commissioned by the *Third World Network*, Penang, Malaysia and *The Ecologist*, UK.

[7] Mooney, Pat. 'The ETC Century'. *Development Dialogue.* Forthcoming.

Appendix 1: Actions for change

What are your suggestions, demands and visions for the future? What should governments, corporations, civil society activists, the media and ordinary people do to overcome environmental and health problems? How can your visions be transformed into reality?

Below you will find a first and very tentative list of points that relate specifically to the issues brought up in this paper around which spcific actions are planned. Please discuss them with your friends and colleagues and then add to the list. Your own and everybody else's suggestions will be taken into account in the preparations for a *People's Charter for Health.*

- Lobby for the implementation of the *precautionary principl.* This principle has been endorsed by most countries and calls for restraint in cases of uncertainty. Even the suspicion of a technology or a policy having potentially negative consequences should motivate restraint and shift the burden of proof to those in favour of it.
- Mechanisms should be developed and implemented to choose relevant, and environmentally and socially appropriate, *technologies*, while rejecting destructive ones.
- *Economic theory* has to be redefined to recognise social and environmental constraints.
- 'Tax shifts' should be introduced to increase the tax on the 'bads' (energy consumption, waste disposal etc) while decreasing the tax on labour and means that combat unemployment.
- Accounting practices that take into account both environmental and human well-being should be developed—both for national accounting purposes, companies and public institutions. *Environmental management systems* should be implemented and expanded to include health and social justice concerns.
- Consumer products should be labelled so that consumers can choose to buy products that are environmentally and socially responsible.
- Overconsumption and affluent lifestyles must be curbed—both in the North and the South. Industrial countries in the North must aim on average for a tenfold reduction ('Factor Ten') of their consumption and pollution levels.

A 'People's Chamber' of the United Nations and a 'World Sustainable Development Organisation' should be established. The latter institution should have the power to challenge, for example, the World Trade Organization (WTO) when environmental and social values are being threatened by a shortsighted, trade-oriented agenda.

Appendix 2: Examples of issues to discuss

- What are the important environmental problems that affect you locally. Are you affected, directly, or indirectly, by global environmental problems?
- In what ways do these problems affect people's health?
- What are the causes of these health and environmental problems?
- What health and environmental groups could you link up with?
- Do you have any stories from your area that illustrate what has been discussed in this paper, as well as other aspects of the environment and health crisis?
- Can you identify 'new' or emerging threats to the environment and health in your area? What are possible future threats?
- How can environment and health activists work more closely together?

5 communication as if PEOPLE mattered

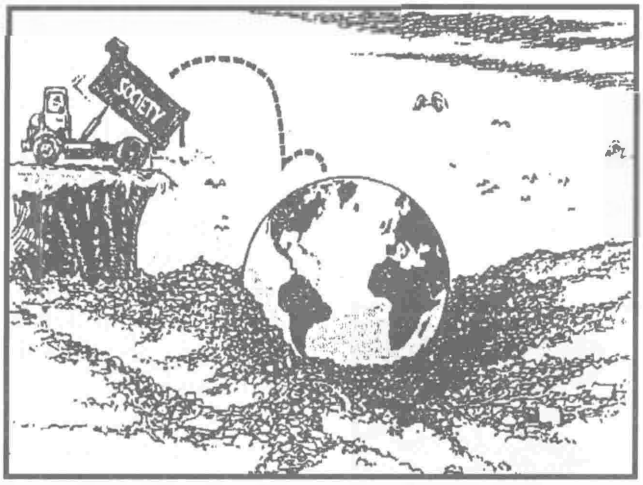
adapting health promotion and social action to the global imbalances of the 21st century

by David Werner

DEMOCRACY as a prerequisite for a HEALTHY SOCIETY

Why participation is essential – and how it is undermined

The well-being of an individual or community depends on many factors, local to global. Above all, it depends on **the opportunity of all people to participate as equals in the decisions that determine their well-being**. Unfortunately, history shows us that equality in collective decision-making—that is to say **participatory democracy—is** hard to achieve and sustain. Despite the spawning of so-called 'democratic governments' in recent decades, most people still have little voice in the policies and decisions that shape their lives. Increasingly, the rules governing the fate of the Earth and its inhabitants are made by a powerful minority who dictates the Global Economy. Thus **economic growth (for the wealthy) has become the yardstick of social progress, or 'development,' regardless of the human and environmental costs**.



And the costs are horrendous! The top-down 'globalisation' of policies and trade—through which the select few profit enormously at the expense of the many—is creating a widening gap in wealth, health and quality of life, both between countries and within them. A complex of worldwide crises—social, economic, ecological and ethical—is contributing to ill-health and early death for millions. Increasingly, giant banks and corporations rule the world, putting the future well-being and even survival of humanity at risk. Driven more by hunger for private profit than for public good—the massive production of consumer goods far exceeds the basic needs of a healthy and sustainable society. Indeed, its unregulated growth compromises ecological balances and imperils the capacity of the planet for renewal.

Yet in a world where unlimited production and resultant waste have become a major health hazard, there are more hungry children than ever before. According to Worldwatch's *The State of the World, 1999*, **the majority of humanity is now malnourished**, half from eating too little and half from eating too much!

Mahatma Gandhi wisely observed: 'There is enough for everyone's need but not for everyone's greed.' Sadly, **greed has replaced need as the driver of our global spaceship**. Despite all the spiritual guidelines, social philosophies, and declarations of human rights that *Homo sapiens* (the species that calls itself wise) has evolved through the ages, the profiteering ethos of the market system has side-tracked our ideals of compassion and social justice. Humanity is running a dangerous course of increasing imbalance. To further fill the coffers of the rich, our neoliberal social agenda systematically neglects the basic needs of the disadvantaged and is rapidly despoiling the planet's ecosystems, which sustain the intricate web of life.

The dangers—although played down by the mass media—are colossal and well documented. Forward-looking ecologists, biologist, and sociologists sound the warning that our current unjust, un-

healthy model of economic development is both humanly and environmentally unsustainable.

'Yes, we know that,' say many of us who believe in Health for All and a sustainable future. 'We are deeply worried.... But what can we do?'

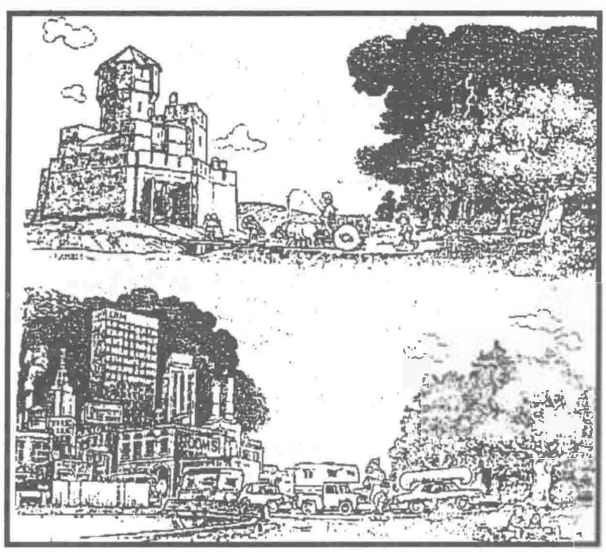
There are no easy answers. The forces shaping global events are gigantic, and those who accept them as inevitable so impervious to rational dissent, that many of us hide our heads in the sand like ostriches. And so humanity thunders headlong down the path of systemic breakdown—more polarisation of society, more environmental deterioration, more neglect of human rights and needs, more social unrest and violence—as if our leaders were incapable of thought and our populations anaesthetised.

What action can we take, then—individually and collectively—to change things for the better, for the common good?

The purpose of this background paper

The interrelated crises of our times—the ways that globalisation, corporate rule, and top-down, 'development' policies undermine democratic process and endanger world health—are discussed in other background papers for the People's Health Assembly. The purposes of this paper are:

1. to examine the strategies used by the world's ruling class to keep the majority of humanity disempowered and complacent in the face of the crushing inequalities and hazards it engenders;
2. to explore the methods and resources whereby enough people can become sufficiently aware and empowered to collectively transform our current unfair social order into one that is more equitable, compassionate, health-promoting, and sustainable.



TOP-DOWN MEASURES of SOCIAL CONTROL

Disinformation

With all the technology and sophisticated means of communication now available, how is it that so many people appear so unaware that powerful interest groups are undermining democracy, concentrating power and wealth, and exploiting both people and the environment in ways that put the well-being and even survival of humanity at stake? How can a small elite minority so successfully manipulate global politics to its own advantage, and so callously ignore the enormous human and environmental costs? How can the engineers of the global economy so effectively dismiss the emerging risk of unprecedented social and ecological disaster?

In short, what are the weapons used by the ruling class to achieve compliance, submission, and social control of their captive population?

True, riot squads have been increased, prison populations expanded, and military troops deployed to quell civil disobedience. But far more than tear-gas and rubber bullets, **disinformation has become the modern means of social control**. Thanks to the systematic filtering of news by the mass media, many 'educated' people have little knowledge of the injustices done to disadvantaged people in the name of economic growth, or of the resultant perils facing humanity. They are unconscious of the fact that the overarching problems affecting their well-being—growing unemployment, reduced public services, environmental degradation, renewed diseases of poverty, bigger budgets for weapons than for health care or schools, more tax dollars spent to subsidize wealthy corporations than to assist hungry children, rising rates of crime, violence, substance abuse, homelessness, more suicides among teenagers—are rooted in the undemocratic concentration of wealth and power. Despite their personal hardships, unpaid bills, and falling wages, ordinary citizens are schooled to rejoice in the 'successful economy' (and spend more). They pledge allegiance to their masters' flag, praise God for living in a 'free world,' and fail to see (or to admit) the extent to which the world's oligarchy (ruling minority) is undermining democracy and endangering our common future. And our textbooks and TVs keep us strategically misinformed.

One dollar, one vote: private investment in public elections

One way 'government by the people' is undermined is through the purchase of public elections by the highest bidders. In many so-called democracies a growing number of citizens (in some countries, the majority) don't even bother to vote. They say it makes no difference. Politicians, once elected, pay little heed to the people's wishes. The reason is that wealthy interest groups have such a powerful political lobby. Their big campaign donations (bribes?) help politicians win votes—in exchange for political favours. The bigger the bribe, the more campaign propaganda on TV and mass media. Hence more votes.

This institution of legal bribery makes it hard for honest candidates (who put human need before corporate greed) to get elected. Democratic elections are based on one person, one vote. With the deep pockets of big business corrupting elections, results are based on one dollar, one vote. This makes a mockery of the democratic process.

The erosion of participatory democracy by the corporate lobby has far-reaching human and environmental costs. Hence the biggest problems facing humanity today—poverty, growing inequality, and the unsustainable plundering of the planet's ecosystems—continue unresolved.

Sufficient wisdom, scientific knowledge and resources exist to overcome poverty, inequity, hunger, global warming and the other crises facing our planet today. But those with the necessary wisdom and compassion seldom govern. They rarely get elected because they refuse to sell their souls to the company store. Winners of elections tend to be wheelers and dealers who place short-term gains before the long-term well-being of all.

To correct this unhealthy situation, laws need to be passed that stop lobbying by corporations and wealthy interest groups. In some countries, citizens' organisations are working hard to pass such campaign reforms. But it is hard to get them past legislators who pad their pockets with corporate donations. Only when enough citizens become fully aware of the issues at stake and demand a public vote to outlaw large campaign donations, will it be possible for them to elect officials who place the common good before the interests of powerful minorities.

But creating such public awareness is an uphill struggle—precisely because of the power of the corporate lobby and the deceptive messages of the mass media. To make headway with campaign

reforms, institutionalised disinformation must be exposed for what it is. To accomplish this, more honest and empowering forms of education and information sharing are needed.

Schooling for conformity, not change

It has been said that **education is power**. That is why, in societies with a wide gap between the haves and have-nots, **too much education can be dangerous**. Therefore, in such societies, schooling provides less education than indoctrination, training in obedience, and cultivation of conformity. **In general, the more stratified the society, the more authoritarian the schools.**

Government schools tend to teach history and civics in ways that glorify the wars and tyrannies of those in power, whitewash institutionalised transgressions, justify unfair laws, and protect the property and possessions of the ruling class. Such history is taught as gospel. And woe be to the conscientious teacher who shares with students 'people's history' of their corner of the earth.

Conventional schooling is a vehicle of disinformation and social control. It dictates the same top-down interpretations of history and current events, as do the mass media. It whitewashes official crimes and aggression. Its purpose is to instill conformity and compliance, what Noam Chomsky calls 'manufacturing consent.'

For example, although the United States has a long history of land-grabbing, neocolonial aggression and covert warfare against governments committed to equity, most US citizens take pride in their 'benevolent, peace-loving nation'. Many believe they live in a democracy 'for the people and by the people, with liberty and justice for all'—even though millions of children in the US go hungry, countless poor folks lack health care, prison populations expand (mainly with destitute blacks), and welfare cut-backs leave multitudes jobless, homeless and destitute.

the NEED for BOTTOM-UP approaches to communication

To see through the institutionalised disinformation, and to mobilise people in the quest for a healthier, more equitable society, we need alternative methods of education and information-sharing that are honest, participatory, and empowering. This includes learning environments that bring people together as equals to critically analyse their reality, plan a strategy for change, and take effective united action.

Fostering empowering learning methods is urgent in today's shrinking world, where people's quality of life, even in remote communities, is increasingly dictated by global policies beyond their control.

Alternative media and other means of people-to-people communication

There have been a number of important initiatives in the field of alternative media, communication, and social action for change.

The alternative press. While struggling to stay alive in recent years, the alternative press (magazines, flyers, bulletins, newsletters, progressive comic books) has provided a more honest, people-centred perspective on local, national and global events. Some of the more widely-circulating alternative magazines in English (often with translations into several other languages) include:

The New Internationalist
Z Magazine
Resurgence
The Nation
Third World Resurgence
Covert Action Quarterly
Multinational Monitor

Also, there are many newsletters and periodicals published by different watchdog groups such as the International Forum on Globalization, IBFAN, BankWatch, the National Defense Monitor and Health Action International, among others. It is important that we subscribe to and read (and encourage others to read) these progressive alternative writings.

Alternative community radio and TV. The role and potential of these is similar to that of the alternative press. Stations that do not accept advertising are less likely to belong to or sell out to the controlling elite. But to survive they need listener support.

Internet. Electronic mail and websites have opened up a whole new sphere of rapid, direct communication across borders and frontiers. The Web is, of course, a two-edged sword. The Internet is currently available to less than 2% of the world's people, mostly the more privileged. And instant electronic communications facilitate the global transactions and control linkages of the ruling class. But at the same time, E-mail and the World-Wide-Web provide a powerful tool for popular organisations and activists around the globe to communicate directly, to rally for a common cause and to organise international solidarity for action.

The potential of such international action was first demonstrated by the monumental worldwide outcry, through which non-government organisations (NGOs) and grassroots organisations halted the passage of the Multilateral Agreement on Investment (MAI). (The MAI was to have been a secret treaty among industrialised countries, giving even more power and control over Third World Nations.) The primary vehicle of communication for the protest against MAI was through the Internet.

Mass gatherings for organised resistance against globalised abuse of power. The turn of the Century was also a turning point in terms of people's united resistance against global trade policies harmful to people and the planet. The huge, well-orchestrated protest of the World Trade Organization (WTO) summit meeting in Seattle, Washington (now celebrated worldwide as the 'Battle in Seattle') was indeed a breakthrough. It showed us that **when enough socially committed people from diverse fields unite around a common concern, they can have an impact on global policy making.**

The agenda of the WTO summit in Seattle was to further impose its pro-business, anti-people and anti-environment trade policies. That agenda was derailed by one of the largest, most diverse, international protests in human history. Hundreds of groups and tens of thousands of people representing NGOs, environmental organisations, human rights groups, labour unions, women's organisations, and many others joined to protest and barricade the WTO assembly. Activists arrived from at least 60 countries. The presence of so-many grassroots protesters gave courage to many of the representatives of Third World countries to oppose the WTO proposals which would further favor affluent countries and corporations at the expense of the less privileged. In the end, the assembly fell apart, in part from internal

disaccord. No additional policies were agreed upon.

Perhaps the most important outcome of the Battle in Seattle was that, despite efforts by the mass media to denigrate and dismiss the protest, key issues facing the world's people were for once given center stage. It was a watershed event in terms of grassroots mobilisation for change. But the activists present agreed that it was just a beginning.

The People s Health Assembly, with its proposed 'People's Charter for Health' and plans for follow-up action, holds promise of being another significant step forward in the struggle for a healthier, more equitable approach to trade, social development, and participatory democracy. For that promise to be realised, people and groups from a wide diversity of concerns and sectors must become actively involved around our common concern: the health and well-being of all people and of the planet we live on.

EDUCATION *for* PARTICIPATION, EMPOWERMENT, *and* ACTION *for* change

The term 'Popular Education,' or 'Learner-centered education,' refers to participatory learning that enables people to take collective action for change. Many community-based health initiatives have made use of these enabling methodologies, adapting them to the local circumstances and customs. Particularly in Latin America, methods of popular education have been strongly influenced by the writings and awareness-raising 'praxis' of Paulo Freire (whose best known book is *Pedagogy of the Oppressed.*)

Education of the oppressed— the methodology of Paulo Freire

In the mid-1960s the Brazilian educator, Paulo Freire developed what he called **education for liberation**, an approach to adult literacy training, (which proved so revolutionary that Freire was jailed and then exiled by the military junta.) With his methods, non-literate workers and peasants learned to read and write in record time—because their learning focused on what concerned them most: the problems, hopes and frustrations in their lives. Together they critically examined these concerns, which were expressed in key words and provocative pictures. The process involved identification and analysis of their most oppressive problems, reflection on the causes of these, and (when feasible) taking action to 'change their world'.

Learning as a two-way or many-way process

With Freire's methodology, problem-solving becomes an open-ended, collective process. Questions are asked to which no one, including the facilitator have ready answers. 'The teacher is learner and the learners, teachers.' Everyone is equal and all learn from each other. The contrast with the typical classroom learning is striking. **In typical schooling**, the teacher is a superior being who 'knows it all'. He is the owner and provider of knowledge. He passes down his knowledge into the heads of his unquestioning and receptive pupils, as if they were empty pots. (Freire calls this the 'banking' approach to learning because knowledge is simply deposited.)

In education for change, the facilitator is one of the learning group, an equal. She helps participants analyse and build on their own experiences and observations. She respects their lives and ideas, and encourages them to respect and value one another's. She helps them reflect on their shared problems and the causes of these, to gain confidence in their own abilities and achievements, and to discuss their common concerns critically and constructively, in a way that may lead to personal or collective action. Thus, according to Freire, the learners discover their ability to 'change their world'. (For this reason Freire calls this a 'liberating' approach to learning).

The key difference between 'typical schooling' and 'education for change' is that **the one pushes ideas into the student's heads, while the other draws ideas from them**. Typical schooling trains students to conform, comply, and accept the voice of authority without question. Its objective is to maintain and enforce the status quo. It is disempowering. By contrast, education-for-change is enabling. It helps learners gain 'critical awareness' by analysing their own observations, drawing their own conclusions and taking collective action to overcome problems. It frees the poor and oppressed from the idea that they are helpless and must suffer in silence. It empowers them to build a better world—hence it is 'education for transformation'.

examples of GRASSROOTS health programmes that have combatted ROOT CAUSES of POOR HEALTH

Community-based health programmes in various countries have brought people together to analyse the root causes of their health-related problems and to 'take health into their own hands' through organised action. In places where unjust government policies have worsened the health situation, community health programmes have joined with popular struggles for fairer and more representative governments. The following are a few examples of programmes where people's collective 'struggle for health' has led to organised action to correct inequalities, unfair practices and/or unjust social structures.

Gonoshasthaya Kendra (GK). GK is a community health and development programme in Bangladesh that began during the war for national independence. Village women, many of them single mothers (the most marginalised of all people), have become community health workers and agents of change. Villagers collectively analyse their needs and build on the knowledge and skills they already have. Repeatedly health workers have helped villagers take action to defend their rights.

One example of this is over water rights. In analysing their needs, families agreed that access to good water is central to good health. UNICEF had provided key villages with tubewells. But rich landholders took control of the wells and made people pay so much for water that the poor often went without. Health workers helped villagers organise to gain democratic, community control of the wells. This meant more water and better health for the poor. And it helped people gain confidence that through organised action they could indeed better their situation.

Another example concerns schooling. Villagers know education is important for health. But most poor children of school age must work to help their families survive. So the GK communities started a unique school, which stresses cooperation, not competition. Each day the children able to attend the school practise teaching each other. After school these same children teach those unable to attend school. This process of teaching one another and working together to meet their common needs, sews seeds for cooperative action for change.

Jamkhed, India. For over three decades two doctors, Mabel and Raj Arole, have worked with poor village women, including traditional midwives. These health facilitators have learned a wide variety of skills. They bring groups of women together to discuss and try to resolve problems. In this way, they have become informal community leaders and agents of change. They help people rediscover the value of traditional forms of healing, while at the same time demystifying Western medicine, which they learn to use carefully in a limited way.

In Jamkhed, women's place relative to men's has become stronger. Women have found courage to defend their own rights and health and those of their children. As a result of the empowerment and skills-training of women, child mortality has dropped and the overall health of the community has improved dramatically.

The Philippines. In this island nation, during the dictatorship of Fernando Marcus, a network of community-based health programmes (CBHPs) evolved to help people deal with extreme poverty and deplorable health conditions. Village health workers learned to involve people in what they called **situational analysis**. Neighbours would come together to prioritise the main problems affecting their health, identify root causes and work collectively towards solutions.

In these sessions it became clear that **inequality—and the power structures that perpetuate it—were at the root of ill health**. Contributing to the dismal health situation were: unequal distribution of farm land (with huge land-holdings by transnational fruit companies), cut-backs in public services, privatisation of the health system, and miserable wages paid to factory and farm workers. The network of community-based programs urged authorities to improve this unjust situation. When their requests fell on deaf ears, they organised a popular demand for healthier social structures. These included free health services, fairer wages, redistribution of the land to the peasantry, and above all else, greater accountability by the government to its people.

The fact that the CBHP network was awakening people to the socio-political causes of the poor so threatened the dictatorship that scores of health workers were jailed or killed. But as oppression grew, so did the movement. The CBHP network joined with other movements for social change. Finally, the long process of awareness-raising and cooperative action paid off. In the massive peaceful uprising of 1986, thousands of citizens confronted the soldiers, putting flowers into the muzzles of their guns. The soldiers (many of whom were peasants themselves, acquiesced. After years of organising and grassroots resistance, the dictatorship was overthrown. (Unfortunately, the overall situation has not changed greatly. With persistent domination by the US government and multinational corporations, gross inequities remain and the health of the majority is still dismal. The struggle for a healthier, more equitable society continues.)

Nicaragua. Similar to the CBHP in the Philippines under Marcus, in Nicaragua during the Somoza dictatorship a network of non-government community health programmes evolved to fill the absence of health and other public services. Grassroots health workers known as **Brigadistas de Salud** brought groups of people together to conduct **community diagnoses** of problems affecting their health, and to work together toward solutions. As in the Philippines, the ruling class considered such **community participation** subversive. Scores of health workers were 'disappeared' by the National Guard and paramilitary death squads. Many health workers went underground and eventually helped form the medical arm of the Frente Sandinista, the revolutionary force that toppled the dictatorship.

After the overthrow of Somoza, hundreds of Brigadistas joined the new health ministry. With their commitment to strong participation, they helped to organise and conduct national 'Jornadas de Salud' (Health Days). Their work included country-wide vaccination, malaria control, and tuberculosis control campaigns. At the same time, adult literacy programmes, taught mainly by school children, drastically increased the nation's level of literacy.

As a result of this participatory approach, health statistics greatly improved under the Sandinista government. Since the Sandinistas were ousted with the help of the US government, health services have deteriorated and poverty has increased. Many health indicators have suffered. But fortunately, communities still have the skills and self-determination necessary to meet basic health needs and assist one another in hard times.

Project Piaxtla, in rural Mexico. In the mountains of western Mexico in the mid-1960s a villager-run health programme began and gradually grew to cover a remote area unserved by the health system. Village health promoters, learning in part by trial and error, developed dynamic teaching methods to help people identify their health needs and work together to overcome them.

Over the years, Piaxtla evolved through three phases: 1) curative care, 2) preventive measures, and 3) socio-political action.
It was the third phase that led to the most impressive improvements in health. (In two decades, child mortality dropped by 80%.) Through Community Diagnosis, villagers recognised that a big

cause of hunger and poor health was the unconstitutional possession of huge tracts of farmland by a few powerful landholders, for whom landless peasants worked for slave wages. The health promoters helped the villagers organise, invade the illegally large holdings, and demand their constitutional rights. Confrontations resulted, with occasional violence or police intervention. But eventually the big landholders and their government goons gave in. In two decades, poor farmers reclaimed and distributed 55% of good riverside land to landless farmers. Local people agree that their struggle for fairer distribution of land was the most important factor in lowering child mortality. And as elsewhere, people's organised effort to improve their situation helped them gain the self-determination and skills to confront other obstacles to health.

The practical experience of Project Piaxtla and its sister programme, PROJIMO, gave birth to 'Where There Is No Doctor,' 'Helping Health Workers Learn,' 'Disabled Village Children' and the other books by David Werner that have contributed to community-based health and rehabilitation initiatives worldwide.

networking and COMMUNICATIONS among GRASSROOTS programmes and movements

From isolation to united struggle

In different but parallel ways, each of the community initiatives briefly described above developed enabling participatory methods to help local people learn about their needs, gain self-confidence, and work together to improve their well-being. Each forged its own approaches to what we referred to earlier as **education for change**.

At first community health initiatives in different countries tended to work in isolation, often unaware of each other's existence. There was little communication and sometimes antagonism between them. But in time this changed, partly due to growing obstacles to health imposed by the ruling class. (Nothing solidifies friendship like a common oppressor.) Programmes in the same country or region began to form networks or associations to assist and learn from each other. By joining forces, they were able to form a stronger, more united movement, especially when confronting causes of poor health rooted in institutionalised injustice and inequity.

National networks in Central America and the Philippines provided **strength in numbers** that gave community health programmes mutual protection and a stronger hand to overcome obstacles.

In the 1970s, community-based health programmes in several Central American countries formed **nationwide associations**. Then in 1982 an important step forward took place. Village health workers from CBHPs in the various Central American countries and Mexico met in Guatemala to form what became the **Regional Committee of Community Health Promotion**.

This Regional Committee has helped to build solidarity for the health and rights of people throughout Central America. Solidarity was particularly important during the wars of liberation waged in Central America (and later in Mexico), when villages were subjected to brutal and indiscriminate attacks by repressive governments and death squads.

Learning from and helping each other

One of the most positive aspects of networking among grassroots programmes and movements has been the cross-fertilisation of experiences, methods and ideas.

Central America. For example, in the 1970s, the Regional Committee and Project Piaxtla organised a series of **'intercambios educativos'** or **educational interchanges**. Community health workers from different programmes and countries came together to learn about each other's methods of confidence-building, community diagnosis, and organisation for community action.

At one of these Intercambios, representatives from Guatemala, in a highly participatory manner, introduced methods of 'conscientización' (awareness-raising) developed by Paulo Freire, as they had adapted them to mobilise people around health-related needs in Guatemala.

Likewise the village health promoters of Piaxtla, in Mexico, introduced to participants a variety of methods of discovery-based learning, which they had developed over the years (see below).

Reaching across the Pacific. An early step towards more global networking took place in when an educational interchange was arranged between community health workers from **Central America** and the **Philippines**. A team of health workers from Nicaragua, Honduras and Mexico visited a wide range of community-based health programmess, rural and urban, in the Philippines. In spite of language barriers, the sharing of perspectives and sense of solidarity that resulted were profound. Social and political causes of ill health in the two regions were similar. Both the Philippines and Latin America have a history of invasion and subjugation, first by Spain and then by the United States. Transnational corporations and the International Financial Institutions have contributed to polarising the rich and poor. And in both regions, the US has backed tyrannical puppet governments that obey the wishes of the global marketeers in exchange for loans and weapons to keep their impoverished populations under control.

Participants in the Latin American-Philippine interchange came away with a new understanding of the global forces behind poor health. They became acutely aware of the need for a worldwide coalition of grassroots groups and movements to gain the collective strength needed to construct a healthier, more equitable, more sustainable global environment.

the life and death of PRIMARY HEALTH CARE

Health for All? The United Nations established the World Health Organization (WHO) in 1945 to co-ordinate international policies and actions for health. WHO defined health as 'complete physical, mental, and social well-being, and not merely the absence of disease.'

But in spite of WHO and the United Nations' declaration of Health as a Human Right, the poorer half of humanity continued to suffer the diseases of poverty, with little access to basic health services. In 1987, WHO and UNICEF organised a watershed global conference in Alma Ata, USSR. It was officially recognised that the Western Medical Model, with its costly doctors in giant 'disease palaces,' had failed to reach impoverished populations. So the world's nations endorsed the **Alma Ata Declaration,** which outlined a revolutionary strategy called **Primary Health Care (PHC)**, to reach the goal of **Health for All by the Year 2000**. The vision of PHC was modeled after the successful grassroots community-based health programmes in various countries, as well as the work of 'barefoot doctors' in China. It called for **strong community participation in all phases**, from planning and implementation to evaluation.

Health for No One? We have entered the 21st century and are still a long way away from 'Health for All.' If our current global pattern of short-sighted exploitation of people and environment continue, we will soon be well on the road to 'Health for No One.' The current paradigm of economic development, rather than eliminating poverty, has so polarised society that combined social and ecological deterioration endangers the well-being of all. But sustainable well-being is of secondary concern to the dictators of the global economy, whose all-consuming objective is GROWTH AT ALL COST!

It has been said that Primary Health Care failed. But in truth, it has never been seriously tried. Because it called for and the full participation of the underprivileged along with an equitable economic order, the ruling class considered it subversive. Even UNICEF—buckling under to accusations by its biggest founder (the US government) that it was becoming 'too political'—endorsed a disembowelled version of PHA called **Selective Primary Health Care**. Selective PHC has less to do with a healthier, more equitable social order than with preserving the *status quo* of existing wealth and power.

The World Bank's take-over of health-planning

The kiss of death to comprehensive PHC came in 1993 when the World Bank published its World Development Report, titled 'Investing in Health.' The Bank advocates a restructuring of health systems in line with its neo-liberal free-market ideology. It recommends a combination of privati-

sation, cost-recovery schemes and other measures that tend to place health care out of reach of the poor. To push its new policies down the throat of poor indebted countries, it requires acceptance of unhealthy policies as a pre-condition to the granting of bail-out loans.

In the last decade of the 20th century, the World Bank took over WHO's role as world leader in health policy planning. The take-over was powered by money. The World Bank's budget for 'Health' is now triple that of WHO's total budget. With the World Bank's invasion of health care, comprehensive PHC has effectively been shelved. **Health care is no longer a human right. You pay for what you get.** If you are too poor, hungry and sick to pay, forget it. The bottom line is business as usual. Survival of the greediest!

COALITIONS for the health and well-being of HUMANITY

Primary Heath Care as envisioned at Alma Ata was never given a fair chance,—and globalisation is creating an increasingly polarised, unhealthy and unsustainable world. — In response, a number of international networks and coalitions have been formed. Their goal is to revitalise comprehensive PHC and to work towards a healthier, more equitable, more sustainable approach to development. Two of these coalitions, which have both participated in organising the People's Heath Assembly, are the following.

The Third World Health Network (TWHN), based in Malaysia, was started by the Third World Network, which has links to the International Consumers Union. The TWHN consists of progressive health care movements and organisations, mainly in Asia. One important contribution of the Network has been the collection of a substantial library of relevant materials, their lobby for North–South equity and the promotion of networking between Third World organisations.

The International People s Health Council (IPHC) is a coalition of grassroots heath programmes, movements and networks. Many of its members are actively involved in community work. Like the TWHN, the IPHC is committed to working for the health and rights of disadvantaged people—and ultimately, of all people. Its vision is to advance towards a healthy global community founded on fairer, more equitable social structures. It strives towards a model of people-centred development, which is participatory, sustainable, and makes sure that all people's basic needs are met.

The IPHC is not just a South–South network for underdeveloped countries, but also includes grassroots struggles for health and rights among the growing numbers of poor and disadvantaged people in the Northern 'overdeveloped' countries.

For the last two years the Third World Network and the IPHC have worked closely together in the preparations for the People's Health Assembly.

METHODOLOGIES of EDUCATION for CHANGE

One of the most rewarding activities of the IPHC was a post-conference workshop held in Cape Town, South Africa, on Methodologies of Education for Change. Health educators from Africa, Central America, Mexico, North America, the Philippines and Japan—most with many years of experience— facilitated group activities. Each demonstrated some of the innovative learning and awareness-raising methods they use in their different countries. The challenge of the workshop was **to design or adapt methods of education for action to meet the new challenges of today's globalised and polarised world.**

From micro to macro, local to global: ways of making and understanding the links

The Cape Town Workshop participants agreed that a global grassroots movement needs to be mobilised to help rein in the unhealthy and unsustainable aspects of globalisation.

To do this, learning tools, methods, and teaching aids must be developed to help ordinary people see the links between their local problems and global powers:

- People need to understand how their growing hardships at home (low wages, unemployment, rising food prices, cut-backs in services, growing violence, etc.) can be traced to the global forces that manage the flow of money and resources in ways that make the rich richer and the poor poorer.

- Villagers and shanty-town dwellers in the South need to understand how decisions by wealthy, powerful men in Northern cities lead to hunger, diarrhoea and the death of their children.

- They need to know who is responsible for the decisions that allocate vast amounts of money for weapons, pet food, tobacco, golf courses and trips to the moon, when millions of children don't get enough to eat.

- They need to understand how the World Bank and IMF put the squeeze on poor countries to keep paying interest on their huge foreign debt...and how structural adjustment programmes imposed by the Bank and IMF—which force poor countries to cut-back on public services—make poor families pay for health care and schooling.

Having become aware of the links between their local problems and global policies, people need to learn ideas and information about what they can do:

- They need to know what efforts are being made—locally, nationally and internationally—to oppose these harmful high-level policies and decisions.

- They need to know what they can do personally and collectively at the local level to help work toward the changes at the global level that can shape a healthier world.

No one has a road map through these vital issues. That is why Education for Change needs to be open-ended and fully participatory. It is why the facilitator and the learning group need to look for solutions—or at least ways of coping—together. This kind of learning process, in which people learn from each other and look for a way forward together, as equals, itself becomes a microcosm of the kind of equity-oriented, people-centred, participatory environment we aspire to achieve at the global level.

Storytelling, role play and theatre for awareness-raising and change

Storytelling can be an effective way to help people understand and identify with problematic situations, and consider possibilities for strategic action. This is especially true if the story is a true one, based on something that happened in the participants' village or neighbourhood— something they are all familiar with and which concerns them deeply.

Stories for change. Stories can be told in many ways: by **storytellers**, as **skits**, as **role-play** or **socio-dramas**, or as **puppet shows**. Some of the best stories or socio-dramas for analysing situations and exploring options for action are open-ended and constructed through the participation of the entire learning group. After a key theme or problem is identified, someone starts the story around that theme, and develops it to a point of crisis or crucial choice. Then another person continues the story, up to another crisis point. Then yet another person continues it. And so on. Or after the story has been developed to a critical point, participants can divide into smaller groups, each developing the story in a different direction. Thus it becomes a way of brainstorming alternatives for action in which everyone thoughtfully takes part.

From stories to theatre to action. In Project Piaxtla, Mexico, sometimes participatory stories or role-play evolved into a plan for community action. Health workers in training would develop it into a theatre skit or puppet show and present it to the whole village as 'farm workers' theatre'. At times this resulted in a collective course of action to cope with the underlying problem. Below are four examples of stories or role-play that evolved into community theatre and finally into organised action.[1]

- **Problem-based story:** A few rich families illegally possess most local farmland, resulting in landlessness, exploitative share-cropping, hunger, and high child mortality.

  Theatre skit (developed from story): Poor villages explore options of borrowing, renting, or invading and reclaiming unused illegally-held large land-holdings.
  Consequent action: Poor farm workers collectively occupy and farm the large holdings. Eventually they demand legal title, and redistribute the land among the landless.
  Results: Improved physical health (more food,

fall in child mortality) and psycho-social health (self-confidence, empowerment, determination collectively to better their lives).

- **Problem-based story:** Alcohol. Frequent drunkenness of men leads to violence, family discord and malnutrition of children (money spent on booze).

  Skit: 'Village Women Unite to Overcome Drunkenness.' Skit first shows miserable situation. Then women join together to close down the 'water holes' (illegal bars).

  Action: After the skit, when a rich man opens a bar in the village, the women organise a protest, demand closure of bar and protest against alcohol-related corruption by authorities.

  Results: Despite the brief jailing of health workers, the bar is shut down. Fewer killings. Better health. Newspaper articles inspire women in other villages to take similar action.

- **Problem-based story:** Village midwives, mimicking doctors, inject hormones (pituitrin) to speed birth and 'give force' to mother. This causes needless deaths, or defects in babies.

  Skit: Scene 1: Shows mother giving birth; hormone injected; baby born blue and dead. Scene 2: Same mother delivers without hormones. Baby healthy. Audience explains why.

  Action: Midwives and mothers jointly decide: NO HORMONE SHOTS FOR NORMAL BIRTHS.

  To reduce bleeding, mothers breast-feed newborn babies at once (to free natural hormones).

  Results: Fewer ruptured uteri; fewer epileptic, dead or brain-damaged babies; demystification of modern medicines; more appreciation of the body's own abilities.

wiphn news, vol 20, summer

- **Problem-based story:** Poor families borrow maize from the rich at planting time, pay back triple at harvest time; this leads to big debts, increased poverty and hunger.

  Skit: Shows how high interests on maize loans devastate poor farming families.
  Then families come together to form a co-operative grain bank—with success.

  Action: Health workers help villagers start the co-operative maize bank, which loans grain at low interest rates. They also build rat and insect-proof storage bins.

  Results: The maize bank pulls poor farmers out of debt. Eventually they are able to produce surplus grain and have no need borrow. Better fed, healthier children; fewer die.

Stories linking local problems to global policies

While the above stories and skits proved useful in their day, they are dated. They focused on local problems that to a large extent had local solutions. For example, landless villagers could join together and 'reclaim' land-holdings that were illegally large. But today many of the people's most disabling problems have their roots in international trade and the global economy. In preparation for the North American Free Trade Agreement (NAFTA), the Mexican government was forced to change its Constitution. Agrarian Reform laws, which had protected the land rights of poor farmers were annulled. As result, poor farmers are losing their ancestral land. Two million have migrated to city slums, where the glut of jobless workers has reduced real wages by 40%. Resulting hunger and despair have led to a wave of crime and violence. The village of Ajoya (where the above stories and skits helped people solve earlier problems) has had 10 kidnappings, frequent killings, and repeated hold-ups of buses. In their current 'community diagnoses', villagers see crime and violence as among their biggest health-related problems.

Similar situations now exist worldwide. A few years ago, when Mexican school-aged children did their own 'community diagnoses', they identified problems such as diarrhoea, coughs, skin sores and 'being too thin' as their biggest health-related problems. But today—whether in Mexico, the Philippines, Pakistan, South Africa, or the slums of Chicago (USA)—children tend to identify as their biggest health-related problems such things as crime, violence, drunkenness, drugs, fighting within families, beating of children and similar social issues. **These symptoms of system failure and social upheaval can often be traced to the global policies that are deepening poverty, undermining workers' rights, reducing jobs and wages,**

and cutting back on public services.

People in poor communities around the world suffer the effects of these global policies, often without even knowing such policies exist. They have little awareness of how decisions made by overfed men in suits sitting around a table at the World Bank translate into fewer health services and more costly medicines for their sick children.

For the new 'macro-problems' of the 21st Century, new kinds of awareness-raising stories are needed—stories that make the links between local problems and global events; stories that build a chain of causes from shanty-town hardships to global boardrooms.

In preparation for the People's Health Assembly, persons involved in community health activities (and in all sectors affecting the well-being of people or the environment) are being asked to **collect eye-opening stories that make this kind of 'micro-to-macro' or 'local-to-global' links**. One example of such a story—called 'The White Death'—is included in the Preparatory Packet for the PHA (and is briefly summarised in this paper).

The 'But why? game' and the 'chain of causes'—used with stories for situational analysis

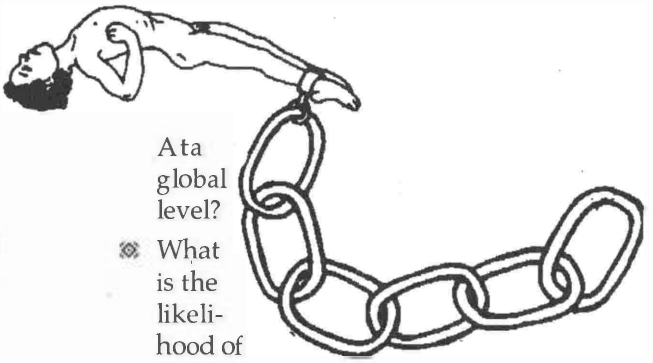
Of various participatory learning methods to raise awareness of the root causes of poor health, ones involving **situational analysis of a true story** have proved successful in many countries. The process is in four parts:

1. The story portrays a series of events that lead up to a tragic ending, such as the death of a child. (People's attention is captured better if the story is based on a recent, local sequence of events, which everyone is familiar with.)

2. After the story, participants play a (usually very serious) 'But why?' game, to itemise and analyzing the series of factors leading up to the child's death.
3. Then they collectively build a 'chain of causes' linking the sick child to the grave.

4. Finally, the group discusses which links of the chain they may be able to break in order to prevent similar loss of health and life in the future. They ask themselves:

   - Which links can be broken by the informed action of a concerned individual?
   - Which links require action at the family or community level?
   - Which require action at a national level?



At a global level?

- What is the likelihood of successfully breaking different links?
- What are the preparations and resources needed? What are the risks?
- With which links can we most effectively begin to take action?'

'The Story of Luis'—presented in the handbook, *Helping Health Workers Learn*—has been used effectively as a teaching tool in health programmes around the world. Based in a Mexican village, this true story unveils the 'chain of causes' that lead to a boy's death from tetanus.[2]

The 'But why?' game (an example analysing a child's death from diarrhea). After the story to be analysed is told, the facilitator asks a series of questions and participants answer. In response to each answer the facilitator asks 'But why?'. Here is an example of how the 'But why?' game might develop from a story of a child's death from dehydration due to diarrhoea:

> **Juanita died from dehydration.... But why?**
>
> 'Because she had severe diarrhea.' ... **But why?**
>
> 'Because she swallowed harmful germs.' ... **But why?**
>
> 'Because the family didn't have a latrine or clean water.' ... **But why?**
>
> 'Because her father had no money to install them.' ... **But why?**
>
> 'Because, as a share-cropper, he had to pay half his harvest as rent?'... **But why?**
>
> 'Because he didn't own any land himself.' ... **But why?**
>
> 'Because the government failed to enforce the Agrarian Reform laws.' ... **But why?**
>
> 'Because rich land barons bribe politicians, and no one stops them.' ... **But why?**

When one series of causes is exhausted, the facilitator can ask questions exploring another series. A sequence of questions may lead from local to national factors (as above), or even international ones (as below). Note that answers need not come only from details of the story; participants can

also draw on their own observation, knowledge and previous awareness-raising discussions.

> **Oral rehydration therapy (ORT) can help prevent death from dehydration. Yet Juanita didn't receive ORT ... But why?**
>
> 'Because her mother couldn't afford commercial packets of oral rehydration salts (ORS), and hadn't learned to make a low-cost rehydration drink at home.' ... **But why?**
>
> 'Because the government, which used to give ORS packets free to poor families, now makes people pay.' ... **But why?**
>
> 'Because the World Bank required that health ministry introduce 'cost recovery' by charging for medicines and services.' ... **But why?**
>
> 'Because our country has a huge foreign debt and has to pay by cutting benefits to the poor.' ... **But why?** ... Etc.

Building the chain of causes. To extend the situational analysis of the 'But why?' game, the learning group can build a chain of causes. To make learning more dynamic, large links can be cut from cardboard. To add to the depth of the analysis, five categories of links can be labelled as:

> PHYSICAL (things)
> BIOLOGICAL (worms and germs)
> CULTURAL (attitudes and beliefs)
> ECONOMIC (money)
> POLITICAL (power)

To these five—because it is increasingly important in the causal chains—some folks add:

> ENVIRONMENTAL (nature of our surroundings)

Two additional figures can be made of cardboard, one representing the sick child and the other a tombstone. These figures are attached to a wall (or trees) about two metres apart. With the cardboard links, the group builds a 'chain of causes' from the child to her grave. Each participant has one or more cardboard links. The story is told again, using the method of the 'But why?' game. Each time a cause is stated, a person with a corresponding link (for example ECONOMIC) comes forward and hooks her link into the growing chain. Eventually the chain extends from child to grave.

The process of participatory analysis. Though the story may be based on the death of a real child and a sequence of real events, the process of analysis, with construction of the causal chain, can and should be somewhat open-ended. The sequence of causes (both in the 'But why?' game and using the cardboard links) can develop in a variety of directions, following the lead of the group. Participants may have knowledge of local events or factors not included in the original story. These add important new dimensions.

Discussion and debate—and the airing of different opinions—are encouraged. The purpose of the activity is to help participants explore issues in depth and form a comprehensive, multidimensional picture—like fitting together pieces of a puzzle.

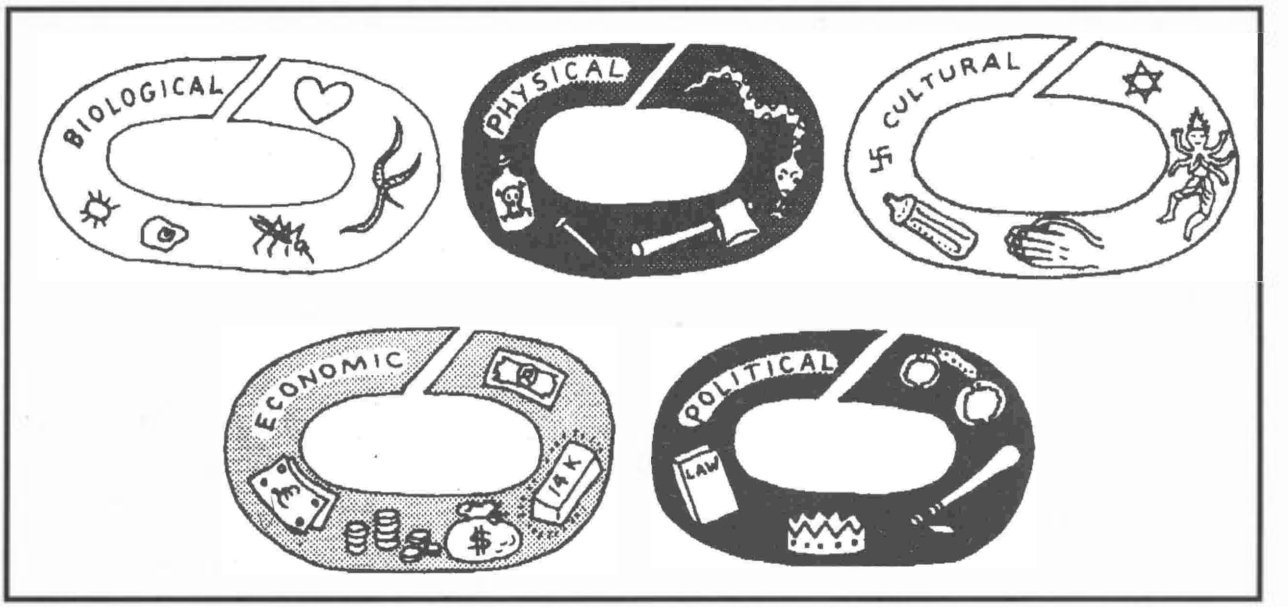
Some participants may argue that building a linear chain of causes is simplistic, that causal factors interlink in many ways, more like a web than a chain. Some programmes prefer to build a mosaic on a blackboard rather than connecting cardboard links. Teaching methods (like oral rehydration technology) can always be improved. Group criticism and collective improvement of the teaching methods should be actively encouraged. This, too, is 'education for change'.

Breaking the links. Perhaps the most important part of the 'chain of causes' activity is the follow-up discussion about WHAT TO DO. Studying the causal chain, the group considers **which links they may be able to break** and **what action to take**. Some links can be broken through individual action (such as a mother learning to make a homemade rehydration drink). Other links may require community action (such as putting in a communal potable water system). Yet others may require joining national or international networks or coalitions (such as participation in the campaign of Health Action International to restore the right to free essential medicines to families too poor to pay).

Examples of stories with local-to-global links: 'The White Death' and 'The Story of Sam'

The packet of materials for the People's Health Assembly titled 'Invitation to Participate in Pre-Assembly Activities,' includes as examples three stories that make local-to-global connections. The first two, 'The White Death' and 'The Story of Sam,' are designed to be followed by 'But why?' and 'chain of causes' activities.

'The White Death' is adapted from a story developed with village women in Sierra Leone, Africa. It tells of a woman who becomes ill and finally dies from 'weak blood' (anaemia), identified by the women as their most important health problem, and the biggest killer of women. Through group discussions and use of innovative teaching aids (such as a mosquito made from syringe and



bits of a tin can) the women came to realise that 'weak blood' has many interrelated causes and to understand why it kills more women than men. They found the causes for 'the white death' range from LOCAL to GLOBAL and from BIOLOGICAL (e,g., malaria) to CULTURAL (e.g. men have first grabs at available meat) to ECONOMIC and POLITICAL (e.g. to produce money for foreign debt payment, the country is required by the World Bank to cut down native forests that used to have iron-rich game animals and herbal cures for malaria).

By piecing together this story from their own collective experiences, and then retelling it using 'But why?' questions and a 'chain of causes,' the women gained better understanding both of their own bodies and of the links between their local health problems and global economics.

With their new knowledge about the multiple causes of weak blood, the women were better able to take *personal action* such as growing and eating blood-strengthening foods, and *collective action* such as joining the growing trans-African movement to require the World Bank to be more responsive to human and environmental needs.

Stories like 'The White Death' and 'The Story of Sam'—and other stories that are pieced together locally around common concerns—can help ordinary persons understand how their local hardships are linked to global forces. Analysis of the stories can help prepare people to take meaningful part in the growing worldwide debate about **how economic and development policies should serve human and environmental needs**, and **how to make high-level decisions more transparent and more democratic**.

Discovery-based learning - and Learning by doing

The effort to make global policies socially just and democratic will be an uphill battle. The world is unwisely ruled in a selfish, shortsighted way by a tiny privileged minority with huge wealth and power. To change this situation for the common good will require a vast united front of concerned people. Folks from all races, nations and walks of life—farmers and labourers; the jobless and the underpaid; the poor, the hungry and the sick; prisoners; illiterates, students and academics; the middle class, and even the very rich who worry for their children's future—must understand the big issues and what is at stake.

But understanding the issues is not easy. As we have already pointed out, **institutionalised disinformation is the modern tool of social control.** Schools, newspapers, television and market propaganda are designed to keep those on top on top by 'manufacturing consent'. For people to find their way through the maze of politically filtered information, cover-ups, and the Siren-like incentives to conform without questioning, requires—above all else—an **ability to observe and think for oneself**.

To transform our top-heavy system will require a massive uprising of peace-loving fighters for social justice—people who can sort their way through the beguiling veil of disinformation, and discover for themselves what is happening around them, for better and for worse. For such a massive movement of thoughtful, well-informed people to be formed, a simultaneous educational revolution is needed, one that espouses **a less authoritarian, more liberating approach to teaching and learning than most of us were schooled by**.

We have mentioned the enabling educational methods of Paulo Freire and others. A related approach is called 'discovery-based learning', now much used in community health education.

Discovery-based learning encourages participants to make their own observations and arrive at their own conclusions. The facilitator does not push ideas into people's heads, but helps to draw them out. This action-packed, problem-solving approach helps people think for themselves and gain confidence in their own perceptions and experience. In many community initiatives this empowering methodology has become a basic tool in 'education for change'.

Discovery-based learning and **learning by doing** go hand in hand. There is an old saying:

> If I hear it, I forget it.
> If I see it, I remember it.
> If I do it, I know it.

To this, health educators in Latin America have added,

> If I discover it, I use it.

When teaching methods enable learners to build on their own observations and discoveries, the knowledge they gain is their own. They can apply it, adapt it, and build on it more effectively. Also, it equips participants to learn about other things directly, to dig out the truth for themselves rather than to swallow unchewed what teachers and TV tell them. Thus it prepares people to be actors on life's stage, not just passive followers. It helps transform people living in quiet resignation into active agents of change.

The gourd baby—a tool for teaching that uses discovery-based learning

A classic example of discovery-based learning involves the 'gourd baby,' a teaching aid to help groups of mothers, school children, health workers, and others learn about diarrhoea and 'the return of liquid lost' (dehydration and rehydration). We include discussion of the gourd baby here, not because of the linkage of the high child death rate from diarrhoea to the global economy, but because the gourd baby is such a delightful tool for teaching community educators about an empowering and effective way of teaching.

The teaching aid is made from a hollow gourd, preferably the kind with a narrow neck separating two round ends. (A plastic bottle will also work.) The gourd, painted to look like a baby, has all the 'holes' that a real baby has (mouth, urine hole, butt hole, and two tiny eyeholes for tears. The mouth, urine and butt hole are stoppered with small plugs. The round opening at the top of the gourd represents the baby's fontanels (soft spot) and is covered with a small cloth.

The challenge for the facilitator is to help the learning group discover the signs of dehydration, without telling them. To do this, the group experiments with the gourd baby. They fill it with water, pull the plug to give it diarrhoea, and watch what happens. They observe the soft spot sink in, then the eyes stop forming tears, and the urine flow slowing down. They conclude that these signs occur because water (diarrhoea) is flowing out. Thus they discover the signs of dehydration. Because they discover these signs in a hands-on way (learning by doing) and by drawing their own conclusions from their direct observations (discovery-based learning) they never forget it.

Through similar hands-on experimentation with the gourd baby, learners observe that to prevent the 'baby' from dehydrating when it has 'diarrhoea,' they must replace at least as much fluid as the baby is losing. (This discovery is extremely important, since studies show that village mothers taught in the typical top-down way ('Do what I say and don't forget!') often give rehydration drink to their dehydrating baby as if it were a liquid medicine, a spoonful now and then. When their babies die, they spread the word that oral rehydration therapy doesn't work. So the underuse of ORT and corresponding overuse of costly, useless anti-diarrhoeal medicines continue worldwide.

Many benefits derive from the gourd baby methodology. Mothers who learn about diarrhoea management from their own observations are in a better position to question the many puzzling things they are told. For example, following standard advice, many mothers spend their last food money on commercial packets of oral rehydration salts (ORS) when they could get as good or better results by giving their baby home-made rice or maize porridge with a little salt. It is important that mothers learn to value their own experience and to critically question directives from outsiders unfamiliar with mothers' day-to-day circumstances, limitations, and abilities.[3]

community diagnosis as INTRODUCTION to discovery-based learning

Many health-worker training programmes, as well as local gatherings to resolve unmet needs, use 'community diagnosis' or 'situational analysis' to start off the group process of identifying and prioritising health-related problems or other shared concerns.

There are many ways to conduct a community diagnosis. The most successful ones tend to be hands-on, action-based and designed to encourage full, thought-provoking participation.

One approach to community diagnosis that has been used effectively in many countries uses a flannel-board and small pieces of cloth with line drawings of different health-related problems. By using pictures rather than written words, non-literate people can participate in creating a graphic representation of the problems in their community and evaluate their relative importance.

First the group places on a large flannel-board (or blanket on a table tipped on its side) drawings of all the health-related problems they can think of. If there is no pre-existing drawing of the problem, the person who volunteers that problem creates a quick sketch to represent it. It is important the group include not just 'health problems' or 'sicknesses', such as diarrhoea and skin infections, but also 'health-related problems', such as poverty, smoking and unfair land tenure. (To help people understand the broad spectrum of 'health-related problems', it is often helpful to first tell a story using the 'But why?' game and 'chain of causes'.)

After the major problems affecting community health are put in rows on the flannel-board, the group systematically analyses their relative importance. To do this, they use small flannel figures, representing the different characteristics that need to be considered when weighing the relative importance of each problem.

Little round faces represent **frequency**: how often the problem appears in the community, and how many people it affects. Everyone is given several little faces, which they take turns placing next to the problems they consider most common. As more faces are added, the group tries to agree on a pattern of relative frequency.

Skulls represent relative **severity**: how likely the problem is to cause life-threatening illness or death. Persons place skulls of different sizes next to problems, trying to arrange them according to how relatively dangerous or deadly they are.

Three little faces, with arrows from one face to the others, represent **contagion**. Participants place these figures on the problems or illnesses that spread from person to person.

A long wiggle arrow represents a problem that is **chronic**. Participants place these figures on the problems that are long-lasting, or have long-lasting effects (like polio).

This graphic portrait of the relative frequency, severity, contagiousness and duration of the problems helps the participants weigh their relative importance in the community.

However, another factor also needs to be weighed: **How are the different problems interrelated? Which problems that contribute to or lead to some of the others problems?** Participants place pieces of yarn between problems where they believe there are causal links. The end result is a complex **web of causes**. It becomes clear that **some of the problems listed are 'root causes', which contribute to many of the other problems**.

The final step in this process of community diagnosis is to discuss **where to begin**. The graphic representations help the group get an overall picture of the relative importance of interrelated problems affecting the community's well-being. In constructing a plan of action for improving their situation, the group needs to consider:

- What is the relative importance of the different problems? (As investigated

above)

- Which are the underlying problems that contribute to many other problems? (Also investigated above)

- Which problems can be dealt with locally, safely, with limited investment and with positive, visible results? (It is often wise to start by taking action against problems that are likely to have fairly quick positive solutions that everyone can see and appreciate. Good early results help build confidence and bring more people on board, in order to tackle more difficult or risk-incurring problems at a later date.)

- What are the resources, human and otherwise, required to overcome the different problems?

Seeking answers to these questions helps the group decide where to begin. As discussed earlier, some problems can be resolved at the individual or family level, others at the community level. Many of the biggest, underlying problems that link back to the global power structure cannot be resolved at the local level. However, certain coping measures may help the community cope better with the hardships caused by the underlying global problems.

For example, faced with privatisation of health services or the introduction of user fees, a village might set up a community 'health insurance' plan. That way the whole community helps pay the emergency medical costs of one of its members, when disaster strikes.

Although it is often wise to begin by attacking easy-to-resolve local problems when planning local action, it is important not to lose sight of the underlying problems at the macro (or global) level. However, strategies for taking local action on global issues require a different approach. They involve networking or joining coalitions and taking part in key demonstrations. They may involve educational campaigns to raise local awareness so that more people vote for politicians who dare to take a stand for the interests and needs of the common people.

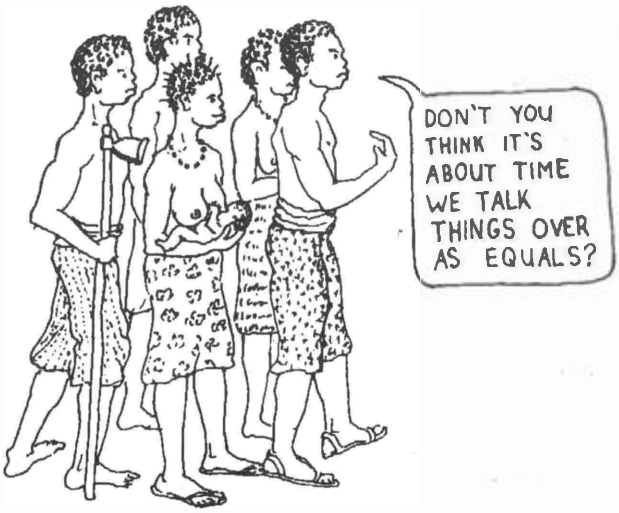
child-to-child
Empowering children to become CARING AGENTS of CHANGE

The children of today are the social architects of tomorrow. If children are to grow up to be independent thinkers and compassionate agents of change, they need to be encouraged to learn from experience and to draw conclusions from their own observations, not just to memorise lessons and do what they're told. If they are to help construct a more healthy, more caring world, children need a learning environment based on co-operation rather than competition, where helping one another to advance together—and giving friendly assistance to those who might fall behind—is valued more than getting top grades.

Child-to-Child is an innovative educational methodology in which school-aged children learn ways to protect the health and well-being of other children, especially those who are younger or have special needs. Launched during the International Year of the Child in 1979, Child-to-Child is now practised in over 60 developing countries as well as in Europe, the USA and Canada.

Child-to-Child does much more than impart information to kids about common health problems. At best, it is a liberating experience that helps children learn to think for themselves and work together to create a healthier, more caring environment. Children learn to reach out in a friendly, helpful way to those who are most vulnerable.

Child-to-Child emphasises learning



through experience. (The gourd baby as a tool for 'discovery-based learning' was first developed through a Child-to-Child activity.) Rather than simply being told things, **children conduct their own surveys, perform their own experiments**, and discover answers for themselves. They are encouraged to think, observe, explore, analyse and invent. This makes learning an adventure, and fun. Children develop ways of looking critically and openly at life. The activities encourage independence of thought and co-operative spirit that helps form leaders in the process of change.

In Child-to-Child, children learn to work together and help each other. Older studentd organise to help teach younger ones. Younger ones conduct activities (storytelling, puppet shows, seeing and hearing tests) with pre-school children. Everybody teaches and everybody learns from each other.

Child-to-Child is pertinent to the process of social transformation. When introduced into schools as it has been in many countries, it can help make schooling more relevant to the immediate needs and lives of the children, their families and their communities. It introduces methods of 'education for change' into the classroom, counteracting and undermining the authoritarian, conformity-building, status-quo-conserving role of the conventional school system.

Latin America has taken the lead in introducing 'education for change' methodology into the Child-to-Child process. Typically, a group of children starts off by conducting their own 'community diagnosis' (as described above). Or they build 'chain of causes' stories (or draw composite pictures of 'our community' to explore the interrelated problems in which they live.

We mentioned above how children in many parts of the world, in the process of their community diagnosis, now tend to say that **their most important problems affecting their well-being are violence, gangsters, drunken parents, fighting between parents, and cruel treatment by adults.** This 'diagnosis' makes it much more difficult for the children to take a lead in corrective action on their own. However, the mutual understanding and support that comes from sharing their common concerns can be of great assistance to children who fell lost and forgotten in a world where money rules and where democratic principals, human rights, and basic needs are grievously neglected.

Child-to-Child is important to the process of social transformation because it helps children develop skills and values based on kindness, understanding, defence of the underdog, and the joy that comes from working cooperatively for the good of all. It can help the children of today become more able and compassionate architects of tomorrow.

CONFIDENCE-BUILDING

To be fully healthy requires self-esteem. An internalised low self-image is one of the biggest obstacles to the full participation and involvement of people who have been marginalised, disempowered and kept in a subservient role. They have been told so often that they are worthless and ignorant and lazy that they begin to believe it. Their lack of respect for their own qualities prevents them from joining in the struggle for fairer social structures.

For this reason, 'education for change' puts a lot of emphasis on confidence-building. It values and

builds on the experience, ideas and opinions of participants. It helps villagers rediscover value in their traditional beliefs, customs and forms of healing. It demonstrates that the knowledge, understanding and compassion of individuals who cannot read or write can be as important to sustaining health as the knowledge and abilities of highly trained professionals.

People with little formal education to help them stand up for their rights must free themselves from the low self-image that has been thrust upon them. They need to discover that they have a wealth of knowledge, skills, and human qualities, which privileged folks often lack. To provide new insight and build the self-confidence of underprivileged people, stories that temporarily reverse social roles (as in Charles Dickens' 'The Prince and the Pauper') are especially helpful.

Fables for building confidence and self-esteem: an example. In the mountains of western Mexico, village health workers in training often began with low self-esteem. They saw themselves as too 'backward' to master even the most basic skills of health professionals. Doctors in the city hospitals—as if by God's will—were somehow smarter, better and more gifted than they were. From their limited exposure to school (for those who had any) they felt more comfortable passively memorising facts than actively learning through an open-ended, problem-posing process based on their own knowledge and experience.

For trainees with a low opinion of themselves and their abilities, the following fable—developed through group discussion—about a doctor in distress, proved enlightening.

Facilitator: Suppose a huge hurricane has destroyed the coastal city. Days later a doctor who survived the disaster arrives at our mountain village. Exhausted and hungry, he has only the clothes on his back.... How would you treat him?

Villagers: Well, we'd give him something to eat. We'd probably invite him to stay in one of our huts until he figures out what to do.

Facilitator: Why would you do that?

Villagers: When a person needs help, we do what we can. Even for a stranger. If we didn't help each other in hard times, we wouldn't survive.

Facilitator: Suppose the doctor, lost without his medicines and hospital, decided to plant maize (corn) on the mountainside, like you folks do?

Villagers: He couldn't do it! Not without help. First, he'd have to cut down the brush with a machete, poor guy. I've seen those doctors' hands: their soft as silk! He'd get blisters in no time! And he doesn't know the poisonous snakes, scorpions and stinging trees. Or which wild fruits are edible. Or which cactus have drinkable water. Or how to keep the insects, birds and peccaries from eating his crops. Alone, he couldn't make it!

Facilitator: And would you help him learn to farm?

Villagers: It would be lots of work.... Like teaching a kid. It takes a person years to learn how to survive in these hills.

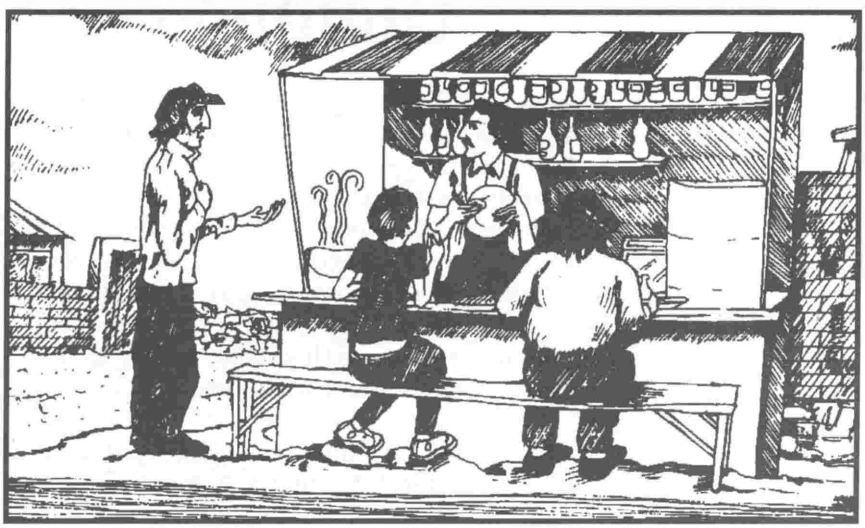
Facilitator: But you would help him?

Villagers: We couldn't just let him die!

Facilitator: For helping him survive, how much would you ask him to pay you?

Villagers: To pay? How could we? You said he arrived with nothing.

Facilitator: You are very kind! ... Now let us imagine that tomorrow one of you breaks a leg. So you go to a doctor in the city. If you don't have any money, will he treat you?



Villagers: No way! ... That's true. My mother died because we had no money to pay the doctor!'

Facilitator: And yet you would help the doctor who has nothing, after the hurricane?

Villagers (after muttering among themselves):

'Spose so.

This sort of awareness-raising dialogue helps people with little formal education realise they have a wealth of life-protecting knowledge, skills, and values—different from the 'highly educated,' but no less important. It helps them discover a new sense of self-worth and take pride in their own qualities and experience. The self-confidence they gain lets them stand up to others as equals, and become actors in building a more equitable and compassionate society.

CONCLUSION: towards interaction to transform the WORLD

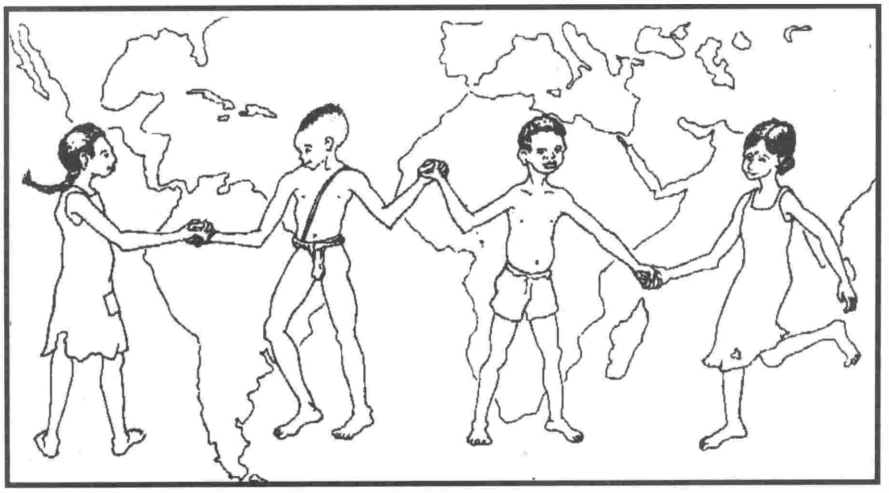
When, 40 years ago, Paulo Freire wrote that **with critical awareness disadvantaged people can 'transform the world'**, social scientists said he spoke metaphorically. 'Transform the world' meant to change and improve your local situation, your immediate surroundings. No doubt, our own back yard remains a good place to begin. In the words of E. F. Schumacher, 'Start small!'

But the world has changed since Freire's time. Globalisation— with its hazardous trade agreements, structural adjustment policies, cut-backs of public services, and institutionalised neglect of those in need—has made comprehensive change at the local level harder to achieve. Disadvantaged people—even nations—have less and less voice in decisions that shape their well-being.

Freire's insistence on 'transforming the world' was in some ways prophetic. Today, for local communities to overcome the injustices and inequities that diminish quality of life, they must join the growing international grassroots struggle literally to CHANGE THE WORLD. Not until the world's resources and power are more fairly shared, can sustainable well-being for all—or for anyone—be achieved.

To transform the world's power structure, we the world's people, in all our marvellous diversity, must learn to **respect our differences and embrace what we have in common**. We must work together as a family: locally, nationally and internationally. **To build the global solidarity we need, we must first of all find ways to communicate truthfully and directly, relying not on the *mass media* but on the *media of the masses*.**

The Internet, for those with access to it, provides an avenue for fast and free (potentially liberating) communication. No less important are the communication tools of less privileged folks: storytelling, street theatre, neighbourhood 'rags,' awareness-raising comics and novellas, community radio and TV, and the alternative press. As the Battle in Seattle made clear, well-planned protests, demonstrations, open forums and strategic civil disobedience also have their time and place. Such organised resistance serves not only to impede abuses of the power structure, but to raise awareness of more people. We cannot transform the world in a day. Years of organised struggle will be needed to build the kind of compassionate, foresighted, global democracy in which solidarity defends diversity and safeguards the sustainable well-being of the planet and its people.



In building the foundations of action for change, education of children—and of us grown-ups, too—is essential. **The best education is not only free, but freeing.** It gives people tools for independent thought and social responsibility. It enables people to discover what makes our social order tick, and then to figure out a course of action to help improve the situation in which we co-exist.

The transformation of our schools (and colleges and universities) into centres of education for change is essential for social transformation. This is why Child-to-Child—with its participatory, problem-solving, child-led approach—is so important.

But we also need adult-to-adult (and adult-to-child) activities that bring diverse people together for the common good. At all social levels—cutting across the divisions of race, class, age, gender and areas of concern—people need to identify common ground and take collective action for change.

The role of non-government organisations is critically important. NGOs concerned with human well-being and with environmental protection need to work together. NGOs in a range of fields need to form networks and coalitions to take the unified action needed to have an impact on global decision-making. The International People's Heath Council is one such coalition.

The People's Health Assembly promises to be a big step forward. But if it is indeed to contribute to creating a healthier world in these difficult times, it must be much more than a single meeting of 600 or so people who fly to Bangladesh in December 2000. Preparatory activities and follow-up are as important as the December meeting itself, and need to be oriented towards education and action.

One of the most important aspects of the PHA, with its pre- and post-assembly activities, is what Paulo Freire called **critical awareness-raising.** Only when enough people from all countries and cultures and fields of endeavor become painfully aware of the enormous injustices and inequities of our present global system—and the dangers these inequities bear for our common future—can we collectively tip the scales of the global agenda to put the needs of the many before the greed of the privileged few.

Notes

[1] These short summaries are oversimplified. More detailed versions can be found in the book *Helping Health Workers Learn* by David Werner and Bill Bower.

[2] For details about the methods of story-telling for participatory analysis using the 'But why?' game' and 'Chain of Causes', we suggest you read Chapter 26 of *Helping Health Workers Learn.*

[3] The gourd baby and discovery-based learning are discussed in the book *Helping Health Workers Learn.* The debate on oral rehydration therapy is covered in *Questioning the Solution: The Politics of Primary Health Care and Child Survival.*

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