People's Health Assembly

Health in the Era of Globalisation

from victims to protagonists

A discussion paper
prepared by the
PHA drafting group

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* More complete papers on each of the four main determinants of health and well-being covered in part C of this framework are available as supplementary background material. A number of 'issue papers' on various related topics are also being made available.

For additional information and background discussion materials contact:
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People's Health Assembly

WHO ARE WE?

The People's Health Assembly (PHA) is an international, multisectoral initiative aimed at bringing together individuals, groups, organisations, networks and movements long involved in the struggle for health. The idea started 15 years ago when peoples' organisation realised that the World Health Assembly of the World Health Organisation (WHO) was unable to hear the people's voice and a new forum was required. It is just now that we are making this dream come true.

We believe that health is a fundamental human right that cannot be fulfilled without commitment to equity and social justice. Our strength lies in numbers, and in the sharing of creative, alternative ideas for solutions. By creating a world-wide, inter and multi-sectoral collective of caring people and groups that includes people from all classes, castes, creeds, ages, gender, disabilities, ethnic origins and nations, we strive to make our voices heard.

WHY THE NEED for a PEOPLE'S HEALTH ASSEMBLY?

Individuals and groups behind this initiative believe that, through the active participation of well-informed and concerned people, the fight for a healthier, more just and sustainable world is possible.

The prime objective of the PHA is to give a "**voice to the people and make their voices heard**" in decisions affecting their health and well-being. It is through collective action that we will begin to change the unfair and unsustainable top-down process of globalisation – and its current negative impact on our overall health and well-being.

The PHA provides an opportunity to present people's perspectives on health. We invite you to add to these ideas by putting forward your own visions and dreams for a healthier society.

HOW WE WILL ACHIEVE OUR OBJECTIVES

The PHA process has three phases: pre-Assembly activities; a major international Assembly event and post-Assembly activities. Large numbers of people are already involved in the pre-Assembly activities and we expect many more to get involved before December 2000. In particular, we hope that people will get actively involved in PHA activities in their home countries.

Pre-Assembly activities

These include local, regional and national discussions focusing on the problems affecting different people and communities, and their struggles for change. People's experiences and collective efforts to cope with, reform, or transform their current unhealthy situation will be shared through the collection of stories and case studies,. These experiences have fed into this background paper and the associated discussion papers. They will also provide a major input to the formulation of a draft *People's Charter for Health* (PCH). These experiences

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will be presented and shared during the Assembly event.

The Assembly event

Scheduled for 4–8 December 2000, the Assembly will be held at Gonoshasthaya Kendra (GK), Savar, 37 km North of Dhaka, Bangladesh. We expect around 600 participants, representing people and their experiences from across the globe.

The Assembly will be followed by a three-day Follow-up Forum, where participants will have further opportunities to share experiences, network and meet with local community groups in Bangladesh. Through these interactions, the PHA will gather additional in-depth content.

Post-Assembly activities

The focus will be on disseminating, promoting and seeking wider endorsement and implementation of the *People's Charter for Health* and other materials generated by the Assembly. Advocacy and lobbying activities at the local, national and international levels will be planned, and mechanisms for further networking among participating individuals and organisations will be coordinated. The post-assembly activities will form a long-term process of organisation and action for change.

CURRENT STRUCTURE OF THE PHA

The PHA is currently coordinated by representa-tives of eight convening interna tional organisations (the Coordinating Group) which represent groups and networks actively involved in promoting health and people's empowerment around the world. Regional Coordinators have been appointed to facilitate the work of the PHA, communicate and foster participation in all regions. National Preparatory Committees are working in some countries.

There is a Secretariat in Savar, a Fundraising group and an drafting group. There is continuous communication between all these groups.

HOW YOU CAN PARTICIPATE in the PHA

We invite all people and organisations that subscribe to the concept of health as a human right and comprehensive Primary Health Care to participate in the PHA process.

There are several ways to participate:

- We invite you to share **stories and case studies** where you describe your health problems and / or locally generated solutions with the PHA.
- You can **organise meetings** in your community or organisation (please contact the regional or national coordinator for support and registration).
- During the pre-assembly process you can **participate in planned PHA meetings** at local, regional or national level (please contact the regional or national coordinator for a list of upcoming meetings).
- You can participate in the development of the PHA **analytical background documents** (such as this paper) and the **People's Charter for Health**.
- Some will be able to participate in the **PHA assembly** in Savar, Bangladesh, 4-8 December 2000. The number of participants will be approximately 600. Our aim is to ensure geographical spread and gender balance. Preference will be given to people from the grassroots level. To achieve this balance a participatory selection process coordinated at

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the regional level has been developed. (For further information please contact your regional or national coordinator).

Despite the relatively small number who will be able to attend the December event, we hope people will involve themselves in local, regional or national activities, contribute to the PHA documents and / or interact through our website (www.pha2000.org).

Application forms for the December meeting may be obtained from the PHA Secretariat or the regional coordinators (see addresses below).

The preparation of the **background documents, the People's Charter for Health** and **the Action Plan** involves two key components:

- the analysis of the causes of global and local problems affecting people's health and well-being, and
- a review of actions and alternatives people have adopted to cope with or overcome these problems.

We believe that, we will collectively produce solid, hard-hitting background documents that will provide some useful evidence to grass-root organisations in our fight to improve people's health and address the global health crisis.

The PHA drafting group has begun by drafting an overview paper (which you are reading right now) and five `sectoral' papers on the topics: the political economy of health, the social environment and health, the physical environment and health, the health sector and a paper describing strategies and methods to improve communication and learning. These papers can be used as discussion materials at your local, regional and national meetings.

We are also in the process of finalising a first draft of the People's Charter for Health as a basis for discussion. This Charter has as its starting point the Alma Ata declaration, the Patient Bill of Rights, Child Rights, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and other relevant people oriented declarations and Charters. We hope you will send us your comments and inputs in time for the Assembly event where the PCH will be endorsed.

We welcome feedback from concerned individuals and groups on all the documents prepared for the PHA, including this paper. Further, we would welcome your submissions of concrete action points that you would wish to see included in an overall action plan.

We urge you to help us identify suitable stories, case studies, papers and audio-visual materials that may illustrate some of the realities experienced by you and illustrate the points made in these papers (or points not yet made!). Such material is being gathered from all over the world and will serve as a basis for deliberations at the Assembly.

The draft background documents may be obtained from the
PHA Secretariat, Gonoshasthaya Kendra Savar
E-mail: phasec@pha2000.org or downloaded from www.pha2000.org

the PHA VIEW on world health

INTRODUCTION

The need for the `democratisation of global decisions' is critical as we move into the new century. Global policies affecting our present and future well-being are made by few powerful institutions like the World Trade Organisation (WTO), the World Bank (WB) and the International Monetary Fund (IMF), together with the transnational corporations (TNC) and the Northern and Southern governments supporting globalisation. These `power cliques' of the global economy are pushing globalisation at the cost of people's lives and the deterioration of the environment.

The resulting gap between rich and poor, both between and within countries, has led to deepening poverty, falling real wages, unemployment, deterioration of health, increased disease and disability, despair and a global epidemic of crime, violence, disease, disability and despair. While some people lead lives of over-consumption that damage their health and endanger the planet's ecosystems, millions suffer from hunger and deprivation. This unfair global socio-economic system is as unsustainable as it is inequitable. The ideology of 'growth at any cost' is leading, at an accelerated pace, to the disintegration of our social fabric and the destruction of the environment.

Despite this grim scenario, there is a myriad of positive examples of individuals and groups from all over the world, coming together to fight injustices and seek alternative solutions. While these movements are still in their infancy, they are beginning to threaten established power structures. In all the diversity of the causes they represent—health, agriculture, education, environment, human rights, disarmament, gender or ethnic equality—these popular movements are forming networks and increasingly discovering the common roots of their sectoral problems recognising the inter linkages and alternatives of action they can share and support.

Health, which in its fullest sense encompasses the physical, mental, social, economic, environmental, and spiritual well-being of people, is of concern to everyone and has the potential to unite a broad base of people's movements. The potential has never been greater and the need has never been more urgent.

The time to take united positive action is now!

THE STRUCTURE OF THIS PAPER

This draft paper aims to provide an overview of the current health situation, its major determinants and a number of suggested solutions. It also serves as an introduction to the five background papers and we hope it will be a source of inspiration when you consider the People's Charter for Health, and proposals for the Action Plan.

The analytical part of the paper begins with a discussion of the C*urrent health situation* in the world and a definition of *What we may mean by `health'*. It is followed by a discussion of the major *Causes and determinants of the current health crisis.* We have divided this into four broad sections: the political economy, the social environment, the physical environment, and the health sector. (These four areas are explored in more detail in separate background papers.)

Following the analysis, there is a section on S*trategies and actions for change.* This analyses and reflects on what is needed to challenge the current unfair and unhealthy situation. We conclude by offering some C*oncrete examples and suggestions for action* at different levels—from local to global.

Throughout the document, you may find questions that can be used to start discussions and give your feedback to the PHA process.
We are very interested in your feedback and suggestions on this draft paper.

THE CURRENT HEALTH CRISIS

An analysis of the health situation and its determinants is a story of inequality and unequal distribution. Although the last 50 years have witnessed improvements in life expectancy, declining mortality rates (especially infant mortality), and lower fertility rates in most countries, these numbers tend to hide the *real disparities* between and within countries, between social classes and between men and women.

In 1999, 20 million people died before reaching the age of 50, while the mean world life expectancy was 66 years. Taking this relatively modest age as a minimum of what should be morally acceptable, we can conclude that 40% of all deaths in that year could be considered premature and preventable.[1]

While *mortality rates* in children under five years old are less than 10 per 1 000 live births in most countries in the North, most countries in the South have rates of between 50 and 100, and over 10 countries in Africa have figures of over 200. Furthermore, in a number of sub-Saharan African countries infant mortality rates actually started increasing in the 1980s due to economic recession, structural adjustment, drought, wars, civil unrest and HIV / AIDS. Since the beginning of the epidemic there are more than 13 million orphans due to AIDS[2].

Even so-called developed countries have seen worsening of health indicators among certain sectors such as decreased life expectancy among males in rural areas in Australia brought about by long term unemployment caused by globalisation and consequence of depression and suicide. Other examples are found in the higher morbidity and mortality rates of Afro-Americans in the United States.

In short, despite some gains, we have not made substantive improvements in the main underlying determinants of health. Levels of poverty remain unacceptably high, natural resources have been drastically depleted and there has been further degradation of the global environment, in the longer-term threatening everybody's health. Although the world produces more than enough food to feed its entire population adequately and medical technology has made many advances, these benefits are unevenly distributed. Wealth and knowledge are increasingly concentrated in First World countries and the gap between the have and the have-nots continues to widen in all countries. This is a central issue of human rights and social justice.

Each year, over 12 million children continue to *die from preventable diseases*. An underlying cause in more than half of these deaths is undernutrition or hunger. 'Diseases of poverty', mostly infections and parasitic diseases, as well as women's reproductive health problems, and chronic diseases or 'diseases of modernity', are on the increase. Cancer, hypertension, diabetes, obesity, accidents and depression have become serious world public health problems. Third world countries are faced with the double burden of disease where infectious and chronic diseases are on the rise. This requires investment and adjustment of the health services which are impossible given the economic and political constrains they face.

There has also been a resurgence of '*old diseases*' such as tuberculosis, malaria, and vaccine-preventable diseases. This is as a direct result of increasing poverty, deteriorating living conditions and inadequate health services. New diseases such as *HIV/AIDS* have appeared and are spreading most rapidly where social and gender inequalities are the greatest. Increasing crime and violence add to this growing health crisis. The same is true for substance abuse, increasing violence, suicide and other 'diseases of despair.' Far from reaching the international goal of 'Health for All by the Year 2000,' the health of humankind is sadly compromised.

Equality between the genders has been on the political agenda of many countries and organisations, and progress is apparent in some countries. However, discrimination against women continues to be a world-wide problem seriously compromising their health. In some countries, discrimination

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starts before birth and remains part of women's lives until death. More than half a million women die every year due to conditions related to motherhood. The overwhelming majority of these preventable deaths occur in the developing world, especially in Africa.

The increasing number of *elderly* in all societies requires that conditions be created now for healthy ageing. Attitudinal, physical and economic barriers to the inclusion of *disabled people* have still to be removed to ensure their full participation in each society.

AIDS is set to alter history in Africa—and the world—to a degree not experienced by humanity since the Black Death.

Poverty and the lack of general medical care caused by rampant inflation and joblessness are major contributors to the AIDS epidemic in Africa – along with the social and cultural particularities of that continent. In Zimbabwe for example, nearly 40% of the women who present themselves for HIV counselling and testing turn out positive. Studies have also found that the HIV infection rate among 15–20 year old girls is five times that of boys of the same age. AIDS is really a development and poverty issue and should be treated as such.

Large numbers of people of all age groups are finding it harder and harder to cope with such characteristics of modern life as increased unemployment, solitude, crime, domestic violence, environmental degradation, mental health problems, and the lack of physical, emotional and economic support systems.

Important disparities also exists in the provision of health services. It is paradoxical but in the world's poorest countries, most people, particularly the poor have to pay for health care from their own pockets at the very time they are sick and most in the need of it. The World Health Report 2000 finds that "many countries are falling far short of their potential, and most are making inadequate efforts in terms of responsiveness and fairness of financial contribution"[3].

In the face of these alarming developments, more and more people are finding the need to organise themselves and find solutions to their underlying problems.

A central thrust of the PHA process is to foster and multiply such efforts through which people acquire the power to make the necessary changes.

What can you add to this overview of the current health situation?
Do you have experiences and/or knowledge that support or challenges these points?
What important aspects have, in your view, been left out so far?

WHAT DO WE MEAN BY HEALTH?

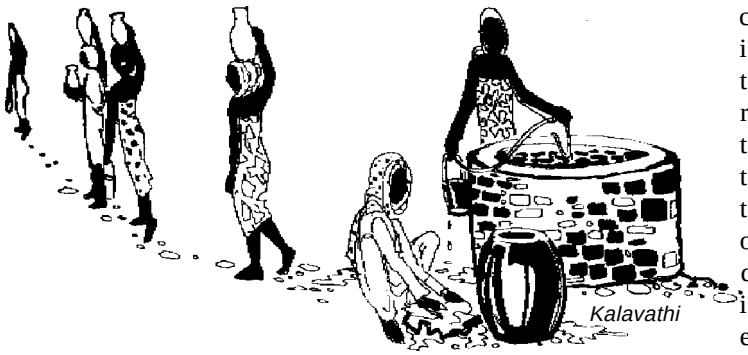
The paper is based on the objectives and aspira tions of the People's Health Assem-bly, which strives to ensure that all people, regardless of age, gender, race, disability, nationality, social class, caste, place of residence, and sexual or religious preferences, have the opportunity to fulfil their potential.

We accept the World Health Organisation's definition of health as a complete state of *physical, mental and social well-being* and not merely the absence of disease or infirmity. This holistic health concept views health as a state of equilibrium between human's external and internal environment.

However, in the PHA we take the issue of health further and see *health and sustainable well-being for ALL* as the central objective of social development. We see health as a fundamental human and social right to strive for.

To ensure health, peoples' basic needs for food, water, sanitation, housing, health services, education, employment and security must be met. To enjoy more than just physical health, people need self-esteem; they need a sense of purpose, meaning and belonging. Healthy societies require a balance between individual freedom and responsibility. Love, culture of compassion, care and respect for life and spirituality are as important to the well-being of individuals, communities and nations as is the economy.

Do you agree with this view on what health consists of?
Do you have a different definition of health?



Kalavathi

DETERMINANTS of the HEALTH CRISIS

The PHA is founded on the belief that *together we can build a better world*, and that *organised grassroots action* can bring about positive social change. Action for change needs to be grounded on a sound assessment—or 'situational analysis'—of the current reality. Such a collective analysis needs to explore the immediate, underlying and basic causes of ill health and how these relate to the interconnected crises of our times.

This paper starts by looking at the problems that face humanity and compromise its health. Some pointers follow this to ways forward. It discusses methods of awareness-raising, and explores a range of possibilities for positive, constructive action. It includes examples of effective action people have already taken to change their situation.

Causal factors affecting health

Different factors, acting at different levels, determine the health of individuals, families, communities and nations.

The most **immediate factors** that affect health relate to starvation, lack of access to water, inadequate food intake, exposure to infectious diseases, intoxication from an unhealthy environment, smoking, inadequate treatment by health services, accidents and violence. The **basic factors**, in turn, relate to lack of food security, lack of safe water, unsafe working conditions and the way the health services are organised in terms of their accessibility, adequacy and quality. The **underlying causes** are those major cross-cutting issues such as the shape of the economy, environment, agriculture, employment, fairness of wages, human rights, gender issues, and education.

These factors are **interrelated** and reflect the economic and socio-political conditions of a country—and increasingly, our globalised world. In order truly to achieve health for all, far-reaching transformation of society at the underlying level is needed. Such transformation must be directed towards a more equitable distribution of power and resources, participatory democracy and good governance with improved accountability and transparency.
Health cuts across all aspects of soci-

ety. Any division into clusters or thematic areas is therefore arbitrary. For purposes of our analysis we have chosen to present them in the following four areas:

1. The political economy
2. The social environment
3. The physical and natural environment
4. The health sector

1. The Political Economy of health

The most significant determinants of health in the world today are economic and political factors that have colonial roots. Who has control over resources and decision-making, and who has the power over whom, determines the way countries and the world are organised and ruled. This impacts on the health status of people and the way health services are organised. Most of the *underlying* and *basic* causes of ill health can be found here and the solutions being offered benefit much more the planners, loan givers -usually international financial institutions and the associated governments- than the recipients. Their needs are usually not met and end up loaded with heavy debt servicing, which results in further expenditure cuts in essential social services. From a health point of view, the current trend towards economic globalisation, the lack of equity and distributive justice aggravates the growing health crisis and widens the growing inequality gap.

Statistics show the existence of overwhelming inequalities in the world today:

- Total GNP per capita (global production per person) has more than doubled in the last 50 years. More than enough food and goods are produced to meet all people's basic needs. Yet one in every four children is malnourished.

- At the end of the 1990s, a fifth of the world population living in 'rich' countries commanded 86% of the world's GNP while the poorer fifth commanded only 1%.[4] As a result, poor people are denied access to basic resources like food, clean water, shelter, a safe and clean environment, and are increasingly exposed to violence.

- Wealth and power have become more and more concentrated in the hands of a small powerful minority. A handful of transnational corporations (TNCs) currently control 33% of the world's productive assets, while they employ only 5% of the global workforce[5] . Annual turnover of many TNCs exceeds the annual budgets of several large developing countries.

- Today the 450 richest persons in the world have an annual income greater than that of the poorer half of humanity. While the chief executive officers of giant corporations have incomes in the millions of dollars, one fourth of the world's people struggle to survive on less than USD 1 dollar per day. Many have to do so by selling their last resource, namely themselves, that is their blood, organs and engage in sexual slavery.

- Financial institutions such as the World Bank and the International Monetary Fund have been major influences in determining the current model of development. They have universally prescribed structural adjustment programmes (SAPs), which have cut employment and investment in the social sectors, and removed protection to local industries, barriers to outflow of funds and labour regulations. These programmes have had important consequences for the level of investment and development of the health services as well as for the major determinants of health.

It is not absolute shortage but rather the increasingly unfair distribution of resources that leads to the current unacceptable levels of hunger, poor health and impoverishment. It is the globalisation of the inequitable and unsustainable market economy that underlies the overwhelming health, environmental and socio-political crises of our times.

a. Globalisation – some features

Not only has the gap between the rich and the poor widened dramatically in recent decades, but globalisation has aggravated the hardships of the disadvantaged millions. A host of laws, policies, and trade agreements have been introduced, which advance the planetary reach of TNCs and speculative investors. At the same time the rights and self-determination of the poor and relatively powerless peoples and nations are undermined.

What are some of the impacts of the current thrust of globalised economy?

- It has increased poverty, which is the single most important underlying factor causing ill health.
- It has increased the disparities between the rich and poor, further fuelling poverty and disrupting the social fabric of individual nations.
- It is driven by short-sighted, growth-centred economic policies, which lead to overexploitation and destruction of the environment. This affects the health of people and threatens the medium- to long-term life-support systems of our earth.

- It is directed by corporate interests with profit maximisation as the primary objective.
- States are reluctant and unable to take responsibility for the common good. Greater debt burdens have not facilitated the economic situation many states find themselves in.
- Global competition drives companies to cut costs and places further pressure on individual countries to 'sell out' their environment and labour standards.
- Growing unemployment and underemployment leads to further social problems and ill health.
- Weakened tax bases, forced decreases in import tariffs and lifting of quantitative restrictions obstruct countries' ability to provide basic social services. Severe cut-backs in the social and health sectors have a direct effect on the health status of people.
- This globalised 'casino economy' is increasingly removed from any connection with place and reality, and is characterised by enormous financial flows and speculation. Profit maximisation for shareholders is a driving force. Ironically, a significant proportion of the shareholders is made up of ordinary workers in the North, who through the speculation of their pension funds, accelerate the trend towards cost-cutting—thereby risking their own jobs and social security.

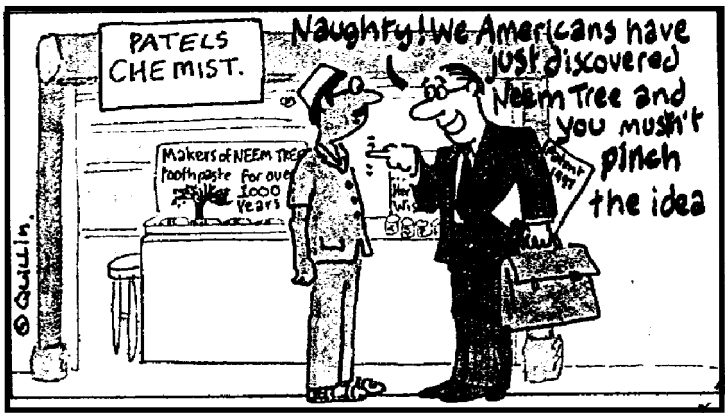
Further features of the globalised economic order can be identified :

- The emphasis on free trade has increased the 'unfair trade' between developed and developing countries. This has seen the devaluation of Third World currencies— supposedly implemented to increase developing countries' export trade, but instead having the effect of depressing the wages and standard of living of vast segments of the population around the world.
- There is an increase in the rate of unemployment—seen even in developed countries. Increasing numbers of people, especially the young, are unable to find jobs in the formal sector—which traditionally provided security and a sense of stability. As a consequence, large numbers of people, including 100 million children, are forced to seek employment in the informal sector.
- An increase in the external debt of Third World countries has meant that a significant share of their income is used to pay back their debt with often crippling interest rates. This has resulted in an increased flow of resources from the Third to the first World.
- The implementation of economic reform programmes such as SAPs has destroyed the domestic economy, limited governments' positive participation in their economies by reducing their employment capacity as well as public spending in critical social services such as education and health.
- Human and environmental costs are secondary in the thrust to privatise virtually all sectors of production and public services. More value is placed on private profits for the fortunate few than on public goods for everyone.
- It has increased the unit cost of development in poorer countries thereby increasing corruption and dependency.
- For the marginalised population, all these increased hardships have led to widespread deterioration in physical, mental, social and environmental health.

As 'big industry' increasingly shapes the world, policies that protect human well-being are systematically eroded. The production of harmful technology, goods and products, in it a crime against humanity has proliferated out of control. The world's three largest industries—weapons, illicit and addictive drugs, and oil—all promote their products in ways that contribute to physical and structural violence. These industries take an enormous toll on human and environmental health. The tobacco, alcohol and pesticides industries, among others, have powerful political lobbies, ensuring that weak governments subsidise rather than seriously regulate or restrain them.

The military industry is very large and profitable and depends on conflicts and violence, which are so prevalent. In 1999 it was worth USD 745 billion dollars, USD 125 dollars per capita. The poorer regions spend the highest percentage of their GNP on the military, many times their health or education expenditures.[6]

On the other hand, new international organisations such as the WTO are increasing their influence, through various agreements, and having an ad-



verse impact on health, food security and the environment. The Trade-Related Intellectual Property Rights (TRIPs) regime that, among other things, allows patenting of seeds will pose a threat to genetic resources, sustainable agriculture, food security and the well-being of farmers. Increasing patent protection will lead to increasing prices and reduced access to medicines, which will continue to be under monopoly control.

TNCs are promoting and dumping harmful products, processes and technologies such as tobacco, asbestos, pesticides, dioxin, genetically manipulated foods and genetically engineered seeds without adequate biosafety trials and dumping of toxic waste. In particular, they are releasing toxic, chemical and nuclear materials in Third World countries where they benefit from weak governments and weak prohibitive legislation.

What is the impact of globalisation in your community?

2. The social environment

As a result of these economic and political factors, there is an increasing erosion of the social fabric of societies, institutions, communities and families.

a. Weakening of institutions

One important trend resulting from the current global socio-economic development model is the weakening of national public institutions with forced rapid privatisation of services and disinvestment of public sector institutions, which is increasing unemployment, creating social and financial insecurity and decreasing government control and accountability. At a time when governments need to increase their capacity to create and enforce mechanisms that will ensure equity and participation, governments around the world are in fact losing their capacity to fulfil their basic responsibilities of ensuring security and promoting equity. Increasingly governments' roles and responsibilities are being transferred to the private sector, corporations and other national and international institutions, which are not transparent or accountable to anyone.

Other traditional institutions, such as political parties and trade unions, are under increasing stress. People no longer feel that political parties represent their interests, and they are disillusioned with the electoral processes—this is at a time when there is an increasing need and demand around the world for greater democracy and participation.

Trade unions are under threat of losing their constituencies and the confidence of workers. This is mainly as a result of the current trend towards individual, productivity-oriented labour relations, which do not foster workers' organisations and in many instances represses them. At the same time there is a new trend where workers' organisations in different countries are organising and addressing issues related to international agreements, taking a labour perspective, supporting each other and challenging the unjust corporate decisions.

There is increasing use of money and disinvestment of public sector institutions, which is increasing unemployment, creating social and financial insecurity and decreasing government control and accountability. Corruption is endemic in all kinds of institutions, playing a further role in weakening their legitimacy.

b. 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. Globally more than 35 million people are unemployed, and another 10 million are not taken into account in the statistics because they have given up looking for a job. Among youth, one in five is unemployed.

In both poor and rich countries, the neoliberal model, with its economic and corporate restructuring and dismantling of 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.

c. The role of corporate media

The promotion through corporate media of unethical advertisement and unhealthy lifestyles have displaced indigenous, natural nutrition and cultural practices (e.g. bottle-feeding versus breast-feeding, fast foods replacing nutritious and cheaper local foods). In addition media is also promoting tobacco, alcohol and drugs.

Through unethical and aggressive promotion

corporate media is presenting women as sex objects, which has a negative effect on their self-esteem and image, is degrading, worsening discrimination and increasing violence.

d. Conflict, violence and war

War and conflict over control of resources are present in every region of the world (e.g. Sierra Leone over diamonds, Iraq over oil). Intolerance and increasing conflicts over ethnicity and religion have divided communities and created war and destruction, especially hurting and maiming women and children. The dislocation of populations due to migration for economic, political, and ethnic conflicts has a direct influence on the health and well-being of millions of people and an important number of people are disabled as a result of land mines explosions.

Violence in all its forms is present in every society. We are witnessing an increase in domestic violence, human trafficking, children soldiers and drug-related violence.
The sex industry has expanded as women and children are pushed into prostitution to try to ensure the survival of their families and dependants. Sexually transmitted diseases and AIDS are most common where there is the most exploitative gap between men and women.

e. The family

Adverse socio-economic conditions have altered traditional family structures all over the world. There is an increase in the number of divorces and single parent families, without the required social and economic structures to support them. This is especially taxing on women who find themselves under greater stress as they are left with the responsibility of caring for the home, and trying to eke out a living.

f. Education

Education inequalities—in access, attendance, quality of teaching and learning outcomes—perpetuate income and social inequalities in developing countries across the world. Poor children attend poor schools and have less opportunity to complete their basic education or go on to secondary and higher education.

Misallocation of resources, inefficiencies or lack of accountability are prominent attributes of the organisational structure of education in developing countries, contributing to the poor state of education.

Is the situation described above relevant in your setting?
Are there other important social factors in your community and country?
What are people and governments doing to address them?

3. The physical environment

Although the destruction of the environment is not new to the present era, it is reaching unprecedented levels. Fuelled by a runaway global economic system, the resulting environmental deterioration threatens to harm the planet's ecosystems irreversibly. If not urgently countered, global environmental changes will endanger our entire social and economic systems, with disastrous effects on the health and even survival of our own and many other species.

a. Environmental threats to health

Environmental threats to people's health are both direct and indirect.

Direct threats include exposure to toxic substances, contaminated water, polluted air, radioactivity and environment-induced natural disasters. New technologies such as genetically modified foods and nano-technology can compromise health and upset ecosystems.

Indirect threats include environmental degradation, for example, food shortages due to the changing climate that damage both farmland and forests. There is an increase in health problems among 'environmental refugees' in situations where people are forced off their homelands because of the destruction of local environments; and people are being killed or maimed in wars fought over scarce natural resources.

Environmental problems may have *immediate* or *delayed* effects on health.

Immediate effects are easier to recognise. For example, people get sick from drinking chemically and biologically polluted water or breathing air polluted by poisonous chemicals, or starves because farmlands have been destroyed with crop failure, pests and climate changes.

Delayed effects are often more difficult to link to their causes. For example, there is an increase in the incidence of cancer believed to be caused from exposure to pesticides, carcinogenic chemical substances, or low levels of radiation used in industry and food-processing. These threats have an erosive effect on the health of the people of our planet.

Changes in the environment pose some of the most alarming threats to human health. Changes in the world's climate caused by global warming are a threat especially to islands and coastal areas, where increased incidence of droughts and floods could kill millions of people and cause new health epidemics. In the future whole regions may lose their capacity to grow food.

Disputes over resources have already lead to regional wars (for example, oil in Iraq, Nigeria and Somalia, forest in the Amazon and Sawara, Diamonds in Sierra Leone). In the near future, ownership of biologi-

cal wealth through unjust international regimes of TRIPS can also lead to conflict.

b. A crisis of justice

The environmental crisis is a crisis both of nature and of justice. Although the growing population of the Third World is often blamed for the destruction of the environment, the industrial societies in the North and the elites of the South are in fact the major culprits. On average, a person in the United States consumes about 50- 100 times as much energy, water and non-renewable resources, and leaves behind 50-100 times as much garbage and pollutants, as does a person in Bangladesh. Yet the Bangladeshis will suffer much more from environmental imbalances.

Millions of people's health will be at risk as the climate changes and global warming causes sea levels to rise, largely a consequence of affluent lifestyles in the North. In both the North and the South, the poor and marginalized will suffer the most. They have the most environmentally hazardous jobs, live closest to waste dumps and polluting industries, and are the first to become environmental refugees as their livelihoods are destroyed.

The need for GNP growth and industrial development in the South is undisputed. However these processes need to be based on environmental regeneration rather than continued environmental degradation, to ensure the sustainability of the planet and the well-being of the populations in the South.

c. Underlying causes

Our current environment and health crisis is associated with the following:

- The misleading view of progress and development as a universal, linear pattern of societal change where different societies all take part in the same race towards industrialisation and ever-increasing wealth;
- The notion of nature as an inert, mechanical construction, existing only to be extracted and exploited for human short-term benefit;
- The failure of economics to base its theories in an environmental context and to recognise ecological constraints;
- The unsubstantiated belief that neoliberalism, corporate concentration and unchecked international trade policies will lead to 'trickle down,' fairer consumption patterns and the eradication of poverty.

In your opinion, what are the environmental threats to your community?
What is producing them?
Is this an issue for you or your organisations?
Is something being done?

4. The health sector

Health services today are **inaccessible, unaffordable, inequitably distributed and inappropriate** in their emphasis and approach.

Throughout history societies have responded to illness and disease by organising their health services, with different approaches, practices and staffing. In most countries traditional and Western medical systems have coexisted and people have used them either for different purposes, or in an arrangement that suits their needs and resources. People make the initial decision of what system to use depending on their culture, perceptions and assessment of either system's capacity to solve their problems, as on the accessibility of both systems.

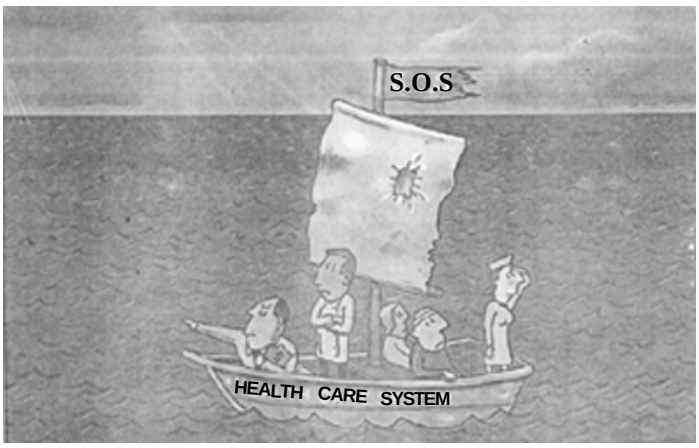
The particular organisation of a system depends on the mix of human, financial and material resources. In most countries the Western medical model is applied in the public and private sectors. The extent and level of care provided by different countries range from universal public services (Cuba), universal health insurance (most countries in Europe, Canada and Australia), to a variety of social security schemes (Mexico) or of private schemes (United States).

There are innumerable examples of peoples' struggles for health over the last century, with different countries and communities evolving their own systems to manage illness and health. Community-based Primary Health Care (PHC) programmes developed by communities and trained community health workers (CHWs) have been very important in the improvement of the health conditions of many rural communities around the world.

The effectiveness of these experiences were recognised and became the basis of the 1978 Alma Ata Declaration, where comprehensive PHC was accepted and endorsed by all the WHO and UNICEF member states. The prime basis was the acknowledgement that we need to act upon the underlying determinants of health, including those political and economic factors that determine the health status of people and populations.

The economic policies of the 1980s led to the implementation of structural adjustment programmes (SAPs), which increased the pressure on governments to decrease their participation and commitment to universal health services, limited the implementation of comprehensive PHC and promoted a wave of health care 'reforms'.

The widespread efforts and experiences of PHC projects in the 1970s and early 1980s were boycotted or ignored, and the projects themselves were under pressure to abandon their comprehensive approach



a. Health care as a commodity

Health care has been converted from a basic right into a product that can be sold or exchanged for profit, resulting in an emphasis on the curative aspects of health at the expense of the preventive and promotive dimensions of health care.

The dominance of curative care has been reinforced by the commercialised and pharmaceuticalised health care industry, the medicalised education of health professionals and a renewed emphasis on "cost-effective" health interventions.

in favour of more 'practical and feasible' strategies, *i.e.* selective primary health, child survival, other limited targets and now vertical programmes pushing limited agendas.

Severe cuts in national budgets for health resulted in the deterioration and often the collapse of services at many levels. These conservative fiscal policies, with inadequate resource allocations for capital and recurrent costs, resulted in deteriorating health facilities, shortages of equipment, drugs and transportation, reduction in the numbers of health personnel, and deterioration in their performance as a result of worsening working conditions.

The funding cuts brought about by certain components of Health Sector Reform, notably decentralisation and privatisation of services, concentrated health services in urban and affluent areas. While decentralisation of health care management has been promoted as a mechanism to improve the efficiency and accountability of health services, it has, in effect, frequently become a mechanism for further withdrawal on the part of central government from their financial responsibilities.

Health Sector Reform has promoted privatisation through such mechanisms as public–private partnerships and other approaches to health-financing. These initiatives, together with the lack of human and other resources in the underfunded public sector, have led to the rapid growth of self-medication and a growth of the private health sector. Large numbers of poor people have been left with little or no access to any health care.

In this context however, many communities have strengthened or developed their programmes and there are examples of CHWs working in non-governmental community health programmes which are addressing people's needs.

What is your experience of privatisation of health services?

The past decades have witnessed an increase in the influence of the health care industry that produces, for example, pharmaceuticals, medical equipment and baby food. Funding for research on 'diseases of poverty' is minimal compared to that allocated for the study of 'diseases of affluence' in the industrialised world.

The medical equipment industry has mushroomed. Although this has facilitated the diagnosis and treatment of some conditions, it has driven up medical costs, has further inflated the 'magic bullet' myth of curative care and rendered services less affordable to the poor—or put them out of their reach altogether.

Health professionals' education remains dominated by a biomedical approach (treatment of illness rather than promotion of health). With few exceptions, training programmes have failed to integrate the principles of public health and PHC into their core curricula. PHC has at most been a small component of a marginalized public health course, rather than informing the whole curriculum.

b. Problems in the implementation of PHC

The institutional mechanisms needed to implement comprehensive PHC have been relatively neglected. Insufficient thought, resources and energy have been allocated to important aspects of PHC, such as the development of intersectoral action and community involvement. Little effort has been made to incorporate the lessons learned from the innovative experiences of a multitude of community-based health projects. The dominant technical approach is medically driven, vertical and top-down and reflects in the organisational structuring of many ministries of health and the WHO itself.

Many PHC projects today focus on medical and technical interventions, such as the child survival initiative, which mainly promotes two 'technological fixes'—immunisation and oral rehydration therapy.

This trend has been reinforced recently by new methodologies designed to promote cost-effectiveness in health. The development of DALYs (disability-adjusted life years) as an index to quantify the burden of disease, and to cost the effectiveness of certain interventions, has resulted in the shift of focus towards selected medical technologies at the expense of broader social interventions. The DALYs approach, promoted by the WB, and uncritically embraced by WHO, has also in effect devalued important aspects of health care, such as caring, which cannot be easily measured for cost-effectiveness.

c. Health care as an instrument of social control

Health care is increasingly used as a subtle and widespread instrument of social control. Central to this is the ideology of medicine, which mystifies the real causes of illness, often attributing disease to faulty individual behaviour or natural misfortune, rather than to social injustice, economic inequality and oppressive political systems. This is particularly apparent in situations of war and political oppression.

Examples of such victimising and conservative approaches to health care include the heavy-handed promotion of family planning, in isolation from social development, as a means of population control. Further oppressive forms of health education, which tend to blame ill health on people's 'lifestyles' while neglecting the social determinants of their 'bad habits' and patterns of consumption, are dominant.

We would like to know how accessible health services are in your community and if you think there are problems in the way they are organised and managed.
Are the services comprehensive?
Does your community feel they address your needs?
What is the role of health workers?
What are their work conditions like?

THE WAY FORWARD

challenging the current INEQUITABLE and UNHEALTHY GLOBAL MODEL OF DEVELOPMENT

1. Movements for change

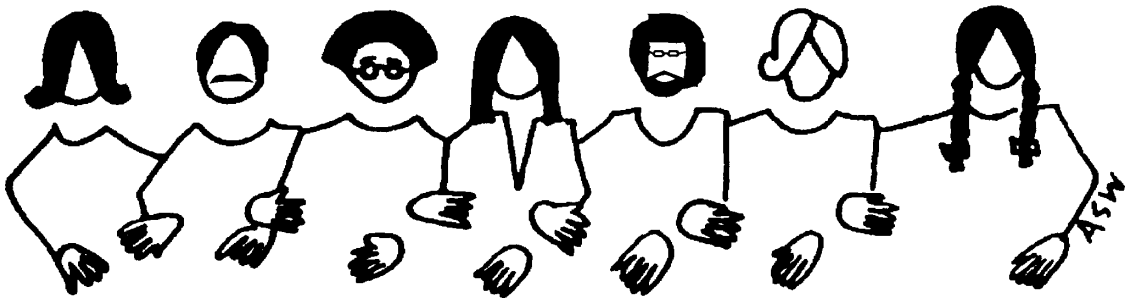
The dimensions and complexity of the major problems affecting human and environmental well-being today are hugely different from the situation that confronted past generations, and far more difficult to challenge. There was a time when people in one part of the world could come together and take a stand against unfairness or injustice at the local or even national level and succeed. Today, the forces that threaten human and environmental well-being are increasingly global, powerful, sophisticated and well coordinated.

New strategies are needed in the struggles for social change, to match the size and character of the forces that we are dealing with.

Actions for positive change need to be taken at the local, national and / or international level. Individuals, groups of concerned people, progressive organisations, or networks of national or international coalitions can take them. In today's world, where obstacles to personal and community well-being are rooted in global policies and decisions, actions to resolve injustices at the local level should lead people to join in more far-reaching global action for change.

In the struggle for a common cause, there is a need to bring together:

- a wide range of diverse sectors and movements;
- activists from all nations;
- concerned people of different races, classes, castes, sexual preferences, ages and professions;
- people and groups whose work for change is focused at different social levels: individual, family, national and global;
- NGOs, labour unions, women's and human rights groups, watchdog groups, environmentalists, health promoters, community health workers, progressive political parties, social activists in diverse fields, eco-economists, peace / anti-war and anti-nuclear groups, groups working for universal health coverage.



As the worldwide crisis deepens and more and more people from all positions on the social spectrum begin to realise that the current global economic system has lethal flaws, the groundswell for change is gaining momentum.

There is an urgent need for a new, alternative vision of development—one that promotes human and environmental well-being.

Such a vision is taking shape among many people's organisations around the world. Despite their diversity, certain common threads stand out. These include:

- an attempt to increase public participation to counter the concentration of economic, political and corporate power;
- an effort to establish healthy communities;
- reshaping the global economic order to ensure environmental sustainability, equity and social justice;
- the call for a closer and more spiritual relationship with nature and communities; and
- a commitment to collective solutions that maintain considerable individual freedom.

The quest for sustainable societies calls for drastic changes in the current world order. It requires the formation of strong broad-based people's movements. All movements (health, environment, social, women, among others) must join forces and be seen as part of the same, overall movement for social change, social and gender justice.

We need to focus on a wide range of issues including corporate responsibility, election financing reforms, social and gender justice, foreign debt cancellation, corporate accountability, participatory democracy, disability and elderly rights, progressive education, biodiversity and community health care.

2. Types of Action for Change

What types of action are available and have been used successfully by individuals and movements working for change? The possibilities are numerous and have proven to be effective time and time again.

- Actions to **counter misinformation** and raise awareness;
- activities that help **empower people** to assess their needs without mystified prescriptions and to take action themselves;
- activities to promote better **coping strategies**, provide **services** and develop local **alternative solutions** to immediate problems;
- actions that drastically improve **networking** and information-sharing;
- actions that promote **solidarity** between and among people's organisations;
- exerting and multiplying **political pressure** to counter policies and decision-making that only benefit the few;
- **pressure governments** to involve pro-people organisations in policy decisions;
- actions to **claim rights** and force those in power to listen;
- promote **self-governance** by the people;
- acts of civil resistance;
- **economic pressure** through our roles as consumers, taxpayers and holders of investment funds;
- advocate **participation** in social and political events at all levels, from the villages, regions, nations and internationally;

The way forward is not only paved by grand designs. There are many ways to contribute to a healthier world. All meaningful gestures and small personal acts of kindness and solidarity also matter. Because this is not enough, we have to work together to plan action that goes from the local to the global level. That is our challenge for this decade and beyond!

Building on people's positive traditions is an important way forward. By way of example, in the

Punjab of India, even in the poorest communities there are almost no street children. Families traditionally welcome children into their homes, including those who are orphaned or abandoned. Through their tradition of helping one another in hard times, people living in extreme poverty find ways of coping. But coping is palliative; overcoming and resolving the causes is the challenge.

Action for positive change can be approached in many different ways, most often beginning with a particular focus of concern, such as on environmental issue, changes in health policies, globalisation, economic equity, fair trade, women's rights, debt cancellation, or food security. It is important, to coordinate activities and work together with organisations, movements, NGOs and community groups that have a track record of being 'community-supportive' at the local, regional or national level.

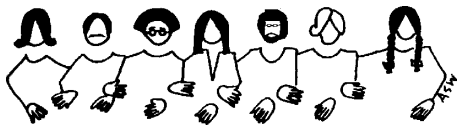
What follows is a selection of different approaches of taking action for change. With each approach, an example of programmes, networks, or coalitions working in this field are given.

a. Awareness-raising and empowerment

Misinformation has become the modern means of social control. People—regardless of educational level—often have little knowledge of the injustices done to disadvantaged people. The media has a way of keeping us strategically misinformed.

Only when enough citizens become fully aware of the issues will it be possible to place the common good before the interests of powerful minorities. Creating such public awareness is an uphill struggle. More empowering forms of education and information-sharing are needed. Currently, schools tend to teach history in ways that glorify those in power, and follow teaching methods that instil conformity and compliance.

To counter this misinformation and to mobilise people for a more equitable society, we need *alternative methods of education and information-sharing* that are honest, participatory, empowering and that can bring people together as equals who can critically analyse their reality and take united action.



Project Piaxtla in Mexico has developed different educational methods for information sharing. Since the mid-1960s, the village health promoters working in this rural area have developed interactive teaching methods to help people identify their health needs and work together to overcome their problems. As a result, resource books such as W*here there is no doctor, Helping health workers learn and Nothing about us without us* (by David Werner) are now used as educational tools worldwide.

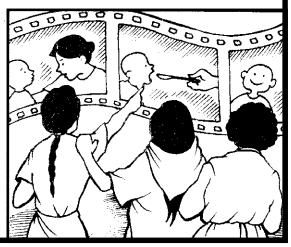
Another method developed by this project and later shared with other organisations in Central America and Asia is the **Child to Child** programme which works with school-age children learning ways to protect the health of other children. Children learning through experience do that. Children conduct their own surveys and discover answers for themselves; they learn to work together to help each other.

Further, we have to build on global solidarity and find ways to communicate truthfully and directly. ***Alternative media***, including the Internet, for those with access to it, provide avenues to be exploited. Storytelling, street theatre, awareness-raising comics and novellas, as well as community radio and TV, and the alternative press, offer vital complementary outlets that we need to use more efficiently.

A few examples of alternative periodicals that provide examples of watchdog initiatives and grassroots action for change include:

Multinational Monitor
YES, A Journal of Positive Futures
Third World Resurgence
Resurgence
The New Internationalist
The Nation
Dollars and Sense
The Progressive
Health for Millions
Z Magazine
Mother Jones
HAI Bulletin
Medico Friends Circle Bulletin
Journal of Medical ethics
Beeja
Health Action

Telemanita is an NGO working in Mexico, that has been training women to use video technology to make their own documentaries, promotion and training materials.



b. Activities that empower people to take action

Community-based health programmes and community initiatives in health care planning and development in various countries have brought people together to take back control over their health and raise awareness of the underlying causes affecting their health. These programmes start with a community diagnosis where it becomes clear to people that inequality and the power structures that perpetuate them are the root cause of ill health.

A *community diagnosis/situational analysis* is one way of starting a group learning process —participants are able to identify and prioritise health-related problems and other shared concerns.[7]

Gonoshasthaya Kendra (GK*)* is a community health and development programme in Bangladesh, which began during the war for national independence. Village women have become community health workers and agents of change. Villagers collectively analyse their needs and build on the knowledge and skills they already have.

Using this approach GK has expanded in many areas. It has different training courses that enable women (in particular) to get non-traditional jobs. GK is currently working in 13 Districts and 21 sub-districts where it covers a population of over 600,000.

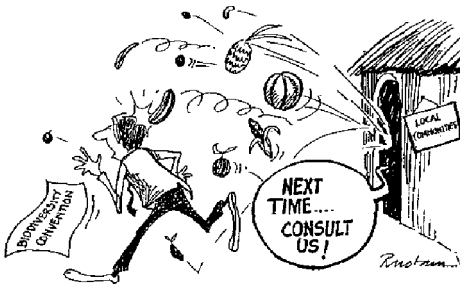
The Centre for Information and Advise in health (CISAS) Nicaragua provides popular education and communication services since 1983. Health work is seen as an instrument for communities to develop and organise, think and transform their reality through collective action. It has different offices and documentation centres throughout Nicaragua and is active in the coordination of regional primary health care networks. All its work has a gender perspective.

Are you aware of any successful examples of similar community-based initiatives?
Do you know of any story or case study that would illustrate or add to some of these points?
Can you help us enrich this resource by sharing your own experiences?

c. Networking and information-sharing

Effective international South–North advocacy networks on health and equity issues are being formed. These link together existing and newly established networks active in Public Health, bridging continents and connecting grassroots movements with people working on lobbying and advocacy.

By joining forces we are able to consolidate a stronger base to confront injustice and inequity. Strength in numbers not only gives us protection but also makes us a force to be reckoned with. Networking allows for cross-fertilisation of experiences, methods and ideas. People need to know what efforts are being made elsewhere to oppose global forces and improve communities' conditions.



Health Action International (HAI) lobbies governments and international bodies (such as WHO) to formulate codes, pass resolutions and develop policies to ensure that people who need them have access to safe, appropriate and affordable medicines and these are used rationally. It monitors the unethical behaviour of industry and the selling and promotional practices of drug companies. It challenges international regimes of TRIPS and WTO.

The **International People's Health Council (IPHC*)*** is a coalition of grassroots health programmes, movements and networks. It is committed to working for the health and rights of disadvantaged people. It strives towards a model of people-centred development, which is participatory, sustainable and makes sure that all people's basic needs are met.

Self-employed Women's Association (SEWA) in India is a Trade Union of women in the informal sector based on Gandhian ideology. It has linked workers rights with health and economic rights. It supports different services: training programmes, health services, loans, income generation programmes and finds markets for women crafts.

Electronic networking for change needs, wherever possible, to be exploited more decisively as a useful avenue for dialogue between grassroots groups engaged in popular struggles. Currently, however, computers and the Internet are available to only 1% of the world population.

Hundreds of progressive, social-action and environmental action 'e-groups' exist. For example:

- **Equinet** is a mostly African discussion group of activists working for fairer, more equitable distribution of health and other resources.
- **E-drugs** is a group that shares information about essential drugs, relating to policy, product safety, quality and rational use of drugs.
- There are different e-groups dealing with HIV/AIDS both from the medical and the human rights perspective.

d. Political pressure and resistance

Watchdog groups and organisations working for corporate accountability and social justice have an important role to play. A watchdog group is a collective of people who monitor the activities of corporations, government agencies or international institutions, and 'blow the whistle' (and encourage public protest) when these entities violate human rights or endanger human or environmental well-being.

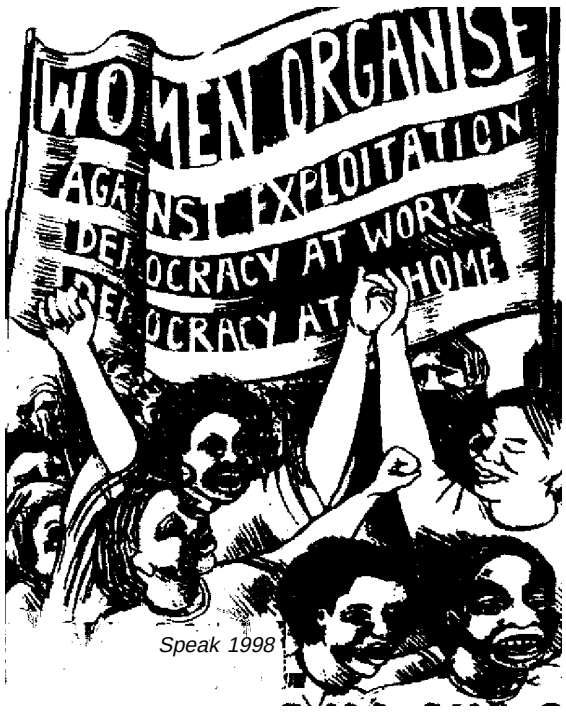
Watchdog groups are proving influential in curbing the abuses of big business, especially in the absence of needed government regulations. Often, their most important weapon is to raise public awareness and outrage, motivating people to take action. Where the mass media is unsympathetic to the issues raised, we need to utilise the alternative press, radio and community TV.

Bank Watch monitors and reports on the policies and projects of the international financial organisations**,** especially the World Bank.

The **'50 Years is Enough' alliance** has involved over 200 organisations around the world and demanded that the World Bank stop its policies and programmes that favour the interests of big business at the expense of human and environmental well-being. In the United States, 50 Years is Enough lobbied the government to restrict funding of the World Bank and International Monetary Fund until they improved disclosure, environment, and workers' rights policies.

The **International Forum on Globalisation**, with citizen representation in both the First and Third World, is one of the leading collectives of activists attempting to raise public awareness on the health and environment-damaging aspects of the global economy, as well as pushing for corporate accountability. It has successfully campaigned with others against MAI and contributed to it being squashed.

The **International Breast Feeding Action Network (IBFAN)** is involved in health education about the importance of breast-feeding; at the international level, it campaigns to stop the unscrupulous promotion of bottle-feeding by transnational corporations. IBFAN spearheaded the world-wide ***boycott*** of the Nestle corporation and stood behind the International Code on breast milk substitutes introduced by UNICEF, WHO and the United Nations and endorsed by virtually every nation except the United States. At the national level, to give the code legislative support, the government of Papua New Guinea passed a law prohibiting the sale of baby bottles and infant formula except by prescription. What started out as organised action by a group of concerned women has gone a long way toward raising public consciousness and opposing the profit-before-people behaviour of giant transnationals.



Speak 1998

Advocacy and lobbying can play a particularly important role in the struggle to improve policies both at the national and international levels. In this area, efforts are made from the local to the international level.

An example is the campaign of the **Multinational Resource Centre** and the **Physicians for Social Responsibility** against the burning of hospital waste, an industry that contributes to poisoning the global atmosphere with dioxins, mercury, and other deadly and cancer-causing poisons. They are protesting against the World Bank for promoting the use of these medical waste burners in health sector projects in at least 20 countries. A Senegalese anti-incinerator network says of the World Bank's health sector projects in Africa, 'We want funds to treat us and not to poison us'.

The **Zapatista uprising** in Chiapas, Mexico, was launched by a handful of impoverished tribal people on 1 January, 1994, the day that the North American Free Trade Agreement (NAFTA) came into effect. The Zapatistas did not want to overthrow the Mexican government, but to make it respond to the people's most basic needs for land, food and health care. At first, the Mexican government tried to crush the 'mini-revolution' by brutal military might. But through their well-planned communications network (including the Internet) the Zapatistas sent an SOS to people's organisations, progressive NGOs and news reporters around the world. To a large extent it was the international outcry that forced the Mexican government to hold back its assault and enter into negotiations with the Zapatistas. While the results so far have been far less than hoped for, at least some of the laws protecting the rights of small farmers were partially reinstated. The struggle continues to this day and international support continues to be vital to its success.

Advocacy efforts in the area of trade and investment are increasing in order to oppose threats to equity-oriented health policies and systems, such as the current developments in the areas of services and government procurement under the WTO and the plans to establish a multilateral investment agreement. Advocacy can be focused on specific, local issues or can take the form of large international campaigns.

An example is the **Jubilee 2000** campaign to solve the problem of Third World debts. Jubilee 2000 is a coalition of religious and secular groups from all around the world working on this issue.

Another example is the proposed tax on international financial transactions: the **Tobin tax**. The proposal is to use the proceeds from such a tax to meet basic human needs. While such a tax would do little to transform our unjust and ultimately unsustainable free market economy, it could at least provide huge proceeds to help redress the damage.

One of the most effective means of gaining public attention and support for an alternative position are ***organised mass demonstrations, protests and 'alternative assemblies' around key international events***. This is especially appropriate when the event is staged at the same time and in the same place as a major summit or meeting of the dominant system and if it includes a strong, well-organised educational component.

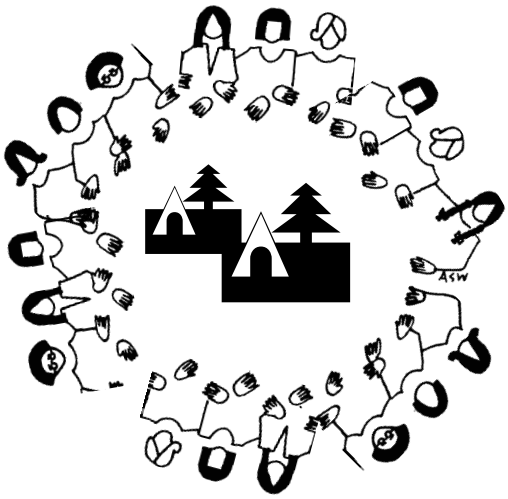
The **Battle in Seattle** in 1999 was a massive international protest against the WTO summit in Seattle. It was a turning point in terms of showing that democracy has avenues other than elections, and that a groundswell of well-organised and well-informed people can make themselves heard. All the activists in the Battle in Seattle recognise that while the event itself was important, it will be the continuity of follow-up that can make a lasting difference. A follow-up demonstration took place in Washington DC coinciding with the semi-annual meetings of the World Bank and the International Monetary Fund in March 2000.

During the UN Social Summit in Denmark, progressive NGOs from around the world held a ***parallel Summit*** nearby, gave lectures and led demonstrations to counter the economic globalisation promoted by corporate interests and the World Bank. An 'Alternative Copenhagen Declaration' was drafted and endorsed by hundreds of NGOs.

There are many examples of ***acts of resistance***, when people organise and take a stand for the common good that can lead to public outrage and sometimes to an eventual retracting by the authorities.

The **Chipko 'hug the trees' movement** in India arose when contractors coming to cut the village trees of the Garhwal hills were resisted by women led by Gaura Devi. The women hugged the trees preventing them form being cut. Later women in Nabi Kala in the Doon Valley fighting to safe guard their water resources and fields from lime stone quarry contractors used the same way of resistance.

Chipko originated 300 years ago in Rajasthan when Bishnoi community members hugged the trees to protect them from being cut by the King's men and were killed.



Militant resistance to the Chico dam. In the Cagayan valley in the Philippines, the Kalinga tribal people plant rice on the steep slopes of the Chico River gorge, which they have laboriously terraced for thousands of years. They were not consulted when, in 1967, the IMF and WB, in collaboration with transnational companies, started to build a dam that would flood their ancestral homeland. The people's formal petitions were unheeded. So they resorted to civil disobedience led mostly by women. Repeatedly they removed the tents and equipment of the dam-building crews, and barricaded the roads. Women lay down on roads to prevent entry of big equipment. But soldiers forcefully removed them and the dam-building began. In desperation, they dynamited the dam. Finally, in 1987, after 20 years of active resistance, the government called a halt to the dam-building. Reportedly, this was the first time that an IMF–WB funded project was successfully stopped by militant opposition on the part of the people.

e. Mobilisation of consumers in international boycotts

Increasingly, consumers are mobilising and boycotting companies and initiatives that are unfair or endanger the health of the people and the environment. These involve actions from the personal to the global level and have had an important impact on companies' behaviour.

f. Advocacy

A strong advocacy movement has to be one of the results of the PHA. This network will be able to express and demand changes from the local to the international level.

At the local level: we will present recommendations and experiences of the PHA to decision-makers at the local and municipal levels. We will look for support and endorsement of the PCH by networks, people's organisations and concerned individuals.

At the national level: we will support the advocacy efforts of local, national and international people's organisations in the form of lobbying, campaigning, presentations, discussions, seminars, etc. Such efforts can be directed at a broad range of national institutions, organisations and companies that have important impacts on health, as well as at the national offices of targeted international and regional institutions and organisations present in the country.

At the international level: we will join together with community health-oriented organisations which are lobbying and putting pressure on international organisations. For example, WHO, other UN agencies, funds and programmes, multilateral and regional development banks will be lobbied to ensure they promote and finance comprehensive PHC, assess the effects of SAPs and health care reforms. We will also lobby international trade and financial institutions and TNCs to develop policies that take into account and minimise the health and environmental consequences.

This section has given just a handful of examples. We cannot begin to do justice to the innumerable concerned groups that have taken and are taking action to fight for the people whose rights are being violated. We only want to stress that the struggle is not new. But it needs more strength. PHA joins in filling a space in the defence of people's health. We are taking on a big responsibility, we know. But we also know that there are thousands of you out there who feel exactly as we do. This initiative can bring all of us together. Only by acting together do we have the chance to succeed.

examples of SPECIFIC ACTIONS for a healthier world

AN EMERGING PHA ACTION PLAN

Drawing on this wealth of experiences, methods and strategies promoting change, what should the **PHA Action Plan** for a healthier world look like? What are the important points we should focus on? We invite you to add to this first, rough version of an action plan, which we present below. We hope that in the time leading to the People's Health Assembly event in Dhaka, there will be many contributions from all corners of the world.

1 Living up to the political challenges to people's health (actions needed)

- Document the consequences of the SAPs and the international trade agreements on the health and well-being of people, their working conditions and the environment.
- Reassess the neoliberal economic model and propose viable alternatives.
- Lobby to place health and well-being as the objective of development and its measurement as an indicator of success or failure of economic policy.
- Lobby to make human and environment sustainable development the objective of economic policies placing it at the centre of the discussions on restructuring the Bretton Woods institutions.
- Participate in the global campaign to promote fair terms of trade and combat and prosecute financial speculation.
- Support the implementation of a tax on financial transactions (TOBIN tax) and debt cancellation.
- Establish a World Sustainable Development Organisation with power to challenge the WTO environmental and social values, which are being violated by a short sighted, trade-oriented agenda.
- Support the proposals for a 'People's Chamber' in the United Nations.
- Advocate that all governments assume their responsibilities and abide international charters, declarations and conventions.

2 Living up to the social challenges to people's health (actions needed):

- Promote and support legislation and programmes that empower women.
- Support indigenous people in their struggle for equality, forest, land and water rights.
- Participate in the fight against corruption, for accountability and transparency.
- Develop support mechanisms for families, including childcare, women's right to work and workers' right to motherhood.
- Promote alternative education systems that foster self-esteem, autonomous thinking and teaches life skills.
- Promote a code of ethics for the media

3 Living up to the environmental challenges to people's health (actions needed):

- Lobby for the adoption of the *precautionary principle,* which calls for restraint in cases of uncertainty. Using this principle even the suspicion of potentially negative consequences of a technology or a policy should motivate restraint and shift the burden of proof on those in favour of it.
- Develop and implement mechanisms that favour relevant, environmentally and socially appropriate *technologies* while opposing destructive ones (like genetically manipulated foods, genetically engineered seeds).
- Campaign for a redefinition of *economic theory* that recognises environmental constraints.
- Support the introduction of *tax shifts*. These would increase the tax on the 'bads' (*e.g.* energy consumption, waste disposal, pollution, etc) while cutting the taxes on labour, thereby combating unemployment.
- Lobby for the development of accounting practices that take into account both environmental and human well-being— both for national accounting purposes, companies and public institutions.
- Promote the implementation of *environmental management systems* and their expansion to include health, environmental and social justice concerns.
- Lobby for adequate labelling of consumer products both in terms of their production and

trade (environmentally and socially appropriate products) as well as their potential harm (caution notices on foods and medicines).

- Advocate the curbing of over-consumption, affluent, unhealthy and unsustainable lifestyles both in the North and the South. Industrial countries in the North should aim, for on average, a 10-fold reduction of their consumption and pollutions levels ('Factor Ten').
- Advocate for the respect of the White papers on arms trade.

4 Living up to the health sector challenges and people's health (actions needed):

- Assert at national and international levels health as a central objective for sustainable development.
- Lobby WHO to assume a stronger advocacy role in the promotion of health as a development objective.
- Advocate to increase government investment in health at national and international levels.
- Gather and disseminate information that expose inequities in health and develop mechanisms to monitor the situation.
- Advocate for equity in health and health care.
- Advocate for and promote policies and projects that emphasise intersectoral actions for health.
- Demystify the causes of ill-health and promote a better understanding of its social determinants.
- Expose the real underlying structural causes of ill-health.
- Promote comprehensive Primary Health Care as a model to address priority health problems and organise the health services.
- Promote community participation in planning, management and evaluation of health services.
- Reassert the value of community-based health workers (CHWs).
- Promote the use and dissemination of appropriate health technologies.
- Foster changes in health personnel education and health management making education problem-oriented and practice- based.
- Outlaw secret, not transparent or unethical research.

FEEDBACK

The paper you have just read presents an overview of the situation and is very general. It is important to know if it is relevant to your specific situation and, if so, in what way.

Please let us know what you would like to see added so that your situation is addressed.

We also hope you will contribute your experiences in the form of case studies or stories that we can use to bring to the PHA specific analyses of different situations; this will stimulate others to find their own solutions.

We are particularly looking for *experiences or stories that make the links between local problems and the global economic system,* and *that describe people and communities' empowering initiatives that are already under way*.

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Please send feedback by October 10, 2000. Be sure to identify the name of your group, your country, the number of participants in your meeting, and the main characteristics of your group.

Also please send a summary of the points discussed during your discussion of this draft framework.

Finally, please identify and send the main issues you would like to see included in the People's Charter for Health.

feedback

Notes

1 World Health Organisation. 'World Health Report 1999'. Geneva, Switzerland.

2 UNAIDS. Report on the global HIV/AIDS epidemic- June 2000.

3 World Health Organisaation. "World Health Report 2000". Geneva. Switzerland

4 UNDP. 'Human Development Report 1999'. New York 1999.

5 United Nations Research Institute for Social Development. 'State of Disarray'. 1995. Geneva.

6 SIPRI Yearbook 1999. Armaments, disarmament and international security. Oxford University press.

7 See, for example, the 'But Why?' game and the 'Chain of Causes' exercise in PHA's 'Communication as if people matter' background paper. These exercises can be used with specific stories for better situation analysis.