

Community Ownership: the Key to Sustainability

David Werner, 2002

Note: This document was written as a chapter for a book edited by Jon Rohde, to be titled “Sustaining Health for All,” which was to be the third volume of series of studies on Primary Health Care. Unfortunately this volume was never completed or published (no doubt in part because some of the potential authors shared the misgivings expressed below).

Author’s misgivings in writing this chapter

Although I gladly contributed to the previous two volumes in this series—*Practicing Health for All* and *Reaching Health for All*—it was with certain misgivings that I have agreed to write a chapter for the present volume, *Sustaining Health for All*.

My first misgiving centers on the non sequitur of trying to “sustain” something that remains so far from being realized. The goal of “Health for All” lies on the same slippery uphill path as “Equal Opportunities for All” and “Equal Representation for All.” Yet in the last decade we have in many ways been backsliding rather than advancing toward all these goals. As humanity ventures into the 21st century, the gap between the over-fed and under-fed, the strong and the weak, the rich and the poor continues to widen, both between countries and within them. Effective representation by vulnerable groups has been eroded as wealth and decision-making power have concentrated in hands of a globalized ruling class. The ability of giant corporations and powerful interest groups to swing public elections and to buy politicians has led to a plethora of non-democratic “democracies” that place the economic growth of the elite before the well-being of the many.

My second misgiving comes from the title of the chapter I am asked to write: “Community ownership—the key to sustainability.” Twenty years ago when *Practicing Health for All* was compiled, marginalized communities had more of a fighting chance. At least in some corners of the Earth it was possible for collectives of villagers or working people to construct an effective approach to meeting their health-related needs. Even at the national level—as was documented in a renowned Rockefeller study¹ of 1985—a few poor countries were able to achieve “*Good Health at Low Cost*.” These countries—China, Sri Lanka, Costa Rica, and Kerala state in India—did so through a strong commitment to equity: Equity in the provision of education. Equity in terms of basic health services. And equity in assuring that all people get enough to eat, using methods that do not disrupt indigenous agriculture. In sum, basic education, primary health care, and adequate food were guaranteed as basic human rights to all people, regardless of their ability to pay.

But in recent years, the capacity of communities for self-determination has been eroded. Basic human rights, including the “Right to Health,” and “Freedom from Hunger,” have been undercut by the marketplace doctrine of “you get what you pay for.” Even those states that had achieved “Good Health at Low Cost” have had trouble sustaining their commitment to Equity and Health for All, and as a result the gap between rich and poor, healthy and unhealthy, has been widening.

A similar regressive trend can be seen throughout much of the world. Many of the community-based health programs that 25 years ago provided the inspiring model for Comprehensive

Primary Health Care have faced growing obstacles. Even the most innovative people-centered programs (including some of those documented in the earlier volumes of this Health for All series) have been struggling for survival—or no longer exist.

What lies behind these reversals?

Part of the problem has been that Primary Health Care, since the world's nations endorsed it in the 1978 in the Alma Ata Declaration, has largely been systematically gutted of its egalitarian principles and empowering potential. As originally conceived, Primary Health Care was so comprehensive and equity-oriented that it was potentially revolutionary. Anticipating resistance from existing power structures, it encouraged strong community participation in confronting the institutionalized inequities that perpetuate poverty and poor health. Not surprisingly, therefore, Primary Health Care, was less than fully supported by the privileged class. Almost from the first, efforts were launched to pinion its progressive potential and convert it into a vehicle of sociopolitical stability, not change.

Thus Comprehensive Primary Health Care was reduced to Selective Primary Health Care. Selective PHC was designed to improve health statistics—or at least to reduce death rates—of targeted high-risk groups, primarily children. It focused on a small number of “cost-effective,” technological interventions that could be implemented from the top down without confronting the entrenched inequities that underlie poor health. Needless to say, many high-level officials and their wealthy supporters embraced Selective Primary Health Care wholeheartedly. But the results were mixed. Over the years child mortality declined notably without substantial improvement in children's quality of life, which in some parts of the world has deteriorated.

What makes “community ownership” —or self-determination at the community level—more difficult in the 21st Century is that some of the biggest obstacles to the health of disadvantaged people originate so far away from the communities where they live. Much of the slowdown and reversals in health status in recent years can be traced to macro economic decisions made at the transnational level. International trade agreements, structural adjustment programs (SAPs), and other high-level policies—made undemocratically behind closed doors in Geneva or Washington—consistently put the interests of Big Money before basic human and environmental needs.

It is this global rollback of social progress and democratic process that has made the goal of Health For All more distant than when the world's governments endorsed it in Alma Ata 25 years ago. The World Bank's takeover of the World Health Organization as the lead designer of Third World health policy, has further stripped Primary Health Care of its comprehensive, social justice seeking thrust.

The final *coup de grace* to Primary Health Care as a people-empowering strategy has resulted from the new partnership between the World Health Organization and transnational corporations. (I will address this concern in a moment.)

In short, because today so many of the far-reaching decisions that affect people's health originate in distant, shamelessly undemocratic centers of power, the prospects for community self-determination in questions of health or quality of life have become increasingly tenuous.

Please don't get me wrong! I still do believe that community ownership is the key to sustainable Health for All. Yet I am seriously concerned that this vital "key" has been sequestered by those who profit most from unfair social structures.

Sustaining the Dream

In writing this chapter, rather than speak about "sustaining Health for All," I will focus on changes in our perspectives and methods that are needed for "sustaining the dream" of Health for All.

Community ownership—or collective self-determination—is essential for building a healthier world. In turn, collective ownership requires collective mobilization and organized action. However, in today's shrinking world, community mobilization necessarily entails a new kind of awareness-building. It necessitates strategic coordinated action of communities and popular movements, internationally. It is no longer enough to mobilize for health in isolated villages, or even countries. In a world where decision-making has been globalized for the benefit of a small, powerful ruling class, communities worldwide need to analyze the unbalanced situation in which we all live, and build strategies of united action for change.

"I have a dream!" With these words Martin Luther King began the prophetic speech in which he envisioned a world of social justice based on human dignity and equal opportunity for all. Essentially, this is the dream we must share in pursuing "Health for All." It is the dream of a healthy, caring, and sustainable community, locally and globally. It is a dream of unity embracing diversity, a kind of global grassroots solidarity.

Many of us share the dream of Health for All. In the last quarter-century we have in some ways moved forward toward that dream. But in other ways we have moved backwards. Martin Luther King's "Dream" centered on the struggle for Human Rights for All, and racial equality. Through the civil rights movement and Black Pride, African Americans have indeed managed to gain more equal rights. But they still have a long way to go. Black people—along with Latinos and certain other minorities—are still socioeconomically disadvantaged. The Black community today suffers rates of child mortality, malnutrition and AIDS double those of whites. The incarceration rate of Blacks in the US is four times as great, for similar crimes. Discrimination remains institutionalized.

Growing inequality worldwide.

Health statistics within countries and between them continue to reflect great disparities, despite improvements in some areas. In the world, the last two decades have seen an average increase in life expectancy, and a modest (though highly variable) decrease in infant and child mortality. But quality of life indicators remain deeply disturbing. Today the world has as many malnourished children as it did 20 years ago.²

In the last 50 years, while the human population has doubled, global productivity of food and goods has quadrupled. This means, on the average, there is more for everyone, and there should be less hardship, poverty and hunger. Yet in today's world, 800 million people still go hungry.³ This is not because of total food shortage, but because of increasingly unequal distribution. According to the Food and Agricultural Organization (FAO), 80 percent of hungry children live

in countries that produce food surpluses. There is more than a little truth Berthold Brecht’s observation that “Famines don’t occur. They are organized by the grain trade.”

More than 10 million children under age five continue to die every year from preventable causes.⁴ More disturbing still, a growing percentage of child deaths are linked to hunger. UNICEF’s *State of the World’s Children 1993 Report*⁵, estimated that malnutrition contributed to 29 percent of deaths in children under 5 (Fig 1.0). By 1998, the UNICEF Report estimated that 55 percent of child deaths were malnutrition related! (Fig 1.1) This is surely not an advance toward Health for All.

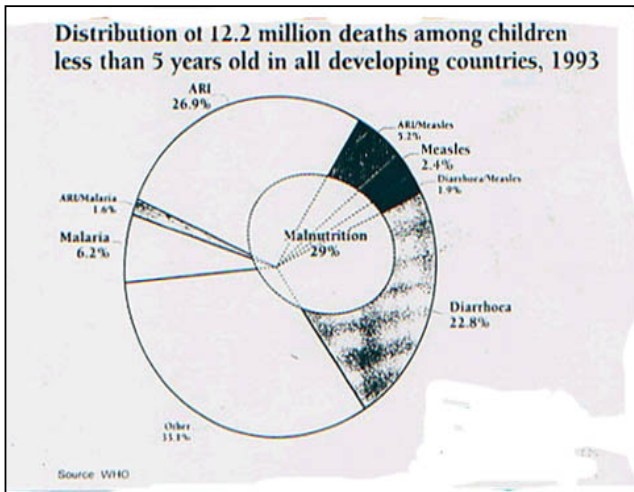


Fig 1.0

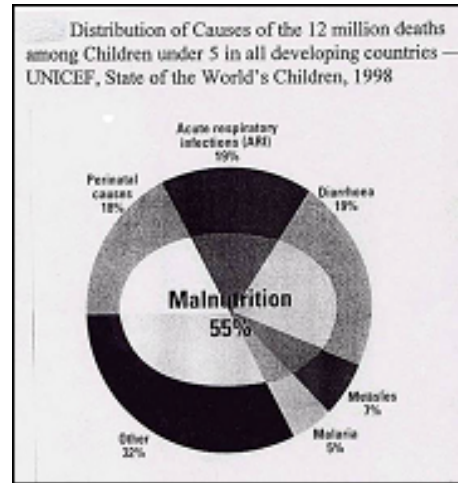


Fig 1.1

Global Warming as a threat to Sustainable Health for All

Advocates of unbridled economic growth try to de-emphasize the increasing socioeconomic polarization of humanity by chanting the mantra that, “A rising tide will lift all boats.” But what is becoming far more certain is that “A rising sea level will sink all coastal towns.”

Global Warming, due to the Greenhouse Effect, results largely from humanity’s excessive and unbridled use of fossil fuels, combined with the destruction of rainforests. Despite high-level attempts to minimize its dangers, Global Warming is emerging as potentially one of the biggest long-term threats to sustainable Health for All. Unless globally coordinated steps are taken soon to reverse the present trend, within a few decades rising temperatures and rising sea levels may jeopardize everyone’s health. Decisive global action is urgently needed NOW!

But attempts at international agreements to reduce Global Warming have been tyrannically obstructed. High-ranking decision-makers, spearheaded by the US Presidency, have undemocratically opposed an effective international agreement. But why? Partly because the United States, with 4% of the world’s population, consumes 25% of the world’s oil and contributes 25% of the greenhouse gases (mainly carbon dioxide) to the atmosphere. The White House measures the well-being of humanity in terms of corporate profits! The fact that top decision-makers in Washington can turn a blind eye on such a far-reaching global danger is symptomatic of the short-sighted ideology of our times.

The *Limits to Growth*⁶ were carefully spelled out by the Club of Rome in 1972. In their 1992 update, *Beyond the Limits to Growth*⁷, Meadows, Meadows and Randers stressed, with greater urgency, the need for a healthier, more sustainable model of development. However, the tunnel-visioned protagonists of the free market still argue that unlimited economic growth is the *sine qua non* for progress. Although they concede that in an unbridled market system most profits go to a wealthy minority, they insist that enough will “trickle-down” so that the “poorest of the poor” will benefit, sooner or later.

However the ever-widening gap between rich and poor, indicates that more trickles up than trickles down.

The widening gap in wealth and health.

Is our current paradigm of globalized economic development leading us toward or away from World Health? The answers different parties give to this question tend to be as polarized as humanity itself.

It is true, on a worldwide average, that in recent decades life expectancy has increased and child mortality has declined. However the gains are far more evident in the so-called “developed” countries of the “North” than in the poor countries and communities of the “South.”

The growing disparity is especially striking when we look at child mortality. (The death rate of children under five years old is widely considered to be a reliable indicator of a population’s overall well-being). Comparison of the probability of death in rich countries and poor, over time, is revealing. According to World Bank data, in 1950 the probability of a child dying before age 5 was 3.4 times higher in poor countries than in rich countries. (Fig. 2.0)⁸ By the 1990s the probability a child dying was nearly 9 times higher in poor countries than rich ones. Given current trends, this disparity continues to grow.

RELATIVE PROBABILITY OF DYING IN POOR COUNTRIES COMPARED TO RICH COUNTRIES (RATIO AT DIFFERENT AGES AND DATES)

Age Group	1950	1980	1990
<5	3.4	6.4	8.8
5-14	3.8	6.5	7.0
15-59	2.2	1.8	1.7
60>	1.3	1.4	1.4

Relative probability of people dying in developing countries dying (across the ages indicated) expressed as DDC/(FSE+EME) (the ratio of Demographically Developing Countries to the combined Formerly Socialist Economies and the Established Market Economies). Calculated from data in the World Bank’s 1993 World Development Report by David Legge.

Fig 2.0

Equity as a determinant of health

More and more studies, in both rich countries and poor, are demonstrating that the relative equity or inequity within a population is an important determinant of health. In developing countries, the Rockefeller study of 1985 made clear the importance of a strong political commitment to equity as the key determinant of “*Good Health at Low Cost.*” More recent studies show a similar importance of equity in the more affluent “developed” countries. In his book, “*Unhealthy Societies: the Afflictions of Inequality,*” Richard Wilkinson pulled together these latter findings, and concludes that:

*“Among the developed countries, it is not the richest societies that have the best health, but those that have the smallest income differences between rich and poor. Healthy, egalitarian societies are more socially cohesive.” . . .*⁹

- Richard Wilkinson, *Unhealthy Societies: the Afflictions of Inequality.*

“The advantages of living in a cohesive society may outweigh those of living in a free market. If we share the resources of our country more fairly, we shall have a more cohesive society and reduce inequalities. It will not happen the other way around.”

- George Watt, Professor of General Practice at the University of Glasgow

The inequality that endangers health is not only that of relative wealth, but also of decision-making power.

Growing disparities within the USA

The widening gap in health status occurs in rich countries as well as in poor. In the United States of America the gulf between rich and poor, both in terms of wealth and health, is staggering. And the gulf is widening.

When considering the goal of Health for All, it is important to look at policies, practices, and trends within the United States. As the world’s remaining superpower, the US has disproportionate influence worldwide. Some of that influence is dangerously unhealthy.

In the last few years the United States surpassed France as the industrialized country with the widest income gap. In spite of the country’s enormous food surplus, millions of children in the US regularly go hungry. One in five US children are undernourished. (By comparison, in East Asia one in three children are malnourished; in sub-Saharan Africa one of two; overall, 23% of the world’s children are malnourished.¹⁰ Such levels of undernutrition in the US, a country with such enormous surplus, is unconscionable. By comparison, Cuba, with 1/20th the per capita income of the US, has a far lower percentage of undernourished children.

Malnutrition in the United States has two faces. While nearly 20 percent of young children are chronically or acutely undernourished (undersized or underweight), 55% of Americans—including children—are overweight and 23% are clinically obese. A vast number of Americans suffer from health problems related to over-consumption (heart disease, stroke, cancer, diabetes, etc.), which are also the commonest causes of death. The lost wages caused by obesity in the US are estimated at \$118 billion per year. Wealth problems related to obesity account for 12 % of the nation’s annual health budget.¹¹

At the same time, one in 5 children are clinically undernourished and more than 40 million persons are not covered by health insurance. The growing nutritional and socioeconomic polarity helps explain why the US has the worst health statistics of the 21 most developed countries.¹²

Globalizing poor health

More worrisome, still, is the imposition by the US of its unhealthy policies and practices on the rest of the world. The US government has increasingly become a lackey of giant corporations. As the world's remaining Superpower, it imposes its power and influence in ways that put corporate profit before the health of humanity and the planet.

The US has a long history of riding roughshod over small struggling nations who dare to put their people's basic needs before the neocolonial objectives of the free market economy (where "free" means unregulated).

In recent decades the US government has repeatedly obstructed international agreements to promote international health and security.

For example, the United States . . .

- was the only country not to endorse the 1981 International Code of Marketing of Breast Milk Substitutes, designed to protect babies against the unscrupulous (and often deadly) practices of the transnational baby food industry.
- was the only nation that refused to ratify the UN Convention Rights of the Child.
- refused to attend the 1987 UN international meeting on Disarmament and Development.
- was one of the few countries not to sign the International Treaty Against Landmines.
- has consistently dragged its heels on nuclear disarmament. It has recently "unsigned" earlier treaties, and is planning for possible "limited" nuclear attack on certain countries.
- has refused to sign the international Kyoto Agreement to reduce Global Warming.
- has consistently pushed for World Trade Agreements that favor transnational corporations—even when such agreements endanger global ecosystems and erode local, potentially sustainable, food production.
- continues to impose its non-sustainable model of privatized, profiteering, economic development worldwide. The "downsizing" of the rural and urban workforce, and its replacement with oil guzzling machines, contributes to urban drift, mass unemployment, deepening poverty, socioeconomic polarization, Global Warming, and environmental demise. It is antithetical to health-promoting sustainable development.

Structural violence. In analyzing the overarching obstacles to reaching Health for All, we must bear in mind how the world's "military-industrial-complex," backed by big government, has repeatedly obstructed possibilities for peace and equity. In the self-seeking pursuit of huge

profits, it has promoted a phalanx of colossal industries with little regulation of their negative impact on human and environmental health.

Currently the world's three biggest industries are:

- 1) the military and arms industry (over US\$800 billion annually) ¹³
- 2) illicit drugs (over US\$500 billion annually) ¹⁴
- 3) the oil industry (over US\$450 billion annually) ¹⁵

When we stop and think about the health impact of these dominant industries—and their danger to the future of humanity—it is terrifying! How could Homo sapiens, the self-named “wise” species, follow a path of “development” in which our three most prosperous industries are so perilous to sustainable wellbeing? Certainly the implosion of Enron and other corporation giants, with their embarrassing ties to top government officials, has made it evident that the Achilles’ heel of the prevailing market system is institutionalized GREED!

Arms, illicit drugs, and oil! Let’s look at the health-threatening features of these 3 interconnected and sickeningly co-dependent giant industries.

1. **The military and arms industry**, as the world’s biggest, most lucrative industry, compromises health in many ways, direct and indirect. Most direct, of course, is the trauma caused by armed violence. But we must not forget the indirect health costs resulting from the huge amount of resources consumed by the military and arms industry. If more wisely allocated, these resources could meet the unmet health and food needs of everyone on earth!

With its enormous political clout, the military and arms industry can, quite literally, get away with murder. Through its powerful lobby, it underwrites the election of politicians who do its bidding, thereby distorting the priorities of government to its own end. This is especially evident in the United States.

For example, the US was the only government that refused to attend, and actually boycotted, the September 1987 meeting of the United Nations to discuss the theme of Disarmament and Development. The US claimed that disarmament and development are unrelated! ¹⁶

The total military-related expenditures of the US add up to the giant’s share of its total spending—by some calculations more than 50% of the annual discretionary budget. ¹⁷

The current “war on terrorism” has been used to beef up the military budget still more. And when more funds have been budgeted to military, public services for the disadvantaged are ruthlessly cut.

US military spending vastly exceeds that of any other nation. ¹⁸ The US is the world’s biggest exporter of weapons. It has repeatedly supplied weapons to despots and “rogue states” willing to kowtow to the US global agenda. Among others, the US has provided massive arms shipments to Saddam Hussein, and has permitted supplying him with the ingredients for producing chemical and biological weapons. ¹⁹ In the recent US bombings of Afghanistan, the Stinger missiles used against US planes had been provided to the Muhajeddin by the US in the 1980s. ²⁰ Osama bin Laden was initially trained and armed by the CIA. ²¹

The colossal amount of money and resources used for instruments of war, has contributed to poverty and poor health in the following ways:

- The number of persons injured, killed, disabled, displaced and psychosocially devastated by armed violence runs into hundreds of millions.
- Reduced public spending is part of the collateral damage. Military expenditures divert money away from health services, education, welfare, and environmental protection.
- War-related environmental damage is far-reaching.
- Vast use of oil for military purposes adds to the Greenhouse Effect.
- The need for oil leads to military disputes for control of oil-producing regions (e.g. the Middle East) —which, in turn, are used to justify further military buildup.
- Collateral damage of wartime politics includes repressive, authoritarian measures of social control, with an attack on civil liberties, social diversity, and popular dissent, all curtailed in the name of national security.
- Widespread contamination with radioactive, biological, and chemical toxins increases cancer, genetic defects, and other maladies, sometimes with very long-term consequences.
- The build-up of virtually indestructible nuclear waste will haunt humanity for centuries, and cost billions for attempts at containment.

War is incompatible with world health. Yet shortsighted world leaders, catering to the powerful arms industry that helped get them elected, routinely beef up military spending and expedite the profiteering of the arms industry. The world's most powerful industry has enormous political clout. As the author/poet Eduardo Galeano has observed, "Arms manufacturers need war like umbrella makers need rain."

2. **Illicit drugs.** That illegal drugs have become the world's second most lucrative industry is appalling. Just think how much benefit could result if the US\$500 billion spent annually on illicit drugs—plus the related costs of police and prisons—were devoted to food and health care for the hungry!

Who can say which has done more harm: addictive drugs themselves or the hypocritical War on Drugs? What is certain is that millions of peasant families, smalltime drug peddlers, and relatively harmless users of relatively harmless drugs (such as marijuana) have been brutally treated. Millions of the "little guys" in the drug world—often members of oppressed minorities—have been chewed up by the legal system and spit into the jaws of the mushrooming (and increasingly privatized) prison industry. (In the United States, private, profit-making prisons have become one of the nation's fastest growing industries, with a strong political lobby for prolonged incarceration rather than rehabilitation.)

Meanwhile, the "big guys" —the international narcotics dealers and drug lords—too often go scot free. Why? Because of their links with the U.S. government's covert operations! The insidious "arms for drugs" deals which the CIA has masterminded with big-time drug traffickers and mercenary troops in various countries over the past 40 years are well-documented by social scientists and even by congressional committees. US government complicity in "arms for drugs" deals as part of its role as "global policeman" has led to a massive escalation of the global drug trade.²²

This complicity has extended from the Golden Triangle in Vietnam War days, to Central America during the US-backed Contras' war against Nicaragua's Sandinista government. It

was also a covert part of the U.S. sponsored Mujahideen (forerunners of the Taliban) and the Afghan Northern Alliance, in their terrorist attacks as mercenary “freedom fighters” against the Russian occupation in Afghanistan.²³

How much have US covert operations escalated the global drug trade? Substantially! For example, Afghanistan and Pakistan reportedly had virtually no opium trade before the CIA became involved. But on the heels of “the Company’s” intervention, Afghanistan soon became the world’s biggest conduit of heroin for the European market.²⁴

In view of all this, when we consider the structural changes needed to reach, practice, and sustain Health for All, it is important to understand the paradoxical, high-level forces at work behind the multibillion dollar drug trade and the heavy-handed but unsuccessful “War on Drugs.”

3. **The oil and energy industry.** While perhaps not as obvious an impediment to Health for All as arms and illicit drugs, the world’s huge, unbridled consumption of oil products (gasoline, plastics, blacktop highways, etc.) may in the long run be an even greater threat to World Health.

We have already touched on the looming problem of Global Warming. The powerful lobby of the oil industry— and the energy industry in general—has used its “black gold” revenues to grease the hands of top US politicians, who in turn push policies that bolster the industry’s profits. At the time of this writing, the current U.S. President, Vice President, and many statesmen had themselves been CEOs and/or major stockholders in the oil (and arms) industry. Small surprise, then, that the White House puts short-term oil interests (and military buildup) before the sustainability of humanity on the planet.

But there are other ways that powerful oil interests jeopardize human well being. To guarantee the flow of oil from the Middle East, the U.S. government has instated, armed, and defended despotic rulers who maintain regional stability by repressing the poverty stricken masses with an iron fist. The Saudi monarchy is a prime example. Saddam Hussein is another. Saddam was supported and armed for years by the U.S. until he stepped out of line.

Likewise, Afghanistan’s Taliban government was for years bolstered by the US, regardless of its horrendous human rights violations. In part this was because U.S. oil companies planned to run a massive pipeline from huge oilfields in Turkmenistan through Afghanistan to the Indian Ocean. Only after it became clear that the Taliban might not comply with its wishes, did the US decide to topple it. According to reliable reports, secret plans by the US government to bomb Afghanistan were already underway months before the tragic events of September 11, 2001.²⁵

Other killer industries. Arms, illicit drug, and oil are, of course, not the only industries that obstruct the possibility of sustainable Health for All. There are scores of others, not least of which are the tobacco and alcohol industries. Tobacco, says WHO, has become one of the major killers in the world today, taking far more lives than AIDS. Not only is tobacco a dangerous and addictive drug, but its multimillion dollar lobby is extremely corrupting. Big tobacco growers are still heavily subsidized. The US government has repeatedly threatened trade sanctions against nations that refused to import US tobacco. In China, the Health Ministry’s attempt to reduce cigarette smoking was recently thwarted by the World Trade Organization’s demand that China reduce its sales tax on tobacco, and permit importation and advertising of big-name foreign

brands. Because transnational tobacco corporations plan to target Chinese women, who have traditionally not been smokers, it is predicted that during the next decade, smoking in China will kill an additional 3 million persons.²⁶

From knowledge to action. Strategically, it is important that communities everywhere know how giant corporations put billions of lives in danger. Such knowledge can motivate people to take health-protecting and harm-opposing action.

For example, in Mexico, health workers had long tried to get villagers to quit smoking, carefully explaining the dangers. But compared to all the other, more immediate threats to survival, the risks from tobacco seemed minor. So they continued to smoke. Then health workers took a different approach. They explained that because so many people in the North had quit smoking, tobacco companies are now targeting the South as their newest, most vulnerable market. On learning this, especially the young men were so outraged that many swore they would stop smoking. They did this not for health reasons, but because they refused to be further tricked and victimized by the Gringos. They have an old saying: “Poor Mexico, so far from God and so close to the United States!”

The military-industrial-governmental complex. However, by far the biggest danger to health comes not from individual industries, but from the way the interconnected corporate world—which former US President Dwight Eisenhower called the “military-industrial complex”—has influenced the ideology of what is called Development. In his well-researched book, *When Corporations Rule the World*, David Korten (a former economist for USAID who became disillusioned) makes it clear that:

“The one thing at which free unregulated markets are truly efficient is in transferring wealth from the many to the few.”²⁷

As long as this unbridled concentration of wealth continues, Health for All will remain a distant dream.

But what can be done to rein in the forces of greed and work toward a healthier more sustainable global community?

Community ownership—Is it still the key to sustainability?

Why, you may ask, if “Community ownership—the key to sustainability” is the title of this chapter, do I talk so much about the global economic barriers to Health for All?

The answer is that we live in a changing world. The underlying causes of our health-related problems have new dimensions. Community strategies that helped to improve health locally, today are often less effective. While participatory methods of “community diagnosis,” collective action, and empowerment remain essential, they need to be adapted to the new reality.

Today’s world poses new health threats for everyone, but most immediately for the poor. Some of the biggest threats no longer come from local causes. Rather they come from the undemocratic, publicly unaccountable ways in which policies and decisions are made at the international level. Too often these policies and decisions compromise the self-determination and ability of disadvantaged people to resolve their health needs for themselves.

When we talk about “community ownership” as key to health, the key issue—at least in rural areas—turns on the ownership of land. The struggle for health comes down to the struggle for fair land distribution. That is to say, democratic agrarian reform.

Gains and setbacks: an example from Mexico. Let me give a brief example from rural Mexico where I have spent much of the last 37 years involved in mountain villagers’ struggle for their to health and rights. (I wrote about this in *Practicing Health for All*.)

Project Piaxtla, the villager run, community-based health program in the mountains of Western Mexico, achieved over several decades remarkable improvements in health. Since its modest beginnings in 1964, the program involved through three stages. First it focused on *curative medicine*, next on *preventive measures*, and finally on *sociopolitical action*.

The sociopolitical action included poor people’s organized struggle over land rights. Up until 1994 the Mexican Constitution had remarkably egalitarian laws to protect the land rights of small farmers. Nevertheless, due to bribes and institutionalized corruption, much of the best farmland was still held by big plantation owners. To confront this situation, the village health promoters helped the landless farmers learn their constitutional rights. Poor farmers began to organize for lawful redistribution of the illegally large landholdings. As the grass-roots organization grew in numbers and strength, it managed to gain title to and redistribute over 50 percent of the best riverside alluvial land. Because more families now had land to grow food on, health improved dramatically. Child (under-5s) mortality dropped from 340 per 1000 in the late ‘60s to around 50 per 1000 by the early ‘90s. Villagers agreed that the improved child survival was due, in part, to better curative care, and even more to preventive measures. But they insisted the biggest improvements in health were due to their organized struggle for their constitutional land rights. In the past, as sharecroppers, they had to give up half their harvests to the wealthy landlords. Often there wasn’t enough left to feed the family. But now that they had reclaimed their own land and could keep all the food they grew, at last their children had enough to eat. The poor farmers proudly insisted that through their collective struggle for their constitutional rights, they had become the masters of their health. That new sense of ownership—of their land and health—motivated them to take other collective action in defense of their wellbeing and their rights.

However, in 1994, the situation changed drastically for the worse. The underlying cause of the reversals was not local but international. It involved “NAFTA,” the North American Free Trade Agreement between the United States, Canada, and Mexico. To join NAFTA, Mexico was required to change its national Constitution by repealing the agrarian reform laws that had protected small farmers. These constitutional changes have allowed big American agribusiness to take over huge parcels of Mexican land and grow fruit and vegetables for the US market, while paying Mexican workers 1/10 the minimum wage in the United States. Millions of hectares of the best farmland has concentrated again into giant plantations, many controlled by giant US corporations. This is why critics speak of NAFTA as “neocolonial.”

Another setback with NAFTA was that Mexico had to lift its tariffs on imports of US government subsidized grain and cattle. This flooding of the Mexican market drove tens of thousands of Mexico’s small maize and cattle farmers into destitution. (While the US government, through the World Bank and World Trade Organization, forces poor countries to terminate most subsidies and tariffs, it continues to heavily subsidize its own giant corporate agribusiness, which export their surplus at prices that are below production cost. As a result of

this subsidized dumping of US surplus, Third World farmers cannot compete and are driven off the land. In the last 10 years, Mexico has gone from a maize exporting to a maize importing country. The increasing price of maize tortillas—the main staple in the Mexican diet—has caused mass rioting as well as increased levels of hunger among the poor.)

The result of these international policies—involving the termination of Mexico's agrarian reforms and protective tariffs—was a mass exodus from the countryside. Since NAFTA began, over 2 million impoverished peasants have migrated to the mushrooming slums of the cities. This huge urban influx of job-hunting peasants has weakened labor unions and pushed down wages. Even before NAFTA, wages were already so low that poor families had trouble adequately feeding their children. And since NAFTA began, real wages in Mexico have fallen by 40 percent!

Adding to the people's hardships, on the heels of NAFTA, came the peso crash of 1995. This was triggered by the sudden pullout of foreign investors who had speculated that NAFTA would spur Mexico's economic growth, but were then scared off by the country's increasing social instability. The capital flight of billions of dollars caused the closure of more than half of Mexico's businesses (mostly smaller ones). This resulted in massive unemployment, even of professionals. The situation became desperate.

Further worsening the plight of the poor, the Mexican government introduced austerity measures to try to stabilize the economy. These "structural adjustments" included cut-backs in public assistance, increase in sales taxes, reduction of food subsidies, and increased public hospitals fees—all at a time when millions more people were destitute and hungry.

Despite all the pro-NAFTA propaganda in the mainstream media, the result of the "free trade" agreement and the related peso crash in Mexico has deepened poverty and caused severe socioeconomic polarization. This situation has provoked a pandemic of street children, drug trafficking, and petty crime, which has escalated into a chaos of kidnappings, assaults, murders, and organized crime. In turn, there has been the inevitable backlash of police brutality, endemic corruption, and unsolved human rights violations. Growing numbers of human rights activists and investigative journalists have been assassinated. For the poor, the cost of "free trade" has been sickeningly high.

This insufferable situation in Mexico led, in 2000 AD, to the ousting of the powerful PRI (Institutionalized Revolution Party), the notoriously corrupt oligarchy that had wielded heavy-handed single-party control continuously for 70 years. Citizens had high hopes that the new coalition party, PAN, under President Vicente Fox, would fulfill its promises to fight corruption and reduce crime. But in terms of crime and kidnappings, the crisis has worsened.

Although President Fox talks eloquently about "lifting the poor out of poverty," his real commitment is to economic growth of the rich. A former CEO of Coca Cola Mexico, the Harvard-trained plutocrat is a great pal of George W. Bush. (The fact that Fox kicked Fidel Castro out of the 2002 Monterrey Economic Summit reveals his true stars and stripes). Despite Fox's pro-poor rhetoric, his social policies are regressive. He has pushed to increase the federal sales tax and extend it to include basic foods and medicines. He has proposed "user fees" for the nation's rural health centers, which historically have been free of charge. (Introduction of this kind of cost-recovery "health reform package," consistent with Structural Adjustment mandates of the World Bank, has lowered health status in a number of poor countries. For examples see

Werner and Sanders, "*Questioning the Solution: The Politics of Primary Health Care and Child Survival*" HealthWrights, 1997).

The current prolonged crisis in Mexico has aggravated polarization. Since NAFTA began, the numbers of people living in poverty and of malnourished children have increased. Millions of destitute persons struggle to find jobs and feed their children. Wages are so low that young people see no future and turn to drugs and crime. Yet at the same time, the very rich have benefited enormously. It is said that currently Mexico has more billionaires per capita than any other nation! The richest man's wealth equals that of the country's poorest 32 million people: a third of the population! No wonder that in Mexico kidnappings occur on a daily basis. Young people whose grandfathers fought a revolution for "land and liberty," see no way to fight the inequalities wrought by globalization, and turn to "secuestros" (kidnappings) as a short-cut to redistribution of wealth. But this is not a healthy or sustainable solution.

What is the way forward? One thing is certain. The ongoing pandemic of crime, kidnappings and violence now ravaging Mexico will not be reined in by beefing up the police and military. Traditionally, many police and high-ranking military officers have ties to organized crime and drug cartels. Healthy and sustainable change will be achieved by working toward socioeconomic policies that reduce poverty and hopelessness. Fair wages and fair distribution of land are essential, as is increased access to health care and other services, especially for the most vulnerable.

However, these changes will require a participatory democratic process whereby poor and disadvantaged people gain an effective voice in the decisions that affect their well-being. For this, standard elections are not enough. To put such a participatory democracy in place will require an approach to education—of children and adults—that encourages cooperation rather than competition and questioning of authority rather than blind obedience.

But such changes—which require a well-informed and socially conscious population—are unlikely to be initiated from the top down. They are only likely to come through organized mobilization from the bottom up. It is here that revival of community ownership is of vital importance.

No nation is an island

The crisis of social dysfunction—with socioeconomic polarization, cutbacks in public assistance, widespread unemployment, starvation wages, desperation of youth, and escalating delinquency—is by no means unique to Mexico. Similar crises are emerging around the globe, in rich countries as well as in poor. As in Mexico, a common cause of this dis-integration of the social fabric is the widening gap between the haves and have-nots. As the very wealthy gain increasing political influence, egalitarian principles are eroded and social unrest increases.

In country after country, the plethora of crime and violence has reached pandemic proportions. Its negative impact on health of communities, and especially on the wellbeing of children and youth, cannot be overestimated.

Institutionalized brainwashing. In today's top-heavy world, disinformation has become the most powerful tool of social control. The mass media—newspaper, radio, and television networks—are mostly owned by the same giant corporations that own the arms, oil, energy, and

tobacco industries. “The news that’s fit to print” is filtered and sanitized in such a way that the public is systematically brainwashed.

Knowledge is power. People in rich countries and poor need to clearly understand the powerful forces at work in the world today, which have led to increasing hardships and decreasing representation. True, people in communities still need to work together to cope with local problems. But to cope in more effective and sustainable ways, they need to understand the manner in which their local problems relate to global policies and decisions.

To begin to work toward solutions of the overarching problems rooted in the inequitable model of economic development, people in communities need to join with neighboring communities and eventually with communities in many parts of the world. They need to learn about and join grass-roots coalitions working for fairer, more sustainable policies at the national and international levels. If community ownership is to be the key to sustainability, isolated communities must unite to form a global community that puts need before greed.

To help speed this process of working together for change, let’s take a look at Child-to-Child.

Child-to-Child as an entry point to education for change

“Child-to-Child”²⁸ is an enabling educational process that has been introduced in more than 70 countries. At best, it is a discovery-based approach whereby school-aged children learn to actively respond to health-related needs of their younger brothers and sisters, and of persons with special needs. In addition, groups of children collectively tackle some of the health, sanitation, and environmental needs in their village or neighborhood. When introduced to schoolchildren, Child-to-Child can help make education more relevant to their lives, their health, and their communities.

Health promoters in Latin America see Child-to-Child as a step toward transforming conventional schooling into what the Brazilian educator, Paulo Freire, called “education of liberation.” Let me explain.

We all know that education can be a doorway to improving health. For example, study after study has shown that “female literacy” lowers child mortality.

But from the viewpoint of the ruling elite, mass education can be a two-edged sword. This is especially true in inequitable societies where a privileged minority enriches itself at the expense of the many. Schooling can help enable people to understand the root causes of their problems and join together to stand up for their rights. Because knowledge is power, education is potentially subversive. It can be the seedbed for social change.

To minimize this liberating potential, public schooling has conventionally had a strong authoritarian component. The teacher is ordained as an all-knowing authority. The students are trained to follow orders, to obey without questioning, and learn their place in the social hierarchy. Thus schooling becomes a process not of “education for change” but rather of “training to resist change.” It inculcates and perpetuates the injustices of the status quo.

In Latin America, with its long history of authoritarian power structures, health workers committed to the wellbeing of their people necessarily become “agents of change.” When they introduce Child-to-Child activities into government schools, their objective is not simply to teach

kids about health. Rather it is to begin to transform conventional schooling into an empowering learning process for change. Pupils are encouraged to think for themselves, make their own observations and draw their own conclusions, then to collectively create their own plan of action and work together to improve their situation.²⁹

This process involves “learning by doing.” By putting into action in their homes in communities what they learned through Child-to-Child, the children’s education relates more to their lives. By cooperating rather than competing, they learn that the wellbeing of each depends on the wellbeing of all. Thus the children become budding agents of change for building a healthier, more sustainable society.

But in recent years a new dynamic is emerging. With the shifting pattern of health problems in the world, increased societal dysfunction has made the Child-to-Child process more difficult and more challenging. I have witnessed this transition over the last 25 years in Child-to-Child workshops in North and South America, Asia, and Africa.

Wherever I help facilitate Child-to-Child, I use a methodology developed in Latin America. The children begin by conducting their own “community diagnosis.” Using a series of line drawings placed on a flannel-board (or on the ground), they form a colorful “map” of the health-related problems they consider important in their community.

Two decades ago the pattern of health problems that children considered most important was fairly consistent, in country after country. They prioritized such maladies as diarrhea, pneumonia, skin problems, intestinal worms, and “not enough food.” They also often mentioned poverty, lack of health facilities, shortage of clean water, and other underlying health-related problems.

But in recent years this pattern has radically changed. When the children are asked “What are your most important health-related problems?” they now stress such disturbing events as violence, robberies, street gangs (“gangsters”), gunfights, glue sniffing and other harmful drugs, drunkenness, family breakdown, beatings by parents, police brutality, “hopelessness,” fear, and rape. Hunger, poverty, low wages, and “no jobs” are also stressed. But problems like diarrhea, head lice, or worms, though still prevalent, they rank as less important.

This pattern of violence, crime, cruelty, and destructive behavior turns up again and again, everywhere from rural Mexico and the favelas of Rio de Janeiro to the squatter settlements of Cape Town and the slums of Manila. Likewise, a similar pattern of violence and social chaos was also cited by children doing Child-to-Child activities in the ghettos of Chicago and Detroit.

Obviously, using Child-to-Child to help a group of children try to cope with violence and social injustice is far more difficult than helping them deal with the more traditional “diseases of poverty.” School kids can easily learn how to rehydrate a baby with diarrhea. By comparing the breathing rate of a sick baby with a rock swinging back and forth on a 32 cm string, they can spot an early sign of pneumonia (rapid breathing) and seek medical help. But to ask children to figure out something to do about problems of crime, street gangs, or domestic violence may be asking too much.

Amazingly, however, even with such problems there are some worthwhile things that children think of and manage to do. For example in Cape Town, South Africa, a group of schoolchildren reached out in friendship to one of their peers who had dropped out of school, joined a gang, and

begun to sniff glue. They provided the encouragement and friendship to convince the troubled boy to return to school, join their sports club, and give up his more destructive pursuits. Such effective interventions by school kids are, however, exceptional.

Perhaps the most important contribution Child-to-Child activities can make under such troubled circumstances is to help children begin to look at their problems collectively, with hope, rather than just accepting them as fate or “God’s will.” They discover that they can turn to one another for help and understanding. They begin to discuss underlying causes and collectively explore possible solutions.

Admittedly, such activities may do little in the short-term to solve these deeply rooted problems. But they sow the seeds of thoughtful analysis, of reaching out to help each other, and of working together to improve their situation. As these children grow up, some may become leaders of collective action for change. In Mexico, Nicaragua, and elsewhere I have seen this happen.

Clearly, the core problems of today’s lopsided world will not be resolved overnight. The struggle for a fairer, healthier, more compassionate social order may take decades. But today’s children are the leaders and/or followers of tomorrow. The more we can do to help them gain the knowledge and tools to look forward with hope, work together for the common good, and discover that kindness brings deeper satisfaction than cruelty, the better are the chances that humanity will design a healthy and sustainable future.

Participatory epidemiology and breast-feeding

The content and methods of children’s education is so important to community and ultimately to world health, that I would like to explore a bit longer how the Child-to-Child approach can contribute to this challenge.

As we have noted, the overarching determinants of health have been changing. Macroeconomic factors, spearheaded by powerful transnational corporations, play an increasing role in determining human and environmental health. It is crucial that the young learn to observe and consider such overarching factors when they try to “diagnose” the causes of poor health in their communities.

Consider, for example, the importance of breast-feeding as a low-cost, health-protecting measure. In Latin America it is estimated that 70% of mothers now bottle-feed their babies. That practice kills or compromises the health of millions of babies. This tragedy is in large part due to unscrupulous promotion of infant formula by Nestles and other transnational corporations in violation of the International Code of Marketing of Breast Milk Substitutes.

If school children (who in a few years will be parents) can discover for themselves the importance of breast-feeding to a baby’s health, and the dangers of bottle feeding, they will be better prepared to resist and oppose misleading advertising.

Discovery-based learning. Children learn best through what we call “discovery-based learning,” that is, by making their own observations and discovering the truth for themselves. There is an old Chinese saying:

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

To which in Mexico we have added:

If I discover it, I use it.

In Child-to-Child activities in Mexico, schoolchildren discover important health information for themselves through “participatory epidemiology.” To help them discover the importance of breast-feeding, their teacher asks them to go home and ask their mothers, “How many times has my baby brother or sister had diarrhea in the last year?” Next day, the children put their findings on the blackboard. They also record which of the babies have been breast-fed or bottle-fed.

When schoolchildren in the village of Ajoya conducted this survey, they discovered that the bottle-fed babies had diarrhea 5 times more often than the breast-fed babies. Because this finding was their own discovery, it had a big impact. The children and their mothers realized how they had been fooled by the pictures of fat healthy babies on the cans of Nestles’ “Nido” in the village shops. They had believed that Nido would make their own babies just as fat and healthy. To further validate their discovery, in a community meeting a village health worker compared the children’s findings with research conducted in many countries, showing similar results. The children and their mothers were appalled to learn that bottle-fed babies are up to 25 times more likely to die from diarrhea than are exclusively breast-fed babies³⁰.

The health worker also explained that concerned groups of women in many parts of the world had formed a “watchdog group” called IBFAN (International Breast Feeding Action Network), which in 1981 successfully helped pressure the World Health Assembly to pass the International Code of Marketing of Breast Milk Substitutes. This code, she explained, has helped to rein in the unethical corporate promotion of bottle-feeding. However, Nestles continues to violate it.

A group of mothers in Ajoya, became so fired up that they organized a street theater skit demonstrating the importance of breast-feeding and the dangers of bottle feeding. At the end of the skit, the children held up big signs they had made saying, “BOTTLE FEEDING CAUSES DIARRHEA” and “BREAST FEEDING KEEPS A BABY HEALTHY.” (A photo summary of this skit is in *Helping Health Workers Learn*, by David Werner and Bill Bower, Hesperian Foundation, 1982).³¹

In this way—by starting with their own local participatory research, then exploring how their local problems relate to a worldwide problem, and finally organizing a popular response—the mothers and children of this village enabled themselves to take decisive action. They also discovered the need for international solidarity and the value of a global grassroots movement to oppose unscrupulous practices of powerful transnational corporations.

Making the links between distant causes and local events

To raise critical awareness among enough people to rein in the inequitable global economy will require worldwide encouragement of “popular education” at the community level.

By “popular education” I refer to what Paulo Freire, the Brazilian educator and author of *Pedagogy of the Oppressed*³² called “education of liberation.” It is this learning approach that enables ordinary people to understand their place in the world order. Based on their own observations, critical reflection leads to collective action, through which they begin to “change the world.” Rather than relying on information that has been filtered and sanitized through mass media controlled by the ruling class, popular education starts through people sharing information with one another. It makes good use of alternative media.

In the last several decades, community-based programs around the world have developed a wealth of methods and tools for “popular education.” Many of these methods are still very useful today. But given the changing dynamics of decision-making power in today’s shrinking world, the methods, tools and content of popular education need to be adapted to this new overarching reality.

“But why?” games and the “Chain of Causes.” One of the most useful teaching methods—used to help communities look at the interrelating factors that contribute to sickness and death, involves the so-called “But why?” game and construction of a “Chain of Causes.” First a story is told, preferably a true one that describes a series of events leading up to the tragic death of someone in the local community. When the story ends, the facilitator tells it again, but backwards, starting with the moment of death. “The person died of such and such a cause. But why?” “Because such and such happened.” “But why?” “Because something else happened.” “But why?” . . . And so on.

A “But why?” story that has been successfully used in many countries is the “Story of Luis,” related in the book, *Helping Health Workers Learn*³³ by Werner and Bower. It is based on the true story of a young boy in a small Mexican village, who died of tetanus. Many contributing causes are built into the story, including the fact that Health Department’s immunization program had not been completed, and that when Luis was finally taken to the distant health center, tetanus antitoxin was unavailable, partly because of its outrageously high price. The “But why?” analysis goes like this:

*The boy Luis died from tetanus. But why?
Because he stepped on a thorn. But why?
Because he didn’t have sandals. But why?
Because his father was too poor to buy them. But why?
Because his father was a sharecropper. But why?
Because he had to hand over half his harvest to the wealthy land baron. But why?
. . . Etc.*

After the “But Why?” game, a set of cardboard chain links are handed out to participants. The links are illustrated according to five categories:

Physical (things),
Biological (worms and germs),
Cultural (customs and beliefs),

Economic (concerning money), and
Political (concerning power).

The “But Why?” analysis is then repeated. As the story unfolds again, the group identifies the corresponding category of link for each cause. Whoever has an appropriate link brings it up and hooks it into the gradually lengthening chain. In this way, participants build a tangible “chain of causes” linking the cardboard figure of the sick child to a cardboard gravestone.

After the chain is complete, analysis for action begins. Participants discuss which of the links they might be able to break to prevent a similar death in the future. They consider which links could be broken by *the family itself*, which would require *community action*, and which would require *united action by many communities*, or even by the *peoples of many nations*.

The original version of this story took place long before NAFTA had called for the Mexican Constitution. Very progressive agrarian reform laws, though poorly enforced, still legally protected the land rights of small farmers. Therefore, in the “Story of Luis,” answers to the question, “But why did Luis’s father work as a sharecropper and give half his crop to the land baron?” were different than they would be for a similar story today. Answers focused on the government’s failure to enforce the laws requiring redistribution of large plantations to landless farmers.

To bring the story up to date, it would need to be “structurally adjusted” to include events and questions relevant to the North American Free Trade Agreement (NAFTA):

“But why are so many small farmers now migrating to the cities?”

“But why are they losing their land?”

“But why were the Agrarian Reform laws removed from the Mexican Constitution?”

“But why can’t poor people in the cities find work?” “But why do wages keep falling?”

“But why are there so many more Mercedes Benzes on the city streets today, and so many more children sniffing glue and begging?”

The “modernization” of such time-tested learning methods is critically important. Today’s “Health Education for Change” needs to help people understand the links between local events that jeopardize their health, and high-level policies at the national, international, and global level.

For example, an updated version of the above story might lead to questions like the following:

“But why did Mexico, despite so much popular protest, decide to join NAFTA?”

“But why was the United States able to subvert the Mexican Constitution?”

“But why do the politicians who run the Mexican government, if they were voted in through national elections, not represent the poor majority?”

“But why are real wages north of the US-Mexican border 10 times that of wages south of the border.”

In a community of poor farming people, a heated discussion around such issues is likely to result. It is the job of the facilitator not to provide his personal opinions or answers, but to help the participants build on their own observations and draw their own conclusions. Where necessary, the facilitator may provide them with objective factual information pertinent to their concerns.

In a good “But why?” process, participants will go far beyond the story’s original content in exploring the underlying network of causes. What is most important is that at some point the discussion shift from critical analysis to a systematic search for effective action:

“Which links of the chain can we, as a local community begin to break?

“Which will require the action of a larger or even global community?

and

“How can we, as a local group, link into the larger struggle?”

Coalition building

In adapting health education to our shrinking world, an important role of the facilitator is to help people in a village or community make links with other villages or communities that share the same concerns and are looking for ways to take collective action.

In Mexico for example, scores of independent community-based health programs country-wide formed an association called PRODUSSEP (*Promocion De Servicios De Salud Y Educacion Popular A.C.*). PRODUSSEP has taken stands on many health-related issues. One such issue linked to global policies was an attempt by the World Bank to timber the mountain forest lands of the Tarahumaran Indians. The so-called “useless” scrub pine forests would be converted into paper pulp and exported to the United States to help service Mexico’s huge foreign debt. However, the Tarahumaras’ livelihood depends on the forest. Its destruction would be genocidal. Therefore, the Tarahumaran people together with health activists across the nation mobilized organized action. The World Bank plan was successfully blocked, at least for the time being.

Unfortunately, there are many high-level obstacles to health where organized action within a single small country can make limited inroad. For this reason, nearly 30 years ago PRODUSSEP (*Promocion De Servicios De Salud Y Educacion Popular A.C.*) joined similar community-based health associations in other countries of Central America to form a coalition called the “Regional Committee of Community Health Programs”

International People's Health Council. Extending this international network still further, in 1991, the Regional Committee played a key role in the formation of a worldwide coalition called the International People’s Health Council. The goal of the IPHC is to revive the pursuit of Health for All through focusing on questions of equity and social justice. It brings together health workers, analysts and activists from popular movements around the world to raise awareness of the most far-reaching and sociopolitical causes of poverty and poor health. And it tries to mobilize coordinated action around fundamental health-related issues. The IPHC has held groundbreaking international meetings in Nicaragua, Palestine, and South Africa.

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People's Health Movement. The International People’s Health Council has also played a key role in the planning, and in preparation of background material, for the People’s Health Assembly (PHA), a landmark event held in Savar, Bangladesh in December, 2000. Attended by nearly 1500 health workers, activists, and academics from 97 countries, the PHA helped put the

health implications of globalization on the international agenda. To sustain the momentum of the PHA, participants decided to form the so-called People's Health Movement (PHM). The People's Health Movement currently has active branches in many parts of the world. It has taken part in the 2001 and 2002 World Health Assembly in Geneva and in other important policy forming activities. In this way it has begun to get "the voice of the people" an entry into the echelons of decision-making power. *For further information write: PHM Secretariat, Gonoshasthaya Kendra, PO, Mirzanagar, Savar, Dhaka 1344, Bangladesh. Website: www.phamovement.org E-mail: gksavar at citecho.net*

While they are beginning to get a voice at the higher levels, it is important to realize that coalitions such as the Regional Committee, the International People's Health Council, and a People's Health Movement have grown from the bottom-up, out of community-based programs working directly with peoples in need. This lends them a level of validity they must be careful to sustain.

The dynamics of community ownership

As action-oriented terms like "participation," "empowerment," "mobilization," and "self-reliance" have, one after the other, been co-opted by the establishment and reft of their revolutionary potential, they have been replaced by new buzz-words. The latest mantra of the sustainable development jet-set harps on "community ownership." It well may be that "community ownership is the key to health." But whether it is key to good health or bad health depends on such questions as, "In whose hands does community ownership lie?" and "Who in the community has decision-making power?" These questions are as important for the "global community" as for the local community.

The typical "community," of course, is anything but homogeneous. Characteristically it includes a hierarchy of people and groups ranging from poor to rich, powerless to powerful, considerate to selfish. Before we eulogize about "community ownership," it is essential to consider how decisions in the community are in question made, who controls the resources, and who holds the power. In short, who owns what and whom?

Unfortunately, most geographical communities have an entrenched pecking order. Regardless of whatever democratic structures exist in theory, usually there are a few people who have more control over resources and power than others. Such "community leaders" range from a benevolent headman to self-seeking tyrants. One way or another, those with the disproportionate wealth and power tend to influence community decision-making for their own ends.

There is an adage that, "Power corrupts and absolute power corrupts absolutely." Martin Luther King said that,

"History is the long and tragic story of the fact that privileged groups seldom give up their privileges voluntarily."

Health within a community is determined, in large part, by the fair distribution of privilege: that is to say by the equitable distribution of resources, opportunities, and public assistance for those with special needs. Such equity, in turn, depends on fair distribution of decision-making power. Nearly all the "struggles for health" I know of at the community level have centered around the organized demand by disadvantaged sub-groups in the community for equal rights and an equal voice in the decisions that affect their lives.

It is for this reason that I interpret “community ownership” as closely linked to collective self-determination. It is a dynamic whereby people with common needs join together to gain control of decisions that effect their wellbeing.

Unfortunately, today there is virtually no community or nation on earth that is sufficiently buffered from global decisions and events to say that it is fully self-determined regarding public health. The overriding threats to health drafted in the world centers of power affect us all. Many of these threats relate to the social, economic, and environmental imbalances exacerbated by the practices and ploys of transnational corporations. The most ominous and far-reaching of such threats include:

- massive arms production and escalation of armed conflict
- atmospheric contamination with carcinogens and toxins;
- use of terrorism to fight terrorism, adding to global instability;
- the increasing likelihood of nuclear war;
- global warming;
- deforestation and desertification;
- planetary fresh water depletion: the drying up of continental aquifers (accelerated by large-scale water and fossil-fuel guzzling agribusiness)
- the prevailing model of development which squanders world resources for the further enrichment of the wealthy, while neglecting urgent human and planetary needs;
- the massive foreign debt of poor nations, which limits their capacity to reduce poverty reduction or to provide adequate services to those in need;
- structural adjustment policies imposed on poor countries, which put the burden of debt payment on the poor;
- the “global casino” of transnational speculative investment, which leads to boons and busts of entire national economies, precipitating massive hardship and hunger.

All of these far-reaching threats to sustainable health can in large part be traced to the global power structure dominated by giant corporations and governments. Not only does this globalized power structure impose on the world its inequitable paradigm of socioeconomic “development”, but it aggressively opposes any self-determined “people’s republic” that tries to put the common good before corporate profit.

Given this new reality of top-heavy world power, the concept of “community ownership” has to be reexamined. Because self-determination of local groups is now so overpowered by global decisions, we need to think of it in terms of a coordinated struggle by the “Global Community.” Not until humanity collectively recognizes that all people have equal rights to a fair share of what the Earth provides, and that we all share responsibility for the stewardship of our endangered planet, can we seriously consider approaching Health for All.

There is no roadmap showing the way forward. No easy answers. But clearly, widespread awareness of global issues is an essential first step. A critical mass of concerned people needs to become well informed about the way today’s world works—why poverty and hunger remain so prevalent in a world with such incredible affluence—and then to share their knowledge and concern with others on every rung of the social ladder.

While the struggle for a healthier social order needs to be spearheaded by those on the bottom, it needs also to be championed by more enlightened persons on the top. Already there are signs of

this happening. Some of the cleverest strategists from within the world's most powerful institutions have begun to question the viability of the dominant model of economic development. Former high-level economists at the World Bank or International Monetary Fund, such as Herman Daly, Davison Budhoo, and Joseph Stiglitz, have become outspoken advocates of more people-centered and potentially sustainable models of socioeconomic development. If the international financial institutions were to heed Herman Daly and John Cobbs' recommendations in their groundbreaking book, *"For the Common Good: Redirecting the economy toward community, the environment and a sustainable future."* this could be a big step towards a healthier, more compassionate, more sustainable world order. The authors include an Appendix that constructs an "Index of Sustainable Economic Welfare" intended to replace Gross National Product as a measure of economic wellbeing.³⁴

In addition, some other world's richest businessman, such as George Soros and Bill Gates, have begun to see that poverty reduction and universal access to certain health services are important to the long-term well-being of the human family. They have poured millions into their pet projects such as immunization against polio and The Global Fund. Unfortunately, however, these transnational heavyweights still need to learn more about democratization and participatory process, as well as the need for comprehensive and participatory health strategies. Just because someone owns Microsoft or has made a killing through speculative investment doesn't mean he owns the key to Health for All. Such ownership needs to be collective.

Nevertheless, it is a potential step forward that some of the brightest, most forward thinking pioneers of the market system are beginning to step back and question the validity of trickle-down economics, and are beginning to look for viable alternatives. More friendly dialogue is needed.

Health has to do with building bridges. Some activists for social justice can only see these free market potentates as "the enemy," and write them off. It is important that we who are committed to sustainable development try to find common ground with those who have a different world-view. Within progressive movements there has been far too much righteous "preaching to the choir:" too much waving of banners and shouting of slogans, with too little reaching out across perceptual divides. This exclusiveness has perhaps been the Achilles' heel of both the International People's Health Council and the People's Health Movement.

Just as the gap between rich and poor needs to be narrowed in economic terms, so it needs to be bridged in terms of the search for sane and sustainable solutions. No one has all the answers.

Three levels of community action for change

The main thrust of this chapter is that *far-reaching structural changes at the macro level are needed if we are ever to achieve sustainable Health for All.* A lot of us who have spent much of our lives working to improve health at the village or community level, have witnessed setbacks stemming from global policies, and have therefore shifted our attention to these overarching concerns. In the last decade, I personally have devoted more and more time and energy to the global impediments to sustainable health. A little like David fighting Goliath!

Yet in our efforts to change the global system, it is imperative that we not neglect the urgent life-and-death needs of vulnerable people. As Gabriela Marcel pointed out in her poem "My Name

is Today,” the starving child cannot wait for us to build a fairer social order. That child’s needs must be met as best we can, NOW. This is a first job of any community health worker.

But at the same time, it would be a mistake for community health workers to spend all their time caring for hungry and sick children. In the long run preventive measures save more lives. And in communities where the strong exploit the weak, helping “those on the bottom” gain a stronger voice in the events that shape their lives can have an even bigger impact on health. When communities learn to work together—locally, nationally, and internationally—so that the neediest people gain a voice in the high-level decisions that affect their well-being, this is a big step toward Sustainable Health for All.

In trying to reach a balance between efforts to meet urgent short-term needs and overarching long-term needs, it is useful to look at the struggle for health on three interrelated levels.

Three Levels of Action in the Struggle for Community Health			
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Objective	Timeframe	Level of action	Process
TO COPE with urgent	Immediate	local: family or community	Involves helping people in difficult circumstances find ways to cope with day-to-day life-and-health-threatening needs
TO REFORM unjust policies	Intermediate	united action; larger numbers; national & regional organizations	Involves working within the existing system to reform or mollify unfair practices and laws, and demand that just laws and human rights be compassionately enforced.
TO TRANSFORM unjust systems	Long-term	ultimately global; international coalitions	Involves a fundamental change in the structure of society, the balance of power and prioritization of needs and objectives.

In working toward the long-term health of the community it is important that we approach the more immediate objectives in a way that prepares the ground for the next level. The health worker can help the community cope with urgent day to day needs through a collective problem-solving approach that also prepares people for taking united action to resolve underlying problems. This is what empowerment and ownership are all about. Thirty years ago I described this enabling process of community action for change in a paper I wrote years ago called “The Village Health Worker, Lackey or Liberator:”

“If the building of latrines brings people together and helps them look ahead, if a nutrition center is built and run by the community and fosters self-reliance, and if agricultural extension, rather than imposing outside technology, increase the internal growth of the people toward more effective understanding and use of their land, their potentials and their rights...then, and only then, do latrines, nutrition centers and so-called extension work begin to deal with the real causes of preventable sickness and death.”

“This is where the village health worker comes in. It doesn’t matter much if he spends more time treating diarrhea than building latrines. Both are merely palliative in view of the larger problem. What matters is that he get his people working together.”³⁵

Combating the health threats of the pharmaceutical industry through community action for change: an example from the Philippines

The pharmaceutical industry is a two edged sword, and so is the entire medical and health-care industry, when it becomes so commercialized that it puts profit before people.

This paradox became very clear to me on an exchange visit to the Philippines several years ago. A group of village health workers from Central America were visiting a network of community-based health-care (CBHC) programs in the Philippines. On the island of Leyte we visited the Makapawa Health Program on the outskirts of a city. The local health workers proudly told us that in the two years since the program had begun, both child malnutrition and child mortality had significantly decreased. We asked why. They said, because of the nutritional advice they gave mothers. However, the mothers present said Nonsense! They said, “We’ve heard that same advice from visiting nurses and extension workers for decades. When our children are malnourished, it’s because we couldn’t afford to buy them enough food.”

However, the mothers agreed that their children were now healthier and that fewer died. So we asked the mothers if they now earned more money to buy food. They replied that, on the contrary, food prices had risen faster than their wages.

“Then how do you explain that your children are better fed and fewer are dying?” we asked them. No one had an answer.

So we went on to the next activity: herbal medicine. The health workers had helped mothers rediscover the value of some traditional forms of healing. In groups of five households, mothers now collectively prepared their own herbal remedies for common ailments like colds, coughs, scabies, and worms. For diarrhea they prepared an oral rehydration drink using guava juice, lemon, and sugar cane syrup with a carefully measured amount of salt. The mothers happily showed us how they prepared these homemade remedies. We asked if they worked.

“They not only work,” insisted one mother. “They save us a lot of money!”

“That’s right!” explained another mother. “We used to spend a bundle on trips to the doctor and on medicines from the pharmacies.”

“And the price of medicines keeps going up!” added another mother.

All the mothers echoed their agreement. Then one mother suddenly exclaimed, “Now I know why our children are fatter and die less often! Its because, with the money we save by using our own homemade medicines, we can buy more food for our children!”

Again, the mothers all voiced their agreement.

“Good Lord!” cried yet another mother, “Do you realize what we’re saying? We’re saying that what was killing our children was health services and medicines! Because of their high cost! Because we used up our food money to pay for them!”

“Now that we can buy more food for our children, they get sick less often. So we spend even less on medical care, which lets us feed them better still! So that’s why they’re healthier now!”

In this way, the mothers discovered that health care can be dangerous to health, when it costs too much. By rediscovering the value of traditional medicine, the community took a decisive step toward taking health into its own hands—and toward “community ownership.”

So far so good. But this community’s ownership of its health is, of course, not complete. While their home remedies work for common minor ailments, for more severe illnesses they still must turn to costly professionals and commercial drugs. And as one mother pointed out, the prices of commercial pharmaceuticals keep rising. Currently in the Philippines, the transnational pharmaceutical companies sell their drugs at more than double their price in neighboring countries. Apparently they put their prices as high as the market will bear. If poor people die because they can’t afford lifesaving drugs, tough luck! Business is business.

To combat such deadly exploitation, Community Based Health Care (CBHC) programs in the Philippines have formed networks and organizations that collectively pressure the government to do something about the inflated price of pharmaceuticals. And recently the government has taken modest steps to lower the price on critically needed drugs. Philippine non-government organizations like HEAD (Health Alliance for Democracy)³⁶ and HAIN (Health Action Information Network: www.hain.org)³⁷, in turn, have close links with international coalitions such as HAI (Health Action International: www.haiweb.org)³⁸ and BUKO (BUKO Pharma Campaign: www.bukopharma.de/English/english.htm)³⁹. These are watchdog groups that keep a close tab on the pharmaceutical industry. They expose and protest price fixing and bribery. They pressure the World Health Organization to take a stronger stand on essential drug policies. They challenge patent laws that in effect price lifesaving drugs out of reach of millions. And they educate the public (and doctors) about the importance of generic drugs.

The united struggle for drugs for HIV/AIDS. As in the Philippines, active community groups and coalitions around the world have played an important role in urging national governments and international agencies to monitor and regulate the pharmaceutical industry on life-and-death issues. The confrontation over drugs for AIDS is a case in point. Astronomical prices on patented drugs have prevented millions from using these life-prolonging drugs. The recent breakthrough, whereby international trade agreements now allow poor countries to produce or buy generic equivalents at a small fraction of the brand name products, was successful in large part because of the organized demand by people’s groups in many countries. The community of persons infected with HIV has played a courageous and decisive role in this process.

WHO’s risky alliance with the corporate world

Many community activists are rightfully critical of the growing “partnership” of the World Health Organization (WHO) and transnational corporations. For private industry the bottom line is profit. As the unscrupulous practices of Nestles, Enron, the tobacco, arms, and transnational drug industries have demonstrated, large corporations have a less than admirable track record when it comes to safeguarding human needs.

Transnational corporations have a long track record of co-opting government and international agencies, including the World Health Organization. Sadly, one of the most dangerous plans on the drawing board is a pact between WHO and the giant food corporations to “fight malnutrition” by dicing commercial junk foods with vitamins and iron. Promoting such nutrient-enriched goodies in poor communities is potentially as counterproductive as it would be for WHO to endorse vitamin-enriched infant formula. In the same way that costly pharmaceuticals, bottled baby foods, or commercial packets of ORS contribute to malnutrition when poor families spend their limited food money to buy them, the same is true for costly transnational food products. Already the money that poor families spend on costly soft drinks and junk foods contributes to under-nutrition of millions of children. WHO’s stamp of approval for such misguided expenditure is a clear and present danger.

To block this pernicious plan, a strong protest by the international health community must be mounted. So must a campaign to raise awareness of these dangers, aimed at everyone from village mothers to WHO hotshots. UN agencies should not be allowed to sell their souls to the company store.

Reining in the “global casino” for the ‘Common’ Good: the Tobin Tax

Although the arms, illicit drugs, and oil, and pharmaceutical industries are among the world’s most lucrative, the amount of money that changes hands in these giant enterprises is dwarfed by that of the so-called “global casino.” Each day US\$1.5 trillion (\$1,500,000,000,000) changes hands through currency exchange and international speculative investment. This colossal sum is approximately 100 times the amount that changes hands daily for real goods and services.

Because such colossal sums are involved, such currency speculation has played a decisive role in recent financial crises, causing widespread chaos and poverty. When worried speculators suddenly pull out their money from one country and invest it where they think the returns will be higher, entire national economies have crashed. Such was the fate not only of poor nations like Mexico, Brazil, Venezuela, and Thailand, but also of Malaysia, Indonesia, and the other “Asian Tigers.” When such economic disasters occur, invariably it is the poor who suffer most. To jump-start “economic recovery,” the World Bank and IMF impose structural adjustment programs (SAPs), which demand cut-backs and privatization of services to those in greatest need. This further increases their hardships and compromises their health.

In the long run – to achieve Sustainable Health for All – obviously the entire globalized economic system needs to be radically transformed. It must be replaced by a people-centered system that fosters equity and social justice, not further polarization. But achieving such transformation will be a long up-hill battle.

In the meantime, one reform measure with vast potential is the so-called Tobin Tax. First proposed by Nobel prize-winning economist James Tobin in the 1970s, this consists of an international tax of around 0.1% on all speculative investment and currency transactions. Because of the huge sums involved, such a tax could yield up to \$1 billion per day! If this money were wisely allocated for the public good (a big *if*), it could provide free primary health care to everyone on earth who currently lacks it (including free treatment for AIDS, tuberculosis and malaria). It could go a long way toward providing adequate food for the world’s hungry, reducing poverty, ensuring universal education, and meeting all people’s basic physical needs.

Advocacy of the Tobin Tax for the common good is currently being spearheaded by War on Want and hundreds of other NGOs and grassroots groups. Finland has already instituted a Tobin Tax, and a number of countries, including Canada and France, along with the UN, are pushing for an international agreement to make it a global policy.

But needless to say, there is an extremely powerful lobby rallying to resist such a tax on the rich. For it to be widely introduced, a worldwide grassroots movement – based on education, awareness-raising, and organized action – is essential. While clearly the Tobin Tax is only a reform within the existing inequitable system, it could nonetheless be a big step toward the eventual transformation of the present system into one that is more equitable and sustainable. And in the meantime, the billions of dollars generated, if well-directed, could allow millions of people to cope more effectively within our current unjust socioeconomic order.

As both a coping and reform measure, introduction of the Tobin Tax through the United Nations could potentially be an enormous stop-gap measure for ameliorating poverty and improving health. Those who wish to take part in grassroots advocacy for a Tobin Tax to help reduce poverty and improve health can contact War on Want (www.waronwant.org)⁴⁰ or Tobin Tax Initiative (www.tobintax.org)⁴¹.

Or join (or start) a local group that promotes it. Community action and international solidarity around this issue is vitally important to restoring Primary Health Care as a Human Right.

The need to see the larger picture

I choose to believe that there is a core of goodness—or at least of common sense—in most people. At one level or another most of us, rich and poor, share an interest in helping create a world that is conducive to our mutual well-being, and the well-being of generations to come. Our survival instinct is not only personal but collective. Over the millennia we have developed brains that can think and look ahead. The “Golden Rule” exists in some form in every belief system. What goes around comes around.

On our long slow progress toward civilization, human beings have begun to discover what we might call *eco-understanding*. We have begun to realize that harmony, balance, fairness, and kindness provide greater security and deeper satisfaction than do selfishness, cruelty and greed. Our greatest joy comes from a shared experience which some people call love, wherein giving and receiving become one. The bigger chunk of the universe we embrace in that feeling of oneness, or love, the fuller our lives become. When we give the best of ourselves, we all benefit. What goes around comes around, but in a spiral: rising to a higher level.

Much of the inequity, cruelty, and violence in today’s world results from incomplete, distorted or false information. *The road to Health for All must be paved with better understanding*. There is need for more effective and honest communication. Bombarded as we all are by partial and distorted information, too often we are like the blind men who try to describe an elephant by touching different parts of it. It’s a rope, a tree, or a huge sack, depending on whether they touch its tail, its leg, or its belly. We need some way to stand back and get a more complete picture: to be more completely in touch. We need to put the different pieces of the puzzle together, and to share our perspectives openly and honestly with one another.

Getting a complete picture of what is needed to achieve Sustainable Health for All will not be easy. Some of us want to do it through market forces, with the proverbial “big stick,” or with a bag of cost-effective technological fixes, depending on our particular training and perspectives. But first we need to see the bigger picture, and learn from one another. Collectively we can begin to put together the pieces of the puzzle, until we can glimpse that colossal elephant (or turtle?) that miraculously holds up the world.

Politics of Health Knowledge Network

With this goal of collectively putting together the pieces of the global puzzle, we at HealthWrights (Workgroup for People’s Health and Rights) and the International People’s Health Council have taken on an ambitious project. We call it the “*Politics of Health Knowledge Network*.”

The main purpose of the Politics of Health Knowledge Network will be to provide credible data, well-balanced analysis, and workable alternatives to the international community of health workers and activists who share the dream of Sustainable Health for All. It will have the following characteristics:

- It will serve as an easy-to-understand resource of relevant, accurate information for those concerned with questions of health and development policy, and social justice.
- Information will be carefully researched, fully referenced, and presented in a clear, objective, and hopefully non-rhetorical manner.
- An effort will be made to place each piece of information within the larger picture of the determinants of health, from local to global level.
- To do this, information will be organized within a map or matrix designed to show the links or causal chains between different health related issues at different levels.
- Users can enter the Network with anything from personal to global health-related concerns. From whatever entry point they can explore or follow up links in many directions. They can see how their particular issue fits into the larger context. They will also be able to see how policies and decisions in different sectors have a direct or indirect impact on health.
- Information will cover a wide range of topics and sectors that impact on health, or which either enhance or obstruct the pursuit of Sustainable Health for All. Data will cover everything from macro or global policies to first hand accounts of micro or local events, and the impact of one on the other.
- Key information will be presented as summaries and extracts. References to full articles and sources will be provided, where possible with internet links.
- Information will be presented in the form of comparative studies, data, charts, and real life stories. It will draw on credible publications, but will also include first hand accounts by people whose health and lives are jeopardized.

- The Network will stress *positive alternatives and possibilities*. While it will include critical analysis of current policies and practices, it will attempt to juxtapose negative situations with examples of more equitable and sustainable options. When a problem is analyzed, you can click on a "positive action" button to see possible solutions or suggestions for constructive action, with relevant resources or addresses. This emphasis on positive action will, we hope, make the Network motivational rather than depressing.
- The plan is for the Politics of Health Knowledge Network to be interactive and participatory. It will start off as an interactive web site on the Internet, but may evolve to include a paper and CD-Rom version. Its evolution and comprehensiveness will depend on the input of users, and active participation of dedicated volunteers.

To support or assist in the development of the Politics of Health Knowledge Network⁴² contact: **web@politicsofhealth.org**

In conclusion, the answers to hunger, poverty, polarization of society, environmental demise, violence, terrorism, and poor health lie not in military force nor in trickle-down economics, but in understanding, equity, and solidarity. Not in stricter rules but in more humble, caring interaction. Not in building fortresses but in embracing difference. Not in security blankets or nuclear shields, but in sharing and compassion. If we move collectively toward such people-centered structural adjustments, the time may come when the global community will take ownership of the quest for Sustainable Health for All. Only then may this still distant dream begin to be realized.

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