HEALTH CARE IN SOCIETIES IN TRANSITION:

A Report on a Small International Meeting Held in Managua, Nicaragua December 4-9, 1991

International People's Health Council

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In addition, we hope that the English edition will be available through the regional coordinators of the International People's Health Council, whose addresses are listed at the end of this report.

ACKNOWLEDGEMENTS

This report of the international meeting on *Health Care in Societies in Transition*, held in Managua, Nicaragua in December 1991, was prepared by David Werner and the staff of the Hesperian Foundation with the help of Steve Babb, Damon Barslow, Lisa de Avila, Maya Escudero, Barbara George, Bruce Hobson, Mariam Khambaty, Carol Thuman, Hopi Wilder, Alexa Wilkie, and María Zúniga.

The report was prepared from transcriptions of tapes of the meeting. For this demanding task we extend warm thanks to Martha Parajón of Nicaragua. Transcribing the tapes was especially difficult— as was condensing and converting the transcription into a readable report — because the original tapes were incomplete and out of order. Also many of the participants — who spoke with a variety of accents depending on their countries of origin — were hard to decipher on tape. The meeting was held in English and Spanish, with informal translation.

The final draft has been prepared after receiving corrections and feedback from the meeting participants and a limited number of friends. We extend our thanks to all of them. The final draft will be translated into Spanish by Ricardo Loewe of Mexico.

We hope that the final report will receive wide circulation, especially among groups working for people's health and rights in the context of social change. The intention of the report is to stimulate thought and discussion, not provide clear-cut answers to the many issues that have been raised. We have chosen a format which we hope will entice you to write down some of your own opinions, thoughts, and ideas.

The International People's Health Council, a new grassroots network for persons and groups committed to long-term improvements in health through organized popular action for social change, is trying to extend its base. A short description of the IPHC and its objectives is at end of this report. If you wish to become involved or participate in the information sharing network, please contact any of the addresses on the previoous page or the regional coordinator in your area (see pages 113 - 114).

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BACKGROUND AND OBJECTIVES OF THE MEETING

In December, 1991, an international group of health rights activists met in Managua, Nicaragua to discuss health care in societies in transition.

Plans for this meeting had got underway several years before, when a number of leaders in progressive health care movements saw a need to explore the links between people's struggles for health and popular struggles for liberation or self-determination in different countries and circumstances. It was felt that much could be learned from sharing experiences and forging common bonds.

The original objectives of the meeting were stated as follows:

1. To exchange experiences of innovative approaches to health and health care in different situations of unfolding political struggle or transition.

2. To identify common features of diverse programs and grassroots initiatives so that factors predisposing to either success or failure can be identified.

3. To consider the mechanisms by which the positive lessons can be applied to health care in specific situations of struggle or transition.

4. To consider whether a regular means of coordination and communication between diverse progressive movements is desirable and feasible, and what form this might take.

In the early planning stages (in the late 80s) the meeting planners had considered 'transition' in the positive sense, that is, in terms of change toward healthier, more people-empowering social structures. In this context, Nicaragua was chosen as an ideal meeting site. Transition from a repressive dictatorial state (under the Somoza dictatorship) to a more popular, equitable government (under the Sandinistas) was seen as part of an ongoing revolutionary process. Thanks largely to strong popular participation, both health, health care, and living standards had improved dramatically.

With the defeat of the Sandinistas in the 1990 elections, however, a more conservative, less egalitarian government abruptly came to power. As public services were reduced or privatized and the real wages of working people decreased, the gap between the rich and the poor began to widen. Poverty and unemployment increased, and the recent progress in both health and living standards started to backslide. Today, unquestionably, Nicaragua is still a 'society in transition'. But in terms of most people's well-being, the current trend of change is retrogressive.

With the overthrow of the Sandinistas in February, 1990, the 'Transitions' meeting — then scheduled for April 1990 in Managua — was postponed. Both logistically and philosophically, doubts were raised as to whether Nicaragua would still be an appropriate place for the meeting. Alternatives were considered, including Oxford, Britain. But as the global political shift to the right in the 90s began to unfold, the actual appropriateness of 'post-revolutionary' Nicaragua as a meeting place became painfully obvious.

Nicaragua's recent reversal in social progress is indicative of the conservative retrenchment that is taking place worldwide. The sweep of 'neo-liberalism' and the militant 'New World Order' are systematically undoing many of the gains of the last 40 years in terms of the rights, needs, and self-determination of the world's disadvantaged countries and peoples. Taking Nicaragua's reversal in direction of 'transition' as a sign of the times, the decision was again made to hold the meeting in this Central American country whose people, though beleaguered and experiencing a temporary setback, continue to struggle for social justice.

INTRODUCTION OF PARTICIPANTS AND THEIR ORGANIZATIONS

The participants invited were mostly from countries in socio-political turmoil if not always 'transition'. All were leaders in community health work with disadvantaged groups, many in the context of struggle for liberation or for far-reaching social and political (structural) change.

Represented were participants from three continents and 13 countries. The countries, persons, and organizations/programs represented were:

- **El Salvador** - Guadalupe Calderón, coordinator of APROCSAL, an association of grassroot health promoters. Guadalupe has been a community health promoter since 1975, and has been active in the Regional Committee for the Promotion of Community Health for many years.

- **Guatemala**- Andrés Morales, a Guatemalan physician and community health activist is a member of the Guatemalan National Revolutionary Unity.

- **Honduras** - Virgilio Joya*, physician and trainer of community health promoters.

- **Mexico** - Martín Reyes is a leader in project Piaxtla, a villager-run health program in the mountains of Western Mexico. For the past four years he has also been a coordinator of PROJIMO, a community-based rehabilitation program. In addition, Martín has become an international leader/trainer in the CHILD-to-child program — an education project to assist children in learning to help meet the health needs of their younger brothers and sisters.

  Ricardo Loewe, physician, founder of the Tlaphtialcalli Clinic (the house where one is cured), in Tepoztlán; active member of PRODUSSEP, a Mexican association of community-based health programs, and member of the Mexican health movement.

- **Nicaragua** - María Zúniga, public educator, co-founder of CISAS (Information Center and Advisory Services in Health) and the Regional Committee for the Promotion of Community Health in Central America and Mexico.

  Leonel Argüello*,physician, ex-Vice Minister of Health and Director of CEPS (Center for Promotion of Health).

Carlos Hernández*, physician, ex-planner Ministry of Health, and public health consultant.

- **Panama** - Maribel Coco*, nurse and member of a newly formed non-governmental organization designed to provide grassroots health education.

- **Dominican Republic** - Prasedez Polanco, physician and founder of COSALUP, a community-based health collective, working in marginal areas of Santo Domingo, especially making use of traditional culture and medicinal plants.

- **USA** - David Werner, a biologist by training and the director of the Hesperian Foundation in Palo Alto, California. For 27 years he has been an advisor to project Piaxtla (mentioned earlier), and for 12 years he has worked with project PROJIMO (also mentioned earlier). He is author of the widely used self-help books *Where There Is No Doctor, Helping Health Workers Learn*, and *Disabled Village Children.*

- **India** - Mira Shiva, physician and member of AIDAN and the People's Health Network; also coordinator of the All India Drug Action Network, Head of the Public Policy Division of the Voluntary Health Association of India (VHAI), and active member of Medico Friends Circles, People's Health Network, Third World Network, and Health Action International.

- **Bangladesh** - Zafrullah Chowdhury, physician and founder of Gonoshasthaya Kendra (People's Health Center), which has sought to promote an essential drugs policy and integrate these drugs into a broad program of health and development.

- **West Bank** - Umaiyeh Khammash, physician and one of the founders and leaders of the Union of Palestinian Medical Relief Committees, a network of health workers committed to the health rights and self-determination of the Palestinian population. The UPMRC has trained community health workers to serve villages and neighborhoods deprived of medical services. It also provides emergency care to those injured by the occupying Israeli forces.

- **South Africa** - Frank Sibeko, Aslam Khalil Ahmed Dasoo, and Krishna Nealchund Vallabhjee of SAHWCO (South African Health Workers' Congress). SAHWCO organizes health workers in the struggle for better health and for a non-racial, non-sexist, democratic South Africa.

  Frank Sibeko, a radiographer, is the Chairperson of the East Rand branch of the National Education, Health and Allied Workers Union (NEHAWU), and a member of the National Negotiations Team for NEHAWU; he is also a member of the Transvaal branch of the South African Health and Social Services Organization (SAHSSO), the African National Congress (ANC) Department of Health, and the SACP Health Desk. He is active in the unionization of health workers.

  Aslam Dasoo, a physician, is a member of the ANC Department of Health and the SACP Health Desk. He is active in the areas of unionization of health workers, health policy work, and the development of grassroots health projects.

  Krishna Vallabhjee, a doctor and community health registrar, is the National Media Officer of SAHSSO, Chairperson of the PHC Committee of Umlazi Ward in Kwazulu, a Management Board Member of the Industrial Health Unit, Vice President of the Tongaat Civil Association, a member of the Southern Natal ANC Health Interim Committee, and a former National President of SAHWCO.

Also representing South Africa was David Sanders, pediatrician, community health doctor, and university professor. He is a member of the ANC, the ANC's Regional Health Policy Subcommittee, the East-Central and Southern Africa Public Health Association (ECSAPHA), and an executive member and Vice President of the Zimbabwe Public Health Association (ZPHA). David is the author of *The Struggle for Health: Medicine and the Politics of Underdevelopment*, and of a number of booklets and articles on the political economy of health, health policy, community child health and nutrition, and medical education.

* Attended part of the meeting

SITUATIONAL ANALYSES OF THE COUNTRIES REPRESENTED

Following the introduction of participants, the conference began with a situational analysis of each country represented. Speakers reviewed the various factors and events, both positive and negative, which affect the state of health and health care in their part of the world.

In this report, rather than try to encapsulate the structural analysis for each country (which in many ways would be repetitive) we will try to pull together key concerns that the several analyses had in common — and to point out some of the differences.

Features common to the situation of different countries

In most countries the percentage of the population living in absolute or relative poverty has grown.

In general, participants from around the world agreed that during the last few years there has been a significant turn for the worse. Virtually all the speakers spoke of increasingly hard times for the growing numbers of disadvantaged and impoverished people. Many reported deterioration both in health and health care systems. This was related to deterioration in living standards, in public services, in the state of the environment, and in basic human rights. In most countries — even those that reported economic growth — the percentage of the population living in absolute or relative poverty has grown. Except for an elite minority (who often continue to do well) real earnings have dropped, in some countries by as much as 40% over the last 10 or 15 years. Underemployment, unemployment, and homelessness are on the rise. The steady progress in lowering infant mortality rates (IMR) which took place during previous decades has declined and in some countries has been reversed. The prevalence of malnourished children in many countries has increased (now 60% in Guatemala; over 50% in some communities in the West Bank). In several countries there has been a resurgence of the diseases of poverty, notably cholera, tuberculosis, and malaria. (Even in the United states, as an indicator of spreading poverty (and AIDS), tuberculosis is again becoming an intractable health problem.)

In most countries, public services have been drastically reduced.

Adding to the hardships of the poor in most countries, public services — including health care, education, food subsidies, and public welfare — have been drastically reduced. Fewer children are in school, and in some countries illiteracy is increasing. (This has particularly unhealthy implications for women, since many studies have shown a strong correlation between female literacy and a reduction in child mortality.)

Major investment by governments in military build-up and purchase of arms, while people's basic needs remain unmet, is a stark example of misplaced priorities.

Major investment by governments in military build-up and purchase of arms, while people's basic needs remain unmet, is a stark example of misplaced priorities. The devastating impact on health of war, low-intensity conflict, and armed aggression by governments — sometimes against their own citizens, dissidents, or minority groups — was also discussed, as was the role of rich countries in keeping poor countries armed to the teeth.

Centralized, repressive systems of social control are increasing.

In most of the countries represented, centralized, repressive systems of social control are increasing. In spite of the so-called 'democratization' that has taken place in numerous countries — involving replacement of the single-party state with a multi-party system and public elections — governments in many cases are becoming less representative of and less accountable to the people. It was felt that today people have less and less control over the forces and decisions that determine their lives. Labor is less able to organize or defend workers' rights. In many countries conservative regimes are doing a relatively effective job of suppressing popular organizing and dissent, either

through outright force or, more often, through new, sophisticated techniques of brainwashing and co-optation. The latter, more subtle forms of social control have been particularly instrumental in allowing these governments to contain the growing popular unrest caused by heightened levels of misery. The methods used to keep the people in line range from institutionalized disinformation, infiltration, and buying off of progressive groups (in all countries, but especially the US), to police brutality (in every country represented), to collective punishment of whole communities (Palestine), to death squads and intimidation by terror (South Africa, Guatemala, El Salvador).

Most of the speakers related their present economic, environmental, and health crises to the harsh inequities within their countries: the socio-economic class structure and in some countries the caste system, racial and/or gender discrimination. They also blamed pervasive corruption and lack of accountability by government to the people. Too often governments — even those said to be 'democratic' — back the interests of the rich and powerful at the expense of the poor majority.

But even more, the speakers linked their countries' worsening economic and social conditions to international events, often using such terms as "imperialistic", "neo-colonial", and "neo-liberal". (One participant defined neo-liberal as "promoting the wolf of free-market economy in the sheep's clothing of democratization.") They also cited the top-down, growth-at-all-costs development model imposed by the North on the South. They felt that this model was largely to blame for the debt crisis, structural adjustment policies, and the present net flow of 50 billion dollars a year from poor countries to rich. One speaker summed up the present global situation: "Both within countries and between countries, the rich are living off the backs of the poor."

There was consensus that the dominant economic development model, which is founded on unbridled exploitation of both people and the environment, has contributed to the current extremes of poverty and wealth as well as the depletion of non-renewable resources and environmental degradation. It has precipitated the debt crisis of poor countries and legitimizes the unfair structural adjustment policies imposed on poor countries by the World Bank and International Monetary Fund (IMF). Participants felt that the impact of these international factors — above all *structural adjustment*—has contributed so much to the deteriorating conditions of poor countries that a separate discussion on development policies, debt, and structural adjustment was needed later in the meeting (see p. 51).

To highlight some of the concerns that came out in the situational analyses — and which often became themes for subsequent discussion — we will now focus individually on several of the issues that were raised.

Recent reversals in progress toward 'health for all'

Slowdowns and reversals in progress toward improved levels of health — as indicated mainly through statistics on infant and child mortality — were a common theme in the situational analyses of virtually all the countries represented. Speakers attributed recent negative trends to both national and international factors.

Discriminatory treatment of certain groups

The inhuman treatment (including substandard medical care) of Palestinians both in Israel proper and the Occupied Territories was one of the most blatant examples cited at the meeting of discrimination against disadvantaged ethnic or social groups. Umaiyeh Khammash of the West Bank spoke of the backslide in health and the health care system since the Israeli occupation:

> During the last 24 years, infant mortality in the region is so high, estimated in some areas from 50 to 70 per thousand. Morbidity [illness and injury] levels were also high for the entire period. Fifty percent of all children in some communities suffer from malnutrition. Parasite infestation remains a major problem, also affecting about 50% of children.

It was the governmental health sector — where the majority of people served and received health care— that was most negatively affected by the condition of military rule. The health services budget was slashed and most hospital and other health facilities were closed down. At the moment, the Israeli government is spending 350 dollars on the health of every Israeli citizen but only 20 dollars on the health of each Palestinian.

Apartheid exists in a variety of forms in many parts of the world.

Similar examples of harsh discrimination that compromise health were given for all countries. Looking at comparative health statistics, it was evident that apartheid (institutionalized racial, ethnic, gender, or class bias) is not limited to South Africa. It exists in a variety of forms in many parts of the world, including much of North and South America. In the US the 'fairness gap' between non-whites and whites — looking at all indicators ranging from health, education, employment, and income levels to police brutality and prison occupancy — has been growing steadily wider since the early 1980s. In Guatemala the indigenous majority has been persecuted and cruelly exploited from the days of the Spanish conquest up to the present. Similarly, in Mexico the levels of child mortality, malnutrition, tuberculosis, and other diseases of poverty are much higher in the surviving indigenous communities than in the general population. And the situation of indigenous peoples is worsening as their marginal forest lands — on which they depend for their livelihood — are being lumbered on a massive scale as part of a World Bank project to generate national income for servicing Mexico's foreign debt.

Ethnic and racial discrimination contributed to disproportionate suffering and poor health of disadvantaged people in many parts of the world.

Mira Shiva spoke of how hundreds of tribal communities in India are being forced off their land by giant dam projects sponsored by the World Bank and IMF. One of the purposes of such dams is to provide irrigation for large-scale agribusiness, which in turn drives still more peasants off the land.

Clearly, ethnic and racial discrimination contributed to disproportionate suffering and poor health of disadvantaged people in many parts of the world. Some speakers noted, however, that emphasis on racial bias may tend to obscure what is by far the most universal and damaging form of discrimination, namely that against economically depressed groups. Prejudice is not as 'black and white' as it is often made out to be. Not only do socio-economic classes still exist, but in many countries class differences — in terms of wealth, privilege, health, health care, and basic human rights — have been growing. Over the past decade, this increasing discrimination against lower-income groups has become a common feature of many so-called 'democratic societies'. This raises serious questions as to how democratic they truly are. This became a focus of later discussions.

Denial of women's rights

The role of women as second class citizens in most of the world has a drastic impact on the health of the entire society.

Another universal and entrenched form of discrimination is gender-related. The role of women as second class citizens in most of the world has a drastic impact on both women's and children's health, and thus on the health of the entire society. The traditional male dominance *(machismo)* in Latin America was noted. But in many ways it seemed mild in comparison to the very low social position and denial of rights of (most) women in India and Bangladesh.

Mira Shiva explained that, although things are changing slowly in India, traditionally girls and women are treated as virtual slaves of men. Although there is a law prohibiting child marriage, this practice continues, particularly in states in which women's literacy rate and general status are low (for example, Rajasthan, as opposed to Kerala, which boasts a high female literacy rate, a relatively high overall status for women, a higher age of marriage for women, a low birth rate compared to the rest of India, and the lowest infant and mortality rates of any state in the country). Similarly, despite a law banning dowries, many men still physically or mentally abuse their wives in order to punish them for bringing too small a dowry or to pressure their families into contributing a larger one. At its extreme, this can lead to "dowry death," a situation where a young bride or wife actually is killed or commits suicide. Mira reported that violence against women is on the rise in India. And, as in so many countries around the world, women and girls eat "last and least." This is even true

of pregnant women, a fact which Mira feels contributes to India's maternal mortality rate of 460 per 100,000 live births — a figure which is high, even by Third World standards. Finally, Mira noted that some Indian parents are now using modern medical technology to carry the traditional preference for sons over daughters a step further: they employ the technique of amniocentesis to determine the gender of the fetus and then get an abortion if it turns out to be female. Although the use of amniocentesis for sex determination has now been outlawed, the practice will no doubt continue until the appalling poverty in India — which has become in aggregate terms a relatively prosperous industrialized nation — is dealt with.

On the subject of abortion, many participants — especially the women from Latin America — spoke of how in many countries both church and government deny women freedom of choice, and cause increased suffering and mortality of both young women and unwanted or destitute children, by laws prohibiting safe abortion. In several countries, complications from illegal abortions are one of the highest causes of maternal death.

In Islamic societies — which comprise one fifth of the world's population — the social position and rights of women are especially low. Recent fundamentalist trends in many of the Islamic countries have limited women's rights even further. In Iraq, for example, a 1990 decree prohibits legal prosecution of any man who kills his mother, sister, daughter, or niece for adultery.

In striking contrast, however, to the severe gender discrimination in many other Islamic societies, in the Palestinian Occupied Territories there is today far greater equality between the sexes. Umaiyeh Khammash equated this with the increased social awareness and mutual support (solidarity) in a political climate where virtually the entire Arab community is mobilized in resistance to the Israeli military occupation.

Similarly, Zafrullah Chowdhury's People's Health Movement in Bangladesh, which grew out of a popular struggle for national autonomy, has done much to break down that Islamic society's deep-rooted gender discrimination by training women (often single mothers, who are at the very bottom of the social pecking order) in work roles conventionally reserved for men, such as welding, carpentry, and program management.

Several participants in the meeting commented on how long-standing gender biases tend to give way to fuller equality when people unite in organized struggle for their rights. During the Sandinista Revolution in Nicaragua, the social position and rights of women improved substantially. Many women rose to leadership positions (including that of Minister of Health). However, the Revolution did not bring women full equality, as indicated by the fact that the Sandinista Party's top policymaking body, the National Directorate, remains all-male to this day. In the ANC and the progressive community health movement in South Africa, many women have begun to take a stand, not only against white oppression but against male oppression as well.

There was general recognition that in many grassroots struggles for political liberation — including, as Andrés pointed out, the guerilla movements in Guatemala and (until recently) El Salvador — women have often played a vital and courageous role, thus commanding greater equality and respect. One way or another, popular 'struggles for liberation' often tend to embrace women's liberation as well — although sometimes the women have to press the issue.

Everyone agreed that achieving equal rights for women — and for all those whose basic rights are routinely denied — is a crucial precondition to a healthy society.

Achieving equal rights for women is a crucial precondition to a healthy society.

War, terrorism, and military spending

There was deep concern about the impact on health of war, terrorism, and military spending. Speakers from Guatemala, El Salvador, Nicaragua, Honduras, and Panama all described how historically, and often into the present, the US government has either provided military assistance and training to help unpopular (rightist) governments remain in power, or has helped to arm and train reactionary groups to overthrow popular (leftist) governments.

Likewise, the speaker from the West Bank pointed to the enormous amount of military and economic aid the US provides to Israel ($3 billion a year, amounting to one fourth of the entire US foreign aid budget), which effectively supports the Israeli government's military occupation of the Palestinian territories and its flagrant violations of human rights and international law, which have undercut the living standards and health of the entire Arab population of the Occupied Territories.

Speakers from South Africa gave an account of how security police and the military have been used to sustain apartheid and suppress organized resistance. Neighborhood health centers that focus on community organization and human rights have repeatedly been attacked, bombed, and otherwise terrorized by the police. In addition, the South African government has sponsored guerilla wars against the popular (black rule) governments of Mozambique and Angola. In these wars, health centers and schools have been selectively targeted. The Nicaraguan speakers pointed out that this same pattern of targeting health centers and health workers was used in the US government-sponsored 'low intensity conflict' against the Sandinistas.

In recent wars — and especially in so-called 'low-intensity conflicts' — 80%-90% of the casualties are typically civilians. Add to this the enormous numbers of displaced persons (refugees), the disruption of food production, the psychological trauma (especially to children), and the extensive damage to the economy and environment caused by protracted warfare, and it is clear that the impact of war on the health of civilians is far-reaching.

A major factor contributing to the economic and social deterioration of many countries is the huge sums squandered on the military.

Another major factor contributing to the economic and social deterioration of many countries — both rich and poor — is the huge sums squandered on the military, amounting to nearly one trillion dollars a year worldwide.

It has been noted that neither the Soviet Union nor the US were winners of the Cold War. The massive military spending of the USSR contributed significantly to the country's economic and later political collapse. The US is not far behind. With over 60% of the US federal budget directly or indirectly spent on the military (according to statistics of the War Resisters League), the domestic economy over the long haul has suffered enormously in terms of jobs created, productivity, and overall viability. These distorted budget priorities and the economic problems they have contributed to have hit the poor the hardest: they are the ones who have borne the brunt of cutbacks in public spending, regressive tax increases, and decline in real income. The US currently has the largest domestic and foreign debt in the world.

The high social (and environmental) costs of such excessive militarization are becoming clear. While the US economy has gone downhill, the economies of Japan and Germany have surpassed it and taken the global lead. This is due in large part to the fact that, in the years following the Second World War, Japan and Germany were not permitted to build up their military forces. So the losers of the war became the winners.

However, the greatest loss of life and health due to excessive military spending occurs in the Third World. UN studies have found that many poor countries spend more on the military than on health and education combined. Military aid (much of it in the form of loans) and arms purchases have contributed substantially to the suffocating foreign debt of most poor countries.

The greatest loss of life and health due to excessive military spending occurs in the Third World: many poor countries spend more on the military than on health and education combined.

Little is done by Northern development strategists to discourage such unwise and dangerous spending. On the contrary, although adjustment policies imposed by the World Bank and IMF consistently insist on cutbacks in spending for public services, only rarely do they call for reduced military spending. (One exception is Nicaragua, where the army is still controlled by the Sandinistas. Here the IMF insisted that the military budget be cut in half.)

Participants discussed the benefits that could be reaped by redirecting the trillion dollars the world spends annually on the military to peaceful ends. For example, WHO estimates that $2 billion — less than one day's military expenditure — could pay for the vaccination of all the world's children against the childhood diseases that still claim millions of lives. And $300 billion

would cover providing a clean water supply to everyone on earth.

But even with the end of the Cold War, substantial cuts in military budgets are unlikely — at least without massive popular protest and major changes of government. The giant multinational weapons industry has an overwhelming political lobby. Both private arms suppliers and governments of the main arms-producing countries (notably the US, the former USSR, France, Britain, Germany, and China) have profited enormously from the irresponsible sale of weapons to Third World countries. To those who reap the benefits, it apparently matters little that some nation-states receiving massive arms shipments and military aid have long records of aggression against their neighbors and human rights violations against their own citizens. Business is business.

Extensive disarmament has to be a component of any healthy and sustainable approach to development.

It was noted that the US government boycotted the September 1987 UN world conference on 'Disarmament and Development'. Yet all participants at the meeting agreed that, given the economic and environmental constraints in today's world, extensive disarmament has to be a component of any healthy and sustainable approach to development.

Family planning as a strategy for controlling the poor

Speakers from several countries spoke of the way that development planners in the North tend to blame the economic and environmental crises in the South on the 'population explosion', and implicitly on the 'high fertility rate of the poor'. This sort of 'blaming the victim' overlooks the fact that poor families often have many children as an economic necessity. In times of hardship, sickness, and old age, children help provide the social guarantees that society denies them. In today's world, 'overpopulation' is more a symptom than a cause of poverty.

A wide range of evidence suggests that the best way to reduce population growth rate is to introduce economic and social reforms that reduce poverty and guarantee that everyone's basic needs are fully met. Cuba, for example, has a relatively low population growth rate, although it does not have a hard-sell program of family planning, which other Latin American countries do have. Kerala state in India was cited as a similar example.

Unwilling to help poor countries provide basic social guarantees or to tolerate 'popular' governments that put the needs of the poor majority first, the global planners of the North have collaborated with the governments of the South in introducing heavy-handed population control programs under the guise of 'family planning' and 'child spacing'. Ricardo Loewe, of Mexico, spoke of the resulting abuses:

> Our whole external debt is linked to family planning policy. They have used every trick to guarantee decline of the population growth, including injections for birth control, without explaining anything to the population . . . If I am the health worker and I get money for encouraging sterilization, I am not going to talk about other methods.

Ricardo added that Mexican government officials sometimes label population control programs as a form of primary health care in order to give them legitimacy.

Zafrullah Chowdhury of Bangladesh expressed a similar view:

> Family planning is very fashionable among our donors. US, Ford Foundation, everybody loves family planning. They think our population is the problem: 'our people' are the problem. So they want to come to reduce our numbers, while failing to realize that family planning will never be achieved without development. The two go hand in hand.

All participants agreed that *family planning, when introduced with adequate information in an empowering way, can be important for both family and community health.* Often there is a strong felt need. Studies in some poor communities have shown that up to 70% of pregnant women would have opted not to have the

Family planning, when introduced with adequate information in an empowering way, can be important for both family and community health.

child they are carrying had they had a choice. The high illegal abortion rates and correspondingly high maternal mortality rates that many countries are experiencing are in part a consequence of the unavailability (or people's distrust) of safer birth control methods. But in many cases couples are suspicious of family planning because of the hard-sell approach used to promote it. In Ricardo Loewe's words:

> Policy is one thing and strategy is another. Suppose you have a target population that has a negative growth rate. But because they need money, because there is a drought and they have no food to eat, the men will talk the women into going [to get sterilized for a small monetary 'incentive']. So because there was no food, women with two children, or one child, are going to have sterilization — and you cannot ensure the survival of the children.

Several speakers pointed out that, in such circumstances, women who can no longer bear children are often abandoned.

People's distrust of the 'social marketing' of contraception often gets in the way of their desire to avoid another pregnancy. David Werner told how, 25 years ago in Mexico, when the Mexican government frowned on family planning and prohibited printed information about it, many couples in the remote villages he worked with eagerly opted to plan their families. But when, in the late 60s, the government reversed its policy and began pushing birth control through a quota system, which obliged health workers to meet monthly quotas of 'acceptors', this contributed to a lot of abuses and people became wary. The number of couples planning their families dropped to a third what it had been when the government had opposed family planning.

Ricardo Loewe from Mexico agreed that the hard-sell approach to family planning is often counterproductive. And Martín Reyes gave examples of how in Mexico government maternity wards routinely insert IUDs or perform sterilization on women, often without their knowing it. Mira Shiva provided similar accounts from India, noting that Indian women had been subjected to coercive population control policies in the past and that this was still happening in some parts of the country. For example, many post-menopausal women, widows, or married women with a single child have been sterilized in India. Mira went on to say that basic health services for women were still grossly inadequate in her country, and that women's health issues needed to be given much higher priority there. Ricardo Loewe summed it all up:

> What family planning means to you [participants at the meeting] is not what it means to most people. Family planning for them means population control. So we have to differentiate the terminology that we use. We [who work closely with the people] are talking about rational contraceptive care, women wanting contraception.

On the positive side, Zafrullah Chowdhury spoke of the 'user-friendly' approach to birth control taken by Gonoshasthaya Kendra, the village health program he leads in Bangladesh. Women health workers, many of whom are villagers themselves, help women or couples make a well-informed choice. For those who choose sterilization, simple surgery in a friendly setting is performed by some of the women health workers themselves, who have been carefully trained. The average rate of complications is lower than that for Bangladesh's obstetricians.

The environmental costs of foreign debt and structural adjustment

In many parts of the world human devastation of the environment is increasingly having a harmful impact on health. One of the most dramatic examples can be found in Africa, where the spread of deserts caused by the overharvesting of forests, the overgrazing of grasslands, and the soil- and water-wasting technology of 'modern' agribusiness has led to worsening droughts and famine. Similarly, the destruction of the world's rainforests impacts on human health in at least three ways: it destroys the livelihood of many tribal peoples, depletes the natural resources of many poor countries, and contributes to the Greenhouse Effect.

In order to service their huge foreign debts, poor countries are depleting their natural resources and polluting the environment at a reckless pace. Many rich Northern countries are relocating their primary polluting and environmentally damaging industries to the South, where labor is cheaper and environmental and worker safety regulations less enforced. Ricardo Loewe pointed out that the US is doing this with respect to Mexico:

> Never before has there been so much destruction of the environment. This is due to foreign investment because all the contaminating industries from abroad are brought into Mexico because we don't have [adequate regulations] against pollution like they do in the US or Europe.

Plans for a healthy, sustainable society must look to alternatives that nurture rather than exploit the planet and its people.

Participants at the meeting stressed that plans for a healthy, sustainable society must look to alternatives that nurture rather than exploit the planet and its people. To be viable over the long haul, an economy must aim less at growth and more at getting back in harmony with nature. Uncontrolled and environmentally damaging growth is called cancer. In this case the planet is the patient.

The spread of prostitution, sexually transmitted diseases (STDs), and AIDS as a reflection of growing poverty and cutbacks in public spending

Speakers from several countries spoke of the increasing numbers of women, young girls, and boys who sell their bodies in order to help feed themselves and their families. Leonel Argüello reported a disturbing study that had just been completed:

> In Nicaragua, the dramatic increase in prostitution is a reflection of the extreme need. In a recent study we did with the university, 80% of the women who are working as prostitutes started within the last year. . .. This is a result of the neo-liberal policies of the current government.

Increasing prostitution in response to abject poverty has contributed to the pandemic of STDs and AIDS, which tend to be more prevalent in most marginalized sectors of the population. David Sanders discussed the social and economic factors behind the rapid spread of AIDS in Africa. The AIDS epidemic there, he argued, stems from the neo-colonial system of migrant labor. Rural development policies promoting large-scale agribusiness and mechanized farming have forced millions of peasants off the land. Looking for work, vast numbers of men migrate to the cities and mines, leaving their families on small rural farms. In some countries these migrants live almost like slaves in huge all-male dormitories. On pay day they visit prostitutes, many of whom are also destitute country girls who come to the city looking for some way to survive. In this way the workers contract STDs and HIV infection which they carry back to their wives in the countryside on their visits back home.

Sanders emphasized that AIDS prevention that focuses only on the use of condoms and the education of individuals with 'high risk behavior' is just another way of 'blaming the victim'. It is inadequate to check the spread of AIDS. Effective prevention of AIDS in Africa requires transformation of the inequitable socio-economic system that forces people into migrant labor and forces women to sell sex to survive.

Effective prevention of AIDS requires transformation of the inequitable socio-economic system that forces people into migrant labor and forces women to sell sex to survive.

Increased repression and denial of basic rights

In many countries the devastating impact of the top-down development strategies and adjustment policies of the 80s has led to growing unrest among the poor and even middle classes. The governmental response has been to step up measures of social control. These range from disinformation and pacification strategies to a build-up of security police, the construction of more prisons, and outright repression.

Andrés Morales, a doctor and leader of the guerilla movement in Guatemala, explained how the government, in league with the landowning and business elites, uses the military to control and intimidate the people:

> In Guatemala today 80% of the land is in the hands of 5% of the people. The majority of the population (60%) are Mayan Indians, from 23 different ethnic groups. This ma-

jority is discriminated against and marginalized. To be able to control the Indians, the Guatemalan rich rely on the help of the army. They have maintained a counterinsurgency structure since 1954, when the US government and the CIA overthrew a democratically elected popular government and replaced it with a military regime. Since that time there has been a tremendous repression. Over 200,000 persons have been assassinated or 'disappeared'. Over one million people are currently internal exiles. Many of them are living in so-called "Development Villages" that are really concentration camps. According to official figures, there are over 200,000 refugees in Mexico. The real numbers are much higher.

Because of the socio-economic and political situation in Guatemala, the population has been kept ignorant [uneducated]. From 60% to 80% of children under age 5 are malnourished. Forty percent of the population are underemployed or unemployed. The infant mortality rate is around 120 per thousand— and that's grossly underreported. Most children die of malnutrition and diseases that could be prevented.

Pressure for privatization — even if it requires rewriting poor countries' constitutions

Mexico's constitution, which was drafted in the wake of the 1910 revolution, is one of the most progressive in the world, especially with respect to agrarian reform. The basis for equitable land tenure is the *ejido* system, under which the residents of a community collectively control their farmland. The land is fairly distributed among members of the *ejido,* and families retain the title to their land as long as they keep farming it. However, *ejido* land cannot be bought or sold. If a family stops working its parcel, the land is transferred to a family that needs it. Thus, while the *ejido* system has most of the benefits of private ownership and production, it prevents land from becoming concentrated in a few hands — at least through legal means. Constitutionally, if often not in practice, the land rights of small farmers are protected.

Martín Reyes explained how the Mexican community health program he has worked with for many years has helped to organize landless farmworkers to occupy and divide up the huge tracts of land illegally held by big landholders. The farmworkers have succeeded in reclaiming and gaining legal title to this land by vigorously asserting their constitutional rights.

Now, under pressure from the US government, the Mexican constitution is being rewritten to put an end to the *ejido* system. According to the new 'free trade' agreement between the US and Mexico, US businesses have the right to invest in Mexican land. Thus the *ejido* system, which protects the land rights of poor farmers, is regarded as a violation of the free trade agreement, and has to go.

The Mexican government is yielding to this violation of sovereignty by the US because it feels it needs US investments in order to produce more export goods to service its huge foreign debt. Also, many wealthy Mexicans see this as a way to get their hands on poor people's land. Ricardo Loewe of Mexico remarked bitterly:

> We could talk a lot about this privatization of the land. It will again lead to the concentration of private property [into large landholdings] which was the inequity that led to the Mexican Revolution. After 80 years we are reverting [to the prerevolutionary, feudal system], to the big private landholdings. The *ejidos* are disappearing for the sake of investment in production for developed countries— production of food for cattle— while our masses are not able to eat meat.

Martín Reyes explained that in the area of Western Mexico where he lives, the former *cacique* has already begun to pay bribes to local officials so that he can reclaim his former land as soon as the progressive land reform policies have been annulled ("his" land had been taken over by poor campesinos demanding their

constitutional rights). Martín warned that "the greatest achievement of the Mexican Revolution is in danger of being lost."

Outside forces are also pushing for the privatization of public services, including health care. Now that governments are slashing their health budgets, people are being forced to look to the private sector for health care. For example, in Zimbabwe:

> Privatization of the health system is occurring because the state is reducing its spending. And now users are being charged a fee. So today a lot of people are saying, "If I'm going to pay, then I'll go to the private sector. Because at least in the private sector I don't have to wait in line for service." . . . Now the public sector is contracting certain services to the private sector. In Zimbabwe this practice is just getting underway. The public hospitals charge you for pharmaceuticals now. And if they run out, you are given a prescription and told to go to the private sector, which has no difficulty in obtaining the more expensive drugs.

This means that people too poor to pay for health care and medicines often go without. Health care ceases to be a basic human right.

Deteriorating health conditions in the mushrooming urban slums

The majority of people are living in deeper poverty and have less control over their health and their lives than they did five or ten years ago.

Most participants in the meeting concurred that the majority of the people in their countries are living in deeper poverty and have less control over their health and their lives than they did five or ten years ago. The situation is especially bad in the mushrooming urban slums. In most Third World countries urbanization has advanced at an accelerated pace as mechanized farming and large landholdings — promoted through development policies and giant loans from the North — have forced more and more peasants to seek subsistence in the cities. Many countries that were mainly rural only 10 or 15 years ago are now predominantly urban. Today in Mexico nearly 80% of the population lives in urban areas; 20 million live in Mexico City, a substantial portion in slums.

Zafrullah Chowdhury described the slums of Bangladesh, where living conditions are reputedly among the worst in the world:

> In the city of Dhaka there are 7 million people, of which 2.7 million live in the slums. People living in slums are worse off than people living in the countryside. Rural residents have plenty of water. Maybe the water is dirty but they have got plenty of it. At least they have an open place to defecate, they can go wherever they like. But in the urban areas, fresh water does not exist — there is a real sanitation problem. Everything is a problem. Infant mortality is very high in any of the slums.

Increasing poverty in rich countries as well as poor

Poor people in so-called 'developed' countries are also experiencing greater difficulty in meeting their basic needs.

Poor people in so-called 'developed' countries are also experiencing greater difficulty in meeting their basic needs. David Werner, the representative of the 'North', spoke on poverty, infant mortality, and malnutrition in the US:

> In the US the number of families living below the so-called 'poverty line' has increased drastically in the last 10 years. One out of seven families — and one out of every 5 children — lives in a state of poverty. It is estimated that 22 million North Americans are chronically hungry.
>
> There are reasons for this increasing poverty. Since the early 1980s, federal laws have been restructured to reduce the taxes paid by the rich while increasing those paid by the poor. At the same time, benefits and subsidies for the poor, sick, and unemployed have been severely cut. Year after year the gap between rich and poor has been widening. The number of homeless people is steadily increasing. So is the number of

street children, particularly in the big cities. Crime rates, drug abuse, violence, and suicide rates are all on the rise, especially among teenagers. The government's response has been to cut back on prevention, drug treatment, counseling services, education, and other social programs while building more jails and reintroducing and expanding the use of the death penalty.

The US is the only industrialized nation where health is not a human right.

The US is the only industrialized nation where health is not a human right. Basic health services are not guaranteed to all people. Over 40 million people have no health insurance whatever, and another 40-60 million are underinsured. Some public facilities exist, but a lot of people fall between the cracks.

Health services in the US are outrageously expensive. The practice of medicine is a lucrative business: many private doctors earn upwards of $300,000 a year. The medical monopoly, headed by the American Medical Association (AMA), has strongly resisted a national health plan. The AMA's multimillion dollar lobby has consistently purchased the vote of the US Congress to benefit the medical establishment at the expense of the people.

The increasing social and economic inequities in the US are reflected in its health statistics. Infant mortality in the US ranks 19th in the world, among the highest of industrialized countries and almost double that of Japan. What is more, the statistics reflect pronounced racial discrimination. The infant mortality rate (IMR) of African Americans, for example, is more than double that of the white population. The IMRs of the inner cities of Washington, D.C. and Oakland, California are worse than those of Jamaica and China— countries that have an average income a fraction that of the US.

The fact that the US, as one of the world's richest countries, has so much poverty, hunger, poor health, racism, and socioeconomic inequity tells us something about the limitations of democracy within a free market economy. It also raises questions about the role that US foreign policies play and just whom Washington's global development strategies and New World Order are designed to benefit.

OBSTACLES TO HEALTH AND HEALTH CARE FOR ALL

This portion of the conference sought to identify the major obstacles to achieving health and adequate health care. There was a consensus that the most formidable obstacles are not technological, but rather social and political (i.e. structural): they have to do with the balance — or rather imbalance— of resources and power.

The medical establishment, big business, and the state

David Sanders suggested, and nearly everyone agreed, that the greatest obstacles to 'health for all' tended to fall into three broad categories: (1) the medical establishment, (2) big business, and (3) big government (the state). Subsequently, a fourth category: (4) international organizations and funding agencies (which Sanders had suggested including under 'big business') was added and discussed. An attempt was made to list and analyze the obstacles in each of these categories. It soon became clear, however, that most of the obstacles overlapped several categories. The power structures underlying the medical establishment, big business, and the state are so interconnected that attempting to analyze them separately becomes artificial or, as one speaker put it, "mechanistic."

Physicians pose one of the greatest obstacles to effective primary health care.

Consider, for example, *licenced medical doctors.* All the health activists present, from rich and poor countries alike, agreed that *physicians posed one of the greatest obstacles to effective primary health care.*

Zafrullah Chowdhury of Bangladesh emphasized people's dependency on doctors, and the way that

many doctors take advantage of their privileged position to exploit disadvantaged people:

> Doctors have become the most exploiting officials in our country. In Bangladesh we have over 16,000 doctors. Most of them come from upper class families. They have no ties with the villages, and resist working there. On paper, each rural hospital is staffed by about 15 doctors. But usually only one or two doctors are actually present, and even they live in the city. They visit the hospital once a month to collect their pay-check.

Zafrullah noted that people's dependency on doctors has been intensified by their exposure to commodified Western medical care and medicine through advertisements in the mass media, especially on television. He pointed out that the flow of money and resources from poor to rich countries is being paralleled by a similar flow from poor people to professionals, particularly doctors.

Zafrullah argued that the medical profession promotes the medicalization and commodification of health care because it recognizes that this serves its interests. To this end, physicians deliberately mystify medicine and monopolize knowledge. Another reason for such mystification is the fact that doctors are often not capable of communicating clearly with their clients because their class origins have distanced them from ordinary people. Ironically, this deficiency on their part becomes a tool for extracting more money from people. Zafrullah contended that the related phenomenon of "malignant specialization" makes it possible for physicians to send patients on a "diagnostic wild goose chase," thus further padding their profits. Even middle class, relatively educated and health conscious people frequently believe that good health care consists of seeing several specialists and getting a number of tests. All of this leads to a situation where one episode of illness can become a major survival crisis for a poor household.

In poor countries some of the strongest opposition to the training of community health workers and to demystification of medical knowledge has come from the medical profession. In Mexico, for example, Martín Reyes told of how a group of local doctors accompanied by soldiers attempted to close down the villager-run health program he works with.

In the US the American Medical Association (AMA) has long and effectively fought the legalization of alternative (non-allopathic) healers, midwives, and community paramedics, accepting only 'physicians assistants' who are under a doctor's direct control. Also, the AMA, with its powerful political lobby, has repeatedly blocked the introduction of a 'national health plan' to ensure that basic medical needs of the entire population are met. Such a plan would guarantee the right to health of families who cannot afford to buy insurance or to pay the high fees charged for medical services out of their pockets.

Health services comprise one of the largest, most lucrative industries, both nationally and internationally.

The medical establishment — including health professionals, insurance companies, private hospitals, drug and medical supply companies, etc.— not only has close links with big business, it *is* big business. Health services comprise one of the largest, most lucrative industries, both nationally and internationally. But it is the tie with the state that gives the medical profession its special privilege and power. Licencing regulations enforced by the state turn medical practice into an exclusive monopoly. In many countries, including the US, lay practitioners, however competent, can be jailed for 'practicing without a licence'. For example, David Werner knows an emergency medical technician in New Hampshire who was jailed for successfully removing a wart. He was charged with practicing surgery without a licence!

In many countries, particularly poor ones, a licence to practice medicine is a licence to kill. Sometimes the killing is directly caused through clearly unwarranted surgery or unjustifiable prescription of dangerous drugs. But more often the killing is indirect. By charging desperate poor families exorbitant fees for emergency treatment, private (and sometimes even public) doctors

frequently contribute to the death of these families' children from malnutrition.

Moreover, the medical profession tends to blame people for their health problems. For example, doctors sometimes blame mothers for their children's malnutrition. This sort of victim-blaming ideology is often reinforced by the state when it is in conservative hands. For instance, the Thatcher Administration in Britain consistently pushed the idea that poor people are responsible for their ill-health. This position is becoming increasingly common as the terms of the debate shift to the right nearly everywhere.

Similarly, the *multinational pharmaceutical industry* is 'licenced to exploit' through international trade agreements among states. They bombard poor countries with a vast array of medicines, most of them irrational, dangerous, and/or overpriced. Of more than 50,000 medicinal products on the world market, the World Health Organization (WHO) insists that only about 250 are appropriate and needed.

Mira Shiva, who has fought for an essential drug policy in India, pointed out that many multinational drug corporations aggressively push irrational, hazardous, and nonessential drugs in Third World countries like India. She described a number of instances in which pharmaceutical companies marketed drugs in India which had been banned in the companies' parent countries (e.g., the Dutch firm Organon marketed the high dose estrogen progesterone drug Menstrogen). Mira said that the multinationals often circumvent Indian regulations or bribe or otherwise influence the key players (e.g., bureaucrats, politicians, physicians) to look the other way. She noted that India's drug policy was being formulated by the Chemicals Ministry (which falls under the Industry Ministry) rather than the Health Ministry. Mira also reported that the US is using the threat of trade sanctions to pressure India to modify its patent law of 1971, which regulates the marketing of drugs in the country and has been cited as a model law by the United Nations Conference on Trade and Development (UNCTAD).

Laws introduced in the US by the Carter administration to limit unethical 'dumping' of dangerous drugs, chemicals, and toxic wastes on poor countries, were weakened by the Reagan and Bush administrations. The governments of rich countries have a notorious record of defending the 'free trade' rights of the multinational companies, often at the expense of millions of Third World citizens. Patent laws allow for inflated prices that keep potentially life-saving drugs out of reach of the poor majority for years. And even with products whose patents have expired, the big drug companies, assisted by big government, have tried to block local, low-cost production.

Zafrullah Chowdhury gave an account of how multinational drug companies tried to obstruct the opening of the 'Peoples Pharmaceutical Company' in Bangladesh, the main offices of which were recently bombed. Zafrullah also told how, in part at his urging, Bangladesh's Ministry of Health decided to ban the import of many non-essential, irrational, and dangerous medicines. The pharmaceutical multinationals responded by threatening to cut off the flow of all drugs, and the US government backed them up by threatening to cut off its aid to Bangladesh. Amazingly, while making a few concessions, Bangladesh basically held its ground. Now several other poor countries are following its example.

International organizations

International organizations are also wedded to the power structure that gives rise to the major obstacles to 'health for all'.

International organizations are also wedded to the power structure that gives rise to the major obstacles to 'health for all' (although often this is less apparent). It must be remembered that the United Nations (UN) and its agencies represent the world's governments, not its people. As we have noted elsewhere, most of the world's governments, including ones that are purportedly democratic, are controlled by elite interest groups and are neither accountable to nor fairly represent the majority.

So the UN agencies are caught in a double bind. Their formal mission is to advance the health and development of the world's people. But in practice their money is provided by, and many of their officials represent,

the world's strongest governments and ruling classes. Twenty-five percent of the funding for WHO and UNICEF comes from the US government. This creates contradictions, and leads to a situation where the UN agencies feel that they are gagged and their hands are tied on certain issues.

Such contradictions are particularly evident at present in WHO, which appears to be getting more conservative. For example under its former Director General Halfdan Mahler, who was remarkably progressive considering his rank, WHO had launched an outstanding Essential Drugs Program. But when Hiroshi Nakajima (who happens to be a former official of a Japanese pharmaceuticals company), replaced him in 1990, one of his first steps was to dismiss the dedicated head of WHO's Essential Drug Policy Program, cut back its staff, and weaken this initiative.

Often, UN agencies have tried to stand up for the interests and well-being of the poor only to end up conflicting with the interests of big business and, by extension, the big governments which provide the bulk of the UN's funding. These governments react by accusing these agencies of becoming "too political" and threatening to cut off their funding. For example, when UNICEF sponsored an international conference to discuss infant feeding practices, the US State Department threatened to cut off US funding of the agency if the meeting focused on the unscrupulous promotion of bottle feeding by multinational infant formula companies. (UNICEF estimates that bottle feeding results in an estimated one million infant deaths a year.)

Several UN agencies receive money for their operating budgets not only from big government but also from big business. How much this influences their policy decisions is unclear.

Questions have been raised about the approach to oral rehydration therapy that WHO and UNICEF have chosen. David Sanders and David Werner are currently writing a book, titled *Questioning the Solution,* which looks at this issue as a case study of the politics of child survival. They point out that oral rehydration basically consists of giving lots of liquid to combat the dehydration that often results from acute diarrhea— the biggest killer of children in the world today. The safest, cheapest, and most effective rehydration drink is a simple cereal gruel prepared at home with the family's main local food staple, such as rice, maize, wheat, or the like. However, WHO/UNICEF have strongly promoted commercial aluminum-foil packets of 'oral rehydration salts' (ORS). Sanders and Werner argue that this creates dependency on a product that is often not available. Further, encouraging poor families with undernourished children to spend their limited food money on commercial ORS packets could prove counterproductive, since malnutrition greatly increases a child's risk of dying from diarrhea. Yet these UN agencies continue to push ORS packets.

It turns out that the drug company Ciba-Geigy supplies about 70% of the ORS packets distributed by WHO and UNICEF. Ciba-Geigy makes an annual donation to WHO's diarrheal disease control program of over two million dollars.

The role of Non-Governmental Organizations (NGOs) and funding agencies

In addition to the UN agencies, the role of non-governmental organizations (NGOs) was also discussed. It was agreed that *many NGOs have a better track record, in terms of listening and responding to the needs of the poor, than do many governmental or international (UN) health and development agencies.*

However, it was also agreed that progressive movements and community-based health initiatives need to be very careful in their choice of NGOs or funding agencies from which they will solicit or accept assistance.

An increasing number of NGOs have been co-opted by large government development agencies or have 'bought into' their politically loaded development strategies. For example, it is estimated that of the approximately 140 NGOs which are members of the National Council for International Health, the umbrella body for US NGOs, approximately 70% receive at least some funding from the US Agency for International Development (USAID), an instrument of the US government.

Many NGOs have a better track record, in terms of listening and responding to the needs of the poor, than do many governmental or international (UN) health and development agencies.

USAID: more harm than good

USAID very clearly has a political agenda which promotes the interests of big government and big business, sometimes even when these conflict with the interests and needs of disadvantaged people.

USAID, for all its rhetoric about empowerment, community participation, and 'decision-making by the people', very clearly has a political agenda which promotes the interests of big government and big business, sometimes even when these conflict with the interests and needs of disadvantaged people.

For example, USAID, along with UNICEF, has been a strong promoter of 'selective primary health care', a strategy which focuses on a limited number of 'low-cost, low-resistance technologies' preordained from Washington, New York, and Geneva. Selective primary health care contrasts starkly with the potentially liberating concept of 'comprehensive primary health care' as articulated at a landmark world conference sponsored by WHO and UNICEF that took place in Alma Ata, USSR in 1978.

Comprehensive primary health care — which was endorsed (on paper) by most of the world's governments — took a broad view of health, defining it as "complete physical, mental, and social well-being." The strategy it prescribed to achieve this goal was equally broad. This strategy emphasized strong, democratic participation by people in resolving not only the biological and physical, but also the economic and political causes of poor health. It also explicitly called for more equitable distribution of health services, resources, and decision-making power. The Alma Ata conference report envisaged primary health care as "an integral part of the overall development of society," and stressed that:

> The proper application of primary health care will have far-reaching consequences, not only throughout the health sector but also for other social and economic sectors at the community level [and it will] greatly influence community organization in general.

Not surprisingly, this comprehensive approach to primary health care was not enthusiastically received by most governments. USAID and the World Bank offered at best only token support. But when a couple of Rockefeller Foundation policymakers suggested that comprehensive PHC be replaced with the more 'cost effective' selective PHC, USAID and the World Bank along with most of the Third World governments jumped on the band wagon.

In keeping with the policies of the US government, the IMF, and the World Bank, USAID has also consistently championed *privatization*. It has pressured governments that had previously provided free, equitable health services to begin charging a fee for these services. In much of the Third World, USAID and the IMF have pressured for sweeping privatization of health services. This means that poor people, who need health care the most, often don't have access to it. USAID has also been a strong promoter of the private manufacture and distribution of ORS packets. USAID funds have been used to bribe or blackmail poor countries into conforming to US political and trade policies. The well-documented history of collaboration between USAID and the CIA is indicative of the intertwining of USAID money with US foreign policy.

Some of the NGOs that receive funding from USAID manage to retain their autonomy and integrity, and respond to the needs of the programs or communities with which they work without unilaterally imposing their own strategies and ideas. Others follow the USAID line (for example, in promoting selective primary health care, or small private businesses rather than cooperative approaches to production and community needs). There are two possible explanations for their stance: they may genuinely think that their position is the correct one, or they may be taking it to keep the USAID money flowing in their direction.

Some progressive grassroots groups have a policy of refusing grants from USAID. An example is the Instituto de Juan XIII, based in Managua, Nicaragua.[1] The Instituto was approached by USAID shortly after the 1990 elections with an aid offer of one million

[1] *The Instituto, which was started in 1984, is the Nicaraguan liaison for the US group Quest for Peace. The goal of Quest for Peace was to match US governmental aid to the Contras with humanitarian aid to the Nicaraguan people. This project was quite successful, and continues to provide some material aid to community initiatives in Nicaragua.*

dollars plus substantial staff salaries. The USAID representative was summarily shown the door. While staying true to its principles, the Instituto has managed to survive and even expand: since refusing this USAID offer, it has actually doubled the number of grassroots projects it works with.

At the opposite extreme, other NGOs are little more than 'development mercenaries', allowing themselves to be financed and manipulated by the US government, the CIA, or one of the many quasi-private front organizations of the US government such as the National Endowment Fund. These puppet organizations often have deceptively progressive-sounding names and arch-conservative political agendas. For example, in Nicaragua the so-called 'Pro-Human Rights Association', financed by the US government, has devoted its energies entirely to digging up dirt against the Frente Sandinista, while at the same time sweeping the human rights violations of the Contras under the carpet. The CIA and other US government agencies also sponsor proselytizing by ultra-right-wing religious groups as a means of sowing discord and undermining progressive movements.

Positive and negative experiences with funding agencies

Participants related both positive and negative experiences with NGOs and funding agencies. Sometimes their experiences with and impressions of the same funding organizations were contradictory.

For instance, there was a debate about the intentions of the Inter-America Foundation (IAF), a quasi-NGO set up by the US Congress to help grassroots groups in Latin America committed to social change. While some speakers from Latin America spoke highly of the IAF, of the progressive attitude of its field officers, and of the grassroots initiatives it supports, others were skeptical.

Speakers from Mexico gave examples of how large amounts of money given by the IAF to small, struggling grassroots programs seemed to undermine their integrity and community support. One example was that of a far-left health program in a vast urban slum on the outskirts of Mexico City. Before it received IAF funding, it operated on a shoe-string out of a shack. It was rooted in the community, had a strong outreach program, and enjoyed broad community support. The local people regarded it as theirs. But after the group received a large donation from the IAF, its dynamics rapidly changed. The group used part of the money to build a three-story cement building that towered like a palace over the surrounding slum shacks. Volunteers became salaried staff. New people started working with the group, motivated more by money than commitment. The whole feeling of the place changed, and active community involvement faded away.

Is the counter-productive over-funding of such ventures a deliberate attempt to undermine potentially liberating initiatives or simply a well-intentioned mistake? Some conference participants argued strongly for the former interpretation, others for the latter. Persons with direct experience with IAF felt that although its top executives are appointed by Congress and are therefore conservative, many of its field staff are genuinely progressive and manage to maintain a fair amount of autonomy. It was pointed out, however, that the IAF does take directives from the US government. When the Reagan Administration took office in the early 1980s, the leadership of the IAF was replaced and the foundation was directed to shift its support from cooperative community initiatives to small private business ventures. (The same thing happened with the Peace Corps.) This was consistent with the Reagan and Bush Administrations' strategy of defining global development in terms of the free market and private enterprise.

Many US funders feel less comfortable tackling deep-rooted structural inequities that strike close to home than addressing an injustice such as apartheid, which they envisage as a clear-cut, black-and-white problem in which they are not implicated. Most funding organizations shy away from taking on the global power structure, which they themselves are often part of.

Most funding organizations shy away from taking on the global power structure, which they themselves are often part of.

Dividing the blacks in South Africa

In South Africa, the government, following the principle of 'divide and rule', has a long history of sponsoring reactionary black organizations, which it uses as

proxies to foment division and violence within the black community, to undermine the credibility of progressive forces, and perpetuate the myth of 'black on black' violence and of blacks being incapable of self-rule.

South Africa is clearly on the verge of a major transition. But transition toward what? With its back to the wall, the white minority is clearly hoping for a watered down version of 'majority rule' that will perpetuate rule by the rich, if no longer exclusively by whites. The ruling elite has been making every effort to enlist middle and upper class blacks (including Africans, Indians, and Coloreds) into their privileged club. Incentives include more nearly equal salaries, expanded opportunities, and a greater show of respect. This seduction to 'join the enemy' has caused a growing, class-based rift in the black community.

Given South Africa's rich natural resources, its important position in the African continent, and the complexity of its situation, it has been no surprise that certain international organizations and funding agencies are trying to influence the course of events there. Many of the large charitable foundations, especially those with ties to big business or big governments, have a vested interest in ensuring that the nascent democracy in South Africa does not become so democratic that it rocks the boat of free market wealth and power. With this in mind, money and 'technical assistance' are being poured into community groups and grassroots organizations with an eye to strengthening their more 'moderate' elements.

Foreign funding can be a trap for grassroots programs dedicated to social change.

Participants from South Africa reported that SAHWCO has grown so suspicious of the manipulative tendencies of foreign NGOs and funders that it is placing more emphasis than ever on becoming self-reliant, i.e., drawing its support from the communities it serves. They warned that *foreign funding can be a trap for grassroots programs dedicated to social change.* Aid breeds dependency, not only economically but ideologically. There is no such thing as a free lunch.

A broader discussion followed in which leaders of a number of community health initiatives in different countries spoke of their experiences with various NGOs and funding agencies. There was general agreement that *the best funding sources are socially conscious groups which make an effort to get to know the groups they sponsor, come to trust their integrity and judgment, and then take a hands off stance, letting the recipients define their own needs, priorities, and agenda.*

People-supportive NGOs and funding agencies

It was noted that certain NGOs — and government agencies — had a much more 'people-centered' track record than others. In general, the most progressive were those from Northern Europe, mainly the Scandinavian countries and the Netherlands. One of Britain's major international NGOs, Oxfam, also has a fairly good record of funding community-controlled initiatives, as do the German organizations Brot für die Welt and MISEREOR (respectively the overseas funding arms of the German Protestant and Catholic Churches). In the US, funding agencies range from community-supportive to dependency-creating and oppressive. However since so many receive money from the US government, even some of the more community-supportive NGOs compromise their agendas.

It was observed that some of the NGOs which have an outstanding record of supporting people-centered programs with a minimum of red tape are those which have a stated policy of refusing funds from the US government: for example World Neighbors, the American Friends Service Committee, the Hesperian Foundation, and Global Exchange. Many of these are not funding organizations as such, but focus on promoting information-sharing and solidarity.

Deciding what funding sources are acceptable is especially difficult because many of the representatives of funding agencies and NGO are essentially well-intentioned people. Too often, however, they bring with them a set of biases and preconceptions that can lead them to do inadvertent damage. Speaking of the frequent counterproductiveness of northern NGOs and funding agencies, a wizened health educator from the jungles of Ecuador spoke of their "idiosyncratic need to impose their ideas on other people."

Much was learned from this interchange concerning different NGOs and funders. It was decided that this was an area where more networking and 'experience-sharing' among grassroots groups could be valuable to all. For progressive initiatives to retain their integrity within the 'new world order', we must all stay vigilant and as well-informed as possible.

A growing obstacle at all levels: dependency

There is a vital link between health and self-determination.

Mira Shiva felt that another major obstacle — which spans and reinforces the major categories of obstacles already considered — is the growing dependency of people on external agents to meet many of their basic needs. She believes that *there is a vital link between health and self-determination*, all the way from the individual to the national level:

> .... I want to propose yet another factor in the list of obstacles: *dependency of the population.* All three factors mentioned previously are intimately related to the dependency of the population.
>
> This is a factor we encounter daily in our work. It affects how we educate and how the medical profession develops a hierarchy. The [doctor's] relationship with the patient and with the population in general strengthens dependency. It destroys any possibilities of autonomy and it benefits the state by helping make [the population] passive.
>
> I believe this factor of dependency is a result of the general dominance of the [existing power structures] of society. This is an important factor to resolve in the struggle for health. In fact, the development of the autonomy of the population, both individually and collectively, is itself a prerequisite for health. [Health can only be won through] the development of the collective autonomy of the population.

In this connection, Mira pointed out again that dependency on doctors is implicit in the doctor-patient relationship as it presently exists. She stressed that a 'liberating' approach to health care, in which people move from dependency to relative autonomy in meeting their health needs can be an important part of the struggle to achieve *collective popular autonomy*.

List of obstacles and possible actions to overcome them

In the course of the discussion of the obstacles to health and health care, an attempt was made to list the various obstacles posed by each of the four branches of the power structure described above. On the following pages,we reproduce the list, making some minor changes for the sake of clarity. The list of obstacles under 'medical establishment' is disproportionately long simply because this was discussed first. As mentioned above, all of these obstacles are interconnected within the same socio-political system. Many discussed in the first category could be included with equal appropriateness under other categories.

In addition to specifying the obstacles, an attempt was also made to list the respective actions which, in the experience of the participants, have been or might be taken to overcome them.

I. The medical establishment

Obstacles:

- Medical curricula
- Monopoly of knowledge
- Medicalization and commodification
- Mystification
- Individualization
- Creation of dependency
- Selective (as opposed to comprehensive) primary health care
- Undermining and co-option of popular action
- Ethnic, cultural, gender, and class discrimination
- Population control in the guise of family planning
- Biased research and technology (one form of bias being orientation toward male agendas and worldviews at the expense of women)
- Experimentation on poor and disenfranchised people, particularly women
- "Malignant specialization"
- Hierarchical power relations between health workers, which reinforces inequitable class relations
- Privatization

Actions:

- Training community health promoters and other health workers
  - Adopting an empowering learning process
  - Popular involvement in the choice of health workers
  - Medical education with a social focus and a base in practice
  - Community-based, rather than hospital-based, training
  - Change in system of selection/curriculum/exams
- Combating disinformation
  - Linking up with other groups which can correct disinformation
  - Honest information about and review of medical products
  - Networking and political analysis
- Integration of Western-trained health workers into progressive movements, unions, projects, etc.
- Emphasis on political economy and social production of ill-health
- Forging links with other community-based struggles around land, agriculture, etc. to facilitate information and analysis of political economy
- Showing the community the contrast between present state health services and what a more ideal, progressive service would look like
- Health workers need a political connection to social changes in the country; they should be aligned with and be part of the program for liberation
- Use curative medicine as a bridge to socialized medicine
- Put health on the political agenda of liberation movements
- Challenge state/state-aligned organizations on the inequities of current health services and health status
- Provide concrete, quality alternatives and share the experience through documentation and networking, especially at the grassroots level

II. Big business

Obstacles to health: the medical and health industries

- Pharmaceutical industry
- Infant formula/foods industry
- Medical equipment/technology
- Hospital chain industry

Obstacles to health: the 'Killer' industries and policies

- Agribusiness
- Tobacco
- Alcohol
- Armaments and militarization
- Drug-trafficking
- Toxic-waste export/dumping
- "Cattle-ization"
- Medical insurance
- Patenting

Actions:

- Education of public and politicians, plus a demand for accountability
- Challenging the role of the pharmaceutical companies, e.g., their intervention in the formulating of government policies, and exposing the collusion of the state and the medical establishment to make communities more receptive to costly services and drugs
- Closer intersectoral relationships (health, environment, disarmament, land reform, human rights, consumer protection, etc.)
- Multi-level approaches by a range of progressive health activists on the same issue
- Demystification — always link ill-health to oppression, exploitation, and misdirected policies
- Grassroots democratization —all the way from the grassroots to higher level structures — to challenge the power of the medical establishment (e.g., movements of health workers, consumer organization networks, etc).

III. The state

Obstacles:

- Legitimation of monopoly (including medical monopolies)
- Medicalization of health
- Political manipulation of health
- Reinforcement of medical hierarchy
- Centralization
- Agri-business
- Militarization of health
- Food aid/health services as a political weapon
- Divestment of health service
- Reinforcement of capitalism, racism, sexism
- Economic warfare imposed from outside; low-intensity conflict

Actions:

- Recuperate knowledge and skills indigenous to the affected communities to reduce dependency on medicalization/technology
- International networking/information exchange about imperialist forces

IV. International organizations, funding agencies, and NGOs

Obstacles:

- United Nations (WHO/UNICEF) — the fact that the US and other rich Northern governments provide the bulk of these agencies' funding allows big government and big business to set their agenda
- World Bank/IMF — also hostage to US agenda for same reason
- USAID — turns some NGOs into arms of US foreign policy by co-opting them through conditional funding.
- Independent NGOs and funders — well-meaning, but tend to impose their ideas on recipients

Actions:

- Comprehensive policy needed in each grassroots organization and liberation movement regarding its stance toward initiatives by international agencies
- Developing political consciousness, as well as consciousness about the politics of health, at the grassroots through community-based health organizations as part of national liberation strategy
- Exchange information on the people-supportive and people-oppressive aspects of different governmental, non-governmental, and international aid or funding agencies — and sound warnings when appropriate
- Encouragement of self-reliance and self-determination at every level of society: collective autonomy of the population

THE HARM DONE BY 'DEVELOPMENT', DEBT, AND STRUCTURAL ADJUSTMENT

Summary

Historical Background: 'development' leading to debt

- Excess in capital created by oil boom (OPEC)
- Search for markets
- Massive development loans to poor countries
- Growth-centered development: agribusiness and big industry
- Underdevelopment: more landless peasants, growing urban slums
- Debt crisis; economic recession
- Structural adjustment: making the poor pay for the mistakes of the rich

Components of structural adjustment:

- Devaluation
- Restrictions on borrowing
- Balance of payments controls
- Wage freeze
- Government budget policies — decrease in social sector spending
- Removal of food subsidies
- Production for export instead of for local consumption
- Privatization of public services and utilities
- Trade liberalization

Negative consequences:

- Concentration of wealth
- Lower wages, higher prices, fewer basic food staples
- Fewer public services and benefits
- Economic stagnation
- Widening gap between rich and poor — both within and between countries
- More unemployment, poverty, hunger, ill health, environmental destruction and population growth
- Globally centralized political, economic, and social control

Historical events leading up to structural adjustment: development and debt

During the situational analyses of the different countries, and especially during the discussion of obstacles to health and to effective health care, the topic of 'structural adjustment policies' came up repeatedly. It was agreed that of the many events in the last decade that have contributed to the increasing poverty, malnutrition, ill health, and overall hardships of disadvantaged peoples, structural adjustment heads the list.

'Structural adjustment' is the name for a so-called 'development' policy which the IMF and World Bank have, for the last ten years or so, been imposing on the debt-burdened countries of the South, purportedly to revitalize their failing economies. But, like so many of the top-down 'development strategies' formulated in the North, it has not led to real or sustainable development, but rather to the far-reaching 'underdevelopment' of disadvantaged countries and peoples.

Structural adjustment is just the latest manifestation of a long history of colonialism and 'neo-colonialism'.

Participants stressed that today's devastating adjustment policies are not an aberration. Rather, structural adjustment is just the latest manifestation of a long history of colonialism and then 'neo-colonialism' throughout which the rich Northern countries have consistently exploited and subjugated the poor Southern ones.

The real purpose of structural adjustment is to ensure that countries undergoing economic crisis are able to keep servicing their foreign debts. To this end, the IMF makes the provision of 'bail-out' loans to the governments of debt-burdened countries contingent on their agreeing to restructure their nations' economies in ways that make more money available for debt service. Invariably, this entails 'austerity measures' in the form of cutbacks in the wages and public services going to the poorest and least powerful sectors of the population.

The participants briefly reviewed the process of development — or, more precisely, underdevelopment — that contributed to the debt crisis, global recession, and hence to the crushing adjustment policies introduced in the early 80s. This review, facilitated by David Werner, went something like this:

We need to look back to the 1960s and 1970s, when the oil-producing countries of the Middle East joined together to form OPEC and began to control the price of oil on the world market. This led to a surplus of capital in the *nouveau riche* oil-producing countries. Much of this new capital, the great bulk of which was controlled or pocketed outright by the ruling elites of these countries, was invested in Northern banks.

With the sudden influx of capital from the oil boom, the big banks in the North had more money to invest than they knew what to do with. So they jumped on the bandwagon of Third World development. For the banks, this had the double advantage of multiplying their capital through interest payments on massive loans, and — through the encouragement of 'economic growth' in poor countries — expanding the foreign market for Northern products and the growing multinational industries. Since this sort of market-oriented development in the Third World held out the promise of further economic growth in the rich Northern nations, their governments also promoted large scale'development projects' through foreign aid, much of it in the form of long-term loans. So big banks, big business, and big government all joined forces to promote the development of the so-called 'less developed' or 'developing' countries.

Thus, in the 60s and 70s, vast amounts of 'development aid' flowed from the North to the South, a large portion of it in the form of giant loans. Much of it ended up in the pockets of the ruling elites of the poor countries, who turned around and deposited their stolen billions in private accounts in collaborating Northern banks (a process known as 'capital flight').

Part of this irresponsibly loaned and irresponsibly borrowed money was actually

spent on 'development' projects. But the development strategy imposed by the rich country lenders (with the willing collaboration of the ruling elites of the poor countries) was to build the poor countries' economies from the top down by promoting large-scale agribusiness and industry. While it was recognized that this would increase the wealth and power of a privileged minority of big landholders, businessmen, and bureaucrats, it was theorized that the new wealth from the growing economy would 'trickle down' to the poor, and that this process would gradually lead to a rise in the standard of living, and hence the level of health, of the entire population.

But in most countries that followed this top-down model of economic growth, more wealth trickled up than trickled down. In the countryside, large-scale agribusiness concentrated land in fewer hands. Large numbers of landless peasants in search of work migrated to the mushrooming slums of the cities. But in the cities the increasingly mechanized production techniques being used by big industry were also leading to mounting unemployment. As the ranks of jobless people swelled, wages fell and workers' rights and working conditions deteriorated. There was an associated increase in poverty, homelessness, prostitution, and crime. As the growing hardship generated unrest, the state responded with increased repression and police brutality. Thus the development model that the North imposed on the South benefitted the privileged sector of society by bringing it economic growth and luxury imports, while leaving the poor majority no better off and in many cases worse off.

Meanwhile the foreign debt of poor countries continued to grow. For a while the Northern banks made new loans to help the debtor countries keep meeting their interest payments. But, as the burden of interest payments increased to the point that national economies began to stagnate rather than grow, the banks grew increasingly tightfisted. In 1982 Mexico, with a foreign debt of over $100 billion and interest payments of $30 million a day, announced that it simply could not pay. Soon other countries gave notice that they, too, were on the verge of default. The Northern banks panicked. This situation contributed to the global recession that began in the early 1980s.

This was the state of events when the IMF and World Bank stepped in with their bail-out loans tied to implementing their policies of structural adjustment. It is important to remember that the foremost motive for both the loans and the adjustment policies has been, not to rescue the poor countries in the South, but rather to safeguard the wealth of the rich Northern banks.

Sadly, it is the Third World poor who are being forced to pay for the irresponsible loans the Northern ruling elite extended to the Southern ruling elite.

The impact of structural adjustment on poor people's health

Structural adjustment policies have several components, nearly all of which place a disproportionate burden on the poorest sector of the population. David Sanders, who for several years has been studying the social impact of structural adjustment, gave the following overview of its various components and their effect on poor people's health.

Structural adjustment has an impact on factors both outside and inside the health sector, which in turn affect health. The components of structural adjustment policies fall into three groups:

1. The first group of policy components are those things which influence the *balance of payments*. They include:

- *Devaluation of the local currency*, both formal and informal:

- Formal devaluation is carried out by allowing the currency's value to slide against international currencies such as the dollar or pound.

- Informal devaluation is implemented by *lifting price controls while freezing wages*, which results in people not being able to buy as much with their money. In effect, wages are lowered.

- *Restrictions on borrowing* from the IMF.

- *Balance of payments controls*. For example, for some governments there are stringent restrictions on dividends and foreign exchange.

The resulting wage cuts and price hikes affect a number of factors outside the health sector which influence health, such as how much food a family can buy—which is the single most important factor— and people's ability to pay for housing and other services.

2. The second group of components are *government budget policies*, primarily consisting of reductions in public spending on what economists call the 'non-productive' sectors, in other words the social sectors of the economy. These components of structural adjustment involve *big cuts in spending on health, education, social services, food subsidies*, and so on.

Reduction in social sector spending not only means reduction in budget allocations to, for example, the health sector. It also means '*cost recovery*': the introduction of user charges. This policy has been instituted in many countries recently; for example, it was implemented in Zimbabwe last year. As a result of structural adjustment, health care that used to be free is now being charged for. The private health sector is taken as the model, which means that each component of health care is charged for individually. That is, there are separate charges for the hospital bed, the anesthetic, surgical procedure, drugs, etc.

3. The last component of structural adjustment is called '*trade liberalization*', which is related to *privatization*. This means that previous restrictions on trade are removed (for example, tariffs are reduced). So, with the devaluation of the local currency, exports from poor countries are theoretically supposed to increase because the rich countries can now buy them cheaper. Trade liberalization also includes incentives for foreign investment, such as rolling back government regulations that restrict the freedom of action of foreign business.

At the same time, loans are made available (often through the World Bank) so that poor countries can import goods from the West. This helps deal with recession in the rich countries, which have experienced a surplus of goods. (Because incomes of the working class in the North have also declined, markets in the North have shrunk. Consequently, the supply of commodities such as cars, televisions, and luxury goods exceeds the demand.) The liberalization of trade opens up the markets in the South. It allows the middle classes in the South to enter the market. So *trade liberalization is designed in part to rescue the First World economies. It's still imperialism — just a more sophisticated form.*

Trade liberalization is still imperialism — just a more sophisticated form.

You see the results of these liberalized trade policies in African countries, where they are particularly striking because the middle class is very small. You go to a supermarket in Kenya and you can buy anything you want — if you can afford the high prices. While on the one hand there is an influx of luxury goods, on the other hand the poor are not able to pay for health care. They have to pay more for their food because the purchasing power of their wages has declined substantially.

The middle class in Zimbabwe and in most African countries strongly supports structural adjustment. It's the poor who suffer from it.

Rising prices and declining real earnings

Most of the speakers reported that high inflation — with reduced real earnings — was contributing to the rising levels of poverty, hunger, and poor health in their countries. Inflation is part of the 'collateral damage' inflicted by structural adjustment. Poor countries must devalue their currency. This effectively lowers the world market price of the products they export, which theoretically is supposed to increase the volume of these exports they sell, thus generating more capital to service foreign debt. (Often, however, the increase in volume of exports lowers prices, and translates simply as more work for less money.)

David Sanders analyzed how devaluation reduces people's ability to subsist:

> In most countries wage freezes have been introduced. They go under different names. For example, in Zimbabwe we have minimum wages which the government legislates every few years . . . Of course, the private sector regards those minimum wages as maximum wages . . . So you find that for agricultural workers in Zimbabwe, the minimum wage is about 150 Zimbabwe dollars, which is about US$30 a month. Occasionally the minimum wage is raised slightly. But because of devaluation (which leads to price increases), the real value of those wages stays the same or actually drops. Remember, we heard yesterday that today in Nicaragua the minimum wage in industry buys only 30% of people's basic needs. Even the arch-conservative Cardinal Obando y Bravo has called the Nicaraguan government's new wage scale "starvation wages".
>
> Another factor that is causing hardship in many Third World countries is the removal of consumer subsidies. Like the currency devaluation, this policy has the effect of reducing people's purchasing power. Many governments had until recently been subsidizing the market price of basic foods. In Zimbabwe, for example, there were subsidies for the main staples — maize, oil, milk, sugar, and beef. As a result of structural adjustment, these subsidies have been removed, which means that prices go up. I know that in Latin American countries prices go up in the supermarket from week to week, and now it's starting in Africa, because we're about five to ten years behind them in terms of structural adjustment.

Poverty becomes more widespread and deeply felt because the average worker, already underpaid and living on the margin, can no longer make enough money to keep food on the family table. There is an increase in malnutrition and in diseases of poverty. Children have to work rather than go to school. There is also an upsurge in homelessness, petty theft, and the numbers of people who survive by scavenging through garbage dumps. Many people are turning to illegal sources of income. Understandably, in many countries drug-trafficking and crime are on the rise. (Illicit drugs provide the major source of export earnings for several countries.)

Leonel Argüello, ex-Vice Minister of Health from Nicaragua, pointed out how the termination of food

subsidies and cutbacks in funding for other social programs was affecting the poor:

> They're cutting the budget for food subsidies because the IMF pressured them to reduce government spending. Health and education used to be free in this country. Now we have to pay for them. It's the same story in every country that agrees to implement the policies the IMF demands. You have more unemployment, more prostitution, more drug addiction.

Privatization of minority power: structural adjustment in South Africa

With the help of the IMF and World Bank, the South African government has recently been rushing to implement several components of structural adjustment policies — especially the conversion of government services into private enterprises— before the advent of 'majority rule' diminishes the power of the ruling elite. By building up the private sector and cutting back on the economic role of government, they hope to continue to control the course of events from behind the scenes, as is the case in other capitalist 'democracies'.

One of the participants from SAHWCO explained the rationale behind this strategy:

> The South African government is [trying hard] to control the process of transition. It wants to be one of the political parties involved in the negotiations for the future. This is clearly unacceptable to our people because if the government is going to be one of the players in the process, it's going to manipulate the situation to further its own interests. Comrade Mandela has put it well: the Nationalist Party would like to be the referee and the player at the same time.
>
> The government has also tried to restructure the economy in this period of transition before we have a democratic government. ...For example, there's a lot of privatization taking place. Basic services like health, education, postal services, airways, etc. have all been privatized. At the recommendation of the World Bank, a new tax was implemented in our country a few months ago. The poorest people of our country are going to bear the brunt of this tax, since it is levied on medical services, basic foods, etc.

Ricardo Loewe argued that the true opposite of privatization of services, and the goal toward which popular movements should be working, is not necessarily their *estatización* (control by the state), but rather their *socialización* — i.e., their control by the people. Ricardo pointed out that in Mexico and many other countries, *estatización* has only benefited the state, not the people. He contended that the popular struggle for a true *socialización* of public services and of the political economy as a whole needs to focus on the question of power, specifically how to put it in the people's hands.

CHARACTERISTICS OF A HEALTHY SOCIETY

Equity, democratization, and accountability

Having considered in some detail the obstacles to a healthy society, the group felt it would be helpful to 'get our bearings' by trying to clarify the characteristics of the kind of social order which would be conducive to lasting health for an entire population.

There was a general consensus that a healthy society must have three fundamental components:

- *Equity* in terms of assuring that everyone's basic needs are met.
- *Participatory democracy* which allows everyone a say in the collective decisions that affect their lives and health.
- *Accountability* of government and business (and international organizations) directly to the people.

The theme of these three components — and various attempts to achieve them — came up time and again throughout the meeting.

Characteristics of the new, healthy society

The only way to create health is to construct a new society.

The discussion continued as follows:

> What has changed is the concept of health. At the beginning of the century the goal of health care was to *cure illness*. In the last 30 or 40 years this has shifted to *preventing illness* and then to the present concept of *protecting health* and maybe even *creating health*. This means that the individual concept of health is changing to a collective one. I think *the only way to create health is to construct a new society*. This continues to be our aspiration as progressive people.
>
> This new society would be characterized by a fraternal spirit, solidarity, equal social, economic, and political rights, and the meaningful participation of the people in shaping government policies that affect their lives. It would also place a high priority on protecting children and the environment.
>
> However, the problems that 'socialist' societies have recently experienced makes clear that we need to change our strategies for realizing this ideal. I believe that in this stage the most important thing is *to get and stay in touch with the people*. They can help us regain our bearings when we go astray. Health workers have a very important role to play here, because health is one of the basic needs of mankind. Working in this area also permits us to move closer to long-term political change while simultaneously addressing people's concrete problems in the here and now.
>
> It's also important that health workers join forces with workers in other social areas such as education and housing, so as to put forward an integrated, multifaceted, progressive development strategy to counter the reactionary one being advanced by the state.

Health care grounded on structural change: the examples of Cuba and China

David Werner speaking:

> The socio-political ideology of a country obviously affects such things as the availability of housing, education, and above all land tenure and food.
>
> If we look at the ideologies of different countries in terms of how they rate on providing all members of a society with the basics — adequate food, housing, education, and so on — we find that some of the best health statistics in Latin America can be found in Cuba.
>
> Cuba has an ideology based on equity, at least with respect to meeting economic and physical needs. Its political system clearly is not equitable in the areas of power and decision-making — the power in Cuba is very centrally controlled. But the Cuban government tries to implement an ideology based on equity, on fair distribution of services, food, education, health care, and housing. The government's commitment to equity is demonstrated by the way it has responded to the US trade embargo: it has consistently cushioned the embargo's impact on the poor by making health, food, and education the last areas to be hit by budget cuts. The results in terms of health are very impressive.
>
> For example, let's look at the issue of family planning. Although the Cuban government has not heavily promoted family planning, Cuba's population growth rate has dropped more than that of any other Latin American country. How has this been accomplished?

Rather than trying to impose family planning through the hard-sell social marketing of a technological solution (birth control pills, condoms, etc.), the Cuban government encouraged it by providing social guarantees that give poor families a sense of security. In most societies, having a lot of children is an economic necessity for a poor family. In Cuba, poor couples feel that they can afford to have few children.

China is another example. One rarely sees malnourished children there — something that cannot be said about most Third World or even First World countries. Although the Chinese political system is authoritarian and repressive, and its rulers are increasingly adopting Western economic models, the society continues to retain some of the Chinese Revolution's emphasis on equity in the areas of basic social services, health care, education, and — most important — the availability of food. This has had a dramatic impact on the health of China's people.

THE STRUGGLE FOR HEALTH IN THE CONTEXT OF STRUGGLES FOR LIBERATION

Community health work is only valid when it is linked to organized efforts to help people survive oppression and develop strategies for standing up for their basic rights.

One of the main reasons for the 'Transitions' meeting was to explore the role of innovative community health work as a part of organized grassroots struggles for socio-political change. In view of the fact that the greatest obstacles to health for most of the world's people are social, economic, and political, many speakers felt that *community health work is only valid — at least in the long term — when it includes or is linked to organized efforts to help people survive oppression and develop strategies for standing up for their basic rights.*

Participants stressed that one cannot work for popular health in a vacuum, but only within the context of the broader fight for liberation. The struggle to change the approach to health care must be seen as part of the struggle to transform society itself so as to reverse the process of underdevelopment.

The conference participants all agreed that community health initiatives — when they bring disadvantaged people together to work toward solving common problems — can be an important part of the process of grassroots struggle for social and political change. When a group begins to analyze and combat the 'diseases of poverty', they come face to face with the unfairness of the system in which they live. Also, when families learn to manage common life-threatening illnesses — for example, by giving homemade rehydration to children with acute diarrhea — they begin to gain the confidence needed to tackle other, more complex problems, and ultimately to address the root causes of their plight. They find they don't have to depend unquestioningly on the healer, doctor, or other authority. Thus a demystifying, empowering approach to community-based health care can spark the process of awakening and self-determination whereby people start to unite and struggle to change the conditions that affect their well-being.

The struggle for health can therefore be an entry point to the struggle for liberation. And it often has been. In Nicaragua under the Somoza dictatorship, for example, both popular health status and government health services were so miserable that self-help community health projects began to spring up throughout the country. Many of these initiatives were started by religious groups, some of them influenced by liberation theology, which were simply responding to the enormous need, initially often from a politically rather naïve perspective. But the institutional injustices that lay behind the health problems were so blatant that they opened the eyes of many community health workers. These workers in turn started raising the awareness of the people they worked with and organizing them to defend their rights. The government responded by stepping up its repression. Often community health workers and health posts were specifically targeted. As María Zúniga describes it,

> If you worked in health or adult education, you were considered subversive by Somoza and the National Guard because you were seen as organizing people, and basically that's what they wanted to avoid.

As a result, many health workers went underground, joining the resistance and sometimes assuming leadership roles in it. Without question, grassroots health initiatives played a crucial role in awakening and mobilizing the population, thus contributing to the groundswell of opposition that led to the overthrow of Somoza.

Similarly, in the Philippines the massive peaceful uprising which led to the toppling of the Marcos dictatorship did not just happen overnight. It was preceded by a long period of awareness raising and community organization, much of it through the 'theology of liberation' — and a nationwide network of 'community-based health care'. Again, many of the leaders of this grassroots health movement — including progressive nuns and priests, were harassed, detained, tortured or 'salvaged' (executed without trial). But as repression grew, so did popular resistance, until it finally led to the millions strong mass demonstration which culminated in the ousting of Marcos.

Unfortunately, however, the overthrow of Marcos did not lead to the end of oppressive rule. In the Philippines — as in so many countries today — poverty, exploitation, and repression are worse than ever. The struggle for a fair and healthy society has yet to be won. And people in the Philippines, as elsewhere, realize that in today's 'new world order' *the struggle at the national level cannot be won outside a united struggle for fairer political and economic structures at the global level.*

The participants from SAHWCO in South Africa also related how the grassroots health movement has played a key role in mobilizing the oppressed population to join in action and take a united stand for their health and rights. In South Africa, as in many other countries where people have begun an organized resistance, community health posts and health workers have been a selective target. The speakers told hair-raising stories of how clinics in squatter settlements have been bombed or bulldozed down and health workers — including even some progressive white doctors — abused and detained.

Umaiyeh Khammash spoke of similar human rights violations in the Occupied Territories, where community clinics have been bombed and soldiers have thrown tear gas into the Maternity wards of West Bank hospitals. Umaiyeh told how he has been hauled from his home at night, detained and tortured. Despite this repression, the Medical Relief Committees continue to play a central role in the Palestinian struggle for self-determination and national independence.

In sum, there was consensus that at core *the struggle for health is a struggle for liberation, just as the struggle for liberation is also necessarily a struggle for health.*

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CONTRADICTIONS AND PITFALLS COMMON TO PROGRESSIVE GROUPS AND MOVEMENTS

Traps and Contradictions:

- Centralization, bureaucratization, duplication of efforts
- Dependency on international funding
- Grassroots movements often follow a top-down organizational pattern copied from hierarchical models
- Popular organizations dependent on liberation front, leading them to stagnate while waiting for orders
- Poor understanding by political liberation front of social issues such as health
- Liberation fronts sometimes manipulate grassroots movements instead of treating them with respect and responding to their concerns
- Networking — distancing of urban-based headquarters from rural programs
- Disempowerment of grassroots structure by umbrella bodies

Actions:

- Decentralization
- Democratization of grassroots structures
- Volunteerism to prevent bureaucratization
- Construction of powerful, independent mass organizations

- Grassroots organizations should gain entry to communities through structures already present in the community
- Discussion on the issue of *health and national struggle* is necessary for the future; this should include consideration of the association between mass organizations and the bourgeoisie
- Inclusion of grassroots community workers in central networking
- In *progressive* education, an effective balance needs to be struck between *process* and *content*. There needs to be *democratization of the process* and *demystification of the content*.

Review of obstacles and contradictions within the progressive health movement

An overview of the internal obstacles confronting the progressive health care movement was given:

There are four factors that are hampering the struggle for health in our countries:

- One is our *technological and scientific dependency*. If we analyze this we find that there is a great deal of popular knowledge and popular technology that we fail to draw on in our health work. We put aside the medicine that our people have traditionally relied on and that has often proven effective. We must find a way to recover that knowledge.

- Another factor is the *individualistic concept of the human being* that health workers often have. We tend to relate the biological aspects of the body to psychological aspects, but not to the workplace and the broader environment, or to people's forms of social organization.

- Another factor that is obstructing the struggle for health is our *know-it-all approach to educating people*. In the first place, we use knowledge produced in other countries without adapting it to our reality. In the second place, we use top-down instruction methods, without talking with the people. We use passive methods without engaging the people or building on their knowledge — without permitting them to share their own insights into their situation.

- The fourth and final factor that is hampering our efforts is the *undemocratic way we organize our health services*. We tend to adopt a high-cost, vertical model that relies on sophisticated technology and provides only limited, predetermined openings for popular participation. Or else we take a more participatory approach that still falls short of giving people the type of medical care they need, especially in terms of equitably distributing resources and using people's self-perception of their own health as a starting point.

Progressive leadership and the pitfall of concentration of power

Health at any level seems contingent on people and groups 'working together as equals'.

Fairness and relative equality in human relationships appear to be key determinants of a healthy and health-conducive society. Health at any level — from the family, to communities, to nations, to the world and global environment — seems contingent on people and groups 'working together as equals'. To the extent that equality is denied, health fails. First to deteriorate is the health of those who are relatively disadvantaged, but finally the health of the group or society (or humanity) as a whole is jeopardized. History bears this out all the way from village power structures to international relations. Today the health of the planet and its people is dangerously jeopardized by the long-standing 'illness' of inequity.

The prerequisites for a healthy society are participatory democracy, equity, *and* accountability.

There was consensus at the meeting that the prerequisites for a healthy society are *participatory democracy, equity,* and *accountability*. But attempts to put these ideals into practice have been fraught with pitfalls. One of the greatest challenges has been that of sustaining the democratic process. This involves maintaining a fair distribution of opportunity, resources, and deci-

sion making power. But it also means keeping the leadership responsive and accountable to the needs of the group.

The commitment to equity (i.e., the right of all people to satisfy their basic needs on equal terms) is the *sine qua non* of progressive movements and governments. It is the ethical base of the political 'Left', as well as a basic premise of the democratic 'Right'.

Yet when it comes to putting their socio-political ideologies into practice, both the Left and Right have tended to fall short of their respective vision of *people power* or *democratic rule*. At first, when a population breaks away from established tyranny — be it through the Russian Revolution, the American Revolution, the Mexican Revolution, the Chinese Revolution, or the Nicaraguan Revolution — there has tended to be widespread popular involvement and support for the new governing body. Its emerging leaders, however chosen, seem to sincerely represent the majority of people and their concerns. But then, remarkably soon, power and privilege become more and more concentrated in fewer hands. Effective representation begins to erode and the gap between privileged and marginalized citizens widens. As unrest mounts among the disempowered, the ruling elite grows more distanced from the people, more authoritarian, more corrupt. Ultimately, 'democracy' and 'power by the people' are dissipated by the very institutions and officials mandated to uphold them.

The Achilles heel of leftist governments is certainly not their egalitarian (socialist) principles, but rather the sacrifice of those principles as power has become concentrated in the hands of the highly centralized nation state. Such concentration of power and privilege through the state bureaucracy has brought disempowerment, marginalization, and often heavy-handed subjugation of a large sector of the population.

As the Soviet Union and Eastern Bloc economies have floundered and then swung to the right, protagonists of the free market have chalked this up as a victory for 'freedom and democracy'. Yet in terms of resource distribution and attention to basic needs, the capitalist countries, and most notably the United States, are in practice much less democratic than many of the leftist governments. In terms of prospects for the health of the world's people, the shift to the right — with its emphasis on privatization, cutbacks on public services, and relatively unrestricted 'free trade'— must be regarded as a great step backward. By turning satisfaction of human greed into the foremost human right, today's neo-liberal economics makes a mockery of the more basic rights such as health care, freedom from hunger, and self-determination, and the chance for human existence to continue in a sustainable environment.

In terms of prospects for the health of the world's people, the shift to the right must be regarded as a great step backward.

So what can we do?

Soul-searching about 'What's Left?'

Today thinkers and activists of the political Left are going through a lot of soul-searching and re-examination of their social philosophies. Their attraction to socialist ideology has been rooted in a deep sense of fair play, a belief in the equal rights and dignity of all people. For many of us our commitment springs from an identification with, and avid defence for the 'underdog'. Sharing the vision of a fairer, more humane society, we have stood behind (or participated in) popular struggles for social justice and liberation from oppressive government.

We deeply believe in the principles of equity and *power by the people* espoused by the political Left. But time after time we have seen left wing governments which, although they often began with people-centered idealism and strong popular support, have gradually become heavily bureaucratized, distanced from the people, and in some cases downright repressive.

These contradictions within the institutionalized Left raise some very fundamental questions, which include:

- Can a one-party State effectively represent the will of the people? Is pluralism possible within the context of a one-party State?

- Can a vanguard party or liberation front that has spearheaded a disciplined struggle for liberation against an unjust system relax its control a bit and oversee the installation of a people-centered, participatory system of government after coming to power?

- Is not the highly centralized, paternalistic, welfare state contradictory to empowerment of the people and self-determination?

- How can a government guarantee that the basic needs of all people are equitably met, and that the strong do not exploit the weak, without itself becoming paternalistic and authoritarian?

- Both in the Left and the Right, power and privilege tend to concentrate in the hands of a few at the expense of the many. What can be done to make 'people power' (or participatory democracy) more effective?

- What can be done to make sure that leadership is controlled by, rather than the controller of, the people?

- Is the paradigm of Marxism-Leninism still a workable model to follow? (Was it ever?) How should the Marxist-Leninist paradigm be 'de-ideologized' to overcome its practical contradictions? How can the Stalinist deviation — i.e., the concentration of power in the leaders of a vanguard party — be prevented in the interest of 'democratic centralism'?

The Left has tended to favor socio-economic democracy over political democracy. The Right has taken the opposite stance. How can we work toward state structures that foster both? In the final analysis, what path can we follow to assure the decline of the state? To achieve this, to what extent must we rethink our ideological preconceptions (while remaining true to our core values)?

- Is there (or should there be) space within the political Left for challenging standard doctrine and exploring new alternatives? How can the Left become more fully democratic?

All of these questions (which are essentially just different facets of a single issue) were discussed in various contexts and combinations during the meeting. No definite conclusions were reached, except that the time had come for open and critical re-examination of standard doctrine and beliefs. It was agreed that while leftist governments had often done an outstanding job in achieving relative *equity* in terms of health, education, and meeting people's basic needs, that they had often failed in the area of *participatory democracy* and *accountability*.

The time has come for open and critical re-examination of standard doctrine and beliefs.

'Power by the people' must be more than a slogan

María Zúniga spoke of how important it is to the survival of both health movements and liberation struggles that people be given the opportunity to participate meaningfully and exercise decision-making power in the revolutionary process:

> Frequently I hear people saying, "We will not have health until we have a new society. So first you have to wage a military struggle and seize power, and then you can start changing things." I think this view is incorrect: I think that the issue of power is not simply a matter of having control of the state and doing what we want with it.
>
> I think the Nicaraguan experience showed this. For eleven years we Sandinistas stood shouting "popular power!" and we believed we had it. At the end, we had the control of an apparatus, but not popular power — for it was the people that voted the Sandinistas out in the February 1990 elections. Particu-

larly in health, we felt very satisfied with the level of popular participation in health. We considered it an expression of popular power.

I can't say that it was the elections that opened our eyes for the first time and made us see certain things, because we had had an inkling of some of them earlier. Even before the elections, we started seeing that things weren't the way they were supposed to be. What did this *participation* really boil down to? Was it mere rhetoric? Even Pinochet talked about participation! It's a favorite slogan of the international agencies, for instance of UNICEF's Child Survival campaigns, and of many governments that are not genuinely democratic. The question is not only whether or not there is participation, but *what kind of participation* it is.

The Nicaraguan experience gives insight into what can happen when things become over-bureaucratized and centralized. María Zúniga stated sorrowfully:

I think as the Sandinistas became more centralized, they lost touch with the popular movement and the people.

Participatory democracy at the grassroots level is a key prerequisite of an effective, 'healthy' community health program, progressive movement, or society.

This led to a discussion of the difference between the 'weak' participation of compliance and 'strong' participation of shared decision-making. It was agreed that participatory democracy at the grassroots level is a key prerequisite of an effective, 'healthy' community health program, progressive movement, or society.

Ricardo Loewe stressed the importance of linking health actions in a community with people-empowering movements outside the health sector:

What I think is the 'best medicine' is not to just go to a community and start working, but to go into the organizations which are already there — the peasant organizations, the organizations of people struggling for housing, etc. — and help the people create health services that will reinforce those organizations and legitimize them with their own people. This way, people can say: 'We as a peasant movement or as a movement for housing also can help our people by providing health services.' That's the stage in which our group in Mexico finds itself now.

Too little democracy, or too much?

Several participants at the meeting felt that one of the greatest contradictions in progressive movements — and perhaps the Achilles' heel of the Left — has been the tendency of the leadership (or 'vanguard') to be too paternalistic. For all the leadership's professed commitment to equity and 'power by the people', too often the people have little real say in major decisions that affect them. The approach to raising popular consciousness frequently becomes doctrinaire — the opposite of the humble, respectful, open-ended approach that characterizes a genuinely liberating process. As the Brazilian educator Paulo Freire points out, good revolutionaries need to be willing, not only to teach the people, but also to learn from them.

However, there was some debate about the extent to which groups' decision-making should be democratic. The varying opinions voiced by speakers were conditioned by the local context and nature of the struggle they were waging in their respective countries.

Andrés Morales, who is both a doctor and a leader in the Guatemalan resistance, argued that popular movements can fall into the extreme of *too much democracy,* as well as too little. He felt strongly that participation and democratization are essential to achieving a healthy society. But he warned that sometimes the pendulum can swing too far in that direction, leading to anarchistic chaos:

I think we are talking about two issues here. One is the form of participation that should be open to people in the struggle for health and the political struggle. There seems to be a consensus that the struggle for health can't take place without the participation of the people and without links to other struggles.

> We need to consider carefully the relationship of the struggle for health to people's participation, as well as its relationship to other struggles that are taking place in society.
>
> But there's another aspect which worries me. When progressive movements try to encourage maximum popular participation, they sometimes fall into the opposite extreme of anarchy and *too much democracy*. I feel it's necessary to think about the articulation of the different struggles in society and their integration with the class vanguard . . . There shouldn't be a separation but a joining together of interests. To give you an example: What would happen if the Frente Sandinista in Nicaragua didn't have a vanguard? Who would coordinate the community health initiatives there? What happens if there isn't a vanguard to bring people together and coordinate their struggle?

Andrés is a leader of a popular insurgency, where in life-and-death situations instant decisions must often be made with no time for democratic discussion.

In organized, armed resistance, the group agreed, some sort of hierarchy was probably imperative. Quick, undemocratic decisions by leaders and instant group response to orders is a strategic necessity in warfare. (Such arguments have, of course, often been used by heads of governments as pretexts to declare a state of emergency limiting citizens' democratic and constitutional rights, or to maintain one long after the external threat that originally justified its imposition has disappeared. In fairness, though, it must be noted that prolonged pressure from the US and/or other Northern powers has often made it difficult for revolutionary governments such as that of Cuba to let down their guard and relax their grip on power.)

This raised the issue of the difficulty that the leaders of a national liberation struggle may have in readapting to participatory decision-making within a 'popular' government after the liberation struggle (or at least its military phase) is over. Although such leaders are strongly committed to rule by the people and have put their lives on the line in defense of this principle, often they have grown accustomed to exercising near-absolute authority. Believing in democracy in the abstract and adhering to it and making it work in practice are two different things.

It was recognized that within revolutionary movements there is often a tendency, among the leadership, to become authoritarian and dogmatic.

David Werner opined that one of the greatest pitfalls of the progressive Left was the paradox of leaders who, in their passion to create a new, more egalitarian society, try to impose their ideals on the population:

> I think that in looking at our left wing and right wing social structures as they relate to health we need to ask the question: How much is power distributed equally among the people? Is power in the hands of few or many? If we look at the capitalist systems we see that power is concentrated in the hands of wealthy people, industry, corporations and indeed with a government that is bought with that money. If we look at many of the socialist/communist regimes we see that power has become concentrated in the hands of the state and of an elite group that controls the state. I think we're beginning to realize out of this that *the big problem is centralization of power,* whether it be in the hands of the state or in the hands of big business. So what the struggle for liberation comes down to, in essence, is the struggle for decentralization of power. Or, as our friends from SAHWCO would put it, "...the key issue is People's Power. Our struggle to put health in the hands of the People must empower the masses. People's Health for People's Power."

Decentralization of power as the key to health

Within revolutionary movements there is often a tendency, among the leadership, to become authoritarian and dogmatic.

> To be able to achieve and sustain health, I think there is an element of decisionmaking power which is needed for every person, community, society. Many of the socialist and popular struggles have started with a belief in empowerment by the people *(poder popular)*. But too often the leadership has lacked patience to allow the slow popular process of awakening and working together to take place. They have, for instance, used and distorted the methods of popular education in order to indoctrinate people with their particular social ideology rather than helping people to look at their situation, define their needs, and arrive at solutions for themselves.
>
> Some people have said that Castro's greatest failing was that he loved his people too much, and in doing so became too paternal — or too maternal. He wanted to care for them rather than creating a socially liberating structure that allowed them to care for themselves. I think that we find this tragic flaw in the leaders of many popular movements. There is a benevolent, charismatic leader who begins to overpower the community in his attempt to form a new society based on equity. This is certainly a paradox.

Ricardo Loewe differed with this psychological interpretation of leadership. He pointed out that, as noted previously, winning a revolutionary struggle requires a vertical organizational structure and a vanguard political-military party. He feels that, as applied in the Eastern Bloc, Leninism failed to deliver power to the people because it reduced political participation and popular consciousness to a schematic vision of reality. The vanguard which led the people to revolutionary victory in the moment of crisis failed to maintain the revolution's momentum after the crisis was past because it had concentrated power in its own hands and was unwilling to relinquish it to the people. 'Socialism' as it existed in the Eastern Bloc became little more than a mechanism for sustaining economic growth.

Historically, there hasn't been time to create the required party(ies) from below. The central task we face at present is, not the creation of 'the party', but rather the strengthening of the mass movement.

The central task we face at present is the strengthening of the mass movement.

Distancing of the revolutionary front from the people after it takes power

Speakers from several countries spoke to this issue. Those from Mexico told of how, following the Mexican Revolution of 1910, the so-called Institutional Revolutionary Party (PRI) quickly turned into an elitist oligarchy. Although Mexico's revolutionary Constitution is one of the world's most progressive, instituting a policy of land reform designed to protect the rights of small farmers, national control of the country's natural resources, and democratic elections, in practice the PRI has turned the power structure into a pervasively corrupt, authoritarian, often repressive, one-party state. An elitist, three-tiered health care system bas been set up which provides third-rate health care — or none at all — to the poor. David Werner and Martín Reyes told how the Mexican Health Ministry had tried repeatedly to close down a community-run village health care program they work with.

David Sanders, who spent years in exile while taking part in the fight for the liberation of Zimbabwe, described a similar post-revolutionary trend in Zimbabwe. The liberation government, in his opinion, has in many ways become elitist and sold out some of the most basic socialist ideals of the revolution. While the situation is far better than it was under colonial rule, gross inequities — most notably in land tenure and wages — still undermine the health of the less privileged sectors of the population.

In a similar vein, María Zúniga discussed how, after the Frente Sandinista had come to power in Nicaragua following that country's liberation struggle, its leadership in some ways began to distance itself from the people. The Frente's defeat at the hands of the UNO coalition in the February 1990 elections was largely a result of the US-sponsored Contra war and economic sanctions, which gradually wore down the Nicaraguan people's resolve and which the Bush Administration made clear would continue if the Sandinistas were re-

elected. But it may also have been due in part to diminishing popular participation in the Sandinista movement.

María noted that since the Sandinistas have lost control of the government, new, local-level leadership is developing and there is more popular participation. Also, there is more open criticism of the Sandinista Party's leadership and policies. Many consider this a healthy sign.

Pitfalls in the relationships between grassroots organizations and revolutionary movements

The various participants gave very different accounts of the interface between grassroots organizations and the revolutionary movement in their respective countries. For some there tended to be mutual support and fairly close (if sometimes dependency-creating) cooperation. For others certain tensions existed, or conflicts in values or approach. But even where grassroots organizations and the revolutionary front were closely allied, characteristic problems tended to arise. Andrés discussed the origin of some of these conflicts:

> The principal problem of progressive groups and revolutionary movements in the Third World is that they have been trained for many years in a traditional, very top-down kind of way. That hierarchical style may be necessary, particularly for political-military structures, but it has been negative in the aspects of relating these movements to the people in the communities. It is as if there were a big gap between these so-called vanguard political parties and the leadership of the people in the popular organizations in the communities.
>
> In Central America gradually we have been improving on this particular aspect, but not without difficulties. In the case of Guatemala, we [insurgency leaders] have suggested that we have to relate to the people of the mass organizations around a particular program. On the other hand, what we've seen is that the people of these mass organizations have had a greater involvement in joining in and becoming part of the leadership of revolutionary organizations. But I don't think it's a problem that has been entirely resolved, because there are still certain sectors of the revolutionary movement that want to return to the past.

María Zúniga agreed with Andrés that in Guatemala the relatively close ties between the revolutionary movement and grassroots organizations had resulted in a more effective relationship between the vanguard and the people. But she noted that it had also precipitated severe attacks by the government against the civilian population:

> There was a time, especially in the early 80s, when the Guatemalan government assumed that all of the mass organizations were structures of the revolutionary movement. So there was a tremendous amount of repression that effectively reduced the number of people in the mass organizations by thousands, because the army considered them to be a part of the revolutionary movement. This was a very dangerous situation. Leaders sometimes led their people into situations which met with extreme repression: mass torture and the slaughter of whole villages. And the revolutionary movement failed to come up with an effective way to protect these people.

The need for grassroots organizations to maintain their autonomy from political parties and states

The participants from SAHWCO, while generally supportive of the revolutionary movement, recognized the tendency of such movements — and any political party or group— to distance itself from the people once they assume power. Therefore the popular health movement and other grassroots organizations feel it is important to maintain their relative autonomy.

> In the South African situation, SAHWCO and most of the other progressive health organizations have been part of the demo-

cratic movement and closely aligned with the former United Democratic Front (UDF) and now the ANC (African National Congress)-COSATU (Congress of South African Trade Unions)-SACP alliance. We need to continue to work closely with the liberation movements until we achieve a democratic government in South Africa.

However, SAHWCO, NAMDA, HWS (Health Workers' Society), OASSA (Organization of Appropriate Social Sciences in South Africa), OMEGA (Overseas Medical Graduates Association), and possibly PPHC of the progressive health sector are merging into a unitary NGO which will be located in civil society, and which will be independent from all political parties, so that we can work with communities and have members irrespective of their political affiliations, as long as they abide by the aims, objectives, and policies of the new organization.

During the period of transition, the challenge for us is to strengthen the struggle for democracy while at the same time maintaining our autonomy and independence.

David Sanders agreed on the importance that grassroots organizations retain their autonomy even from progressive national structures:

The construction of an independent, self-organized mass movement is the strongest guarantee of the kind of society and specifically health system we're talking about and it's not in contradiction to the process of liberation in your society.

Lupe, in agreement with other speakers from Central America, stated that, "The revolutionary forces are strengthened and nourished by the mass organizations in El Salvador." However, she also recognized the disempowerment that comes from too much leadership from above:

Sometimes what happens is that the relationship is so strong that it's contradictory. Because the mass organizations will wait for orientations from the revolutionary front so things get stagnated.

Lack of understanding by liberation fronts of the importance of progressive health work

Prasedez Polanco, from the Dominican Republic, described how in his country the revolutionary movement has failed to see the potentially liberating and empowering aspect of community action for health. Instead, revolutionary cadres tended to view health work as a form of 'pacification' that was potentially counterproductive to the cause of socio-political change:

The problem of the popular movement in the Dominican Republic is that it always has depended on the revolutionary Left. The Left didn't understand that health was important: they felt that if you were doing health work you were only putting band-aids on the system, and that instead your commitment should be to the revolution. They had an "all or nothing" attitude.

In 1983, when we began to work in the area of health, combining it with cultural work, we were accused of being 'folkloric', of 'only giving assistance'. The Left took the stance that the revolutionary movement didn't have to become involved in the solution of concrete problems in the community because this was the responsibility of the state.

Currently, in part because of all the changes that have taken place internationally, there are certain reforms taking place inside the popular organizations. But we still have a long way to go.

Using the poor

Martín, a village health worker from Mexico, commented on the tendency of so-called 'agents of change' — whether Left, Right, or Center — to impose their ideas on people and to use them for their own ends:

> We have repeatedly seen a pattern of committing the same mistake. Whether it's a health team or a revolutionary team or any other group that is trying to work with people in the community, it's the same. Usually they come with prefabricated plans of what the people should know. This has inevitably created problems. Over and over again I have seen failures.
>
> We have to take into account whether the community has been consulted by the groups working within it, or whether the people are simply being manipulated. Many revolutionary groups do health or other work in the community when they know that the community can offer them the resource of strength in numbers. But they continue only as long as it serves their purposes. Once they have gotten what they want from the community, once they have used it to build up their power base and can take its support for granted, they no longer pay attention to its concerns.

Umaiyeh had a somewhat similar observation:

> I agree that political parties frequently try to control the grassroots movement. Whether in health or in other areas, they try to give the grassroots movement a narrowly partisan character, to tie it tightly into one particular party.
>
> It is always dangerous for the grassroots movement to affiliate with only one party. By doing so, the movement will isolate itself from the larger community and will be viewed as just an arm of a party. It's better for the grassroots movement to maintain relations with a range of political groups, since this gives it greater freedom of action, allows it to retain its independence and its credibility with the people, and prevents infighting within the progressive movement.

Umbrella organizations that lose touch with and begin to dominate grassroots groups

Participants from several countries expressed concern about problems they were experiencing with the umbrella organizations or associations to which their local, grassroots health programs belong. They described how, in the early stages, a number of local programs in a country or region had come together and, feeling the need to maintain ties and exchange ideas on an ongoing basis, had formed a sort of network or umbrella 'association'. Initially, the association, as the creation of its member groups, had no power. Its role was to facilitate information-sharing and coordinate events. But, as time went on, the association grew, began to do its own fundraising, employ its own staff, and create its own rules. The fact that many of the new staff are hired for their management and office skills rather than their direct community experience gradually distances the association from the needs and reality of its community-based member organizations.

A number of years ago, the association of community health programs in Guatemala also went through a period in which some of its staff became very distant, both physically and ideologically, from its member programs. Fortunately, in this case the community-based member programs finally took a strong stand, replaced a number of the association's staff members, and reformed the program to make it more accountable to the member groups.

Mira Shiva also related her experience with the voluntary health sector in India. Mira noted that this sector has recently been undergoing rapid changes in its priorities, the issues it is addressing, its methods of doing work and making decisions, its funding sources and level of funding, and its accountability. Because certain funding agencies were prepared to make large grants for programs of a specific type, many of the larger NGOs in the health field started focusing on these programs while neglecting more controversial

issues that were critical to the interests of the marginalized sectors of society. Moreover, these groups' initially democratic planning and decisionmaking procedures gradually gave way to a top-down managerial approach.

A parallel was drawn between this dynamic and the one that often occurs at the national level when a liberation struggle is victorious and its leaders take power. In both cases, popular participation and accountability may be jeopardized as the leadership commandeers greater power.

How umbrella funding agencies determine the trends in community health care

Mira pointed out that one factor contributing to the alienation of umbrella associations from their grassroots base is the funding agencies themselves. In her country, certain aid agencies which functioned as official arms of their governments and sought to advance these governments' foreign policies tended to exert influence on the umbrella associations by funding activities which were in keeping with their own agenda and priorities. Specifically, these agencies preferred to fund those NGOs that they felt would promote their pet approaches and would not encourage critical questioning of or protest against exploitative and unjust trade policies. In consequence, some of the umbrella bodies and national NGOs reached the point where they became unwilling to touch the key controversial issues with a ten-foot pole and where they shied away from taking tough ideological stands — stands many of them had been willing to take in the past, and that were more urgently needed than ever. This failure to speak out on behalf of the interests of the poor had a dampening effect on other groups and individuals that might have done so and helped sustain the status quo. The net result was that the Indian people were deprived, not only of economic resources, but of ideological ones as well. In India this problem is compounded by a new phenomenon: domestic intermediary umbrella funding agencies which tend to be even less sensitive to the needs of grassroots groups than their parent (often foreign) funding organizations, and more corrupt. As Mira described it:

> ... So right at the grassroots level you have these umbrella bodies raising funds. These are agencies for channelling funds to health work. This is a new phenomenon. It used to be that there were just a few funding sources. If you wanted to work in the area of literacy, you would contact so and so, if you wanted to work in the area of mother and child health, you would contact another group. But now these channelling agencies—who know little and care less about the needs of marginalized people — are becoming like pimps and prostituting health care. It has gotten to the point where these channelling agencies now wield great power. Because they control all the money, they can set the trends of health care. They also have the final say over the publication of alternative health materials and books. So often the most appropriate, potentially empowering health books do not get funded.

Building on small-group democratization

Achieving democratization, equity, and accountability is a problem, not only at the level of associations and nations, but also in many small community groups. Several participants at the conference pointed out that even in their local grassroots programs, abuses of power sometimes take place. Stronger or more assertive members of the group tend to dominate those who are weaker or less assertive. At times, even in small groups, this situation triggers internal power struggles or mini-revolutions which result in greater accountability of leaders to the group and a fairer balance of power. (Martín Reyes and David Werner described how, in the community-run rehabilitation center in rural Mexico they work with, the more disabled members of their group revolted against the less disabled leaders and took over part of the program management.)

In many progressive, grassroots groups, the struggle for equality and leadership accountability is a never-ending battle.

One of the greatest challenges for the group is to develop a dynamic which guarantees that leaders remain responsive to the concerns of the group.

At all levels of human organization, small to large, one of the greatest challenges for the group is to develop a dynamic which guarantees that leaders remain responsive to the concerns of the group.

To strive for fairness in human relationships, as in other pursuits, it makes sense to *start small.* Perhaps the struggle for equity, accountability, and participatory democracy at the micro level can provide insights which will prove valuable in the macro-level struggle to achieve a representative, people-centered social order at the national and international levels. If enough small, struggling groups discover an effective approach to equitable and participatory self-government, eventually they may be able to join together into larger collectives, associations, nations, and perhaps even ultimately a global community where all people have an equal voice in decisions that affect them, and where leaders are held accountable to the will of the group.

The ethical dilemma of organizing by outsiders in situations of repression

David Werner warned of the ethical dilemma that progressive outsiders face when they come into a community and try to organize the people for social change in situations of repression.

> In an interchange between village health activists from Central America and the Philippines that took place in 1981, the Filipinos challenged the Central American group about the failure of revolutionary and progressive groups to provide adequate protection to the civilian population when organizing it to take political action. They argued that it was unethical to catalyze and organize marginalized groups to struggle for social justice without providing them with some means of protecting themselves when the going gets rough. They claimed that in the Philippines the New People's Army makes every effort to provide full protection to the civilians it works with.
>
> Their point was well taken. In Guatemala and El Salvador the repression of the civilian population has been intense, with community development workers and health workers being singled out for especially harsh treatment.[2]
>
> Progressive religious groups and social activists, often from foreign NGOs, have sometimes been guilty of encouraging marginalized people to stand up for their rights on health and other issues, only to abandon them when the axe falls. These outsiders come into a village with their consciousness-raising methods and structural analysis, train health workers and community leaders, and organize people to work together to solve their common problems. But they don't teach the people how to defend themselves against repression, in part because many of them are advocates of nonviolence.
>
> The local and national (and sometimes the international) powers-that-be see the community organizing as subversive. So they send in the army, the security forces, or the death squads. When the shit hits the fan the outsiders hit the road, leaving the local people to their fates.
>
> I am not saying that progressives should not help people to recognize the root causes of their ill-health. Nor am I suggesting that progressives should not organize disadvantaged people to assert their rights. Meaningful change can only be achieved through organized action from below. What I am

[2] *Editor's note: The killings of such persons by death squads in El Salvador have continued, and in some areas escalated, since the peace accord of January 1992.*

saying is that progressives ought to clarify right from the start to the communities they work with the possible consequences of the course of action they are proposing. People have the right to understand the risks they are being asked to run, so that they can make informed choices. Also, progressives who go into a community and organize the people have an obligation to stay by their sides and incur the same risks that they do.

The ideal situation is for organizers and activists to come from the communities or constituencies they work with. In that case, they automatically share the risks of those they are organizing.

The ideal situation, of course, is for organizers and activists to come from the communities or constituencies they work with. In that case, they have nowhere to run to, and automatically share the risks of those they are organizing.

Educational methods that indoctrinate rather than liberate

Martín Reyes and David Werner recalled that, on a visit they made to the Philippines in 1981, the community-based health programs spearheaded by the liberation theology faction of the Catholic Church took a very open-ended, people-empowering approach to health education, in which people analyzed the underlying causes of their poor health and drew their own conclusions.

In marked contrast, the community health trainers in the New People's Army seemed impatient with this participatory learning model, and preferred a more top-down, learn-what-I-tell-you approach.

Popular education too often slips from a progressive, consciousness-raising mode to one that comes dangerously close to brainwashing.

In the process of trying to create a new society from the top down, popular education too often slips from a progressive, consciousness-raising mode to one that comes dangerously close to brainwashing. The participants from Nicaragua pointed out that after the 1979 ouster of the Somoza dictatorship, the Sandinista Education Ministry prepared school textbooks which, although they superficially drew on the 'education of liberation' methodology of Paulo Freire, were designed to indoctrinate people in the ideology of *Sandinismo.* Rather than truly using Freire' s approach, which helps people develop critical consciousness and think things through for themselves, the central government seemed to want to do their thinking for them. So the attempt at progressive education was diluted by the need the Frente felt to impose its political ideology on the population.

Progressive teaching methods: at best empowerment, at worst a ritual

In recent years, progressive community health programs — and even some of the less progressive ones — have been making a big effort to use learner-centered, participatory teaching methods. Their sessions are full of group dynamics, community diagnosis, songs, role-plays, story-telling, and hands-on, learning-by-doing, pedagogical techniques. The teachers — who now call themselves 'facilitators' — try to be relatively non-manipulative, and to 'pull ideas out of the learners rather than pumping them in'. The focus is on critical thinking and the development of analytic, problem-solving skills.

This is a huge improvement on conventional, lecture-style teaching. But there are still some traps that progressive educators can fall into. David Werner spoke very highly of the just-concluded regional training program in CHILD-to-child activities in Nicaragua, in which Martín and he had been guest facilitators. While he and Martín were delighted with the enthusiastic participation of the children and the rich imagination of the instructors, they felt that sometimes the teaching methods were so lively and action packed that they were more entertaining than educational. As David described it:

> There is this new, very action-oriented teaching approach with a lot of group participation and interaction. It gets everyone enthusiastic and involved. But too often the analytic part of it, the structural analysis part of it, is neglected. When 'community diagnosis' was conducted in this dynamic way, the whole thing became a sort of energetic, mindless ritual. Both children and adults knew in advance the answers they were supposed to give, and shouted them out in chorus. What could and should have been a process of thoughtful participation, became

a game of parroting back the 'right answers'. The potential for an empowering learning process was lost.

We need to work towards striking a balance between learning process *and* content.

So we need to work towards striking a balance between learning *process* and *content.* The conventional teacher-knows-it-all approach to education emphasizes content to the exclusion of the process. Now some progressive groups are falling into the opposite extreme of stressing the process at the expense of the content.

Conclusion: the struggle for equity does yield results

For all their limitations and failure to fully realize progressive ideals, revolutionary Third World societies have registered impressive accomplishments.

David Sanders concluded this discussion of progressive movements' contradictions and pitfalls by pointing out that, for all their limitations and failure to fully realize progressive ideals, revolutionary Third World societies have registered impressive accomplishments. It's true that within those countries that have confronted the capitalist system and overthrown it— while falling short of constructing genuine socialism — only a part of the struggle was won. Yet David wanted to distance himself from anyone who claims that capitalism and socialism are equal in terms of people's well-being. Because all the key indices show that in terms of meeting basic, material human needs, China is clearly more advanced than India, and Cuba is more advanced than Haiti or even Costa Rica. And the Nicaraguan people have so far managed to hold onto many of the most significant gains achieved under Sandinista rule, despite the Chamorro and Bush Administrations' efforts to roll back these advances.

THE NEED FOR NEW APPROACHES TO CONFRONT THE GLOBAL SITUATION OF THE 90S

Faced with conservative trends of the 80s and the upheavals of the 90s — including the end of the Cold War, the demise of so-called socialist regimes, and the imposition of a New World Order based on the globalization of a 'free market' economy — participants agreed that there is a need to develop new strategies of organized struggle for securing people's basic rights.

In today's world, no village, community, or country is able to follow an autonomous course free from outside interference. The power structures in both the overdeveloped and underdeveloped countries have become so interconnected, and their strategies of social control so pervasive, that isolated popular initiatives — ranging from attempts at community-controlled health care to national liberation movements— now face more daunting odds than ever. If the grassroots struggle for health and equity is to have a fighting chance, disadvantaged and concerned people throughout the world must join forces to meet the united front of the powers-that-be with one of our own and develop new strategies. It was suggested that these strategies include:

- more comprehensive approaches to social analysis,
- more fully participatory approaches to grassroots organization, and
- more globally interlinked approaches to local, national, and international action.

The strategies of 'pacification' and social control employed by the powers-that-be are complex and multifaceted. In their ongoing quest to suppress discontent and dissent and maintain control, these forces have learned that brainwashing can be more effective than brute force, and is less likely to violate national or international law. The strategies of persuasion these forces employ range all the way from outright terrorism intended to intimidate people into passivity to social marketing techniques designed to 'win the hearts and minds of the people'. It is far more difficult to mount opposition to the latter, more subtle form of social control than to the former; to do so successfully requires higher levels of community involvement and awareness.

There is a need to break down or transcend many of the long-established barriers that separate different groups of disadvantaged and concerned peoples. In order to confront the abuses of the global power structure, there needs to be cooperation among progressive groups

Local grassroots struggles for health, equity, justice, and a sustainable future need to become part of a coordinated global struggle for a fair, sane, and truly democratic world order.

which cuts across national, cultural, and sectoral boundaries, across the North-South divide, and (to the extent possible) even across class barriers. Local grassroots struggles for health, equity, justice, and a sustainable future need to become part of a coordinated global struggle for a fair, sane, and truly democratic world order.

Globalized social control in the 90s: the five D's of strategic deception

Andrés from Guatemala gave a concise analysis of US strategies in Latin America in the 1990s, organized under the heading "The 5 D's." He noted that while all these strategies bear progressive-sounding titles and use people-supportive rhetoric, in practice they are structured to deny or systematically curtail the very areas of social progress they profess to advance. The 5 D's consist of:

1. *Development* of the Latin American middle class so that there will be more consumers to buy US goods, and greater dependency on foreign aid and trade.

2. *Democracy-building,* involving the establishment of the forms of democracy without the substance (for example, elections in the absence of the preconditions necessary to make them meaningful). Democratization is carried out in a very narrow way so as to ensure that control remains firmly in the hands of the reactionary and conservative sectors of society.

3. *Demilitarization* of the apparatus that had been set up for local control and security. But this doesn't mean elimination of armaments or a reduction in the international arms trade. The US cuts back on the amount spent on the military in certain countries, but always maintains a presence. And many of the most repressive national military forces have actually been strengthened.

4. *Human rights (derechos humanos)* to permit a certain level of peace and stability, which favors foreign investment. But at the same time authoritarian structures seek to prevent efforts by workers and disadvantaged groups to organize themselves so as to secure their basic needs and rights. And Washington routinely overlooks the most brutal human rights violations when it's politically expedient to do so.

5. If the above four elements are not successful in controlling the people, then the *'War on Drugs'* is declared to legitimize intervention in Latin America; it is invoked as a pretext to invade countries, provide military aid, tarnish the image of progressive forces, and so on.

Thus in the top-down, disempowering way they have been introduced by the global power structure, 'development' strategies lead to systematic underdevelopment; 'democratization' is in practice anti-democratic; 'demilitarization' is a façade; 'human rights' — including the most basic rights to food, health care, and education — are commodified, subjected to market forces, and routinely denied; and the 'War on Drugs' is brutally counterproductive.

Andrés concluded this analysis by saying, "So what the Americans are doing is finding ways to ensure a measure of stability and peace in Latin America so that they can sell their consumer products and thus compete with other economic blocs, mainly the Europeans, especially the Germans, and the Japanese." It was noted that while the War on Drugs is peculiar to the US, the other four D's are also championed by the IMF and the World Bank. The US initiative is part and parcel of this global plan.

In view of the fact that all of the strategies just outlined are being introduced in ways designed to undermine the potentially liberating principles they profess to uphold, the group agreed to add two further broad strategies which are being used to 'socially market' this retrogressive 'New World Order'. These sixth and

seventh D's are institutionalized *Deception* and *Disinformation.*

Co-opting the terms of grassroots struggle

Words are used as a smoke screen to advance initiatives which run counter to their true meaning.

The use of deception and disinformation in the social marketing of people-disempowering strategies was discussed at length. All the participants agreed that there was a growing tendency for top-down government and international programs to distort terms like *people's participation, community-based, decision-making by the people* and *empowerment* and manipulate them to impose on disadvantaged peoples the policies and behaviors which the ruling elite has decided are 'good for them'. In a sort of Orwellian doublespeak, words are used as a smoke screen to advance initiatives which run counter to their true meaning.

Participants from Mexico and other Latin American countries pointed out how even the term *solidaridad (solidarity)* — which originally referred to unity with and among oppressed peoples struggling for their rights — is being co-opted by authoritarian governments as a façade for policies that in actuality are profoundly disempowering. In Mexico, for example, the central government's new *Solidaridad* program purports to establish a new alliance between government, industry, and workers under which all three groups supposedly work together to assure that workers' needs are fairly met. According to the rhetoric of the initiative, workers now have a seat at the negotiating table and are guaranteed an equal say in policymaking. Through their representatives, their needs will now be amicably and fairly met. Therefore, the argument runs, independent labor organizing outside the government controlled unions, protests, and strikes are no longer necessary. The government has of course been pursuing this strategy of buying off labor leaders and delegitimizing any attempts at independent worker organization for decades, but its co-optation of the term *solidaridad* to mask the policy's true intent is a new, Machiavellian twist.

The commodification of health

Health workers cannot view health and disease outside of a socio-political context.

As far as health care is concerned, Aslam Dasoo provided critical insight into dominant systems of health care and how they affect the larger struggle for people's well-being:

> The dominant system of health care reflects all the features of the capitalist system and reinforces this system. It sells health care as a commodity and individualizes ill-health, blaming it on people's stupidity, ignorance, overbreeding, laziness, etc.

It was agreed that conscientious *health workers cannot view health and disease outside of this socio-political context. They must learn to cross barriers of nationalism and class to address the health problems of the entire population.*

Health worker solidarity with revolutionary forces

In South Africa the health movement, as part of the larger popular movement, helped pave the way for the process of change currently taking place by joining in a mass mobilization designed to "make the country ungovernable by the apartheid structures." Over 600 grassroots organizations took part in this action. From this process emerged the slogans, "Every street committee member a health worker!" and "People's health for people's power!"

The government responded to this popular mobilization with a massive wave of repression, including the declaration of the 1985 state of emergency and the detention of nearly 60,000 people. But it was impossible to detain everyone involved, since committees of industrial workers also participated. To completely suppress the movement, they would have had to detain almost everybody.

The SAHWCO participants stressed that it is this kind of intersectoral grassroots mass action (of communities and workers), in combination with the other components of our struggle (i.e., international isolation of the apartheid regime and support for the liberation movements, the armed struggle, and the political un-

derground), that has led to the present situation of socio-political transition in South Africa.

Nevertheless, Krish from South Africa pointed out that while the mass organizations are independent from the revolutionary movements, they work closely with these movements to strengthen the struggle for democracy. COSATU has given notice that the unions will remain autonomous and develop independently of whatever government comes to power, whether it is a government of the ANC or one of national unity. It was felt that this was important in order to sustain a vibrant, participatory democracy and an accountable leadership and government.

From their presentation, it was clear that the South African progressive health movement is anticipating some of the retrenchment of traditional power that often follows liberation from minority control, and is trying to avoid a repetition of what has happened in Zimbabwe and many other countries.

Krish also emphasized, however, that it is crucial for organizations of health workers to work "very, very closely with the ANC" and the revolutionary movement in general, and not to start distancing themselves from the liberation movement at this time.

The need for a new dialectic

A learning process is needed in which everybody jointly explores problems and searches for solutions.

Given the overwhelming global inequities of the 90s, it was agreed that new, more empowering, participatory methods of grassroots education and organizing are needed to enable revolutionary movements to enter into a genuine dialogue with the people they purport to represent. David Werner discussed the need to incorporate a new dynamic into our methods of communication and teaching/learning. For example, rather than having health workers memorize a lot of facts, we must help them to learn analytic and problem-solving skills. In health work — and education in general — a learning process is needed in which everybody jointly explores problems and searches for solutions.

We have found that leftist groups involved in revolutionary struggle have often been quite resistant to putting the dialectic approach they profess to follow into practice. For example, during a 1981 visit to the Philippines, Martín Reyes and David Werner found that the approach to health education and political education taken by the resistance movement there tended to be quite top-down and doctrinaire. Resistance leaders expressed impatience with the strongly participatory, learner-centered methodologies that have been developed in Latin America. Under the intense circumstances of confrontational struggle, they felt that open-ended, consciousness-raising learning methodologies such as those of Paulo Freire — in which teachers are learners and learners teachers — took too long and were potentially divisive.

In the last few years, however, there has apparently been a gradual transformation within the resistance movement in the Philippines. There seems to be a recognition of the need for a more fully participatory approach, both to education and decision-making. The educational approach that is now being developed there allows for more give and take and fuller participation. This is a big step forward.

South Africa: on strategies for transition to 'majority rule'

Given that South Africa was the single country represented at the meeting where a potentially health-enhancing 'transition' is currently underway, there was a consensus that it would be instructive to hear a more in-depth report on the strategies and processes of this transition from the South Africans present. It was hoped that the South Africa experience — which is fraught with many of the pitfalls and global obstacles of the 90s — would generate insights that might help participants from other countries decide 'where to go from here'.

The South African experience is especially relevant because the progressive health movement is strong. There is an important unity process unfolding in which five to six organizations (including NAMDA and SAHWCO) are merging into a single unitary organization.

Also important are the close links that are being forged between local popular struggles for health and the

national struggle for liberation. The impact of social injustice on levels of popular health is (for most people) indisputable. The South African progressive health movement is playing a key role, not only in the grassroots struggle against Apartheid, but also in the more far-reaching struggle toward a healthier, more equitable socio-political system.

The following is a synopsis of the description the SAHWCO representatives gave of the strategy for socio-political transition they are following.

Priorities for a strong popular base

At present, the main priorities of the liberation movement in South Africa are:

- To build strong structures of the liberation movement among our communities after 30 years of illegality, despite obstacles such as violence, etc.

- To strengthen unity among the various liberation forces, e.g., the Patriotic Front, the PAC (Pan African Congress), ANC, and other political organizations.

- To address the reconstruction and development of our society to overcome the legacy of apartheid.

Steps in the transition

We envision the transition to majority rule to consist of the following three steps:

1) The holding of an all-party conference to which all political parties and liberation movements will be invited. This conference will lay the groundwork for an interim government.

2) This interim government will manage the transition process. This task must not be left to the present government. The transition government must control the security forces, the media, the economy, and all other areas of the government; this is the only way to guarantee that we will have free and fair elections. That is our first demand.

3) Through free and fair elections, a Constituent Assembly will be selected which will form a non-racist, non-sexist, democratic government and adopt a new, democratic constitution.

Strategies for a health system for the new South Africa

As far as health goes, what are our priorities?

First of all, as it stands now health is not even a basic right in our country. The present government treats it is a privilege. We need to change that situation, to say that it's the state's responsibility to provide basic health care to our people.

Second, the current health care system is very fragmented. There are separate departments for different ethnic groups and regions. This is an uncoordinated, bureaucratic arrangement that wastes a lot of money and resources. We plan to remedy this situation by creating a single, unified national health service.

Third, this national health service will be non-racial and equitable. It will be centrally planned, but will allow significant local community control and consultation.

Fourth, primary health care must be the basis of this new health care system. The present system's orientation is heavily curative, high-tech, and hospital-based. It is strongly biased toward the cities at the expense of the countryside. We need to change that. We need to build more community clinics. In fact, there's talk of pressuring the government to declare a

moratorium on building more hospitals until we have a new health plan for our country.

Fifth, we need to set up a new system of financing. A wave of privatization is currently sweeping our country. Half of the doctors are in the private sector. Medical Aid schemes are leading to a lot of corruption and abuse. Alternative approaches to financing health care are currently being debated. Some organizations are proposing that health care should be free at the point of service.

Sixth, traditional healers pose another challenge for us. Nine out of every ten African patients visit traditional healers before coming to a modern health center. There are some 150,000 traditional healers operating in the country. The challenge for us is: how do we integrate traditional healers into the formal health services?

Seventh, research. Most of the research being done in our country is biomedical, inappropriate, and irrelevant. Appropriate research that includes building the organizational capacity of communities and intervention strategies to address the needs of the most disadvantaged should be encouraged.

Eighth, we need to remedy the current situation of undemocratic and poorly managed health institutions. Low wages, poor working conditions, undemocratic management, and lack of proper grievance procedures have led to much frustration and demoralization among health workers, especially in the public sector.

Ninth, the present government, on the other hand, is unilaterally restructuring health services and is passing legislation in this transition period without consulting the liberation movements and the progressive health sector. This has to be stopped.

It was agreed that one of the first priorities for future action should be grassroots empowerment. In this context, David Sanders stressed the importance for leaders in the struggle for health and/or social change to remain strongly rooted in the local grassroots movements in our respective countries, even as we enter into the international arena. In Sanders' words:

> For me, one of the most central things that has come out of this meeting is the importance of empowerment of people at the grassroots level. And so the short and sweet answer to the question 'Where do we go from here?' is 'back to our grassroots involvement in our various countries'.
>
> One important thing we can do is reproduce much of the discussion we've had here at the grassroots level within our various projects and programs.
>
> As we've seen, simply by becoming involved in national organizations one runs a risk of losing touch with the grassroots. This is even more true when one becomes involved at the international level. So, in terms of prioritizing, I think that continuing our involvement at the grassroots is very important.
>
> However, there is a definite place for working at the level of national structures. And there is a definite place for international networking, because the kind of information and experiences from our various countries which we have been sharing here is very important. Such exchanges are crucial because they are often the only way to catch up on how the imperialist world powers are actually operating. I think this became very clear to all of us when we undertook a situational analysis of our various countries. It gradually became evident that there was a common agenda underlying the actions of the World Bank, IMF, etc. We'll have no way to gain insights of that sort if we work in isolation.

FUTURE ACTION: WHERE DOWE GO FROM HERE?

From local action to global solidarity: an overview of priorities

One of the most central things that has come out of this meeting is the importance of empowerment of people at the grassroots level.

Needs for immediate action

In view of the formidable, interconnected obstacles to creating a healthier social order for all people, the participants at the meeting were hesitant to suggest any overall solutions, or anything close to a comprehensive plan for improving the health and health care of disadvantaged populations. It was felt that realistically the best we could do would be to develop an immediate, coordinated plan of action for the individual participants to follow.

Sanders and other participants went on to suggest the need for different areas of action on which participants might work upon returning home:

• The need to act at all levels

> So what I'm saying is that there's a place for action on the full range of levels: from the grassroots to the regional to the national to the international.

• The need to share information as the first concrete action

David Sanders noted that:

> One of the most important issues is disseminating information about the obstacles we face and the range of actions open to us. The issues we have been discussing are important, not just for health organizations, but for other progressive movements as well. We should be able to find a simple way to share information: maybe through a newsletter, a report, papers, or some other method.
>
> I think this is the first step we should take. Perhaps later on, when the group has become larger, we can hold a forum. But we can start disseminating information immediately. We should all share responsibility for doing so. And probably we can also provide other groups with some relevant technology in primary health care, techniques which they can use in their work, and ideas for effective actions they can take to address social needs.

However, David Sanders also warned that:

> With so much information coming out, if we're not careful we run the risk of accumulating so much material that we paralyze ourselves.

• The need to share information about funding sources

> We also need to exchange experiences about funding possibilities. We have seen that funding from the wrong source can subvert the process of empowerment. We have seen that many of the funding agencies are out to impose their policies — their way of seeing things—on our organizations. I don't know if the organizations represented here would be willing to exchange information on their specific funders. But there is no doubt that this is a crucial issue. We should try to circulate as much information as possible.
>
> I think as we begin to take a critical stand on structural adjustment, and the role of big business, the state, and the international agencies, it's clear that our funding possibilities are becoming more and more limited. Perhaps one of the roles of this network should be to help develop strategies for all of us to look for funding sources that are acceptable to progressive, people-centered groups.

• The need to rediscover and build on the traditional strengths and skills of the people

One of the South African participants addressed this theme:

> In order to reverse this insane conservative revolution that is sweeping the world, we need, on the one hand, to recover the knowledge, technology, and skills of our people. On the other hand, we need to develop technologies and approaches that are appropriate

to our particular situations. This would be facilitated by collaboration. Perhaps we could promote an information exchange to make this process easier.

• The need to prioritize and set an agenda for action

Everyone agreed that it was very important for us to be concerned about specifying what we wanted to achieve and what order we wanted to do things in. This way we would avoid plunging into too many actions at once. It was suggested that there were three major areas of work which the group might realistically take on in the relatively near future:

1. Coordinating mass actions to challenge the medical establishment, big business, and the state.

2. Forming a commission to look into questions of international funding and structural adjustment.

3. Addressing the problems the progressive sectors in our various countries are experiencing.

• The need to avoid becoming just another exclusive 'think tank'

A warning was sounded on this point by one of the speakers from South Africa:

> Now I think we need to be careful not to become another impotent little think tank. We need to make sure that we are true to democratic principles in our organization of this group. That's why I go along with David's suggestion. The question to consider is: should we not broaden representation? And, if so, how? Do we hold another conference? If so, then the three themes should be:

- How to oppose or break the monopoly of the sectors obstructing popular health
- How to challenge the dominant international funders and find alternative funding sources, and
- How to correct the imbalances and imperfections within our own progressive structures.

• The need to broaden our base

David Sanders spoke to this issue:

> Looking to the future, I think there are two things to consider.
>
> First, what each of us will do back in our own situations. This we cannot discuss except in the most general terms.
>
> Second is what we can do as a group. I think we need to focus on what we as a group can and should do.
>
> One of the obvious challenges our group faces is how to broaden our base. There is also the related question of what form this group should take. Is it going to be a formal organization, or is it going to be a network? Are we going to maintain some kind of ongoing communication? Does there need to be another meeting? If so, when? What form will it take? What sort of preparations will be necessary for it to happen? How could we get funding for it? In short, how are we going to organize ourselves?

List of group's recommendations for NETWORKING:

1. Exchange information that facilitates demystification and democratization.
2. Facilitate development of groups that are in formation.
3. Facilitate communication between these groups.
4. Share resources, materials, technology, and finances.
5. Denounce disinformation and crooks.
6. Rediscover knowledge and technology of people's health.
7. Give advice to groups that solicit it.
8. Do research on the impact on health of transnationals and structural adjustment, publicize the findings, and use them as a basis for mounting a campaign.
9. Disseminate information on health workers' role and experiences in Third World liberation struggles.
10. Exchange resource personnel.
11. Establish a support network to protest violations of human rights, and/or link up with groups already doing this.

While it was agreed that all of these recommendations were important, the group recognized, that while some could be acted on fairly easily in the short term, others were more ambitious and long-term undertakings. Some would require extensive research. Others might only be possible after a network or commission (assuming one was formed) acquired a certain degree of credibility and 'clout'. It was suggested that the proposed actions be prioritized and laid out on a timeline.

There was a lot of discussion about specific actions that the group could take in the realm of networking. Because these ideas were firmed up in a concrete **plan of action** for the new network proposed by the participants — the International People's Health Council (IPHC)— these activities will be discussed in the next section, about the IPHC.

FORMATION OF THE INTERNATIONAL PEOPLE'S HEALTH COUNCIL

After much debate, the conference participants decided to form an informal, worldwide grassroots network dedicated to working toward the actions recommended by the group and to expanding its base. It took two hours of discussion to decide on a name for this new network, which was finally called the International People's Health Council (IPHC).

The following public statement on the IPHC provides an overview of its proposed structure and objectives, and at the same time serves as a brief summary of this report on the Managua conference on "Health Care in Societies in Transition."

ANNOUNCING A NEW GLOBAL NETWORK:

THE INTERNATIONAL PEOPLE'S HEALTH COUNCIL

What is it?

The International People's Health Council (IPHC) — still in its formative stages — is **an informal network of socially progressive groups, movements, and activists committed to working for the health and rights of disadvantaged people** . . . and, ultimately, of all people.

Its job will be to facilitate sharing of information, experiences, methods, and resources among a wide range of persons, groups, and coalitions involved in community health work oriented toward empowerment and self-determination.

Its goal is to contribute toward a broad base of **collective grassroots power** which can have leverage in **changing unfair and unhealthy social structures** at local, national, and international levels.

Its vision is to help promote **health for all people** — viewing health in the broad sense of physical, mental, social, economic, and environmental well-being. We participants in the IPHC believe that:

- 'Health for all' can only be achieved through the strong, well-informed involvement of people in the decisions that affect their lives.

- Major improvements in a population's health are best achieved through PARTICIPATORY DEMOCRACY (decisionmaking power by the people), EQUITY (in terms of equal rights and satisfaction of everyone's basic needs) and ACCOUNTABILITY of government and leaders to the people.

- The policies of today's dominant power structures — tied as they are to powerful economic interests — have done much to precipitate and worsen humanity's present social, economic, environmental, and health crisis. Those who prosper from unfair social structures are resistant to change. They also have vast power and global reach. So today, changes leading toward a healthier world order must be spearheaded through a worldwide grassroots movement that is strong and well-coordinated so it can force the dominant power structures to listen and finally to yield.

The IPHC hopes to contribute, in whatever way it can, to the formation of this global grassroots network in the struggle for health through far-reaching socio-political change.

The struggle for health is a struggle for liberation
from poverty, hunger, and unfair socio-economic structures.

Who is invited to participate in the IPHC?

The IPHC is not a club with formal membership, but rather an informal coalition of persons and groups who identify with its objectives and wish to participate. Popular organizations, progressive health care movements, and community-based (in the sense of community-controlled) **health initiatives** are all invited to become involved.

We feel that the IPHC should not just be a South-South network within underdeveloped countries. It should also be a South-North network, including grassroots struggles for health and rights among the growing numbers of poor and disadvantaged people in the Northern overdeveloped countries.

Above all, we hope that the IPHC will become a **network of networks,** a vehicle for expanding exchange of ideas and solidarity among already existing coalitions, umbrella organizations, and national or regional associations of people's health and development initiatives.

Important: The International People's Health Council in no way intends to replace or compete with other similar networks. Rather we hope to be mutually supportive. We plan, for example, to work closely with the People's Health Network, an international, primarily South-South network based in Penang, Malaysia. Through some of our coordinators we already have links.

While the main focus of the IPHC concerns health, we hope that the network can to some extent be **intersectoral**, reaching across dividing lines between groups committed to health care, education, workers' rights, minority rights, environmental issues, consumer advocacy, disarmament, government and corporate accountability, human rights, etc. All of these concerns are interrelated, all involve confrontation with the power structure, and certainly all impact on health. At least between the umbrella groups in these diverse areas, links need to be made, so that we all are aware of each other's activities, our common interests, our strategies for change. This way, when a group in one or another of these struggles takes a stand and needs extensive popular support, a wide spectrum of concerned groups can be mobilized.

Where, by whom, and why was the IPHC conceived?

In December 1991, an international meeting of health rights activists was held in Managua, Nicaragua to discuss "Health Care in Societies in Transition" — a meeting that was in the planning for several years.

Most participants came from countries now in socio-political turmoil or transition. Represented were: South Africa, Zimbabwe, Bangladesh, India, the West Bank,

El Salvador, Guatemala, Nicaragua, Panama, Mexico, the Dominican Republic, and the US. Most of us who were at the meeting have a long experience in community health work linked to struggles for liberation or structural change.

At the meeting a **situational analysis** was given for each country represented, focusing on the politics of health. We confirmed that **all our countries are experiencing a similar crisis in health and social integrity.** Speakers related this crisis to the global economic recession and, more specifically, to the **widening gap between rich and poor,** both within countries and between them. The result — in poor countries and rich — is increasing poverty, malnutrition, and the **deterioration of living standards.**

Behind these growing inequities is the global power structure, a hegemony of big government and big business. This consortium of wealth and power has imposed development policies and trade agreements on weaker peoples and nations that have caused increased concentration of land and wealth, an exodus of landless peasants to growing urban slums, massive unemployment, and greater poverty.

Further aggravating this worldwide crisis are the **structural adjustment policies** imposed by the IMF and the World Bank. Their austerity measures are designed to make sure poor indebted countries keep servicing their huge foreign debt to Northern banks. They compel debtor countries to **devaluate local currency, free prices while freezing wages** (thus reducing people's real earnings), **increase production for export while decreasing production for local consumption** (including food production!), **cut back on public services** including health and education, **shift the costs for basic services back onto the poor, privatize government institutions** including those related to welfare, and **reduce subsidies and benefits** for poor and marginalized groups. (Poor countries are not pressured, however, to reduce spending on military, weapons, security police, or major industry. To the contrary, the budgets and benefits for all of these have increased.)

Obviously, it is the privileged who (temporarily) benefit from these 'economic adjustments'. It is the poor who are hardest hit. Far from promoting economic recovery as designed, in most poor countries structural adjustment has contributed to economic stagnation and drastic deterioration in living standards and health, especially for the already disadvantaged.

Adding to the defenselessness of exploited peoples is the fact that the United Nations (UN) also has its hands tied by the global power structure. The World Health Organization (WHO) and UNICEF receive 25% of their funding from the US government— still the nucleus of world power. Whenever WHO and UNICEF try to defend the interests of disadvantaged peoples when these conflict with interests of big business, the US accuses them of 'becoming too political' and threatens to cut their funding. Consequently these UN organizations resort to "low cost, low resistance" technological interventions to fight ills that are fundamentally social and political. For a while, such quick-fix technologies did slightly reduce child mortality. But with poverty and hunger escalating as wealth continues to flow from poor to rich, health indicators for the swelling ranks of destitute people (including those in the US) show relentless deterioration.

Participants at the Managua meeting stressed the colossal obstacles of the 80s and 90s to any people or nation struggling for liberation from these overpowering forces. The worldwide trend toward a free market and free trade ideology is stacked in favor of the affluent. It not only reinforces inequality, but deepens the subservience of poor countries and peoples to forces outside their control. Given the imperial force of the New World Order, no struggling group or nation is master of its destiny, or not for long. Countries such as Nicaragua, El Salvador, Mozambique, or Angola may win their home struggles for self-determination, but the larger power structure quickly intervenes and forces them back into servitude to the so-called free market.

In view of these events, the participants at the meeting agreed emphatically that **new strategies in the struggle for health and self-determination are needed for the 90s.** The global power structure is so vast and far-reaching that local movements for health and social change must move to a whole new plane of action. The best chances for the health of humanity lie in Worldwide SOLIDARITY. **We must join hands across conventional barriers,** bringing together people from a wide range of backgrounds who share a commitment to health and social justice. Only through **global grassroots solidarity** is there much hope for making the present self-seeking and ultimately suicidal power structure accountable to the people and the planet.

To contribute to this process of global solidarity in the struggle for health and social justice, the participants at the meeting on Health Care in Societies in Transition decided to launch the International People's Health Council.

Structure of the International People's Health Council

To try to build up the progressive health network in different parts of the world, five provisional regional coordinators were chosen, plus one overall coordinator:

Africa	David Sanders Faculty of Medicine, University of Natal Box 17039, Congella 4013 South Africa

Far East	Mira Shiva A-60 Hauz Khas New Delhi 110016 India
Near East (plus Soviet Bloc)	Umaiyeh Khammash P.O. Box 51483 Jerusalem
Latin America and the Caribbean	Ricardo Loewe Patricio Sanz 449 Mexico, D.F. 03100 MEXICO
The North	David Werner P.O. Box 1692 Palo Alto, CA 94302 USA
Overall coordinator	María Zúniga CISAS Apdo. Postal 3267 Managua Nicaragua

Present plan of action

• To identify and **make contact with progressive persons, groups, networks, and coalitions** that would like to join the IPHC or be part of the informal communications network. (Please put us in touch with those you think should be part of this network.)

• To put together an **annotated reading list on the POLITICS OF HEALTH.** (Suggestions and volunteer help on this are solicited.)

• To facilitate a process of **information sharing between groups and between regions.** We hope to promote an exchange of key writings, experiences, methodologies, organizational strategies, and teaching materials, especially at the grassroots level. (Again, suggestions and volunteer help are requested.)

• To try to **get translated some of the key materials,** so that different language groups can learn from one another's struggles and experiences. Latin America, especially, tends to be isolated from Africa and Asia because of the language barrier (which is somewhat less of a problem between much of Africa and Asia because of wider use of English). Therefore our immediate concern will be to try to get key materials translated from English into Spanish and Spanish into English. (Help needed!)

• To encourage **more communication between the umbrella organizations and networks of different regions.** When regional meetings are held, we hope to make sure that one or two representatives from other regions are invited, for information sharing and cross fertilization of methods and ideas. (For example, there is very limited communication between the Regional Committee for Promotion of Community Health of Central America and similar community health networks in South America.)

• To exchange our experiences concerning funding agencies and non-governmental organizations (NGOs), and to form **a watchdog data-base about which agencies tend to be more 'people supportive' and which are more conservative, manipulative, or have a hidden agenda.** About 70% of American NGOs assisting Third World programs receive AID funding and many have been co-opted to promote disempowering US health and development paradigms. Some NGOs with progressive-sounding names (and even some human rights organizations) have links with or are front organizations for the CIA. Even some apparently progressive community health networks have doubtful ties. A **global information pool** about different agencies can help us to make wiser choices and avoid pitfalls.*

• To create an **urgent action response network** that can be used to speedily inform members of the network about protests, confrontations, human rights violations, and other important, fast-breaking events, thereby enabling them to lend timely **international solidarity** and support.

If you agree with us, join us! Or help us!

We invite all persons and groups who are sympathetic to the vision of the International People's Health Council to join this communications network, become involved, or help in whatever way you can. There is no formal membership— just a list of persons and groups who share the same goals and want to be in touch.

The Council hopes to remain informal and to avoid a central office or high budget. It will depend primarily on volunteer help. Funding will, however, be needed to

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**The Group Watch Project, an organization linked with the Inter-Hemispheric Resource Center (Box 4506, Albuquerque, NM 97196) researches and publishes profile papers on non-governmental organizations and churches, that reveal both their politics and agendas. We hope to draw on the work of this organization and to cooperate with it.*

cover some secretarial costs, printing of materials for information exchange, postage, and region-to-region networking.

To participate, contact the coordinator in your region.

For the present, the Hesperian Foundation has agreed to coordinate some of the logistics of the information base, specifically gathering and disseminating information for the reading list on the Politics of Health and on the Politics of Funders (the watchdog data-base).**

Hesperian is eagerly looking for volunteers to help in these tasks. Please help if you can . . . or lead us to those who might be interested.

*** Note: The planning group for the IPHC designated Hesperian for this clerical task because of its competent staff, technical facilities, and reliable mail service. The main base for the IPHC is provisionally in Nicaragua and the regional bases are in South Africa, the West Bank, India, Mexico, and the U S . . . a s listed previously.*

PLANS FOR ANOTHER, LARGER MEETING

To broaden the base of the small group of health activists present at the Managua meeting, and to further explore the role between community health initiatives and organized struggle for basic human rights, plans were made for a subsequent international meeting with 80 to 100 participants.

This forthcoming meeting — tentatively titled "Health Care in the Context of National Struggle for Liberation" — is presently scheduled for November, 1992, and is to be held in the Palestinian sector of Jerusalem. The meeting will be organized by the Palestinian Union of Medical Relief Committees.

Participants will be selected through an interchange of the regional coordinators of the IPHC with progressive health groups and popular movements in the respective regions. Attempts will be made to include participants from a wide range of countries in which popular struggles for basic rights and socio-political change is presently taking place, and where grassroots health initiatives are an integral part of those struggles.

The regional coordinators and organizers of the forthcoming meeting are open to suggestions or recommendations for participants.

At the time this report has gone to press, preliminary arrangements for the Jerusalem meeting are underway. Funding sources are being sought. When feasible, the organizations to which participants belong will be asked to cover their travel expenses. However, funding is actively being sought to cover the expenses of those unable to cover their costs.

Any financial assistance from progressive funding organizations, or ideas for possible funding sources, will be much appreciated.