

The Concept of Health Under National Democratic Struggle



By
The International People's Health Council

February 1995

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The Concept for Health Under National Democratic Struggle was a conference held in Jerusalem, hosted by the Union of Palestinian Medical Relief Committees.

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INTRODUCTION

This report brings together the proceedings of the first conference of the International People's Health Council (IPHC). The conference, 'The Concept of Health under Democratic Struggle', was hosted and organized by the Union of Palestinian Medical Relief Committees. Held in Jerusalem in November 1992, the conference supported the previous work of the IPHC toward building an international network of progressive health workers. The conference brought together over 100 people, from more than 30 different countries, all of whom are working, in various ways, with progressive health movements. The conference was designed to: examine the problems associated with implementing primary health care policies in societies in transition; exchange experiences related to the development of community empowerment as a means of health promotion; examine the links between health and national democratic struggle; examine the effects of structural adjustment programs on community development; and to exchange strategies that health care organizations have used in both the North and the South.

In the two years since the conference took place, the political context here in the Occupied Palestinian Territory has changed significantly. The political changes, as will be outlined later, are more a matter of the proliferation of political agreements rather than real empowering democratic changes for ordinary Palestinian people. The struggle for democracy and liberation is far from over in Palestine - despite the claims of some politicians and journalists. As we struggle to adapt to these political changes, to the external and internal threats to democracy, we must also adapt our struggle for health.

In South Africa, the nature of the struggle for health has also been affected by recent political change. The first non-racial democratic elections of South Africa took place in April 1994. Readers should therefore consider that, because of the delay in the publication of this report, the struggle for health and democracy taking place today in many countries has moved on from that taking place two years ago.

These changes in South Africa and the Occupied Palestinian Territory serve to remind us that this is a critical time for both domestic and international politics and, therefore, a critical time for the struggles for both national liberation and health. As the nature of governance and government changes, and as the influence of international agencies and northern governments increases, so we must prepare ourselves for change, and adapt our activities to maximize effectiveness. Thus, the role of the International People's Health Council, and conferences such as this, is increasing in importance.

The IPHC was created following an international meeting of progressive health workers and representatives of progressive health organizations in Managua, Nicaragua in 1991. It was at this first meeting, the theme of which was 'Health Care in Societies in Transition', that many of us realized that, despite working in countries ranging from India to South Africa to Mexico, the pattern of problems we experienced in our health work was very similar. Those attending the meeting in Managua shared a vision of a world in which all people have real social, economic, physical, mental, and environmental well-being. We became determined to contribute towards a broad base of collective grassroots power aimed at challenging unfair and unhealthy social structures.

Our conference in Jerusalem, strengthened both our vision and determination. It continued the work and solidarity begun in Managua and strengthened the ties between progressive health movements in many countries. The speeches and debates of the conference covered a range of topics concerning health, adding greater depth to our understanding of the problems and prospects facing the achievement of health for all.

I believe that the conference, and this report of its proceedings, continues, and adds solidarity to, the efforts of those involved in progressive health work throughout the globe. I hope that it will encourage discussion and the dissemination of ideas and concepts of the international struggle for health. Moreover, I hope that this report, as a part of the worldwide solidarity of progressive health workers, will help us to address the international and external obstacles to achieving health for all. As some of

the presentations in this report argue, the influences of free market ideology manifest particularly in the GATT and structural adjustment programs, the North American dominance of international affairs, and the increasing marginalization of poor peoples in developed and developing countries, must be overcome if we are to achieve full health and national liberation for all people.

Umaiye Khammash

Union of Palestinian Medical Relief Committees, Jerusalem.

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EDITOR'S NOTE

The report is organized into four main sections. The first section contains the key presentations given at the conference. These are reproduced in their entirety with minor editorial changes. The second section contains summaries of the country presentations and analyses. Due to lack of space I have summarized these whilst trying to retain the flavor of the speeches and the most pertinent points relevant to the debate about the struggle for health. In the third section the reader will find summaries of the workshops including recommendations made by each group. Finally the summary statement by Maria Hamlin-Zúniga, the coordinator of the IPHC, is presented.

Since two years have lapsed since the conference, readers should bear in mind the changes that may have taken place during that time. Wherever possible I have clarified and updated potentially confusing points in order to assist the reader.

I apologize unreservedly for any mistakes remaining and to any contributor who feels I have failed to reflect accurately their perspective on the struggle for health and national liberation.

J. Lennox

THE PALESTINIAN CONTEXT

The location of this conference in the Occupied Palestinian Territory could hardly have been more appropriate given that the theme of the conference was 'The Concept of Health under National Democratic Struggle'. Since 1948, Palestine has been under the brutal occupation of the Israelis following the declaration of the State of Israel on Palestinian land. In 1967, Israeli occupation extended itself throughout the remaining Palestinian territory.

Since 1967, the 2.2 million Palestinians living in the Occupied Territory have been subject to one of the most vicious and indiscriminate forms of occupation ever known. Despite the passing of a multitude of United Nations resolutions condemning the illegal occupation of Palestinian territory, the international community remained immune to the plight of the Palestinians. At the same time the United States government, due to the powerful Zionist lobby, almost single handedly financed the State of Israel and its illegal military activities.

The movement for Palestinian liberation, spearheaded by the Palestine Liberation Organization, was active throughout the years of occupation. But it was in 1987 that the 'Intifada', or popular uprising, became internationally recognized as the struggle of the Palestinian people for freedom, human rights and self-determination. The Intifada was crucial in restoring the feeling of national self-reliance and self-determination that had been so cruelly crushed during the previous 20 years of occupation. The Intifada, was an uprising of the whole of the Palestinian community against occupation, with people from all sectors and classes involved. Many health workers and their organizations played an active and important role in the uprising.

Several factors combined with the impact of the Intifada and Palestinian resistance to occupation, to force Israel into the peace negotiations at Madrid. For example, the Palestine National Council's acceptance of a two-state solution for Palestine in 1988 was significant. The Madrid talks

were in progress at the time of this conference. However, one year after the conference, the unexpected signing of the Declaration of Principles (DoP) on 13th September 1993 by the Palestine Liberation Organization and the Government of Israel changed the political context in which Palestinian NGOs work.

The Declaration of Principles (DoP), despite the stage-managed celebrations on the Whitehouse lawn, offers few guarantees for Palestinian autonomy and democracy. Although we are witnessing the emergence of a Palestinian National Authority, control over land, resources, and borders all rest with the Israelis. The final status of the Israeli settlements is unclear and the issue of Jerusalem is not yet even being discussed.

In fact, Palestinians have faced even greater difficulties since the signing of the declaration. The permanent closure of Jerusalem in March 1993 has undermined the fragile economy of the West Bank. Increasing restrictions are being placed upon laborers working in Israel, a major source of income for residents of the Territory. Curfews are still commonplace, the intermittent closure of schools continues, and the shooting of innocent civilians is an almost daily occurrence.

In spite of the emerging Palestinian Authority, NGOs, including those working in health, have an important role to play in the building of civil society in Palestine - whilst resisting Israeli occupation. Many Palestinian NGOs believe that there are a number of immediate aims for their work. These include: the rational and continuous development of Palestinian life; the expansion and consolidation of the process of democratization in all aspects of our society; the promotion of national independence through the consolidation and implementation of the principles and bases for civil society; the defence of the rights of social groups and regions deprived of basic services; and the mobilization of community resources for action.

Health NGOs are actively involved in this work. In addition to their efforts to build civil society in Palestine, they are making sure that all those working in health play a major part in the policy making process. In

this way, health workers are trying to ensure that the Palestinian Authority will guarantee democratic rights and freedoms to Palestinians and, at the same time, satisfy the needs of the Palestinian people for high quality, accessible health services.

SECTION ONE

KEYNOTE SPEECHES

MVUYOTOM

PRIMARY HEALTH CARE AND THE NATIONAL DEMOCRATIC STRUGGLE

Mvuyo Tom, from South Africa, is a family practitioner working in primary health care. He is a member of the health department of the African National Congress (ANC) and was involved in the establishment, in 1992, of an organization comprising of the various health organizations in South Africa working to sharpen their focus on the national democratic struggle. Mvuyo is the founding president of this group - the South African Health and Social Services Organization (SAHSSO).

Introduction

In order to understand our national democratic struggle and how it relates to health in general, and to primary health care in particular, it is pertinent to discuss briefly how we were colonized, and the concept a special type of colonization. After Jan von Riebeeck set foot on our shores, the Dutch were the colonialists. They were followed by the British. The Afrikaaners increased in power until they declared their Republic of South Africa in 1961. The country was no longer a colony of European countries, but now indigenous people were colonized by the white minority, who had no distinct or special separation from them. The systematic colonization of our people meant they were subject to social and political oppression and economic exploitation. All types of organizations of the people, be they social, political, economic, or cultural, were systematically destroyed or distorted in order to benefit the colonialists.

The Afrikaaner was, and remains, partner to our exploitation and oppression. Defeat in the various battles fought against the colonizers meant dispossession of our land and livestock. Thus, poverty and disease were to plague the black people for a long time. The development of the mining industry from the last century onwards meant that more and more people were moved from their land to work in the mines. There were various methods used to achieve this, among them different taxes were imposed, for example on keeping animals such as dogs and cattle, and a poll tax. These taxes inspired an uprising, the Bombatta rebellion of 1906. People had to have money to pay these taxes and the only way to earn money was to become a wage laborer. A new health hazard developed, men were dying like flies in the mines from tuberculosis and accidents. These two causes of death are still prominent among the oppressed.

Oppressed people have, at different times, staged resistance against colonialism. Pockets of uncoordinated resistance date back to the frontier wars and the last, mentioned above, was the Bombatta rebellion. When the colonialists passed the Union Act of 1910, the black people realized that only a united effort could resist this evil. The birth of the African National Congress in 1912 was the result of that realization. It is important to understand that the deprivation of our people started long before institutionalized apartheid. In 1913, for example, the Land Act allocated 87% of the land to whites.

In 1948 the Nationalist Party came to power, with their grand apartheid policies. They were voted into power by whites who stood to gain from their policies. Job reservation and the Group Areas Act meant that more and more black people were unemployed, homeless, and landless. This worked against what people needed for health. Hence, we found, as we still find today, more poverty and disease amongst the oppressed. People were forcibly removed from their land to their allocated 13%. The struggle against these removals was a struggle for survival, a struggle for health. It is no accident that in the clauses of the Freedom Charter we see the logical sequence of political, economic, social and cultural freedoms.

The struggle against apartheid gave people self-confidence and self-reliance, which had been eroded by decades, nay, centuries of colonialism. Whatever we did as a people was always considered heathen or uncivilized unless approved by our captors. New methods of health care, religion, education, culture, etc. replaced traditional methods. This mental warfare made us suffer from an inferiority complex that could only be removed by victories that needed to be scored against the oppressor. The Defiance Campaign of 1952 was a national effort that shook apartheid but did not knock it down. Self-reliance, a basic component of primary health care, was creeping back to the people.

When non-violent means of struggle were met with state violence and brutality in unprecedented proportion - culminating in the Seville Massacre and the banning of the liberation movement - the people were left with no option but to meet state violence with revolutionary violence. Hence, in December 1961, the first acts of sabotage began. From that time onwards, the liberation struggle had to rely on four pillars, namely mass mobilization, underground organizations, armed struggle, and the international isolation of the apartheid state. These pillars have been instrumental in bringing our struggle to where it is today, at the threshold of freedom. Mass struggle has brought health into focus.

Mass struggle and primary health care (PHC)

The national democratic struggle (or national democratic revolution) has led to national liberation and the broadening of democracy and this must permeate all spheres of human endeavor. PHC as elaborated in Alma Ata has, as some of its tenets, community participation, self-reliance, and political commitment. When we say 'The people shall govern' this means making sure that the organs of government allow popular participation after liberation. That participation will not just appear out of nowhere when we are free, but is built through struggle. This participation reinforces self-reliance.

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Our history is rich with examples of self reliance, especially during and after the struggles of the 1980s against the tri-cameral constitution of the apartheid government. In addition, one cannot overlook the role that black consciousness played in the 1970s in promoting self-reliance with the establishment of community projects, including health projects. The broad base of the movement in the 1980s was strengthened by the establishment of the organs of people's power which spearheaded popular participation.

Schooled in struggle, when people participate in their own health care, they bring some of the lessons of popular participation with them. The reverse also applies - when health workers are schooled in primary health care they know exactly what participation entails, and when faced with undemocratic practices in the liberation struggle, they are quick to challenge them.

The issue of political commitment to primary health care can never be addressed by the apartheid regime. The apartheid system was meant to serve the minority and there is no way it can understand primary health care as we understand it, particularly its commitment to the equitable distribution of health care and all determinants of health. It is in this light that we see that the apartheid government has its own version of primary health care, emphasizing treatment for the already ill and paying lip service to other principles of primary health care. The progressive health movement has therefore taken it upon itself to spread the principles of Alma Ata by forming a network of primary health care organizations, called the National Progressive Primary Health Care Network, which organize projects that practice the multidisciplinary and intersectoral approach that is necessary for comprehensive primary health care.

Only a democratic government can commit itself to primary health care. There will only be a democratic government when the people govern, not only by going to the polls, but through their participation in the processes which determine their future. The national democratic struggle must set in place not only structures to tackle the old order but structures that will be consistent with the task of democratization and transformation. The mass

struggle was not only against apartheid, it was for an alternative. The struggles for education, housing, jobs, a living wage, the provision of clean water and eradication of poverty, fit in logically with primary health care struggles.

The struggle for democracy is the struggle for health. Health is sometimes relegated to the background during the national democratic struggle, but this must be resisted because health and health care must be guided by a needs assessment that is, in turn, a product of popular participation. The only guarantee of consistency in policy in all sectors is broad popular participation. This forms the basis for one aspect of primary health care, namely intersectoral collaboration. If one sector knows what is happening in another sector through popular participation, the task becomes easier. We have, therefore, participated in policy debates within the broad liberation movement and with civic organizations.

It is in this light that the forerunners to the South African Health and Social Services Organization (SAHSSO) challenged, and still challenge, the policies of the present government. Government policies are made by the minority for their own benefit and to the detriment of the majority. We, therefore, support moves aimed at the speedy replacement of the present regime by a democratic government. We challenge any unilateral restructuring of health and social services by this regime and conservative health bodies like the Medical Association of South Africa which use structures like the Liaison Forum of Professional Associations. SAHSSO has led mass demonstrations against this unilateral restructuring alongside the liberation movement, civic unions and trade unions.

The mass struggle in the economic arena has also recognized the relationship between national democratic struggle and primary health care. It is a well known fact that PHC depends on the available resources of the country to be successful. Apartheid has wasted some of these resources through its cumbersome and duplicative bureaucracy. Besides that, apartheid has tried, by exporting war, to destabilize the frontline states, especially Angola and Mozambique. We have long pointed out the

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corruption in the homelands and the apartheid state. Those calls were unheeded, but now daily revelations prove us to be correct.

The government wants to restructure the economy unilaterally and is suggesting that social spending is cut. The involvement of the World Bank and the International Monetary Fund is quite clear. We have already seen the introduction of Value Added Tax which was forced down the throats of the opposing majority and has now been extended to food and health care. Our health and social services, together with the liberation movement, battle against this added burden on the already oppressed majority.

International isolation of apartheid and PHC

The focus on health structures in this country was sparked off by the death in detention of Steve Biko in 1977. Since then, the South African Medical and Dental Council and the Medical Association of South Africa have been unable to escape world scrutiny because of the manner in which they dealt with the medical personnel who were supposed to have handled Steve Biko. There was an immediate interest in the care of detainees and new health and social services sprung up in opposition to the traditional and conservative ones.

These organizations later focused attention on the broader aspects of health, especially in relation to apartheid. The Alma Ata conference was held a year after Biko's death and opened people's eyes. The liberation movement in exile and inside the country was involved in an extensive international campaign. This made the work of health workers easier. The detention laws drew health workers, communities, and political organizations closer together. Support groups and health teams were formed to look after ex-detainees. The physical, social, spiritual, and mental needs of ex-detainees, ex-political prisoners, and victims of security force brutality, were taken care of by these alternative structures. This has led to international cooperation between our organizations and

others caring for the victims of torture. We are now in the formative stages of establishing community-based rehabilitation centers.

Conclusion

As we are poised to bury apartheid and march on towards freedom, we know that old tricks die hard and we still need to fight the battle until democracy is achieved. We are still dogged by violence which is disrupting the structures we have formed, displacing families, and destabilizing PHC. The all-embracing comprehensive approach embodied in the Alma Ata primary health care perspective appears to be most logically in tune with the spirit of democracy as well as the spirit of national liberation, whose essential aim should be to redress the social, economic, and political imbalances of the past. In health, these imbalances are evident in the spending on high-tech, tertiary care of diseases of the affluent minority.

Therefore, the struggle for a sustainable national primary health care program must be located and integrated into an overall national comprehensive program. This ensures that PHC is seen as part of an overall program of socioeconomic improvement, thus increasing the chances for consistent and sustainable primary health care programs post-liberation. Above all, we seek to avoid what usually happens after so-called liberation, when health may be relegated to the bottom of the list of national priorities and when it becomes easy for health programs to be subjected to the whims of short-term political expediency.

RITA GIACAMAN

THE STRUGGLE FOR HEALTH IS THE STRUGGLE FOR LIBERATION

Rita Giacaman, a pharmacologist, sociologist and public health educator is a professor at Birzeit University, in the Occupied Palestinian Territory, and founder of the Community Health Unit at Birzeit. She has been active in women's and health movements in Palestine, and has written numerous articles. She has also conducted an in-depth study on health status in three Palestinian villages.

Throughout our history, especially during the 20th century, Palestinians have been victimized, oppressed, dispersed, and dispossessed, but we have not been victims. We have not played the role of victim, we have always had a role in resistance and we have always made our history, and we continue to make our history to this day. This day is part of our health history. At times we have acted well, in a very civilized way, although it was not necessarily Western. This is a response to the image that Palestinians have had, and continue to have, in the West - we are portrayed as bloodsuckers, inhuman, killers, stone-throwers. We do all sorts of things to resist and one of the things we do very well is resist through building infrastructure - in health, with women, and with other movements. In particular, I would like to focus on the intricate and inseparable relationship between national struggles and social movements, simply by using examples from Palestine.

In the Palestinian context, the national struggle was instrumental in giving rise to, and fueling, various types of social movement, including student movements, a voluntary work movement, women's, health, and agricultural movements. The health movement can only be seen within

the context of what is happening in society at large. Yet, at the same time, this relationship between national struggle and the development of social movements is not unidimensional or unidirectional. The national struggle can, and has, assisted social movements, yet has also limited their further development - some of you know this already, it's a paradoxical contradictory relationship. This has been especially true in the case of the women's movement, but also in the health movement. By 1967, when the West Bank and Gaza Strip fell under Israeli military rule, biomedicine, or western medicine, had already firmly established itself in the area, taking the place of the indigenous medical system - which continues to be utilized but only in a diffuse informal way.

With the fall of the West Bank and Gaza under Israeli military rule, a new period emerged. This was a new danger to Palestine that had not been experienced before. Simply stated, people began to slowly realize that the policy of the Israeli government was not merely to win the war and then withdraw, but their policy was to systematically take the land without the people, by pushing people out of the country. This realization happened over a period of several years. The system of occupation became a great threat to the very viability of Palestinian culture and society because of the issue of the land and consequently different types of resistance movements developed.

In the health sector, the first movement was an initial response to the severe deterioration in health care services. Palestinians began to call for staff to continue to work within the military government-controlled public health sector. This used to be controlled by the Jordanian government and was inherited by the Israelis and continues to be operated by them until this day¹. At the time, Palestinians argued that, since this health care structure was serving our people, we had to work within the system despite the great pressure imposed by the Israeli government. The government lacked, at the very least, any interest in developing this

¹ Responsibility for health service provision was handed over to the Palestinian National Authority in December 1994.

system and did, at most, everything possible to destroy it and make the Palestinian health infrastructure totally dependent on the Israeli system.

It soon became apparent that, due to budgetary constraints, severe neglect, and restrictions placed upon employing staff with certain skills, it was impossible to fulfill people's basic needs by relying solely on the government-controlled health sector. This realization, in addition to a further political move for resistance, yielded a new movement, the second movement, which was based on the notion of steadfastness, which was heavily national and political. This was 'Samuud' in Arabic - literally, sticking to the land and doing everything to help people stick to the land by providing services - and it began in the early and mid- 1970s. There was a national fervor growing and, along with it, the health movement began to establish independent Palestinian institutions in health. These institutions would serve Palestinians under the banner of steadfastness and were based on the belief that keeping our people on the land, doing things for ourselves, was an absolute necessity.

This charitable network of clinics and health projects had both advantages and disadvantages. The advantages included a relatively high level of success in moving health care from hospitals to a clinic setting and from urban to rural areas. The main disadvantage which the movement bears to this day, and which is a major limitation, is that at a political level this movement never defied Israeli laws, regulations and authorities. Hence, this movement only established health projects if the Israeli authorities allowed.

Palestinians are governed by at least four types of law. Ottoman-Turkish law, pre-World War I colonial regulations, Jordanian law, and, as if those are not sufficient to repress people, the Israeli military authorities have so far promulgated over 1,000 military orders to ensure control over health, social services, and every other aspect of life.

So, this second health movement, which called for steadfastness and rural, clinic-based care but which did not defy the law, was stunted considerably precisely because the Israeli military had control over its development by

refusing permits for further expansion. This happened in the 1970s and continues to happen now. The Israeli authorities restrict this movement, although it must be said that this movement was still crucial in developing certain kinds of services.

At the social level, in the 1970s and 1980s, this movement was also limited by a view of health that was primarily biomedical and not oriented towards community-based participation, grassroots level activity, health promotion, health prevention, maternal and child health care, or priority groups. As a consequence, this movement mainly provided curative services to the exclusion of other very important services - especially if we think about health as being couched in a social, economic and political context. However, there was and continues to be, exceptions to this rule, some of these charitable societies have gone beyond that.

During the mid-1970s, increasing pressures on Palestinians were becoming unbearable - land confiscation, control of water resources, military violence, imprisonment, harassment, serious economic strife, and a dependence on Israel such that by the mid-1970s we had become the workers building other people's homes on our own land. As a result, new thoughts began to emerge - there had to be another way of dealing with this situation. One of the new approaches that developed was an ideology of resistance which called for going back to the land. The movement of labor away from agriculture to work in Israel led to this call to go back to the land. Community and grassroots activity, solidarity and community action, began to appear on the agenda in ideological terms, and voluntary, grassroots activities began to characterize the late 1970s.

This slowly became a model of resistance to the occupation. The nucleus of this trend developed out of an awareness of the limitations of the various methods that had been used before: services, consciousness, and political mobilization had not reached the majority. Until the late 1970s, political power, political mobilization, and services were all centered in urban areas, that is, in the center of the country to the neglect of the north, the south, and Gaza. So when the political movement realized this, it wanted to spread its political mobilization to the countryside, but along

with that came a social movement that demanded the right to health and to other services as well. What distinguishes this movement from other trends is that it is based on grassroots mobilization, community self-reliance, and resistance. It was trying to address the fact that nationalism had always held a supreme position, constantly making social issues a secondary concern.

This movement argued that whilst the political/national movement is important, equally important is community politics, health-care politics, women's politics, and politics of the disabled etc. We were trying to bring all these aspects into balance, which was not easy - it is an eternal contradiction.

This movement was also distinguished by structures that were based on some form of democracy. The charitable societies and other groups, were controlled by urban-based executive committees. In the political arena, democracy has never traditionally been part of the Palestinian process. I don't think we can be blamed for that. We came from peasant roots and democracy has never been part of the peasant lingo. We came out of a patriarchal, hierarchal system and we are trying to develop but as we try our society has been distorted by external aggression and so our attempts to develop have also become distorted. Despite this, we found that the movement called for the formation of committees from the grassroots upwards representing the invisible for the first time. These committees were established at the village level, including women's committees, and representatives were elected by region.

Suddenly we had a national structure based on representation by village and by region. This was a historic step and, since that time, this movement of committees has flourished. In the case of the alternative health movement, not only did it flourish in terms of service provision, but it was crucial in changing the dominant ideology in medicine and health care away from strict equipment and western models to include - if not completely - primary health care as the mainstay of any health provision in the country.

For example, twelve or thirteen years ago, when people in this movement suggested using midwives they were accused of being unprofessional. Today, everybody in the health care establishment is talking about primary health care (PHC). However, what we mean by PHC may not mean what they mean by PHC, because some have co-opted the terminology but not the substance. For instance, a physician was saying to me once that he wanted to put an x-ray machine in every village in the country. When I questioned whether this was primary health care, he was furious.

At a practical level, these new structures in health allowed people to meet who had never met before and, once you have unity you have strength. Nurses met with doctors, who met with village health workers, who met with researchers and academics - this was historic. These committees, like the Union of Palestinian Medical Relief Committees continue to involve a mixture of people that have traditionally been separated through classical professional segregation and who have now been united into one group involved in mass action in health care. Since the uprising, the alternative health movement has gained legitimacy because it was, like the major hospitals, capable of responding to the pressures exerted by the massive increase in the young injured of the Uprising.

However, to suggest that this alternative movement does not have problems is untrue. What is true is that this alternative movement has succeeded in bringing a balance between the national political and the social by raising particular issues such as issues of women's health. This leads you to a discussion of feminism not just health, because when you talk about women's health, you talk about family violence - so this is a time of change.

This alternative movement is at a crossroads. We are about to either see self-government or perhaps a Palestinian state. Whatever it is, we are going to see a change in our political status. This brings a terrible pressure on the alternative health movement because on the one hand, there is a real and immediate need to institutionalize because building structures of resistance and delivering services at the national level requires institutionalization at the level of administration, management,

supervision. Yet, on the other hand, we need to hold on to the social dimension and continue with volunteer, grassroots, mass-based action. The problem is not that we don't realize that we need to do both - we do. There is a need for both. If we are to influence the structures that will produce a state, then we have to have institutions and institutionalization. Yet at the same time we have to be involved in advocacy, we have to be the conscience of the future. Therefore we have to guarantee the cooperation of social movements, even after liberation, and the question that I address to you is: how can we bring about this balance?

MUSTAFA BARGHOUTHI

NORTH-SOUTH DYNAMICS AND THE QUESTION OF AID

Mustafa Barghouthi is the chairperson of the Union of Palestine Medical Relief Committees, and was a founding member of the Union at its inception in 1979. He has been active in the field of health research and planning is presently the director of the Health Development Information Project based in the West Bank.

The North-South dynamic and national boundaries

The North-South phenomenon is of a socio-economic and political, rather than geographical, nature. There are numerous indicators of this. Firstly, the North, or what is labelled the North, itself suffers from a multitude of internal social and economic problems. Furthermore, many countries in the North, such as Italy, are experiencing the North-South dynamic internally.

Secondly, millions of people from the South now live within the geographical boundaries of the North, but even so they remain part of the South and, as such, they comprise the groups that suffer the most discrimination, as is the case in Germany, Britain, France and Italy.

Thirdly, the collapse of the Soviet Union has demonstrated that many eastern European countries are, in fact, so underdeveloped that they could easily be classified as 'southern' countries.

Fourthly, there are divisions within the South itself. The South is experiencing already the 'center vs periphery' phenomenon. There are divisions resulting from the fact that part of the North already lives in the South. This is true of the Middle East: Israel cannot by any means be classified as a southern country, while the Occupied Palestinian Territory is definitely part of the South. The dynamics of the relationship between Israel and the Occupied Territory, and even with other Arab countries, is similar to that between industrialized and developing countries.

Finally, it must be noted that this is a period of transition worldwide, especially in the economic sphere. As one of US President Bill Clinton's key economic advisers expressed recently "in the future there will no longer be national products or technologies, no national corporations or industries. All that will remain rooted are people that comprise a nation." What he did not state is that within each nation there are, and will continue to be, national divisions. Similarly ignored is the fact that common interests are emerging that unite people across national boundaries. The globalization of certain issues, such as environmental concerns, highlight one of the most important and interesting aspects of North-South dynamics - the very real interdependence between the North and the South. This interdependence is impossible to ignore when examining the issues such as the ozone problem, or AIDS. The nuclear accident at Chernobyl is just one example of an environmental disaster, and a major health problem, incapable of being restrained to the boundaries of one particular nation.

Economic exploitation cannot be restricted to national boundaries. Much of what will happen in the future depends on the level of skilled human resources available in each country. The ongoing brain-drain from the South to the North demonstrates that the industrialized countries are utilizing the economic gap, which widens every day, to continue attracting the most active and educated people from the South. This strengthens both the factors which first led to the economic gap and those factors which will eventually increase it.

The gap between North and South is universal, and has economic, social, political and health aspects. The gap is utilized to maintain control of and to exploit the less developed countries. Third World debt and economic aid have become instruments used to control the economies of southern countries, to keep developing countries in a situation where their markets, resources, and raw materials will always be managed and made available to benefit the interests of the general capital market.

Quantitative v qualitative analysis

At the same time, however, any evaluation of the situation in southern or developing countries must not be restricted to a conventional approach. Quantitative analysis, especially in the field of health, is insufficient. Analysis should not be restricted to measuring infant mortality rates or life expectancy, but should include the question of quality of life and of equality of living conditions between people in developing countries and people in industrialized countries. Inequality is evident even in terms of the consumption patterns that have been imposed on southern countries. Many industrialized countries, when exporting their materials or goods to the South, send second-rate goods. Moreover, it is evident that second-rate development standards are being utilized. The question of quality must be a central one, and thus any evaluation must not be restricted to quantitative measures.

Economic aid and North-South relationships

The first question to be raised here is whether it is truly possible to establish relations on an equal footing between a funder and a recipient. Can one honestly speak of partnerships in this context? One important fact which must be recognized is that over the last ten years, governments have become the major source of aid funding, and the vast majority of development money takes the form of bilateral government-to-government support. There has been an increasing dependence of northern NGOs on their governments, which has influenced a clear change

in the policies of these organizations. The level of professionalization of development aid organizations is such that one can speak of the 'aid business' in the North. The result is that some of these northern aid organizations are, in effect, forcing recipient NGOs to follow along behind them, thus making these southern NGOs dependent on the government aid they are receiving. The United States Agency for International Development's (USAID) funding is a clear example of this: AID funding has always been political and will always be political. However, the question is whether this aid, or the major portion of it, is actually being used in order to develop countries in the South, or whether it is primarily being used to facilitate the economy of the North. It is worthwhile examining how much of the money is used to purchase military equipment or goods that are compatible with northern consumption patterns and serve northern marketing needs.

Allocation of funds

What must be asked is, who is determining funding priorities? Usually, and the Occupied Palestinian Territory is a case in point, funders arrive without defined plans or strategies, equipped with a 'charity' mindset. Priorities are then decided by the funders and not the recipients, which accounts for the emphasis on purchasing equipment. For example, the EEC requires, in most cases, that a substantial portion of its support should be used for the purchase of equipment and, moreover, that equipment must be purchased from the countries providing the funding. Is all this equipment really necessary? Furthermore, if huge sums of money are being provided for infrastructural costs, what will happen in the future if we fail to get the money or resources necessary to cover running costs? The contradiction here, or rather the question to which no one has supplied an answer, is how what is termed 'self-reliance' and 'sustainability' can be achieved when the bulk of donated funds is being spent on equipment and machines rather than on human resources.

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Training and technical expertise

Yet another aspect of this issue which must be considered is the question of training, currently a popular trend among funders. If huge numbers of people in the South are trained but the facilities or money necessary to employ them is not available, eventually they will either leave the South to go to the North or they will be unemployed. The value of training programs must be questioned if they are not clearly linked to the provision of running costs or job opportunities.

Furthermore, while there is a great need in many developing countries for technical expertise, it should come not only from northern countries but from the South as well. There is no reason why experts from India cannot be sent to advise certain programs in the Occupied Territory, or why a Mexican health project cannot benefit from a Palestinian consultant. The flow of expert skills need not always be North to South, but can equally be South to South. This point is even more relevant in terms of cost-effectiveness, when the cost of technical experts from the North is ten to fifteen times the cost of those from the South.

Fashions in funding

Yet another problem affecting the relationship between northern and southern organizations is the constant shift in the priorities of northern NGOs and governments according to the latest trends in development. These shifts have a distinctly negative impact on programs in the recipient countries, as exemplified by the case of one institution which had initiated a child health project. Child health as an issue was attractive to funders at the time and the project was supported. However, the following year the funding agency announced that their new program was to be maternal and child health, so the institution was forced to alter their project to fit in with the concept of maternal and child health. The third year the trend turned towards women's health, and the institution had to change its project once again to suit the interest in women's health. Such a situation

distorts the recipient organization's objectives and forces them either to 'cheat' in their representations to funders, or to adapt their program and not respond to their own priorities.

The concept of sustainability

The majority of funders insist that funding should not exceed a period of one to three years. There are exceptions, those groups that have been involved in long-term development work for many years and have a different philosophy, but it seems the majority set short-term funding conditions which call into question the possibility of achieving real development. Sometimes a project may need at least one to two years to get on a firm footing and if the funding is to last only another year real sustainability is threatened. Yet sustainability is the watchword constantly presented to recipient organizations.

Is sustainability a valid concept when aid is given in small portions, as in the Occupied Territory? In 1991, West Germany poured funds into the former East Germany equivalent to the entire amount of aid that was given to developing countries. In one country of 16 million people, the amount of money utilized was the same as that going to the rest of the world, from all countries, not merely from Germany. This would seem to prove that serious development cannot be achieved by small sums given here and there. Major structural changes are required before true development aimed at self-reliance and self-sufficiency can be realized.

Moreover, while recognizing the value of concepts such as self-reliance and sustainability, a health organization - working under occupation - cannot raise taxes. Neither does it have a government that can subsidize the health system, yet it must be subsidized if it is to reach those most in need. Therefore, an endowment would seem to be the answer, because it would allow a gradual increase in self-reliance. However, with very few exceptions, no funding organization is willing to accept the idea of an endowment. The reason generally given is that with an endowment the funding organization has no guarantee that the character of the recipient

organization will not change over time. However, organizations in the North receive endowment funds despite the fact that their character may also change. Yet, it would be more equitable to apply the same standards in both the North and South.

The administrative burden

Another common requirement is that administrative costs should be kept to a minimum which is fair. Ideally, administrative work should be done on a voluntary basis because this helps a grassroots organization retain its character and integrity. However, when donors require detailed narrative and financial reports every six months as well as audited financial reports, they are in fact pushing recipient organizations toward bureaucratization and forcing an expansion in the administrative structure in order to meet their own demands. In the Occupied Territory, numerous organizations have been forced in the direction of institutionalization and, having arrived at that point, many of them lose their grassroots character.

Monitoring and evaluation

Evaluations pose yet another challenge to an open and fair relationship between funding and recipient organizations. Evaluations are always required by the funder - those providing the money. Furthermore, some organizations choose to send an evaluation mission of two or three people from the funding country to evaluate and critique a program and try and find solutions to problems that recipient countries or organizations have sometimes spent years working out. Never has the evaluation process been reversed, with a southern organization travelling north to critique the work of a funder. The organizations in the South are the primary beneficiaries of the funding process as well as the ones doing the bulk of the work on the ground. Should not these organizations, therefore, be the partner that should evaluate the program and determine its success or failure?

Apolitical advocacy

Finally, there is the widely held view that development aid must be apolitical and, usually, based on the concept of charity. When it comes to advocacy on difficult questions such as the Palestinian-Israeli issue, most organizations claim to be 'apolitical'. When the Soviet Union collapsed, however, most funding went to eastern Europe. This was a political decision. In development, clearly, any move is, in reality, a political move. This is especially clear when one remembers that true development can hardly be achieved in the absence of democracy.

Prospects for the future of the relationship

The first step on the road to changing some aspects of the development/funding process is for southern organizations to be united in their stand, and to engage in dialogue with northern organizations. This should, ideally, have an influence on policy decisions, which would allow changes to occur. However, the objective is not to form an alliance of southern organizations opposing those in the North, but instead to aim for the establishment of a trans-geographical coalition of people who believe in social justice, equity, and democracy, in order to truly influence the development process.

Secondly, southern organizations should determine priorities, rather than people and organizations from outside, and funders should be required to provide long-term commitments. Thirdly, development should always be a democratic process, and it should be true, sustainable development, rather than mere cosmetic changes.

Significant steps must be taken to close the huge economic gap between North and South, since real change cannot be achieved unless this happens. Debts should be cancelled, for unless Third World debt is cancelled, imbalances in the global economy cannot be corrected. Major emphasis should be placed on human resources, specifically on skills.

If the northern countries diverted fifty percent of what they spend on arms alone, to the South, development programs in southern countries could be implemented that could start the process of closing the economic gap between the South and the North.

At a practical level this should be possible, even in the current international situation, primarily because of the interdependence factor and the globalization of the issues discussed earlier. Any environmental problems in the South will effect the North and there will be a growing number of interested groups in the North that will fight for change. What will be needed in the future is a clear vision, a clear strategy, clear policies, and a great amount of creativity. In this regard, the organizations functioning in developing countries must be self-critical, open-minded, and flexible.

Finally, one of the biggest challenges facing grassroots movements and developing organizations in the South is to be able to understand the huge changes that have occurred in the world. Whether they seem desirable or not, they must be fully understood before changes can be made and before the slogan 'Health for All' can be translated from a mere slogan into a real instrument of change in a world that has never been so powerful, and yet has never been so confused in its attempts to find the right path toward the future.

DAVID WERNER

THE POLITICS OF CHILD SURVIVAL

David Werner, a biologist by training and schoolteacher, over two decades ago visited western Mexico taking groups of students to study biology in remote rural areas. He became involved in helping villages in an isolated mountain area to deal with some of their pressing health problems, which were not - and are still not - being addressed by the authorities. Out of the villager-run health care network that developed over the years, grew David's first book, Where There is no Doctor, now translated into more than 50 languages. Other books written by David include Helping Health Workers Learn and Disabled Village Children. His most recent book, Questioning the Solution: Oral Rehydration Therapy, Child Survival and Primary Health Care, will be published this year.

Today as we convene, 60,000 children will die unnecessarily from easily preventable and treatable diseases. Every year, in what UNICEF calls a 'silent catastrophe', 14 million young lives are lost due to undernutrition and the diseases of poverty. Collectively we have the knowledge, scientific resources, food, and potentially the manpower - and womanpower - to meet these children's needs, but with our present social order, we are failing to do so.

As we all know, many of the economic and structural development policies imposed on poor countries place the interests of northern banks and multinational industries before the basic needs of billions of people living in the so-called Third World. More than at the height of the colonial period, the rich are living off the backs of the poor. Through a combination of unfair trade policies and mounting interest on foreign debt,

\$60 billion net now flow annually from poor countries to rich. Most punishing of all have been the heavy-handed structural adjustment policies imposed on poor debtor countries by the World Bank and International Monetary Fund (IMF). To make sure the poor countries keep servicing their giant debts, despite global recession, the World Bank and IMF have compelled the governments of poor countries to adjust their economies in ways that favor the rich - both in the North and the South - at the expense of the poor.

When we talk about the disadvantaged, we must remember that in many poor countries at least 50% of the population is below the age of 15 - so we are talking primarily about the needs of children. UNICEF - the United Nations Children's Fund- has referred to the last 10 years or so as 'the decade of despair'. Responding to the steadily worsening situation of so many children, it launched a strategy called the Child Survival Revolution. USAID and the World Bank quickly jumped on the Child Survival bandwagon. This alone should warn us that the Child Survival initiative is far more conservative than revolutionary. Indeed, some critics have called it "the revolution that isn't", claiming that, rather than promoting the social changes that are needed to achieve 'Health for All', it does more to enrich the unfair and unhealthy status quo.

There is some truth in this. UNICEF has carried out a good analysis - as far as it goes - of the global crisis as it affects children. It has rightly placed much of the blame on the crushing debt burden of poor countries and on the cruel inequities of structural adjustment. But rather than demanding the termination of these colossal abuses, it has reconciled them as inevitable, and has called for reforms that it calls 'Adjustment with a Human Face'. This tries to provide a safety net for millions of children whom our present economic world order increasingly deprives.

The child survival interventions have doubtlessly saved some children's lives, at least temporarily, but in terms of combating the underlying socio-political and economic causes of high mortality and reduced quality of life, many progressive health workers and activists consider this intervention campaign for child survival a great step backwards.

DAVID WERNER

To understand this assertion, we must look at events from a historical perspective. Recall that at the Alma Ata declaration of 1978 the world's governments pledged themselves to Health for All by the Year 2000, and endorsed primary health care as the driving force to work toward that goal. As defined at Alma Ata, primary health care indeed had a revolutionary, even liberating, potential. It not only called for universal basic health services, but for strong community participation in planning and delivery. It revived the WHO definition of health as 'complete physical, mental, and social well-being' and recognized that issues such as fair wages, effective land reform, full employment, and basic human rights, are as essential to health as are curative and preventive medicine.

This very broad, socially progressive strategy of Alma Ata became known as comprehensive primary health care, to distinguish it from the far more narrow and conservative alternative called selective primary health care, which was soon promoted to replace it. Understandably, comprehensive primary health care, which aimed to give people more control over the decisions that determine their health, got less than enthusiastic support from most of the ruling elite both in the North and the South. Within a few months of the Alma Ata conference, international health experts in the US published a paper arguing that comprehensive PHC was unrealistic and not cost-effective. They proposed an alternative that would target just a few high priority health problems that could be attacked through low-cost interventions, mostly aimed at changing the behavior of underprivileged people, especially mothers. This new, selective, approach strips primary health care of its progressive components. By providing a narrow selection of palliative 'stop-gap' measures, it avoids confronting the underlying socio-political causes of poor health. Thus it lets repressive governments off the hook.

Needless to say, all governments that favor the strong at the expense of the weak, jumped at selective primary health care as 'a more practical solution'. The Child Survival Revolution - which targeted children as the highest risk group and promoted a few politically static interventions to lower mortality rates - quickly became its moving force. The results of

this high-powered child survival campaign have been far less than hoped for. Some children's lives have been saved, at least temporarily, but worldwide, after 10 years and many millions of dollars, as many children still die each year.

Why has this massive child survival effort had such limited success? In brief, I would say the two main reasons are:

1. Planning and implementation have been too top down and vertical. Most decision-making has been done in Geneva and New York, without listening enough to the real experts on child survival, namely disadvantaged mothers and families.
2. The child survival strategy takes a very narrow, selective approach to primary health care. It focuses on just a few high priority health problems which can be countered through 'low-cost, low resistance' interventions. In short, it seeks purely medical and technological solutions for problems whose root causes are largely social and political.

The two so-called twin engines of the child survival campaign are immunization and oral rehydration therapy. Both are extremely important health measures. The question is could they save more lives if introduced differently or integrated into a more comprehensive and empowering approach? In a world where one in five children lives in absolute poverty, is helping a few more children to survive enough? Must we not also worry about their quality of life?

Questioning the solution: oral rehydration solution

To gain greater insight into how top-down health measures can in some ways become counterproductive, let us look for a moment at the politics of oral rehydration therapy (ORT). UNICEF and WHO rightly give high

priority to diarrhoeal disease. As the world's biggest killer of children, it claims 5 million young lives a year. Because dehydration is often the terminal cause, promotion of oral rehydration has become a cornerstone of Child Survival.

There are two main approaches to ORT: manufactured products and home mix. The main product in poor countries is the packet - or sachet - of oral rehydration salts, containing glucose, sodium chloride, potassium chloride, and trisodium citrate. Home-mix rehydration drinks, on the other hand, can be prepared by the family using a locally available cereal or sugar and a little salt. They can be adapted around traditional foods or drinks such as porridge, rice water, soups, or gruels.

The relative advantages of packets versus home-mix have been much debated. High-level experts insist packets are safer because the formula is precisely controlled. Community health workers argue that home-mix is safer because it is more quickly and consistently available. A mother can make and give it right away, without having to carry her dehydrating baby for hours in the hot sun, or to wait in line at the health post only to find that the supply of oral rehydration solution (ORS) has run out.

Studies show that the physiological effectiveness of each method is much the same. However, a cereal-based home-mix is often better accepted by mothers than glucose-based ORS, because cereal drinks actually slow down the diarrhoea while sugar-based drinks - due to their adverse osmotic pull - do not.

Politically however, the two methods are diametrically opposed. The use of packets keeps the control of diarrhoea medicalized, mystified, and dependency-creating. Home-mix, on the contrary, gives the family independent control over the management of a killer disease. It helps people to realize that, with a little knowledge and no magic medicine, they can save their children from a powerful enemy. Thus home-mix helps to liberate people from unnecessary dependency and to build self-confidence in their own ability to confront problems that limit their well-being. It is no surprise, therefore, that small community-directed programs

committed to basic rights consistently choose home-mix. Nor is it surprising that many health ministries and large national and international agencies are 'packeteers'.

Commercialization of ORS is a growing problem. When the UNICEF campaign began, packets were distributed free in health centers. But structural adjustment policies imposed by the World Bank and IMF have forced debt-burdened countries to drastically cut their health budgets. As a result, production and distribution of ORS packets have been privatized and sales are promoted through 'social marketing'. So poor families now spend their hard earned food money for the latest ORS 'wonder drug', rather than preparing a cheaper, safer, quicker, more effective, rehydration drink from local resources.

Fifteen cents for a packet of ORS may seem little to many of us. But to a peasant who earns 50 cents a day, it is a lot. Buying ORS means less food for his, or her, children. Since the biggest predisposing cause of death from diarrhoea is malnutrition, user-financing of ORS can make oral rehydration a contributing cause of child mortality. Thus through structural adjustment and commercialization, a potentially life-saving intervention becomes just one more way of deceiving the poor.

Web of causes

The Child Survival campaign promotes oral rehydration as a 'simple-solution' to a major killer. But such a tunnel-visioned approach overlooks the more fundamental causes of death from diarrhoea. Indeed, a whole web of causes - physical, biological, cultural, economic, and political - lies behind each child's death. Central to this web is undernutrition, which in turn has a number of different causes at the local, national, and international level.

The director of Mexico's National Nutrition Institute puts it quite bluntly: "The child who dies of diarrhoea, dies from malnutrition". He asserts that the high malnutrition rate in young Mexican children - from 80% to 90% -

is linked to his country's staggering debt. He calculates that if interest payments on the foreign debt could be suspended for just one day, and the \$24 million saved could be redirected into food subsidies for underweight children, the calorific needs of all Mexico's hungry children could be met.

On top of malnutrition, other causes contributing to death from diarrhoea range from poor sanitation and a lack of clean water, to the unscrupulous exploits of various multinational industries, including the producers of infant milk formula, pharmaceuticals, and tobacco.

We all know about the deadly abuses of the baby milk and pharmaceutical industries. Studies in some countries show that child mortality from diarrhoeal disease is as much as 20 times higher in bottle-fed compared to breast-fed babies. Yet, despite the international baby milk code and the IBFAM boycott, unscrupulous promotion of infant formula in poor countries persists.

In turn, the pharmaceutical industry, according to WHO, sells \$50 million a year of irrational and often dangerous medication for diarrhoea. As you know, most acute diarrhoea in children requires no medicine, only oral rehydration and continued provision of breast milk and food. Yet multinational drug companies misleadingly promote in poor countries products that have been banned in their parent country.

As for tobacco, we know that smoking contributes to 1 of every 6 deaths in the United States. Joe Camel and the Marlboro Man have made it clear that children are a primary target. But with the decline of smokers in the North, tobacco companies are more aggressively targeting the Third World. A study in Bangladesh shows that child malnutrition and mortality are higher in families with fathers who smoke. As with commercial ORS packets, it is the expenditure by poor families on harmful or useless products like infant formula, irrational medicines, and cigarettes, that are the biggest contributors to the undernutrition and high death rates of children.

International trade policies have a lot to do with the continuing high death rate of children. As we have already noted, many northern governments - with the US government setting the trend - consistently put the profits of multinational industries before the needs of disadvantaged peoples. The United States was the only government that refused to endorse the International Baby Milk Code. It also threatened to cut off foreign aid to Bangladesh when that country dared prohibit imports of dangerous and irrational pharmaceuticals. The US government has also used the threat of trade sanctions to force Third World countries to revoke laws prohibiting the import of tobacco.

Time and again, the US government has threatened to cut off its donations to different United Nations agencies, such as UNICEF, WHO, and UNESCO, if they 'got too political' - in other words, if they put the needs and rights of the world's disadvantaged people before the interest of big businesses. So if UNICEF's Child Survival initiative is largely restricted to stop-gap technological interventions, you have an idea why.

The arms industry, militarization, and war

When we consider the high death rate and reduced quality of life of so many of the world's children, we must consider the impact of the arms industry, militarization and war. I think most of us would agree that the inter-connected crises in health, development, and environment, in the world today relate to excessive military spending. The Cold War had no winners. The Soviet Union went bankrupt and the United States is in decline. Today the US has the biggest national debt in the world. Poverty, homelessness, crime, violence, and attempted suicide - especially among teenagers - are on the rise. Public services are on the wane, 30 million North Americans go hungry daily, and 1 in 5 children live below the poverty line. Infant mortality in the inner cities of the United States is higher than in Jamaica or Cuba.

But the US alone has enough warheads to destroy all life on this planet at least 4 times. Its nuclear waste imposes a greater threat to the health and

safety of its children than the Soviets ever did. Yet inflated, irrational military spending continues, "so as not to put people out of work" says the White House. Yet, dollar for dollar, reallocating military expenditures for badly needed public services, child-care programs, and environmental cleanups, would create twice as many jobs. However, the lobby of the military and weapons industry is extremely powerful. The nation's leaders want to get re-elected, and so the insanity continues.

High military expenditures have been more devastating in the Third World. The sale of weapons, even to governments with the worst human rights record, has been irresponsibly promoted by northern governments and arms merchants alike. Military budgets in poor countries have skyrocketed. Many countries now spend more on the military than on education and health combined. Yet the structural adjustment policies of the World Bank and IMF, while requiring poor countries to slash budgets for health and education, have not called for reduced military spending - except in exceptional cases as with the Sandanista- controlled armed forces in Nicaragua. This shows us whose interests these so-called 'development banks' are serving.

Structural violence

When I speak as I am doing now, I am often asked: "Why do you attack the United States for the woes of poor countries? Are not the oppressive rulers and corrupt governments of these beleaguered southern countries themselves to blame?" I reply by asking: "But who put those oppressive rulers and corrupt governments into power? Who props them up in exchange for favors played to multinational interests? Who supplies arms and trains the security police of the Somozas, the Marcos, the Pinochets, the Papa Docs and the Sudhartos. Whose central intelligence agency put Manuel Noreiga into power and engaged him in covert arms for drugs deals to supply the Contras in Nicaragua? And following the US invasion of Panama to remove Noreiga from power, what northern power replaced him with yet another puppet president with an equally dark history of ties with the Columbian narcotics cartels?"

For that matter, who propped up Saddam Hussain for so many years, and continued supplying him with weapons - and illegal, multibillion dollar, loans - despite his monumental violations of human rights and the use of chemical warfare against his own people? In terms of child survival and quality of life, the war and embargo in Iraq have taken a tremendous toll. The massive bombing reportedly reduced the country to a pre-industrial state. Water, electricity, and sewage systems, were systematically destroyed. With increased malnutrition and lack of sanitation, diarrhoeal disease - including cholera - has again become an unmerciful killer. Since the war, the infant mortality rate has tripled, from 41 to 120 per thousand live births.

The recent war in the Middle East, and the events that have followed it, are especially tragic because they could so readily have been avoided. They were a consequence of power games spear-headed by self-seeking leaders on various points of the globe. But the leaders were following the rules of the game. Obviously, the leaders on all sides of such human sacrifice needed to be changed. But that will not be enough. We need to work toward changing the rules of the game, toward transforming the unfair structures of society.

Conclusion

We have explored some of the reasons why international child survival efforts based on a few technological interventions have had limited success. But what can be done to effectively further children's survival and quality of life?

A study sponsored by the Rockefeller Foundation, called Good Health at Low Cost explored why a few countries - China, Costa Rica, Sri Lanka, and Kerala State in India - have achieved relatively high levels of health and child survival despite low economic status. They found that each of these societies demonstrated a strong social and political commitment to equity. This included basic, but comprehensive, health services for all,

MILTON TERRIS

GLOBAL SOLIDARITY

Milton Terris, editor of the Journal of Public Health Policy, is co-chair of the World Health Workers Organization for Social Well-being Health and Peace. He is a visiting professor at the Universities of Montreal and of Toronto and a past president of the American Public Health Association, the Society for Epidemiological Research and the Association of Preventive Medicine.

In 1987, 121 representatives of 94 health workers' organizations met in Moscow to discuss, and take action, on the grave threat to human survival resulting from the arms race and the danger of nuclear war. The 121 participants represented 53 health workers' trade unions, 12 public health associations, 13 professional organizations, 4 other national health organizations, and 12 international and regional organizations. There were 50 countries, 13 industrial-capitalist, 8 socialist and 29 developing. Of the 50 countries, 13 are in Africa, 9 are in Asia and the near East, 16 in Europe, 10 in Central and South America, and 2 in North America.

The participants unanimously adopted both a declaration and an action program. The declaration stated in part that "the arms race is the great enemy of humankind rather than our competing economic and social systems, our differing political views, our varied religious creeds". We went on to note that the arms race has resulted in severe cutbacks in health services, education, nutrition, indeed in every aspect of human services. Deadly diseases continue to destroy and maim our children, men and women, because safe water supplies and basic sanitation facilities are not available, because people have no access to medical services, because

they are hungry and undernourished, because they are poor and illiterate and know little of personal hygiene. Furthermore, we adopted positions on nuclear testing, reduction and elimination of nuclear weapons, and a total ban on chemical and bacteriological weapons. We then discussed disarmament and development, and we fully endorsed the UN General Assembly recommendation for a 10% reduction in the military budgets of the permanent members of the Security Council, and allotment of the 10% of the funds so released for assistance to the developing countries. We ended our declaration with the statement that dialogue and negotiation, not war, aggression, and destruction, is the human norm for conflict resolution among the nations of our single, indivisible, world community.

We then went on to develop, on the basis of this conference, a World Council of Health Worker Organizations for Social Well-being, Health and Peace, but we ran into two kinds of trouble. Some of the health-worker trade unions felt that perhaps we were trying to start another international trade union federation in competition with the two existing ones. We also encountered the objection that we ought not to be concerned with any issue other than nuclear war, that instead we health workers should continue to play a very small part of the original group through which we first met, the International Physicians for the Prevention of Nuclear War. Both of these, trade unionists and the physicians, objected strenuously to the formation of an independent organization of health workers. It took four years before we were able to become an independent organization concerned with social well-being and health as well as peace. In 1991, we adopted finally a constitution, and the current active members of our coordinating committee include: the American and the Canadian Public Health Associations; the Polish Society of Hygiene; national trade unions in Finland (Union of Health Professionals), France (Federation of Health and Social Action, CGT), Japan (Federation of Medical Workers Unions, IROREN), Nigeria (Medical and Health Workers Union), Spain (Public Service Federation, UGT, Health Workers Federation, CCOO), and the United Kingdom (Medical Practitioners Union, Health Visitors Association, and Community Psychiatric Workers Association); MSF; the former USSR (International Confederation of Health Workers Unions); and professional

organizations such as the Polish Nurses Organization, the Sudan Doctors Union, and the Federation of Associations for the Defence of Public Health in Spain.

What brought us together in 1987 was the threat of nuclear war. As we said in our declaration: "The arms race threatens all life on our planet; it must be stopped for the sake of human survival". What brings us together now, when the threat of nuclear war is not as urgent? Let me read the preamble to our constitution: "Health workers of all countries dedicate their lives to promoting health and well-being, preventing disease and injury, treating illness, preventing disability, and restoring individuals to maximum social function. They are profoundly aware of the environmental and social threats to health, not only bacteria and viruses, but hunger, unemployment, poor working and living conditions, toxic chemicals, accidents and violence, and above all, the threat of war and the nuclear annihilation of all human life. Health worker organizations, their trade unions, public health associations, and professional associations, represent millions of health workers and their families. They constitute a powerful force, working together - regardless of their varying social, political, philosophical and religious views - for social well-being, health and peace. It is the objective of the World Council to help promote such collaborative activity through communication, education, and advocacy among all the nations of our world."

What brings us together now is the current era of budget-cutting and privatization that began at the end of the 1970's, with the elections of Margaret Thatcher as prime minister of the United Kingdom in 1979, and Ronald Reagan as president of the United States in 1980. Both were pledged to the reduction of expenditures on public services, increasing privatization, and the shifting of the tax burden from the very rich to the working and middle classes of the population. Both carried out these policies with ruthless determination and considerable success, and their policies continue to be implemented by the Conservative government in the UK and the Republican administration and Democratic congress in the

US². In the United States, budgets for public health and medical care programs have been slashed unmercifully in the Reagan-Bush administrations, and user-charges have been raised sharply. The situation grows worse every day. In the UK, for example, the Conservative government has deliberately starved the National Health Service of cash and encouraged the shift to private hospitals. It now proposes to create a market within the NHS and make its services available to the private sector. These policies have been exported to the rest of the world through the work of the International Monetary Fund and the World Bank, which have followed a consistent policy of demanding adherence to so-called austerity measures - austerity for the working and middle classes and prosperity for the rich and powerful - as an essential condition for receiving loans for their hard-pressed economies.

In the health sector, the World Bank published, in 1987, a book called 'Financing Health Services in Development Countries: an Agenda for Reform', which proposed "an agenda for reform that in virtually all countries ought to be carefully considered". This included four policies: charging users of government health facilities; providing insurance or other risk coverage; using non-governmental resources effectively; and decentralizing government health services. In other words, cut public budgets and privatize services. This is the Reagan-Thatcher strategy which is being applied worldwide, in the industrialized as well as the developing countries. This massive threat to the health of the people of the world, affecting not only health services, but education, housing, nutrition, and other social services which have such an important role in promoting health, was highlighted by the World Council of Health Worker Organization for Social Well-Being, Health and Peace in a resolution adopted at its meeting in England, in February 1989, entitled 'Government Reductions in Health Services and the Drive for Privatization'. The resolution stated that the Organization is deeply concerned by the worldwide trend toward reductions in government budgets for health services, and the drive towards privatization of the

² In 1992, following presidential elections, the present Democratic administration under President Clinton was elected. In 1994, a Republican congress was elected.

costs and ownership of these services. These regressive policies are being vigorously promoted by the International Monetary Fund as the means of reducing deficits and as a condition for receiving new loans. UNICEF's director, the late James P. Grant, stated to the New York Times on December 20, 1988 that: "Most societies, under the pressure of economic adversity, have cut back disproportionately on services in health, education, and social welfare programs."

What brings us together now is not only budget-cutting and privatization. These are simply part of the New World Order, which came into being with the Gulf War, and which represents the interests of a handful of superpowers - the Group of Seven - and a multiplicity of multinational corporations, and is diametrically opposed to the interests of the majority of people in all countries of the world. On January 30 and 31, 1991, our Coordinating Committee called for an immediate cease fire in the Gulf war, stating that "as health workers our goal is to devote our lives to the struggle against disease, misery and death. We have worked for years to reverse the priorities and policies of our governments so that they will provide the resources necessary for health and social well-being". And again in April 1991, our Coordinating Committee, in a resolution entitled "From the Gulf War to Peace Disarmament", stated, among other things, that "the invasion of the sovereignty of any nation by other nations, or by international forces, must be stopped. All existing regional military alliances, such as SEATO and NATO must, like the Warsaw Pact, be dissolved. There must be effective disarmament, and the shift of resources which are now wasted in arms production, to programs for social well-being, health and development, must become the first priority of humanity. The United Nations must never again be used to wage wars; this perversion of the purpose of the United Nations is totally indefensible. The UN must wage peace, not war. The governance of the UN must be democratized. The Security Council, dominated by the big powers with their veto rights and economic pressure, cannot be relied upon to protect the many small countries of the world. It is the General Assembly that represents all countries, and to exclude the Assembly from the crucial deliberations and decisions of the United Nations violates all principles of democracy."

The Concept of Health Under National Democratic Struggle

I have reported these actions by the World Council not to provide any illusion of strength, but to tell you where we stand. We welcome wholeheartedly the emergence of the International People's Health Council. We are proud and honored to participate in this most important conference. We stand with you in a common struggle for a better future for all humanity. We look forward to working closely with you to bring that future closer.

DAVID SANDERS

THE IMPACT OF STRUCTURAL ADJUSTMENT ON HEALTH DEVELOPMENT

David Sanders did his medical training in Zimbabwe, and later qualified in pediatrics and tropical community health in England. In 1980 he returned to Zimbabwe as coordinator of a rural health program and was national coordinator of a children's feeding program. He joined the University of Zimbabwe Medical School and later the Department of Community Medicine. Dr. Sanders is professor of medical education at the University of Natal in South Africa. He is a member of the ANC's Health Department, a policy committee member of the South African Health and Social Services Organization, and a founding member of the International People's Health Council. His publications include The Struggle for Health and articles on the political economy of health and structural adjustment.

I am going to look at the situation in Sub-Saharan Africa, particularly in Zimbabwe where I am most experienced, to reflect on what is, or should be, common public health thinking, and on the history of improvements in public health. If you examine the most common causes of death in infants and children under five in various continents, it is clear that death rates under the age of five are extremely high and that the spectrum of illness causing death is extremely narrow, meaning that a few similar conditions cause most death and illness in different countries across the globe.

The disease pattern and experience in Britain, now an industrialized country, at the turn of the century, was similar to that in the underdeveloped world today, indicating that these diseases are not diseases of the tropics, but diseases of poverty and underdevelopment. Infant mortality in Britain decreased, and by the 1970s had fallen to quite low levels, with sharp sustained falls occurring over much of this century. Accompanying that fall in mortality was reduced morbidity, that is disease experience, and improvements in nutrition as evidenced by improved growth in children and increased stature. The decline in death and disease rates from nearly all of the infectious diseases occurred before any effective medical measures were available. There was a large decline in tuberculosis, for example, before any useful medical intervention was available. The same applies to the common respiratory infectious diseases. Thus, the disease pattern in England and Wales changed from one that was predominantly infectious, to a disease pattern where non-infectious causes were, and are, responsible for most deaths. People have referred to, and I shall talk a little bit about, the dual disease pattern which exists in underdeveloped countries today. The so-called epidemiological transition is really a misnomer; we should be talking about an epidemiological polarization where the poorest will die of infectious diseases and the middle and working class will live longer and experience a greater burden of non-communicable diseases than the upper classes and the elites in their society.

Without discussing the industrialized countries any further, it suffices to say that disparities in health experience still persist. These demonstrate the different experiences of social classes in Britain, ranging from professional to unskilled laborers. Unskilled laborers suffer the greater burden of disease from the four most common causes of death in that country: coronary heart disease, motor accidents, bronchitis and lung cancer. So class disparities still exist and, indeed, are increasing under the present economic crisis not only in the industrialized world but in the underdeveloped countries as well, and between the industrialized world and the underdeveloped world.

In Africa, the experience of the 1980s has been quite negative. It has been a decade of economic crisis. Let me distinguish between three periods here: 1965-1973; 1973-1980; and 1980-1987. Taking gross national product (GNP) as an indicator, a crude measure of aggregate wealth, there was positive growth in most sub-Saharan African countries in the first and in the second period in many countries. But it was almost at zero and shifted into negative in the 1980s. If we consider external public debt as a percentage of GNP, this has increased dramatically during the 1980s so that, on average, the external public debt now constitutes at least 70% of the GNP. Debt service repayments as a percentage of exports was, by 1987, 16.5% and is now undoubtedly higher. Examining some of the social indicators, the crude death rate has fallen as has the infant mortality rate, but the rate of decline has slowed considerably and in some countries the rate of infant mortality has started to rise again. The daily calorie supply per capita increased slightly from the first to the second period, but by the third period the daily calorie supply per capita had dropped and, as I'll show later, this is showing itself in increased undernutrition.

Now I want to look at Zimbabwe as a case study of the relative effects of economic deterioration, health service change, and structural adjustment. In order to improve health, there has to be improved access to those factors which determine health. These factors are really in two broad groups, those originating outside and those originating inside the health sector. Those factors outside the health sector are clear probably to most of us; the most important is probably income. Other factors outside include such social inputs as education, improvements in the environment, access to clean water, housing, sanitation etc., and general economic measures such as food rationing and subsidies. Inside the health sector, there is the usual range of health care provision including curative and preventive services. History suggests that although health sector inputs may be the most obvious determinants of health, the effects of non-sector health determinants are probably much more important. It is difficult, however, to quantify the relative impact of both of these because there are often long lags between cause and effect, with intervening changes which are impossible to isolate, so it's difficult to attribute changes, except with

very particular diseases, to changes in either health sector or non-health sector inputs.

I want to look first at changes in the macro-economy in Zimbabwe and how these might have impacted on health, and then look at changes in the health sector, and try and analyze the relative impact of these. Zimbabwe, which became independent in 1980, inherited a highly unequal society which was reflected in the different disease experiences of the white minority and the black majority. For example, infant mortality for the black population as a whole was somewhere between 100 and 120 per thousand live births, whereas for the white population it was 14 per thousand. This reflected gross disparities in income and other social benefits. Since independence, there have been changes in the economy. In the immediate post-independence period in the early 1980s, growth of the economy became positive and there was a short lived economic boom accompanied by much social sector spending, particularly in health and education. However, the impact of the international economic crisis started to show in Zimbabwe in about 1982, and Zimbabwe adopted an economic stabilization program. This included many of the elements of the later structural adjustment program such as: the freezing of wages; the reduction of social sector spending; the removal of subsidies on basic foodstuffs; and a devaluation of the local currency, resulting in more expensive imports and greater attention to exports in the economy.

One of the first post-independence moves of the government was to legislate for minimum wages. For all categories of workers, domestic, agricultural, industrial and mining, the government legislated minimum wages within six months of independence, thus increasing incomes. This happened successively over the years right up until the late 1980's. However, because of the decline in value of the local currency and other factors, the real value of those wages increased for a couple of years, but by 1983 the real value of the minimum wage was less than that immediately after independence. The government, although it increased wages in nominal terms, actually managed to freeze wages because the real value of those wages stayed the same and, in fact, started to drop gradually as the decade progressed. The current minimum wage for

industrial workers is Z\$245³, but it now only worth Z\$65 in 1980 terms, some Z\$5 less than the original minimum wage.

Now what impact is this likely to have had on health? Well, clearly, minimum wages and the removal of food subsidies, which led to substantial increases in basic food prices, have had an impact on people's diet. There is a lot of evidence that people's diet has deteriorated. Also, a greater proportion of people's income is now spent purchasing their food, so that poor people are spending more than 50% of their income purchasing a basic, yet deteriorating, diet.

Other influential factors outside the health sector include a resettlement program, which has been minimal. The government has been unable and unwilling to move on this, receiving a lot of opposition from the commercial farming sector, which is predominantly white, but increasingly black.

Education has been a big post-independence success, with massive expansion in education, and a three-fold increase in the numbers of children in primary school between 1979 and 1985. Clearly this will have already had a positive impact on health and will continue to have a positive impact, particularly with respect to child health and possibly also maternal health - there is international evidence to suggest that the education of women does, by itself, have a positive impact on health. There have also been improvements in water supply, sanitation, and a large drought relief program which has been activated recently in response to the major drought in that country.

Now what about the health sector itself? There have been a number of changes in the health sector since independence. I've just mentioned the most important ones. Zimbabwe is held up by WHO as the pearl of Africa and WHO launched its whole district health system approach in Zimbabwe in 1987 because it felt that Zimbabwe had the most classically,

³ At the time of publication US\$ = Z\$12.

the most enthusiastically, and the most adequately prosecuted primary health care approach.

Firstly, free health services have been provided to every one earning less than Z\$150 per month in 1980. However, minimum wages in nominal terms exceeded Z\$150 per month by about 1984 even though the real value of those wages had not increased, yet people now have to pay for health care. So, whereas in 1980 46% of the formal sector working class were able to get free health care, by 1989 only 4.6% were able to get free health care because the ceiling had remained the same, while the nominal, but not the real, value of the wages had increased.

Secondly, vigorous hospital and rural health center building programs were established, with nearly 300 rural health centers constructed since independence. The EPI program has been a big success, with immunization rates increasing from 25% in 1982 to about 65% in 1986. The usual classical programs of diarrhoeal disease control have been implemented, but using a home-based solution despite resistance from WHO which wanted us to use packets. Most women in the country now can prepare a safe sugar-salt solution. There have been other programs such as: the national nutrition program; expansion of the child spacing program; an innovative rehabilitation program; village health worker training; and skills upgrading of large numbers of traditional midwives.

Finally, there has been an increase in the allocation of resources to the preventive health sector, increasing from about 7% in the post-independence period to about 14% in the mid- 1980s. However, immunization rates, which successfully climbed from 25% to 65% in a five-year period have stagnated because the money available to sustain the program and reach those at-risk children in the most remote areas, is no longer available.

What then have been the changes in health status which have resulted from these reforms? Like most underdeveloped countries, there are big gaps in the data. We are not exactly sure what our mortality rates are; however, as I said earlier, at independence infant mortality was

somewhere between 100 and 120 per thousand live births. By 1982, infant mortality, by a calculation from the census, appeared to be about 83 per thousand. A demographic and health survey performed in 1988 showed that infant mortality had dropped to about 60 per thousand so there has undoubtedly been a sharp fall in infant mortality and in under-five mortality over a ten year period. What are the causes of this? One can only speculate but, from reports and a number of small studies, it appears that deaths from diarrhoeal disease have declined, and are no longer the commonest cause of death. We rarely see severely dehydrated children presenting at health facilities any more. However, while the incidence of respiratory tract infection has increased it seems that the number of deaths, or at least the percentage of deaths, has declined overall because of improved access to health care through the improved spread of health services to the periphery. The immunization program has reduced measles and tetanus deaths, and whooping cough although that was a much smaller cause of infant mortality. However, over the recent period HIV/AIDS-related deaths have increased quite dramatically and AIDS is now the commonest cause of young child mortality in hospitals, in the whole of eastern and southern Africa.

However, when we look at the nutritional situation, we see that there has been much less change since independence. Different surveys have been done that are difficult to compare, but in the early 1980s about 20% of rural children were underweight, in 1984 there seemed to have been some improvement in that about 16% of children were underweight. We believe that this reflects the short-lived improvement in the economy which occurred over that period. However in 1986-88 when we did studies, we found that the percentage of children below the third percentile was very high, averaging over 20% in many provinces of the country. So there appears to have been a divergence between mortality on the one hand, which has declined for the reasons I suggest, and nutritional status which appears to have stagnated and is poor given the mortality rates in Zimbabwe. I, and the people I work with, believe that this is due to the deteriorating economic situation.

Now is the Zimbabwe situation atypical? I believe not. In Brazil, in Sao Paulo state, the biggest and most populous state, over the period 1973 to 1983 there was a halving in the infant mortality rate and a 71% reduction in the under-five mortality rate. Yet at the same time, there was an increase in stunting and chronic undernutrition, as well as wasting and acute undernutrition. Writers suggest that this was a reflection of the deteriorating economic situation; since during this period, the early 1980s, structural adjustment was being experienced in many countries in Latin America, including Brazil.

When we look at Sri Lanka as one of the examples of success in low-income countries which features in the Rockefeller publication *Good Health at Low Cost*, we find that between 1945 and 1980 there was a substantial decline in infant mortality from 140 to 34 per thousand by 1980, with a corresponding, and significant, increase in life expectancy for both males and females. Yet while infant mortality has continued to decline under economic crisis and recession, nutrition has worsened, with nutritional wasting increasing in Sri Lanka from 6% to 9.4% of all children. This reflects a massive decrease in spending in the social sectors including the food stamps program.

And finally, at the extreme end of the spectrum, Ghana during its adjustment program not only experienced a big increase in child malnutrition rates from 36% of children to 50-55% of children, but also experienced a reversal in the infant mortality rate. Infant mortality levels came down in the period 1960 to late 1970s, but in the 1980s infant mortality has risen to levels which were present several decades ago.

I think that we are seeing something new and very disturbing in public health. Something which we haven't witnessed before, at least I don't think we've witnessed it before. Classically, improvements in health in the West occurred because of social improvements resulting from economic improvements which, in turn, resulted in the exploitation and underdevelopment of the Third World. These improvements in health were later accelerated by health care, by the provision of both preventive and curative services. In the Third World, we were told, we don't have to

wait so long for development to occur. We can see improvements coming more rapidly through the much more robust and widespread technologies which we have developed and which have been popularized particularly by UNICEF in its Child Survival and Development Revolution. I think they now leave 'and development' out of the phrase, I think it's now just a child survival revolution. I suspect it's not just for brevity. We have seen some sharp reductions, even under adverse economic circumstances, of infant mortality but I believe that infant mortality no longer tells us what it used to tell us, because a classic health transition is not taking place in developing countries. We are now seeing a divergence between mortality and morbidity, an 'increasing frailty index' in the community. People are prevented from dying but have a higher prevalence of undernutrition, a higher prevalence of illness, and are living longer to become sicker adults developing non-communicable diseases earlier than the upper and middle classes of their societies. So we have, in a way, the worst of both worlds, and I think what is most disturbing about this is that the progress we have made with health sector interventions appears to be very fragile indeed and easily reversed under the impact of macroeconomic deterioration. For this in turn affects not only peoples's living conditions but also the health infrastructure which delivers those selected health interventions.

So what do we do? There are no prescriptions for any particular country. I think what this does tell us is that we have to return to the brave definition of comprehensive primary health care which affords us the possibility of working together with communities - with the popular classes - who are at the receiving end of international economic and health policies that are failing to benefit them. I think we have to work together with these people through community participation, through health education, enabling them to become equipped with some of the technologies which can help them to protect their own health and, more importantly, to gather their strength to fight against the overwhelming economic and political oppression that they are increasingly suffering. I believe it is not only something which we need to talk about, but I believe that the IPHC through experience is committed to, and I hope that we can bring others along with us in this fight and struggle for health.

N.H. ANTIA

ALTERNATIVE POLICY FOR HEALTH FOR ALL

N.H. Antia is a renowned plastic surgeon in India. He is the director of the Foundation for Research in Community Health. He is also the author of the book People's Health in People's Hands and is a recipient of the Padamshri award for his work in community health and leprosy.

The major problem with India's health care system is that it is a top-down techno-managerial exercise for the 'delivery' of services. It has been designed by the medical profession and the health bureaucracy according to their own perceptions rather than evolving on the basis of the actual problems that affect the health of the vast majority of our people who live in rural India and its urban slums. This relates to the disease pattern which shows wide regional variations and also to the social, economic and cultural factors which are the root cause of these diseases. These socio-economic factors also affect the operation of health services because of the wide cultural and social distance between those who design and operate the services and the people who they serve.

In the case of the private sector, which is responsible for about 70% of manpower and health expenditure, the interest in monetary gain generally takes precedence over other considerations. This sector, with its economic and political influence, has distorted not only manpower production and training in the publicly funded government medical colleges and nursing schools for their own advantage, but also the entire concept of health. Trained at public expense, the majority of doctors and nurses serve in the private sector or emigrate. The rest are technically, as well as culturally, ill-suited to serve the entirely different requirements of

the public sector. The medical profession, despite its vast proliferation, has failed to provide the necessary leadership and support to the large team of community and paramedical workers in the public health system in rural areas. It has also converted urban health into an unnecessarily expensive exercise in specialized curative medicine which chiefly serves the urban rich and influential, regardless of the entirely different needs of, and consequences for, the majority who live in the slums. The gross overproduction of doctors, now increasingly in private medical colleges, of drugs and of equipment has only compounded the problem and resulted in extensive malpractice and corruption at all levels which cannot be adequately condemned.

The health problems of the majority of our people are the result of poverty. Malnutrition, unsafe water supply, lack of sanitation, and the poor environment could be improved by the hands of people themselves through their own effort and political action. Attempts to medicalize these problems have generally failed and have simply become another futile and expensive techno-managerial exercise.

Even for the diseases of poverty which are chiefly of a communicable nature like gastroenteritis, acute respiratory infections, tuberculosis, leprosy and poliomyelitis, medical science has provided us adequate knowledge as well as simple, safe and cheap technology which can be utilized effectively by the people themselves. If diseases were classified according to the facilities and skills required for their prevention, treatment and control, rather than by medical pathology, the vast majority while requiring a low level of technical skills and facilities would need a high level of cultural affinity. This is why village based health and paramedical workers have proved far more effective at dealing with such problems leaving only a few problems that require the greater skills and facilities of doctors and hospitals. In trying to appropriate what is essentially peoples' own functions, the public health system has not only failed to control these diseases but, in the process, has mystified health, created dependency, and lacked accountability to the people whom they are paid to serve.

Four decades of such futile exercise, despite a large number of NGO experiences (as well as the experiences of Kerala and China) to the contrary should convince us that an alternative approach which is cheaper and far more effective is readily available. This can be implemented by the people themselves playing the dominant role with their own health workers. The role of the health services should be that of providing appropriate knowledge, technology, encouragement, as well as organizing the supportive services for the relatively few problems requiring their higher skills and facilities. It should not attempt to appropriate what are essentially people's functions which they cannot fulfil.

The ICSSR/ICMR report "Health For All: An Alternative Strategy" of 1981 based on the original Bhore Committee's⁴ model has clearly defined the role of the people and of the health services which must be under their control. About 80% of all preventive, promotive as well as curative functions can be best undertaken at the Gram Panchayat⁵ level. This would leave only a few problems for the primary health care centers and the community health centers which will also be accountable to the people as they will be under their administrative and financial control and not to an external hierarchical service. In such a decentralized people-based system it is estimated that about 98% of all health problems including preventive, promotive and curative can be catered for most effectively at the 100,000 population level. This would leave only a very few problems needing more expensive tertiary care at a distant urban center. Such a decentralized, bottom-up, people-based service would be technically, economically, and administratively superior to the existing top-down 'delivery' model and much more convenient and acceptable to the people who alone can ensure accountability.

⁴ The Bhore Committee wrote a pre-independence report analyzing the health sector in India and making a number of policy recommendations.

⁵ The Gram Panchayat level is the level of village self government.

JOANNA WHITE

This will however require a redefinition of the actual health problems of people, as well as their role in health. It will also require the training of a large number of female community paramedical and health workers in specific tasks for each level. There will be a refinement of the numbers, as well as the roles of the medical and nursing profession and hospitals, in such a system, providing them training and facilities for specific tasks at each level. This would also mean the abolition of targets such as those for family planning, which have not only failed to achieve their own goal but have also destroyed the health services which could have helped achieve the original targets. There should be only one unified health ministry and national health service.

Furthermore, the role of indigenous systems, which have been neglected in the single minded pursuit of western medicine, needs to be redefined, since they are a part of our culture and have more to offer in the many aspects of health and disease in which western science is deficient.

The forthcoming Panchayati Raj⁶ offers us the opportunity to adopt a rational system for the welfare of the majority of the people. No amount of tinkering with the present system can deliver the goods because the entire approach is faulty and more in keeping with the interest of those who design and operate the service rather than with the people for whom it is meant. It also requires a strong political will to oppose those who have vested interests in what has now become a major, self-perpetuating, health industry.

Such a decentralized health system would apply equally well to the urban situation where unmanageable mega-hospitals with expensive specialized services consume a disproportionately large amount of the country's health expenditure. They could be replaced by much smaller community health centers spread throughout cities and towns. They would not only be a better managed and cheaper system, but would also provide a far

⁶ A system of local government brought in by the 73rd constitutional amendment which also authorizes that 30% of seats be reserved for women.

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more accessible, personalized and humane service to the local population under their own supervision and control.

Such a system would entail a public expenditure of about Rs. 100⁷ per capita per annum or about Rs. 8,500 crores⁸. The country is already incurring an expenditure of Rs. 5,000 crores for health and family welfare on a service which has by and large failed to deliver the goods. This is apart from the Rs. 20,000 crores or more which is being expended by our people in the private medical sector.

⁷ At the time of publication US\$ = Rs. 30.

⁸ One crore is equivalent to 10 million rupees.

JOANNA WHITE

THE SUSTAINABILITY OF HEALTH CARE IN DEVELOPING COUNTRIES

Joanna White is working as a research assistant with SCF UK. Her background is in anthropology and she is currently examining the development of health services in five different countries over the past ten years.

The development of health systems within developing countries is affected, to varying degrees, by the wider international framework and the influences of external investment. Regardless of other contextual factors such as political instability and conflict, governments and local NGOs who choose to work with donors and international NGOs, share a certain commonality in their vulnerability to the influences which these relationships entail. A vulnerability which increases correspondingly with a growing dependence on external investment. The influence of the international aid industry on health system development can be seen as not always being conducive to the creation of a sustainable, self-reliant system. This paper will outline the implications of external influences, drawing from the results of two cases studies carried out by SCF UK in Uganda and Nepal.

SCF's sustainability research

SCF UK is currently running a research program to examine policy, decision-making, and planning strategies and the different interventions of governments, donors and NGOs in the health sector of five countries (Uganda, Ghana, Nepal, Pakistan and Vietnam) over the past ten years, and the relative influence these have had on the creation of sustainable

health systems. This research program has arisen from the current crisis now facing many governments and donors working in the health sector: although massive amounts of capital and technical assistance have been invested in health, still, in many countries, services are inadequate and national capacity has not been developed.

For the purpose of the research program, SCF defines sustainability as: the capacity of the health system to function effectively over time with a minimum of external input. By 'health system' we mean one in which governments play a pivotal role, at least in a coordinating capacity (a mixture of public and private services may be inevitable), in all components of sector development, and the overall system is one in which the health needs of the people, as defined by them, are met as far as possible. On referring to a sustainable health system, we are imagining an ideal to a certain extent, and recognize that there is no formula for an ideal system which is appropriate for every country. However, it is only by creating a sector which is self-reliant, and has the capacity to address the needs of communities over the long-term, that any form of overall sustainable system can be developed.

This research program aims to provide a critical analysis of past activities in the health sector in the case study countries, in order to heighten understanding of the comparative impact of different approaches, and to ensure that the future work and investment of both SCF and other actors in health sector development is appropriate for supporting the creation of sustainable systems.

SCF is not alone in exploring the issue of sustainability, the sustainability of activities is increasingly being referred to by some donors and governments as of fundamental importance when planning health interventions although it must be recognized that differing definitions of sustainability are in operation. Health sector reform and alternative approaches are now heading the agenda. So why this current interest in sustainability?

Economic context

Recession, debt, and in some cases, structural adjustment programs, have all taken their toll on government health expenditure. Health expenditure, as a proportion of public expenditure, has declined over time in both Uganda and Nepal. During this critical economic period a growing dependency on external aid to support their health sectors has developed. This has now generated into an even more worrying situation whereby governments depend on external input not only for sector development work, but even to cover recurrent costs. All this takes place in a climate where donor funding is decreasing in many countries: funds for health, nutrition and family planning declined as a component of total aid from 7.5% to 5% between 1979 and 1987.

Reduced financing capacity has brought the issue of sustainability to the fore: donor funds are being cut and agencies are no longer willing to pour funds into inefficient systems. The question arises: if the system would fall apart if donors pulled out, then what sort of self-reliant capacity has the massive amounts of external assistance over the past thirty or so years been building, and what implications does apparent failure have for future investment?

Beyond the economic context

The problem of sustainability can be seen to extend far beyond the reality of a shrinking resource base. Even if international donors conceded to funding recurrent costs for health sector activities indefinitely, it is debatable whether this fact alone would be enough to ensure that the most appropriate and effective long-term system would be established. The economic crisis has, to a certain extent, only served to reveal the significant influence of the process of investment in the sector. It is this process which SCF is examining.

Case studies : Uganda and Nepal

Data for SCF's research program is still being gathered, but the case studies of Uganda and Nepal are now near completion. While recognizing the danger of generalizing too widely from specifics (these case studies are obviously very specific to country political and economic situations), some clear patterns emerge which are of relevance to health sector work. Obviously, when data-gathering has been completed we will have a fuller idea of the comparative issues, but the two existing case studies raise some interesting questions.

Emergency approach/short-termism

When donors and international agencies first began work in both countries (this was during the 1950s in Nepal; in Uganda this took place in the early 1970s during the emergency period of civil war, and later intensified during the Karamoja famine between 1980 and 1982), their interventions were focused on the delivery of services. Intervention was primarily a method of filling-gaps - providing services when the government was not in a position to play national provider. Services need a solid support system: management, trained staff etc. Where governments could not provide this, then international agencies established their own. In addition to physical services such as health posts, clinics etc., in many cases 'vertical programs' were established, focussing on the delivery of one service/facility (such as immunization or family planning) through programs running parallel to government services. This can be identified as an emergency approach, with the aim of offering vital services quickly and effectively, with tangible results over the short-term.

Although this initial involvement was considered vital to compensate for and support poor infrastructures in-country, it can be seen to have set a precedent for external approaches to health sector work. Some vertical programs and service-delivery work are still in operation and, in terms of delivering services in the short-term, are considered more effective than

attempts at integration to date. But in both case study countries, the consensus by those interviewed was that this emergency focus, operating in parallel to the public system, detracted from the development of the capacity of the overall system. Key factors of this approach were identified. These reveal how the behavior of donors and international NGOs working with the governments in both countries may have impeded the development of health sector capacity and the creation of a sustainable health system. Although all of these factors can be seen to be inter-related, as a functioning system consists of various interactions and relationships, they can be described as follows:

- **Policy-making: priorities often defined through donor conditionality**

As governments have become more dependent on external aid, so donors have had an increasing role in policy-making. This can be seen particularly starkly through the development of structural adjustment programs in both countries, as a result of which the World Bank has played a more active role in policy-making and planning systems (for instance the three year plan drawn up in Uganda in 1991 was primarily written by a World Bank consultant and can be seen to follow World Bank priorities concerning the future development of the health sector). Donors are selective in the activities in which they invest, leading to the development of a range of (often parallel) activities and a sector focus which may not necessarily follow country priorities, but instead follow the latest donor trend.

- **Forced pace of sector expansion**

Donors and many international agencies have operated in parallel to government activities according to the assumption that, ultimately, governments will take over financial and managerial responsibility for these activities. The health sectors in Uganda and Nepal can be seen to have expanded beyond existing capacity through external investment, with activities collapsing or running inefficiently on government take-over. PHC offers a good example of an area of work supported by both

governments and donors as a priority, then pushed into prominence by donors through donor funding. Although it is evident that some countries were not ready for the immediate pace of expansion of the sector which PHC plans brought with them, PHC received the lion's share of donor funding (currently in Uganda, donors are funding about 80% of PHC activities, with government funding about 80% of curative/hospital services). Sectoral development is most effective if run at a pace a country, and its communities, can afford. Donor work to date has been seen to force the health sector to expand government capacity to absorb, and ultimately take over, recurrent costs, activities, personnel etc., and, hence, has created a growing dependence on further donor support.

- **Fragmentation and duplication**

With a focus on particular projects and programs, the development of the sector as an entirety is not taken into account. Programs are often run in isolation with their own self-fulfilling aims and targets. Although this may serve some purpose in offering a measurable impact over the short-term, it ultimately results in fragmentation and problems of final integration.

With many donor-initiated vertical programs operating in both countries, many activities are duplicated, running in parallel to each other, with very little coordination. Numerous examples were elicited of the duplication of training courses, health education activities, budgeting system etc., a strikingly inefficient use of scarce resources. Even in Nepal, where some attempts have been made to integrate some vertical programs, integration only took place at service-delivery points; other activities continued in tandem.

Often donor and NGO health services rival government services to the extent that, in both countries, government services are under-utilized. Although obviously this may be related to levels of quality (or perceived quality), under-utilization impedes the local support necessary for the development of public services to full capacity. The operation of alternative structures can be seen as expression of democracy, in some

cases providing valuable alternative approaches, but effective coordination needs to be developed to avoid the undermining or unnecessary duplication of public health services.

- **Personnel issues**

Although it is generally recognized that civil service salaries are insufficient and staff are forced to take on at least one other form of work to survive, the incentives offered by donors (salary top-ups for attending workshops, meetings etc.; vehicles; travel expenses) ensure that staff (whose initial training is often financed and run by the public sector) will be drawn to work for these agencies. This pull to work for international agencies depletes the capacity of the public sector and, together with under-utilization of public services and lack of a living wage, only serves to demoralize government staff.

As donor parallel activities require high levels of staff, this lead to a corresponding increase in the number of staff requiring payment when the government is required to take over the running of these services. With economies under strain, the recurrent cost implications of this approach can be impossible for the governments to address.

- **Ownership**

The high-profile of donor involvement in selected areas of work can create a confusion as to the ownership of work, and lead to associated assumptions as to the nature of activities and responsibilities. This has implications both for hand-over to government and the grass roots involvement of communities to health sector activities.

This sense of ownership also impacts upon staff perceptions of responsibility, with staff allegiances often aligned to the donor/employer. In Uganda this was cited as an impediment to effective planning as staff operate within particular donor health information systems with their perceived priority being to report back to their employers with valuable information, rather than feeding it back into the sector as a whole.

- **Planning and coordination**

All of the above factors relate to the planning and coordination of activities in the sector. The unwieldy physical expansion caused by separate vertical and service-delivery programs is exacerbated by the lack of coordinated planning and budgeting systems. Although in many cases the Uganda and Nepal governments are expected to take over the running of services originally funded and initiated externally, coordination of planning and running of activities is minimal and the sector develops beyond the control and capacity of the governments. The economic dilemma now confronting this approach may find its roots in the assumptions and economic models upon which donor activity has been predicated. The assumption that economic growth is both desirable and inevitable underlies much development work, based on the assumption that activities can be handed over to be run by governments when economies are sufficiently 'developed'. However, we are facing a foreseeable future for many developing countries, not least Uganda and Nepal, when resources will be constricted over the long-term. It appears that the issue of how to plan and instigate policies for a resource-scarce future (beyond external aid) has not yet been adequately tackled, and as one donor official in Uganda put it "you don't plan in a resource-poor environment".

But even recognizing that, at least in some countries, donor support may be necessary over the long-term, donor behavior, as observed in our two case studies, can be seen to work against effective planning. Beyond issues of financing, relationships between actors in the health sector and overall coordination between government and donors (described in Nepal as a 'token gesture') are seriously lacking as follows:

- ♦ **Lack of continuity**

With a few exceptions, most donors are loathe to commit themselves over the long-term, obliging the governments to plan within donors' various short-term investment cycles. As one MOH official in Uganda described, when there is little knowledge of future funding it's a case of "planning in a never-never land". Also, donor and government planning and budgeting

cycles are often incompatible (eg. in Nepal, UNICEF and UNFPA plan according to 5 year cycles, while WHO plans to 2 year cycles).

♦ **Centralization**

Centralized planning is still strong in both countries, and has been identified as hindering effective resource-allocation. Centralization has been a strategy for many donors to date, they choose only to deal with countries at a central level. This can undermine morale and sense of ownership at district-level, and prevent the district-level from being effectively responsible for the health needs of local communities.

♦ **Multiplicity of activities**

The proliferation of donor and NGO inputs strains coordination and brings with it a wide range of demands. Increasing time and resource demands are placed on governments who must work according to donor and international NGO guidelines, be accountable to various funding sources, and respond to different budgeting systems etc.

♦ **Health information systems**

The lack of effective health information systems across the sector was identified by many respondents as hindering the effective monitoring and coordination of activities. The cited multiplicity of activities may be inevitable in an overall system, but information is vital for the coordination of an efficient, integrated system. This problem becomes increasingly apparent with the current trend of a growing private sector and donors contracting to NGOs and agencies outside public sector.

Relationships with donors: partners or recipients?

Health sector development is an issue of historical relationships and processes, and underlying conflicts of interest can be identified. Governments have a responsibility to meet the health needs of their people in an affordable, appropriate way over the long-term, while also accommodating the demands placed on them by their politicians and external agencies. Donors, and other international agencies, are likely to have different priorities: they need to demonstrate the effectiveness of their investments to their constituencies; they may need to create a high visibility or attain certain targets to reveal the impact of their work; and they may, in the case of bilateral donors, also be motivated to indirectly return their funding to their own country in the form of contracts etc. These conflicting priorities provide the background to health sector work, and have contributed to the current situation.

As has been revealed, the increasing dependence on external aid has led to donors playing an ever more active role in policy formulation and overall sectoral development. When examining relationships with donors we are dealing with power relationships: conflicting agendas and priorities interact. Economic power lies heavily on the side of donor agencies as governments and NGOs compete for an ever-shrinking resource base.

New approaches

The financing crisis is a key factor which has led to increasing recognition of the need for behavior to be modified; attention is now centered on the need for the development of systems which involve more cost-effective investment by donors. Sustainability has arisen as a factor to be considered when planning the most cost-effective investment for the long-term.

- **Capacity-building**

This has more recently been identified by donors as a new method of working towards effective sectoral development. It is another all-encompassing development term, with a distinct lack of clarity as to its meaning. Capacity for what? and defined by whom? At the most cynical level, it could be seen as an acceptable term to be used by donors as a justification for cheaper, more cost-effective forms of investment, while also implying an interest in issues of sustainability.

- **Technical input**

This has been a much-supported form of capacity-building. An estimated 75,000 - 100,000 foreign experts are supported by donors in developing countries each year. In the case study countries, the significant levels of external technical input has led to a blurring between donor support and take-over. Technical advisors were observed playing the role of executive agents, often with inappropriate expertise (to cite an extreme example: at one observed meeting a donor technical assistant, when discussing the development of PHC training networks at district level, commented "give them a few WHO brochures to tell them what PHC is about, that should be enough").

- **Working with existing problems**

From research observations, attempts to build the capacity of a broken infrastructure may serve only to exacerbate existing problems rather than address root causes (eg. attempts by some donors to initiate district-strengthening in Uganda, have only served to increase pre-existing tension between the Ministry of Health and Ministry of Local Government, and confusion as to their respective roles and responsibilities).

As the case studies demonstrate, in both countries systems have been established (partly through the nature of external influence) with very little coherent capacity, and donor attempts to improve this system have served

only to reveal similar problems demonstrated through the 'emergency' approach: duplication; problems in ownership; overall lack of coordination. Problems still remain with relationships operating in the health system, and the process of intervention. In neither case study has a coherent system of mutual consultation, planning, and coordination of activities for long-term capacity been established.

A sustainable future?

Although it may not always appear to be in the interest of governments and NGOs to ensure that real collaboration takes place when planning and implementing health sector activities (some short-term economic gains may be made in playing donors off against each other to ensure funding), it appears that if significant improvements are not made in this area then hopes for the development of a system appropriate and effective over the long-term will remain unrealized.

Governments, donors, and international agencies may share a common constraint because they are bureaucracies; their historical structure and modes of operation, namely the legacy of centralized power and decision-making, are by their very nature resistant to change. However, periods of international political and economic change have proven fertile for employing new strategies. The need for reform of behavior in the health sector, and consideration as to the form this reform should take, are vital if the concept of sustainable health systems, built from working in partnership, is to become a reality.

DIRK VAN DUPPEN

THE CHANGING NATURE OF AID, PARTICULARLY HEALTH AID, FROM EUROPEAN NGOS

Dirk Van Duppen is a representative of the Belgian NGO Medical Aid for the Third World. He is currently working as a general practitioner in a working class and immigrant neighborhood in Antwerp. During the Amal siege of 1985 - 86, he was worked in Shatilla and Burj al-Bureijna Camp in the Beirut area. He is currently carrying out research into North-South contradictions and the role of European NGOs.

As is well-known, the gap between the North and the South is becoming wider every day. The system that backs this conflict has a name: Imperialism. According to the latest UNDP report, the South loses some US\$ 500 billion each year to the North due to its unfavorable position on the World market, whereas the entire amount of aid from the North to the South is only one-tenth of this loss. But the most striking feature of today's imperialism is its ability to mask this reality by using the media and the 'communications revolution'. While the gap has become 30% wider over the last ten years, the concept of the contradiction between North and South is disappearing in image-building about Third World problems in northern countries. While northern transnationals and banks have expanded their control of the world economy by 50% over this same ten years, the words 'multinational' or 'transnational' have been disappearing in reports concerning the causes of the problems of the Third World. Even the famous United Nations Study Center on Transnational Corporations has been liquidated. Yet while the American CIA quadrupled its annual turnover during the Reagan years, the concept of the CIA has hardly been

mentioned in publications concerning war, health, or even military conflict in developing countries.

There is a gap developing between reality on the one hand, and the image-building about the Third World in our northern countries on the other. Only a few people in Europe realize that NGOs bear some responsibility for this phenomenon. In Europe there is a revival of a comprehensive ideology whose aim is to keep the North-South contradiction out of the picture. This ideology has a name: anti-tiersmondisme or anti-Third World solidarity. Anti-tiersmondisme has been developed by the French ultra-right think tank Liberte Sans Frontieres (Freedom Without Borders). LSF was founded by Medecin Sans Frontieres (Doctors without Borders) in 1985. Anti-tiersmondisme seeks to cover up North-South antagonism using two methods. Firstly, in relation to the problems of the Third World, they blame the victims, the Third World people themselves, by focusing on their behavior, on debt management, on ethnic wars (people killing themselves), and on corruption from oppressive rulers without making the link between the corruption, these dictators, and northern countries. Structural violence is neglected, while violence amongst people, which at first glance contains no structural relation to imperialism, will be dramatized. There is an emphasis on a hard-luck analysis, focusing on factors such as drought, climate, natural catastrophe, and helpless victims. Secondly, in relation to the solutions to Third World problems, they depend on a Eurocentric approach. The white doctor has to fly in a C-130 army airplane to the Third World catastrophe to save the black children who are the innocent helpless victims of the violence of their own people or leaders. That is the picture the public in Europe receives from this type of action.

This Eurocentric approach is evident in an important debate taking place in the European NGO world and in the United Nations Security Council. This debate centers around the so-called humanitarian right and duty to intervene. Intervention is envisaged from the northern side only, because of course they would not allow a country like Cuba to intervene in New York to establish medical services for the minorities who are in desperate need for health care, yet Cuba has proved able to develop health care

services for Third World situations such as that in which these American minorities are living. What is kept out of the picture of anti-tiersmondisme is the reason for Third World problems and the responsibility of northern imperialism, and the creativity, strength and capacity of Third World people to help themselves, and liberate themselves in a struggle for national democratic liberation.

The debate about the humanitarian duty to intervene is an important debate that is currently pushing certain European NGOs to act, in effect, as government organizations - organizations which tend to serve the geostrategic interests of their governments. The humanitarian duty to intervene arose during the events in Rumania at the end of 1989. Xavier Emmanuelli, a leader of Medecin Sans Frontieres in France, expressed in *Le Monde* on 4 April 1990 his indignation that Gorbachev did not intervene in Rumania to eliminate Ceaucescu, while the Americans had the courage to recognize their duty to intervene in Panama. The comparison between events in Rumania and Panama, both occurring at the end of 1989, shows how humanitarian organizations can be manipulated by the Western media.

For example, MSF Belgium had 550 special articles in the Belgian press about their activities in Rumania at that time, whereas the testimony of MSF doctors working in Palestine during the first two years of the Intifada received five lines in just one Belgian newspaper. While MSF was concentrating nearly all its efforts in Rumania, no interest whatsoever appeared to exist for humanitarian intervention in Panama. However, in terms of humanitarian need, the number of fatal casualties during the events in Rumania is estimated at a thousand, while the number of deaths caused by the American invasion of Panama has been estimated by Panamanian bishops and human rights organizations at between 4,000 and 7,000. The orchestrated mass graves of Timisoara were shown for hours on television in Europe, while real mass graves in Panama, only gradually revealed, were presented marginally in the news. US troops developed an ingenious strategy for covering up the human tragic aspects of the invasion in front of the entire world. Aid and human rights organizations in Panama were not allowed to get in touch with thousands of refugees.

Hardly any news of the events which occurred in Panama made its way into the European press. General Schwarzkopf, who later led the Gulf War, exercised this media manipulation during the greater part of the Panama invasion. The logic of the duty to intervene everywhere that so-called democracy, human rights, or international law are violated was further developed by Bush in his New World Order and applied on a larger scale during the Gulf War. The same logic was then used during the tragic situation of the Kurds in northern Iraq to create a pretext for American and European intervention. Attempts were made to legitimize the duty of intervention by the United Nations in order that this, and following interventions, could take place under the UN flag.

Using this recent idea of intervention on humanitarian grounds, is easier for imperialist powers to intervene when the policy of a Third World country does not serve their interests. The Americans, and also the Europeans, specialize in orchestrating civil wars, crises, and catastrophes in the Third World, in order to officially appropriate the right to intervene directly in a civil war, the foundation for which they have themselves created.

There are four mechanisms by which pressure is put on some European NGOs to become government organizations in the North: the question of neutrality; the role of the western media; money; and the question of the useful and useless, dangerous victims.

Firstly, the one who seeks to be apolitical turns to the right. There is a logical progression from so-called political neutrality to the ideology which dominates our society. This is proved by the history of MSF France, the organization which lies at the base of anti-tiersmondisme. Secondly, the western media are now functioning as the mouthpiece of the rich. Organizations such as MSF gain a great deal of media attention in a world where the media is falling more and more into the hands of imperialist pressure groups. Media-oriented organizations run the risk of letting themselves float on the wave of politics of those pressure groups. There is an old proverb which says that one goes where his bread is buttered.

MSF Belgium has become the largest NGO in Belgium. The majority of the money they receive comes from the EC's emergency assistance fund. This is a dangerous material basis which can turn an organization like MSF into the medical shock troops of the EC countries. Emergency aid is rarely ever disinterested, but rather serves directly the economic or strategic aims of the West. For example, in late 1990 the EC took an unprecedented decision to provide 40 billion Belgian Francs in aid to the Soviet Union to help during what was called the 'winter of hunger'. However, when Gorbachev's policy no longer coincided with EC directives, the winter of hunger apparently ceased to exist. All help was blocked, with the exception of some funds to Armenia and the Baltic States, which at that time opposed Gorbachev. MSF was instructed to send its humanitarian aid immediately to the opposing states so that everyone could see that the EC was organizing a purely humanitarian action.

The final point is that of useful and useless, dangerous victims. MSF concentrates its help on victims of war and disasters. MSF states that the international community should concentrate on intervening in these insane civil wars. We have just concluded the bloodiest and most violent of wars in terms of intensity of violence - the Gulf war - orchestrated and carried out under the flag of the international community. In addition, lying behind the vast majority of conflict in the Third World is the low-intensity conflict strategy. This is a coercive imperialist strategy based on the United States' humiliating lessons from Vietnam. It is not insignificant that this strategy is called the permanent World War III. As aid organizations are confronted with the direct misery of this conflict, we must be aware of the fact that, from the perspective of the imperialist, there are useful victims - presented by the media in great numbers to reinforce psychological warfare - and there are useless victims. Hundreds of thousands were killed by death squads in numerous Third World countries. Hundreds of thousands were direct or indirect victims of the bombardment on Iraq. Hundreds of thousand die due to IMF policy. UNICEF estimates that, on a yearly basis, five hundred thousand children die from the effects of the debt burden. But who is still talking about the 12 million street children in Brazil, where thousands of children die due to

privation? Or the genocide of the Indians of the Amazon forests caused by the multinationals who plunder these forests and their mineral resources? These victims are harmful to imperialism and are kept quiet and far from the media.

I would conclude with a plea for a conscious, anti-imperialist humanism, because those who are guided only by the dreadful feelings aroused by witnessing misery can serve as unintentional, useful tools for imperialist psychological warfare against the South. When one does not reveal the underlying mechanisms, the underlying opposition of interests, or inequalities and unjust practices, then one is helping to legitimize those responsible for the disasters and wars to which the people will be subjected in the New World Order. A consequent humanism requires an anti-imperialist stand, a political orientation on the side of the South, even if this stand goes against the worker who has to choose between working as a lackey or a liberator; northern NGOs cannot avoid having to take sides.

INDIA

MIRA SHIVA

Mira Shiva is a doctor who has been working in community health for many years. She is coordinator of the India Drug Action Network and the leader of the public policy department of the Voluntary Health Association of India.

The levels of poverty and destitution which currently exist in South Asia were unimaginable five to ten years ago when self-reliance was felt to be a real possibility. But now different forms of impoverishment are being imposed upon us. In India, for example, the General Agreement on Tariffs and Trade (GATT) is creating further problems for us.

SECTION TWO

COUNTRY ANALYSES

In our health sector, the import of western medical approaches to health, with their emphasis on high technology curative care, undermines traditional approaches to health care. We must address our problems. In Asia we know the way to address our health problems. Minimum wages, female literacy, a decent communication and transport system, access to primary health care, access to primary education and land reform will secure good health for our people. Increasing expenditure on family planning does not of itself reduce poverty.

A major problem in Asia is non-preference and bias against women. The degree to which this is a serious problem is reflected in the adverse sex ratio. In a stable population women should outnumber men, as women have longer life expectancy, yet in India there are only 883 women per 1000 men. However, in the state of Kerala, where women have greater status and where the government has a clear commitment to gender equality, there are 1040 women for every 1000 men. In India, medical technology has assisted the systematic discrimination against women.

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In our health sector, the import of western medical approaches to health, with their emphasis on high technology curative care, undermines traditional approaches to health care and is unable to solve our problems. In Asia we know the way to address our health problems: Minimum wages, female literacy, a decent communication and transport system, access to primary health care, access to primary education, and land reform will secure good health for our people. Increasing expenditure on family planning does not of itself reduce poverty.

A major problem in Asia is son-preference and bias against women. The degree to which this is a serious problem is reflected in the adverse sex ratio. In a stable population women should outnumber men, as women have longer life expectancy, yet in India there are only 888 women per 1000 men. However, in the state of Kerala, where women have greater status and where the government has a clear commitment to gender equality, there are 1040 women for every 1000 men. In India, medical technology has assisted the systematic discrimination against women;

amniocentesis and ultrasound are being used to determine the sex of fetuses so that females can be aborted.

Priorities in health spending need to be reoriented. Budgets for primary health care and the treatment of our infectious diseases are being cut. Expenditure on research and development is largely diverted towards the diseases of the rich world, such as cancer, while only 1% of all research expenditure is allocated to the research of tropical diseases.

Environmental degradation is a major problem in Asia. In countries like Malaysia, Indonesia, and India, people have had, for centuries, a special relationship with the forests, but now they are having to witness large-scale deforestation which is taking place in order to produce goods for countries like Japan. Large numbers of indigenous people are also being displaced by big development projects such as the Narmada Dam in India. This is a further example of the Western development model that is imposed on our people without consultation.

The GATT is currently a major area of concern for developing countries and one that has an impact on health. The GATT deals with a country's right to patent its indigenous biodiversity, such as plants and herbs that have therapeutic properties. Multi-national companies want the right to exploit our biodiversity and register the patent in their northern countries which will prevent us from using or selling such plants in the country where they actually grow! GATT also has the effect of preventing us from storing seed to use for a second year. India has its own Patent Act of 1970 that offers protection to local people but we are now under pressure from the US to change this act. The GATT, whose rules are undemocratically determined and then imposed on sovereign countries, will have such an impact that, in the future, its rules will determine what people can eat, drink, wear and think.

Such processes are taking place in the name of development. Asia is not only in the midst of trade and economic wars but is also in the midst of an identity crisis. In the past there was a sense of leadership in self-reliance. Mahatma Ghandi led the civil disobedience movement in Bihar, India

when farmers were forced to grow Indigo. This movement proclaimed "we will grow food, not Indigo for Lancashire or Manchester". The whole of history is now repeating itself in the field of health.

NAMIBIA

MARIANA SHILONGA

Mariana Shilonga was actively involved in the liberation struggle in Namibia. She worked with SWAPO and currently works for the Namibian Development Trust.

Namibia is a vast country with a population of only 1.4 million. After years of colonial domination by Germany and South Africa, Namibia finally achieved independence in 1990.

Colonial occupation of Namibia has had a significant effect on the development of its health services. The colonial system was organized according to ethnic groups with the white minority being grossly favored in health provision. Services were dominated by curative care rather than primary health care and there was a marked urban bias. As a result, people living in rural areas had limited access to modern health care and relied heavily on traditional healing.

A disproportionately high percentage of the population of Namibia suffer health problems that are related to the conflict that has ravaged the country in its recent history. Physical disability, depression, alcoholism and suicides are commonplace yet facilities for treatment, rehabilitation, and counselling, are limited.

Since independence the new government had been trying to introduce primary health care/community-based health care. But the large-scale reorganization of health services is such a long process that few changes are yet evident. However, the government was quick to realize that NGOs had a significant role to play in developing the country's health system. The Namibia Development Trust (NDT) is an NGO aiming to promote the concept and use of primary health care. NDT has held workshops

bringing together a range of health and non-health workers to discuss the prospects for health services in Namibia and the need for intersectoral collaboration.

NDT primary health care programs include:

- Community based health care training for trainers
- Surveys of traditional methods of curing and food preparation in order to improve established methods of preparation whilst valuing community knowledge
- Nutrition and domestication of field food resources as part of programs to increase rural income
- Rural sanitation
- Translation of health information into local languages and its dissemination to marginal communities. This includes family planning and AIDS prevention
- Provision of technical assistance to those community groups willing to start community- based health care projects

NDT staff have already noticed that communities involved in community-based health care projects have started to change their attitude to health, seeing it far more as emanating from the home rather than from hospitals.

LATIN AMERICA

RICARDO LOEWE

Ricardo Loewe from Mexico is involved in a community clinic and health program in Tepoztlan near Mexico City. He is a member of Prodessep, an organization of community based health programs in Mexico, which is in turn a partner in the larger Regional Committee of Community Health Programs in Central American and Mexico.

I will try to present some of the key problems facing Latin America's 350 million people. Firstly, epidemiologists wishing to maintain the status quo invented the term 'epidemiological-transition' with the aim of showing that there has been an improvement in health, and that there has been a progressive substitution of the diseases of underdevelopment by those diseases that, usually, characterize developed countries. In this way, an increased incidence of cancer, diabetes, or cardiovascular disease is presented as good news. Now poor Latin American people have the privilege of getting ill, and dying, just like the rich people of Europe or the US.

However, the incidence of acute respiratory diseases, diarrhoea, malaria, measles, tuberculosis, amoebiasis, and cholera, have increased. This has happened because of the deterioration in the quality of life of people due to the impact of new liberal economic policies for the environment, nutrition, housing and public services. At the same time, the prevalence of heart disease and mental health problems etc. has also increased.

War has also had an impact on people's health in Guatemala, El-Salvador, Nicaragua and Panama. Civil populations are suffering due to increased aggression and stress, in addition to increased numbers of disabled people. War in these four countries is an everyday fact. From Mexico to

Argentina, and in the Caribbean, repression is a substantial part of the modernization imposed upon our countries. Until now, we have not been able to expose the system of torture used to uproot people from their land, and used against those demanding land, housing, justice, or democracy.

While several of our countries have seen a reduction in infant mortality rates, some 50-70% of the deaths in Latin America are avoidable. On the other hand, the increased frequency of diseases related to malnutrition, poor housing conditions, lack of clean drinking water, the exploitation of labor, and violence, means that, for the vast majority of Latin Americans, increased life expectancy means a prolongation of suffering. But there is one exception - Cuba. Cuba has experienced an epidemiological transition over the last thirty years resulting in a spectacular reduction of infectious diseases and a relatively low rate of noncommunicable disease and mental health problems.

Secondly, the official rhetoric of "Health for All by the year 2000" clashes with the drastic shortage of public health resources. It clashes with selective primary health care which prioritizes population control. Almost all vertical programs dealing with tuberculosis, poliomyelitis, vector born illnesses, and screening programs, have disappeared. The only vertical program remaining is the AIDS program, which is based on safe sex and not on solving the deep social causes of this epidemic. The so-called decentralization of health services has meant a withdrawal of national funding. In this context, the government's declaration that they encourage and support community participation in health simply means participation in a system lacking institutional resources. In this way health, which is a constitutional right in some countries, is being transformed into a commodity that can be bought by only 10% or less of the Latin American population. There is again one exception, Cuba. Cuba has universal, free, comprehensive health services despite the trade embargo imposed by the US.

Thirdly, the external debt is the key to Latin America's economic crisis. Every person owes an equivalent of two hundred days wages. Only about

LATIN AMERICA

30% of workers actually have access to a minimum wage, as unemployment is a massive problem. Thirty to fifty percent of the Latin American economy belongs to the informal sector. Latin American governments appear to react to absolute poverty with low levels of social spending whilst increasing national security expenditure.

These conditions have caused many people to struggle to survive. Multinational corporations are the source of many of these problems. Those in the US gain from social and economic inequality in Latin America. During the last decade, the US has subordinated Latin America completely to its own economy. But there is again one exception - Cuba.

Finally, there are reasons for being optimistic. Due to this hunger, injustice, and war, Latin American people have been forced to choose between life and death. The resurgence, development, and multiplication of grassroots organizations for popular assistance and for the defence of basic human rights, including the right to health, is a fact without precedence. The theology of liberation, the indigenous black and popular movements are all playing a central role in this blossoming of grassroots movements. The departure of Father Boff from the official Catholic church, and Rigoberta Menchu's winning of the Nobel Peace Prize, show the increasing strength of these two movements. National liberation movements have shown, both in the struggle and in the territories they control, their commitment to peace and their interest in people's health. This meeting also increases our optimism because it means that we are not alone in our struggle for health and liberation.

THE PHILIPPINES

EDELINA DE LA PAZ.

Edelina de la Paz is the executive director of BUKAS - the Coalition for People's Health - in the Philippines. She has worked in community health since her graduation from medical school in 1980. Recently she has focused her work on campaigning and advocacy.

The constitution of the Philippines explicitly states that health is a basic human right. Despite this, our country's situation has deteriorated from bad to worse. The health problems we face today constitute a deepening crisis of great proportions. It is ironic that the Philippines is now beset by severe poverty and underdevelopment despite having great natural and human resources. The imperialist domination of our economy, the feudal exploitation of the population, and the capitalist monopolization of political power, have bred the widespread suffering and poverty of our people. It is this deprivation that serves as the material basis for disease and ill-health in our society.

When President Aquino assumed the presidency in 1986, people expected her to address the immediate problems plaguing the country. However, her administration has made the lives of Filipinos even more desolate by constantly kowtowing to foreign powers. With the election of Ramos as president the future looks bleak in terms of solving the country's deep-seated problems. The government has chosen to prioritize the payment of the US \$28 bn debt. Thus 40% of our national budget goes to debt servicing, whilst only 22% is allocated to social services. A UNICEF study estimated that one Filipino child dies every hour because money for health and education is channeled into debt payments. Efforts to limit debt payments to 10% of export earnings have been an uphill struggle. In

1989, the government raised an additional US \$1 bn in taxes which fell on the shoulders of the poor, instead of on the multinational corporations.

Meanwhile the multinationals have never had it so good, with foreign investors being offered a wide array of incentives, tax concessions, and so on. The government has become dependent on foreign investments, services, and foreign corporations. Thus the multinational community has successfully pressed for low wages, suppression of trade union rights, and any other benefits which could enhance the standard of living of the Filipino worker. We have one of the world's lowest wages, which is being promoted as an incentive to companies.

As the Philippine economy plunges deeper into debt, women find themselves at a disadvantage. They perform 40-60% of all farm work and are concentrated in low paid, low status jobs. Sexual harassment and low regard for women are pernicious. With the continuing economic crisis, it is the women who augment family income. In 1988, the informal sector, which is made up mostly of women, contributed about 48% to GNP.

With the economy thrust into the exploitation of its natural resources, the country's fragile ecosystem has been severely affected. Logging has depleted our rainforests and if the present rate continues, the Philippines will have no forest cover by the year 2000. Deforestation has caused soil erosion and the loss of top soil, forcing farmers to turn to expensive and imported fertilizers to improve production, and again this is being promoted by the multinationals. Measures to reduce logging have been met with stiff opposition from legislators and businesspeople alike.

Despite the governments pronouncements on democracy, the exercise of political plurality leaves much to be desired. Those who espouse changes are labelled as communists and over the years many health workers have been killed. Peace initiatives are welcome, but the sincerity of the peace process is in doubt. Revolutionary groups have to guard against being co-opted and rendered ineffectual by being absorbed into the government. There are moves to turn the country into a national security state with a democratic facade. Policies suggested include the introduction of a

national identification system, the increase of the powers of the security forces in the community, and giving the auxiliary police the power to do community surveillance and crowd control.

So this is the context in which our health system operates. We can see that, despite the changes in government, the situation of health of the Filipino people has not really changed in the last twenty years. The prevailing diseases remain the communicable, yet preventable, ones. While statistics suggest the health situation has improved, the reality is different. Health was given the lowest priority by the past administration - 3.5% of the national budget 1990. Yet in 1993, debt service once again gets the lion's share of the budget - 38.9%. Meanwhile the cost of living and health service expenditure are continually on the rise and 70% of Filipino people still live below the poverty line. For 1993, the health budget has been slashed from 10 billion to 5 billion Pesos⁹.

Maternal mortality is still on the rise. Malnutrition is widespread, with more than half of the population's 11.5 million children being found, by the country's Nutrition Council, to be suffering from varying amounts of malnutrition. Chronic malnutrition has increased. Illnesses such as cancer, accidents, work-related injuries, mental illness, AIDS, war and conflict related injuries, and physical disabilities are as yet inadequately addressed. Hardest hit by such health conditions are the economically marginalized in our society. Even if the national infant mortality rate has decreased, in impoverished regions the rates are actually increasing. We have been asking the government to publish health statistics broken down by area and occupation so that we can address the health needs of the people more accurately. So far they have refused.

In terms of health resources, we can see that the majority of the health resources are concentrated in the urban areas, to the deprivation of the rural areas. Also, many of our professionals leave the country to work abroad, primarily because our education remains western oriented. In addition, there are few opportunities for health professionals in our

⁹ At the time of presentation US\$ 1 = 26 Pesos.

country and, in fact, the government has recommended that health professionals go abroad so that they can earn dollars for the country. Of the total national health expenditure, only about 26% is spent by government, while the remaining 74% is expended privately, thus the government is virtually abdicating its responsibilities to take care of the health of its people. In addition to government spending, the revolutionary organizations have also been working to improve the health of the Filipinos.

In the light of this dire situation we have strengthened intersectoral relations with our fellow Filipinos in the rural and urban areas, ie. with the peasants, workers, urban poor, students, and professionals. We believe that health is the concern, not just of health professionals, but of individuals and communities too. Our health NGOs have been active in establishing community-based health programs, training community health workers, providing health services to the community, speaking with them and analyzing their problems, organizing them and encouraging them to take action for themselves. Likewise the revolutionary movement, the national democratic front, has its own health group which is also working toward the improvement of the health of our people. To achieve substantive change, we must look at health in its broader socio- economic context, emphasizing the psycho-social, cultural, politico-economic aspects of health care, not just the biomedical factors affecting health.

With this, we envisage a genuinely democratic, nationalist, scientific, and service-oriented health system for the Filipino people. A system geared towards the protection and promotion of people's right to health and quality of life. We envisage health for all Filipinos, and to realize this we must be governed by people truly committed to justice, freedom, national sovereignty and peace.

We thus call on you, our international friends, to support us. We likewise call on our funding partners to understand our situation. We do not want to relate to you just for economic support, but we want to get your moral support and to forge stronger solidarity ties between our peoples.

PALESTINE

JIHAD MASH'AL

Jihad Mash'al trained as a doctor in Romania and has worked with the Union of Palestinian Medical Relief Committees for many years. He has managed the child and rehabilitation programs and is currently acting President of the UPMRC.

Five separate health sectors are active in the West Bank and Gaza Strip. These are: the government sector controlled by the Israeli military authorities; the United Nations Relief and Works Agency (UNRWA); the charitable sector; and the private sector. Finally, there is the popular sector which was formed in response to the existence of Israeli occupation in the West Bank and Gaza Strip, and to which the Union of Palestinian Medical Relief Committees, active since 1979, belongs.

In the Occupied Territory, there is no national health structure, which has led to poor planning and coordination. There has been a severe neglect of the developmental needs of the health sector. Israeli policy has, at best, preserved the status quo and, has at worst tried to destroy the whole structure of Palestinian health institutions. The resultant deterioration of health conditions and health services created a situation where the responsibility for caring for the health of Palestinians has shifted to the Palestinians themselves, through the creation of non-governmental, independent, Palestinian organizations.

The Israeli occupation has affected the lives of the Palestinians in many ways. For example, we are still fighting the collection of taxes by the Israelis¹⁰. Over the last five years, taxation has increased whilst

¹⁰ Taxation collection in the West Bank and Gaza Strip was handed over to the Palestinian National Authority in December 1994.

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expenditure for residents of the Territory has stagnated. In Israel, per capita expenditure on health is \$306, whereas in the West Bank (prior to the Intifada) expenditure was \$30 per capita, falling sharply in 1991 to \$20.

Between 1967 and 1977, most of the population was covered by the national health insurance system. After this increases in the premiums, and the low quality of services, undermined the system. Currently, in some areas of the West Bank, less than 15% of people are insured whilst in Gaza Strip, no more than 30% are insured.

In the rural areas of the north, around the towns of Ramallah, Tulkarem and Jenin, rural communities are very deprived. They often lack sanitation services, safe water supplies, electricity, and telephones. In certain areas, one can talk about these communities as if they were living in the middle ages.

Since 1967, the proportion of services provided by the government has fallen from 92% to 44%. This is not simply due to a decrease in the quantity of services provided, but is also due to the growth of service provision by the Palestinians themselves.

Hospital beds are one indicator of health service provision. There has been a significant fall in the number of hospital beds provided by the government sector in the West Bank and Gaza Strip. Hospitals have been transformed into jails, military centers, and police stations. One hospital in East Jerusalem was closed whilst the Israeli military evacuated Palestinians so that Israeli residents could move in to the area.

In Israel there are 33 doctors per ten thousand people whereas in the Occupied Territory there are only 9 doctors per ten thousand. Yet, at the same time, many unemployed doctors cannot work due to the lack of resources in the health sector.

The Territory's infant mortality rate (IMR) is debatable because of a lack of accurate information. According to some studies and surveys

conducted in different areas of the Occupied Territory, the IMR is between 50 and 70 per thousand live births. In Israel it is about 10.

We are suffering both from diseases of developing countries and diseases of the industrialized world. Studies indicate a high prevalence of malnutrition and anaemia among children. Parasite infestation, which contributes to malnutrition, is rife due to unsafe water supplies, the lack of adequate sewage systems and over-crowding. Parasite infestation is up to 60% in Gaza.

These are not simply statistics, but the harsh realities that professionals have to deal with. Members of the Medical Relief Committees were aware of such problems back in 1979. The first activity of the Medical Relief Committees was to organize mobile clinics to serve the population. These mobile clinics began in the Jordan Valley, a very deprived area with many problems. One major problem was land confiscation; the Israelis were trying to drive the people out of the area because of the land's fertility. People resisted Israeli policy, moving into barracks which had been previously used to keep animals. For those reasons mobile clinics were sent to these areas.

In another village called Al'ouja the water supply to the village runs in open canals. This water supply, which comes from a nearby spring, is now pumped to the Israeli settlements nearby. Just one meter below this pipe is the open channel that supplies the village. We campaigned for 9 years to get permission from the Israelis for the villagers to build a pipe to keep their water clean. Just recently, we won this battle.

Finally, I want to say that we look at development as a long term process. It's like an olive tree in Palestine, it is an olive tree that my father and grandfather planted and we are eating from it now. We are going to plant more trees so that our children in the future will be able eat from them.

NIGERIA

ABDULLAH SAMBO

Abdullah Sambo, a Nigerian medical practitioner, has worked in primary health care for many years. At present, he has been forced out of practice because of government interference.

Nigeria has a population of almost 100 million people, about 25% of the population of Africa. It is a very rich country, exporting 1.6 million barrels of oil per day. However, debt repayments absorb 45% of the government's budget. Since 1985 the situation has not been good. A structural adjustment program (SAP) is in operation, and has attracted a lot of protest from students and migrant workers, many of whom were killed or arrested while protesting.

It is in this context that our health service functions. The health care delivery system itself is organized in three levels, primary, secondary and tertiary. The primary health care level is controlled and financed by local councils, the secondary levels by the state governments, and the tertiary level by the federal government. We have 30 states in the country and 589 local councils.

There has been little development of primary health care in spite of the \$10 million invested in it since 1986. Of course this shows that health is not just about the provision of drugs and immunization, which is what the government has been doing. Despite an essential drug program and immunization campaigns, health indices show no improvement. In fact, they are getting worse. A study conducted recently shows that health status, especially of women and children, is deteriorating, the incidence of malnutrition is rising, the number of children with low birth weight is increasing as are the rates of parasitic infestation, anaemia, and other diseases.

The government refuses to accept this and issues other statistics. It states that attendance at hospitals has gone down over the past 5 years, showing that people are more healthy. However, only government and some private hospitals charge fees, and if you look at attendance at charitable hospitals, which are free, attendance and admissions have increased by almost 10 times in the last 5 years. People avoid using the government hospitals because they cannot afford to pay the charges. The people are becoming poorer because of the economic policies of the government and on top of that, the government is removing subsidies from all the social services and selling off its shares in many companies.

The Nigerian government has introduced a program which we call the 'First Lady Syndrome', but the government calls it the program for A Better Life for Rural Women. By establishing this program, all women's associated activities are contained within the state. No woman can now establish her own association, without having to go through this Better Life Program. All other organizations which existed before, were banned. A small number of conservative organizations survive, but the most progressive one was banned, and its members arrested.

By far the most severe problem is the initiation and promotion of physical violence by the state, all in an attempt to legitimize its own continued stay in power. The government banned the five political parties formed since 1990 and created its own two political parties, one a little to the left and one a little to the right. The government said that each person should read the manifestos and vote for the political party of their choice. Of course we knew that this was pure deception, but that was how it started in 1990 when the state and local government chairmen were elected.

The government saw that people were getting organized and that they would have to hand over power, but their plan was to continue in power. They started infiltrating groups and promoting violence - inter - and - intra-ethnic and religious violence. One outbreak of violence during 1992 was in my state of Karama, in the northern part of the country. Over 3000 civilians were killed and we saw the hand of the government in this

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because of the kind of guns that were used - machine guns - and because the people who were behind it were retired police and military officers. Even the present secretary to the government has been implicated.

Two weeks after this outbreak of violence, the government said that there was too much violence to hand over to civilian rule. So they extended the period of military rule until August 22nd 1993. We are all pessimistic; I don't think they will hand over power.

So the major problems in Nigeria, as you can see, are similar to many other developing countries. The problems are socio-economic and political. Under such conditions it makes no difference how much one does in primary health care, people cannot be healthy, it is impossible. So now we are working to let people know that their greatest enemy is really the government. Here in Palestine there is no government at all, in Nigeria we have too much of it! I think that the only way forward is to try to reduce the role of the government in our everyday lives. Let us do things our own way not the way the soldiers want it.

NICARAGUA

DORA MARÍ A TELLÉZ

*Ex. Minister of Health & Family Welfare, Frente Liberación Nacional
Nicaragua.*

I speak as an amateur in the health sector, because although for a few years I studied something related to health, I left to join the Frente Sandinista. I came back to the area for political reasons, and that is the perspective that I want to share.

I am speaking from the point of view of the Nicaraguan experience. These are my personal reflections, and those of a sector of the Sandinistas. I don't want to generalize the conclusions. When we were in the revolutionary struggle, I had the impression that the revolution could solve quickly the social problems of the country, and that because of the premise upon which our work was based solutions would not be hard to find. In a sense, I continued to have that same impression during the first years after the overthrow of the dictatorship. And it became even stronger because the emphasis of the revolution was on social policy. Underdevelopment in Nicaragua was so great that we felt the political urgency to respond to those problems.

We began the Literacy Campaign where - as a Nicaraguan poet once said - half the population taught the other half to read and write. Among other things, we created a National Health System. We followed the logic of providing universal coverage and free health services. In addition, the promotion of preventive measures, a focus on primary health care, prioritizing rural areas, and educating and mobilizing the population in health, were all part of the first stage.

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The aggression against our revolution started in 1982. By 1985, the health system and the country as a whole was beginning to experience the consequences. Severe war conditions and economic crisis led to changes in the epidemiological profile of our people and limited the capacity of the health system to address health problems.

I think of the health system as repair shops, shops that by themselves do not produce health. Health is produced by the transformation of the economic and social conditions of a country. Our hope had been to do just that, but we were frustrated in our attempts by the realities of war.

Between 1985 and 1990, we had to adjust the system. It was not sustainable under conditions of war and economic crisis. Problems like rehabilitation became uppermost. The lack of economic resources was a major problem, despite our political will.

Because of these problems we made some organizational adjustments, but the reality of the situation created very difficult times for us and eventually we lost the elections. We lost not only because we were developing an adjustment program, but because of its combination with the effects of a long and debilitating war of aggression. In those years, Nicaragua lost almost 17 million dollars and many human lives because of an overwhelming deterioration in the living conditions of the population.

When the government changed, and even before this, we were facing a economic crisis. By 1988, we concluded that we had to adjust the economy, in order to control inflation, to maintain a certain level of productivity, while trying not to sacrifice our social policy. The new government, is now implementing neoliberal economic policies. The effects of these policies are similar to the effects outlined in Zimbabwe and other countries.

We are forced to ask ourselves: what do we do now in the case of health? When we speak about planning for health from the political or the philosophical point of view, we have the answer. Probably, all of those who have been part of the health sector have the right answer: health

promotion, and the development of primary health care, the use of a combination of technologies, the prioritization of resources, and, finally, better economic and social conditions.

But when we, as political leaders, analyze the reality we have to be able to present clear goals to the people to demonstrate the direction that needs to be followed under the present circumstances. Nicaragua is a country in a post-war situation, that has 52% unemployment and growing levels of illiteracy. It is undergoing a drastic structural adjustment program which includes a severe monetary stabilization plan, with reductions in government social expenditure and a tendency to restrict the role of the state.

Due to special circumstances in the country, the present government adopted the policies and priorities of our former government and, in a sense, maintains the same organization of the previous health system. But, of course, the results are worse. In health there can be survivors, a child may not die, but survives. However, this is not a child that lived and grew well, it is one that merely survives.

Would it be enough to demand that the Nicaraguan state remains as it is, with the same conditions and the same budgets with which the health system existed previously? The health system has not been able to be maintained because it's not sustainable, it's entering a crisis. This is a crisis that is ripping parts of the system apart and affecting the weakest.

We have to make realistic proposals to address the present situation. The Left in Latin America does not have clear proposals. The crisis of socialism in Europe has left us without answers. The system fell when its economic basis failed, regardless of its political virtues and defects. The Left in general, including in Latin America, is left with lots of questions and few answers, and I fear that criticism of neoliberalism is so extensive that we should be using this time to prepare alternatives to address the present situation in our countries.

In Latin America, there are rooms full of papers written about neoliberalism and its effects. Great Latin American political intellectuals have written all that is possible about neoliberalism. And all of us are tired of this critique which fails to offer alternatives. We like the rhetoric of utopia, but we must look for ways to help people advance - even under the difficult circumstances that we face.

In many countries of the world, "Health for All by the Year 2000" is still a government slogan. We have to look for an alternative without prejudice, and even to change our perspective in relation to community participation.

There are several questions that go beyond what each one of us believes. Will it ever be possible that Latin American states, or at least the Nicaraguan state, can assume full responsibility for health services? This is no longer a possibility - not with the present government or even with the Sandinista one - we are facing the same problems. Both governments would probably follow the same adjustment program, but with other concerns, with other alternatives from the current government. But material realities are fixed, they cannot be stretched, and you cannot go beyond them.

From the perspective of public health, we have not considered in detail role of the private sector. We must consider their role and responsibilities since we have opened the door to the non-governmental sector. For example, health organizations that promote action in communities, or in particular social sectors, such as those of women, mothers, children or those with AIDS.

NGOs have an important role but we have overloaded them with social responsibility and we have to consider the responsibility of the State vis ... vis these different service providers.

I want to talk about community participation. When this became a fashion, there were two aspects to it: the economic aspect promoted by those with an economic interest; and the political aspect promoted by

those of us with a political interest in popular participation. Many papers about community participation were concerned with saving state resources. The others came from those of us interested - through popular participation - in searching for political leaders to create critical awareness in the communities.

But I think that if we continue to promote popular participation in health - and I'm talking about Nicaragua - based on the idea that the community can respond to, and contribute to, the solution of their health problems, without making health problems into political demands of the communities, we are not solving long term problems. We can limit diarrhoea, we can address some of women's health problems, or support the people with AIDS. We can sponsor campaigns of prevention. But if this is not oriented to raise consciousness, to mobilize political demands for the health sector, we will not be addressing neoliberalism as an economic and political way of thinking.

In Latin America, health demands are not incorporated into political demands which is why we cannot get commitments from governments or international funding agencies to promote better health conditions for the population. The people are not involved in creating political demand. And this happens even in Nicaragua, where people had a great awareness, a great level of organization, and a great ability to mobilize. Elimination of unemployment is a political demand, as is access to a free education. But the deterioration of the health system is not included in people's political awareness and is not incorporated into their list of priorities for mobilization.

We have the obligation to reinstate popular participation, but not just participation so that the community feels that it can solve its problems by using herbal medicines or the basic services it has. It is necessary for people to take care of themselves, to work for better conditions, potable water, and adequate waste disposal. They must make their health rights a part of the political demands of social movements and political parties, in the same way that there are attempts to include women's rights in political platforms. Women's rights would be left aside, and women would

continue to be subordinated if political demands were not made. The same is true of health.

For example, in the United States the Clinton administration has, as one of its priorities, a health plan that has been discussed extensively. This is a result of the demand for and need of the average US citizen for health services. This plan has a higher priority than the plan for unemployment.

The fact that a neoliberal government, like that of President Bush, wasn't concerned about such demands was also a cause of their electoral defeat. This is a message that Latin American governments should receive - that adequate access to health care is a political demand. Social peace without better life conditions, is unthinkable. There will be no political peace without social peace and adjustments in Latin American economies cannot be made without social and political peace.

SOUTH AFRICA

FRANK SIBEKO

Frank Sibeko is a qualified radiographer working with the South African Health and Social Services Organization.

Many problems face the black majority in South Africa. These include: extreme poverty, with 45% of people living below subsistence level; high unemployment accompanied by rising food prices; poor quality housing; low levels of education and literacy - only 45% of Africans over 15 years are able to read and write; and a generalized lack of access to basic utilities such as electricity. The impact of such problems on health status is indicated by the large numbers of deaths from preventable diseases. In addition, the infant mortality rate for Africans is 80 per thousand live births whilst the rate for the white minority is only 12, a figure that compares favorably with that of any major industrialized country.

South African health services have been unable to improve the health of local people. The services that exist are chronically overcrowded, understaffed, and biased towards the urban population. Further problems for the health sector have been created by the apartheid government's imposition of a restructuring of all sectors of local government and social services. This has led to the following changes:

- The introduction of US-style Health Maintenance Organizations. These emanate from Medical Aid schemes that contract their own doctors to work in the clinics, which leaves patients without choice of doctor.
- Increasing privatization including the selling-off of public hospitals to private sector operators. This has led to a deterioration of services in the remaining public sector, in part due to underpayment of staff

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creating instability, low levels of morale and, recently, strikes among staff.

- Universities have been granted the freedom and autonomy to manage teaching hospitals which consume over 60% of the total health budget.
- The responsibility for primary health care provision has been delegated to local authorities which are not only unpopular with the people, but which continue to organize provision along racial lines.
- The retrenchment of large numbers of health workers as part of the increasing rationalization of health services.

This latter problem has resulted in a large increase in mass action with more than 10 million people engaging in different forms of action and a two day mass strike. A positive result of this action has been greater coordination among different organizations which has undermined government attempts to broker deals with individual organizations. A national health negotiating forum comprised of progressive health groups has also been formed.

In some cases there has been joint action by progressive groups and the government. One such case has been the formation of NACOSA - the National AIDS Convention of South Africa. The increasing importance of strategies to combat AIDS has been recognized as in South Africa there are currently 300,000 HIV positive cases and an estimated 400 new infections each day.

Joint activity on policy formation has also been organized between SAHSSO, PPHC, the ANC and other progressive groups. Policy formation is seen as an area of crucial importance if health services are to have an impact on the health problems facing South Africa's people. In addition, progressive groups have been actively engaged in promoting primary health care approaches to health including the training of primary health care workers.

BANGLADESH

ZAFRULLAH CHOWDHURY

Zafrullah Chowdhury trained as a vascular surgeon in Britain, leaving in 1971 to join the liberation movement of Bangladesh against Pakistan. Following liberation he and his colleagues in the freedom struggle organized People's Health Centers - Gonosasthya Kendrae - to provide basic health care in the rural areas. They developed a pharmaceutical factory - Gonosasthya Pharmaceuticals - to produce essential drugs. His work was instrumental in developing the national drug policy of Bangladesh in 1982 which has effectively controlled multinational exploitation. Zafrullah is now experiencing intense harassment and intimidation for his dedication to alleviate the suffering of his people.

Our dream in Bangladesh was shattered within years of independence. Basic human rights are still our dream, but not a reality. The country is no different than it was pre-independence. Health care is no different, education has deteriorated in every respect. The only thing that has changed is that in 1990 we had democratic elections. We have had a democratic government in power for two years but many unjust laws are still in operation.

World Bank regulations are binding us. Our social sector expenditure is being reduced, despite the fact that it already cannot function. We discovered that it is better to encourage NGOs and the private sector. Initially NGOs were doing a good job, however, very soon the big donors and banks wanted to control and manipulate NGOs.

More and more of the recommendations of the World Bank are being followed; while subsidies for poor people are being cut, subsidies for

Third World industries continue. Our fields are turning into tobacco fields, as cigarette companies expand their business in Third World countries.

We all talk about horizontally integrated programs, so did UNICEF and WHO, but in reality what happens is that a program with an integrated way of functioning has a vertical program imposed on it, as in the case of the ARI campaigns.

These are the dark sides, but Bangladesh also has positive aspects. Since we participated in the liberation of our country, many people are very concerned with the plight of the common people and that has probably brought, at least in some sectors, good results. Our experience with primary health care has shown us that ordinary people, if given the opportunity, can look after their own community's health much better than outsiders.

We soon realized that a major factor in the cost of primary health care is the drugs bill. Most drugs were imported by multinational companies at extortionate prices, some equivalent to two days wages. This was our reason for forming Gonosasthya Kendraie (GK) - to produce very cheap, high quality, essential drugs.

While we were working we found that WHO produced a book on essential drug use that had not been distributed. It took us a year, despite much resistance from WHO, to copy it. Similarly with UNICEF, if you look at their old publications you find that they advocate integrated programs yet now they implement vertical programs such as immunization programs and "child survival".

If you look at the history of the 1980s, all of a sudden vertical immunization programs were popular. This is not just coincidence; at that time Grant, an American, became the chief of UNICEF. Handerson, the chief of WHO's small infectious disease control unit, was also an American. At the same time the chief of UNICEF in Bangladesh was an American. These may be seen as coincidences, but they happened at the same time as American companies were producing a lot of vaccines. The

vaccines needed to be used. I contacted UNICEF and suggested that we could produce quality vaccines and they could buy them from us, but they said that was unacceptable.

In the case of our drug policy, we had better luck. We established our factory in 1981 and we showed the government how cheaply we could produce essential drugs - from one quarter to one tenth the price of imported drugs. In 1982 the national drug policy was created. It is nothing unique, there was no innovation, no discovery. Every medical textbook said that every drug has interactions with other drugs so don't mix drugs together in single preparation. So this was our first condition - that drugs should be single ingredient, except where absolutely necessary.

In addition, we suggested that drug companies without factories in Bangladesh should not be able import drugs. This is how multinationals act, they don't invest money in Third World countries but they produce and import drugs. Finally, we argued that the MNCs could compete with us.

It was a sound drug policy for Bangladesh yet the United States, the United Kingdom, West Germany, and Holland, all objected. All these governments, in pursuit of their business interests, insisted that this policy was not acceptable to them.

However, we had support from all over the world for our policy which gave our government the courage to take a stand and as a result, the drug policy survived. We had to pay the price - our factory was attacked and set on fire by two thousand hired bandits but, with the help of the villagers, we were able to survive.

The quality of drugs has improved, business has expanded dramatically, from only 100 thousand million Taka in 1982, to almost 700 million Taka¹¹ today. The multinationals are still operating but their prices have

¹¹ At the time of publication US\$ 1 = 16 Taka.

come down. However, we have not been able to change inappropriate prescription practices.

The way forward in Bangladesh is in the formation of health policy. We have achieved this in the field of drugs. Health policy should ensure health care for all people regardless of where they live or their income. The rich can always buy health care, but the poor cannot and our poor are becoming poorer. Privatization in health care has had detrimental effects on the economic life of the poor. We have seen poor people selling their cows to buy health care, and 25% of Bangladeshis are too poor to pay to see a doctor.

We have tried to establish health care policy which was accountable to the public. The medical professions opposed this, doctors and health professionals went on strike, they burned our offices and accused me of murder and said that I was stealing their livelihoods. Under this pressure the government became very frightened of the doctors. This was, in part, the fault of the government which, while it is a democratically elected government, is not a democratic government. In private it agreed that a health policy was needed but was afraid of the doctor's movement.

Many NGOs were involved in the freedom struggle of the country and so have a good image but now they are embarking on a program to become more professional. Thus the grassroots movement is taken over by professionals who aspire to middle class status and demand a higher standard of living, and they now control the link between banks and these development professionals.

There are many good northern donors, but I think we have to examine them to make sure they contribute to a better future for their country and mine, for the better the South becomes, the better the North will be too. Nowadays most of the northern donors are going into consortia, like the banks. Bangladesh comes to Paris once a year to face the consortium, in the same way that India has got a consortium. A consortium of NGOs is nothing more than a control mechanism; it may mean less work for the donors but it certainly means greater control by them. They claim that

they cannot handle so many small NGOs, so they will cooperate with the bigger NGOs. So the NGOs are getting bigger and are developing a centralized bureaucracy, while the local grassroots organizations are getting smaller. The position they are reaching is similar to that when the Soviet revolution was taking place. Probably you know that was when the people said that while God was far away in the sky and the Tzar was far away in Moscow, then that was the time to make a change. Maybe we will have to wait for just that time for a change in the country.

THE UNITED STATES

BRUCE HOBSON

Bruce Hobson has worked in Pensvanos, a health organization based in the western USA working on Chicano and Mexican-American rights issues. He has also worked with a community health initiative, Prosemo, an organization working for, and with, disabled people in Mexico.

First of all I think the United States is the most complex society in the world in terms of its history and its national makeup. It is the wealthiest society in the world economically, politically, and militarily, and it yields more power than any other nation in the world today. I think that, in terms of its very foundations, there are real similarities between the history of the United States and that of the State of Israel. The United States could be viewed as a nation founded upon the conquest of three great nations with distinct histories, cultures, languages, and a common national identification. These are: the Africans who arrived on the North American continent in chains; the Mexicans who lost 40% of their national territory to American states; and the indigenous Indians who were the principal obstacle to the settler's strategy of opening all of the territories of North America between the Atlantic and Pacific oceans.

In the national elections for president in November 1992, Bill Clinton won the presidency because he recognized the popular disgust with the Republican administration, and people's fear of a future of worsening social and economic conditions. Of those who voted for Clinton, many considered that, in spite of the treacherous features of the Democratic parties, they stood a better chance voting for Clinton than remaining with George Bush. Health care, education, housing, and jobs were to be addressed, giving, to some, an impression that things could become better under a Democratic administration.

A friend of some of us here, Victor Sidal, has long been active in the progressive health movement in the United States. He lives and works in a part of New York city where more community clinics and hospitals have been boarded up and bulldozed, than those that remain. These communities are largely Afro-American, Puerto Rican and Dominican. He spoke about this (in 1982) in a speech he gave in Los Angeles on the medical effects of nuclear war. He said that the closure of these facilities and the restriction of health care services affected all foreign working communities.

I agree with Sidal and I also think that, fundamentally, the policies of Democratic and Republican administrations are identical. The forms of punishment used by the Reagan administration were, however, more perverse than those of the Democrats. The term 'cut-backs' is often used to describe the reason for restrictions in THE funding of social programs, but 'cut-backs' is a misleading term, because it implies that there is less money available. But this is often a lie. What is true is that the government has budgetary priorities which have little to do with human need, particularly the needs of the poor and working people. The war industry is the sacred cow of US policy-makers. With or without an economic recession, certain priorities remain unchanged, for example, the cost of a B1 bomber is, I believe, around 2 billion dollars. For the price of a single B1 or Trident missile, as Sidal explained, every clinic and hospital that WAS closed in the first term of Reagan's administration could be reopened, staffed, and provide nearly free services for one year.

I do not think that Clinton is the answer. If we look critically at him and his party, the Democrats have taken positions equal to, or even more reactionary than, the Republicans, for example, their position on Palestine and Cuba. However, it is significant that in the US there have been some Democrats who respond to some pressure from below. The concept of a national affordable health care system may appear far too socialistic and impossible given the capital system. However, given the state of health care services in many Afro-American, Chicano, Latino, Indian, minority and poor white communities, a national health plan has increasing appeal.

The Concept of Health Under National Democratic Struggle

A significant number of Clinton voters want a health system which is decent, affordable or free, and which won't disappear by the time their children are grown up. To most working people in the US the World Health Organization is largely insignificant or unknown. Yet WHO's pronouncement that infant mortality rates in several black communities are comparable to those in Honduras - one of the three poorest nations in the hemisphere - may make some Democrats and even Republicans think about how to mollify the fears, frustrations, and hatred in oppressed US communities. Clinton may fail to produce something realistic or acceptable to the American Medical Association, the pharmaceutical and medical industries, and the Republicans, but, unquestionably, his moves from the status quo will be an arena of struggle for those communities in which health care is a priority.

PAM ZINKIN

THE UNITED KINGDOM

Pam Zinkin worked in Mozambique on health and human rights issues. More recently, she has coordinated training-for-trainers in community based rehabilitation at the London School of Child Health.

I want to talk about one aspect of health in the UK, and that is the National Health Service and how, though it is valued, treasured, and has been built up for over forty years, it is being destroyed. There were initial faults in the setting up of the National Health Service. There was always a lack of democracy and it never had a community base. Although there were some attempts through community health councils, to make it more accountable to the people, this lack of democracy is one of the reasons for its destruction.

What is important is how the NHS is being destroyed. Firstly, it is being destroyed by lies. Margaret Thatcher promised that: "The National Health Service is safe in our hands" - a lie. Secondly, it is being destroyed through management. The government has used management and restructuring to make the health service ready for privatization. They use management to control workers and to be friendly with workers. Thirdly, they use language to destroy the NHS. The language they use has started to influence us so now we are talking about medical audits. But an audit belongs to the financial world and has nothing to do with valuing what we do in health care. They also use our language when they talk about the patient's charter, about citizen's rights which, in reality, mean nothing at all. Fourthly, they use the concept of choice, but to them this means choice through your pocket only.

Quality is also discussed. For example, we now are considering the closure of five big hospitals in London, some with over a thousand years of history. Officially, these hospitals are to be closed because there are too many hospital beds in London and primary health care needs to be developed. In fact, they will close hospitals, which will be sold for tourist hotels, but the money will not go to primary health care. We know this from our experience of the so-called community based rehabilitation of mental health patients. Many of the homeless and beggars who sleep on the streets of London are there because of the closure of psychiatric hospitals and the failure to transfer resources to community care.

Rationing in health care is done at every level. For example, certain surgical procedures are no longer available free of charge. Every level of the NHS, down to the patients themselves, is subject to rationing. When patients are shown videos of the disadvantages of having operations and the advantages of waiting, this is a form of rationing. The government bribes people, and of course the people who respond best to bribes are the professionals, mainly the doctors.

The government also cuts wages. Just recently, because of the mess of the British economy, a wage settlement, equivalent to a 2.5% cut, has been imposed on all health, and public sector workers.

They also use another sort of bribery, a bribery of the intellectual. When academics tell me to be realistic, it always means be reactionary. They say 'its going to happen anyway so lets make the best of it'. They don't say 'it won't happen if we resist it'. They also threaten professionals who speak out. I am used to most things but I was shocked to see a general practitioner treated like a criminal on television the other day. He was saying that things are wrong in the National Health Service, that we are not able to treat our patients properly. He refused to be identified and he was right to be frightened as they have sacked doctors and nurses for speaking the truth about the state of the health services.

As a coal miner's daughter, I must mention the enormous effect of unemployment on our nation's health. The effects of unemployment on

health are severe, even where unemployed people receive some state benefits. Amongst the unemployed, there are higher levels of suicide and higher death rates from all sorts of causes. People are frightened of becoming one of the four and a quarter million unemployed in Britain. The official total is just under three million but in fact the figure is nearer to four and a quarter million.

Finally, I want to say that the government undermines health through criminal activities. For example, Margaret Thatcher has recently taken a job having lost the prime ministership of Britain. She has taken the job of advisor and consultant to the British-American Tobacco Company. Her retainer fee is, allegedly, half a million pounds a year for which she has to guide the tobacco industry through the complex legislation of the EEC, so that they are able to continue to sell and promote their lethal product.

So, is there any resistance in Britain? There is some. Our unions are weak but there now is a proposal, thanks to lessons from our South African comrades, that our three health unions will unite. A big demonstration held in London brought together a quarter of million coal miners and health workers on one of the wettest and rainiest days that I have ever marched on. But for resistance, I've come here for lessons; I think this the place where we will learn about it.

EL SALVADOR

GUADALUPE CALDERÓN AND VIOLETA MENJÍVAR.

Guadalupe Calderón is the coordinator of APROCSAL - the Base Health Promoter's Association. She has been a health promotor since 1965, and has been active in the Regional Committee for the Promotion of Community Health for many years.

Violeta Menjívar is a physician who has been working during the last 10 years in community health within the structure of the FMLN. Since 1993, she has been the executive director of PROVIDA, a health NGO.

Guadalupe Calderón

El-Salvador is a small country of 21,000 km², with 5½ million people, and one million political or economic refugees living outside the country. It's a country that has lived with a structure of social injustice and where the US government has used all methods of repression available, investing many of its resources, both economic and military, in this repression. This has forced the people to look for different means of struggle, including the armed one.

For us it is almost a dream to be in a place like this, because during the last 12 years our daily worry was would we survive each day. We are survivors of war. The struggle of our people has forced imperialist and repressive governments to enter into dialogue and negotiation. Our struggle now is to make the resulting agreements a reality.

Violeta Menjívar

We want to dedicate our participation here to the health workers that died during the conflict in our country - 20 men and women, including 17 Salvadorean physicians.

I am part of the Coordination of popular health workers, that was begun mainly by health promoters trained during the recently concluded conflict. There are 800 health workers in the country. The health secretaries of the popular movement are also part of the coordination, as well as the different community committees and some NGOs.

Nine months have passed since the end of the armed conflict between the two armies: the National Liberation Army and the army of the dictatorship. Social peace has not yet been achieved. The FMLN is carrying on an open struggle with the political opposition. The most recent liberation struggle spent 22 years developing a political and military strategy, which developed into an open armed confrontation 12 years ago. In December 31st 1992, the FMLN and the government signed peace agreements in Mexico.

There is a consensus that the FMLN had accumulated important political and military strength. Only two years before, in 1989 the FMLN had carried out a military offensive, with the participation of many people in different activities in different parts of the country, including the capital.

The main elements that made the Peace Agreements possible were:

1. The political will to prioritize the negotiation without abandoning the other forms of struggle.
2. The political, military, and diplomatic development of the FMLN.
3. The lack of legitimacy of the army of El Salvador.

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4. The level of intensity and the duration of the conflict, its national and international repercussions, the offensive of 1989, the missiles, the offensive of 1990, and the international concern expressed by the Organization of American States, the non-aligned Countries and the "friends of the negotiation process".
5. The lack of a military victory by the Salvadorean Army, despite the aid they received.
6. The creativity of the FMLN in the process.
7. Pressure from sectors of the North American and European people.
8. The need for regional recovery and economic development.
9. The participation of the United Nations in the process of negotiation.

Main achievements of the agreements

1. Demilitarization:

- The reduction of the constitutional role of the Army.
- A change in the doctrine of the Army.
- A reform of the educational system of the armed forces.
- A reduction in the size of the armed forces.
- The dissolution of the National Guard and Hacienda Police.
- The dissolution of military intelligence service. (Not done yet)
- The declaration of the end to the impunity of the Army.

- The creation of a new National Civil Police, formed by people from the FMLN and social movements.

2. Political:

- Profound reforms to the judicial and electoral systems, including the legalization of the FMLN as a political party.

3. Socio-economic:

- The transfer of land for 7500 fighters of the FMLN and 25,000 families from the areas controlled by the FMLN.
- A program of credit, scholarships, housing, and others, for the fighters which is still pending.
- Two months ago a Socio-Economic Forum was installed, where the government, the private sector, and the labor and union sector participate.

Nonetheless, El Salvador continues to be governed by a rightist group. The agreements and the achievements are important, but the real challenge is to make these agreements a reality.

Progress in health

In El Salvador, during the last ten years, there has been an initiative in health that has made important achievements. This has a deep popular base which began in response to the absence of state health services. Its work is closely related to the national liberation movement. At this moment, we are trying to systematize the health experiences of the FMLN.

This has been mostly work in primary health care in the rural areas. Specialized services and other kinds of health services should come from the Ministry of Health. We agree that non-governmental initiatives are not going to solve health problems completely. The State has the duty to provide health to the country and the Coordination has as a principle that health should be included in demands to the government.

Community participation in this work has been as follows:

- There is a network of hundreds of health promoters. There are general health promoters, dental health workers and midwives. These were all trained during the conflict. They lived in their communities the whole time, and were elected by their communities. Almost 80% of them are women. We are now preparing for the reinsertion of the health promoters from the Frente de Liberación into civil life. They have carried the responsibility for the health of many people.
- The Health Secretaries of the Popular Movement represent structures from the different organizations: peasant, cooperatives, displaced people, repatriated, and urban marginal communities, among others.
- Another form of participation is the Local Health Committees. They are now being integrated into Municipal Health Assemblies, and a Department of Health Assemblies will be developed later.
- There are regular meetings of the communities to discuss health issues and to define their plans of action.

Another characteristic of health work is its interaction with other aspects that gives a global perspective. The first level of coordination is with the different health actors such as health promoters, community committee members, health secretaries and NGOs.

There is another level with other people in development that exists in the communities. For example, there are representatives of health in the Municipal and Department Councils of Development, along with representatives from production, education, and ecological fields. They participate in the struggle for political and economic demands from their organizations.

There is a drive to make development plans for the municipalities and the regions. Within these global plans, health is included. Of course there are problems, but we are already getting some results. We are carrying out several health programs, the rehabilitation program being important because we have many disabled people as a result of the war. In general, we share the concept of local health systems, and we have developed it without realizing it.

Some difficulties

During the war, we had serious difficulties in accomplishing a permanent training program for health promoters. Many of the sessions took place under bombing raids or during attacks. Now there are new possibilities. There is more chance to move and to provide a better training.

Despite the fact that there is an important level of organization, the technical level has to be improved. The Committees and the Health Secretaries have to act by themselves, developing their own decision making and planning skills. This is a hard job, for we have some negative effects of the war experience.

WORKSHOP: WOMEN'S HEALTH

Moderators: Salwa Najab-Khanh / UPMRC / Palestine
Mira Shiva / All India Drug Action Network / India
Edelma de la Paz / Coalition for People's Health /
Philippines

A striking observation was made - that of the 32 workshop participants, only five were men, from the regions of Latin America, Asia, Africa and Europe. There were no male participants from the Middle East.

Discussion

SECTION THREE

WORKSHOPS

The women's health workshops focused on women in their social, economic and political context, and taking into consideration the influence of these factors on their health. "Women's health" is a much more comprehensive concept than just diseases throughout the life cycle, and involves preventive, curative and health care but in all aspects of women's existence. Violence against women throughout their lives was raised as a major issue influencing women's well-being. Equity, gender preference, marriage rights, infertility, the imposition of birth control, disempowering attitudes of health care providers and so on, were discussed in the cultural and religious context of the different countries represented. The participation and support of men in different ways was seen as essential to women's struggle for better health and quality of life. Participation in economic life, control over their own resources, and access to correct information about medical care, are seen as important to self-reliance. Participatory health education and health care, grounded in what women perceive as their needs in their cultural context, was considered an essential approach, rather than using the alternative, top-down approach. Finally, women in political struggles affirmed the necessity of being involved not only in the grassroots struggle but also in leadership positions, ensuring that women's issues are addressed while the struggle is ongoing rather than waiting for liberation.

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RECOMMENDATIONS

1. Women's health should cover not just issues related to a woman's physical health from birth to death, but should include issues related to her psychological and legal needs, her work, her income, issues related to violence against women, women's right to property (in view of increasing desertion rates), women's right to equal custody of their children, and the right to freedom from an oppressive marriage.
2. Women's full potential for life and their new role can develop only with the active support, understanding, and changing roles of men at home and at work.
3. Women's health as an issue must be approached with sensitivity and understanding towards women's cultural, religious and social realities, and their family situation. Midwives (either TBAs or trained midwives) should play a central role in the health care structure and should be encouraged to participate in all aspects of women's health.
4. Women's struggle and the struggle for women's rights has to be an integral part of political and social struggles, since women's empowerment empowers the struggle.
5. Space must be created, in organizations and institutions of mass movements and struggle, for women to take leadership and decision-making roles, and women's contribution must be fully recognized, and not undervalued as currently happens in most societies.
6. Educational strategies such as formal education, literacy programs, health education, training programs, consciousness-raising, must all include sensitization to women's concerns and awareness of existing gender bias. Participatory methods are preferable to passive learning. Women's health education materials from different countries should be collected and shared.

7. We note that the biomedical model, while aiming to improve women's health status, has actually done much to diminish women's control over their own health. We recommend that health service providers should ensure that their services do not, intentionally or unintentionally, disempower women. They should not erode women's own support structures, their traditional skills, nor their sense of personal dignity. Service providers should monitor and evaluate their programs not only in terms of immediate physical outcomes, but also according to how the services actively meet the above objectives.

WORKSHOP: COMMUNITY-BASED REHABILITATION

Moderators: David Werner / Hesperian Foundation / US
Pam Zinkin / Institute of Child Health / UK
David Henley / Sweden
Peter Coleridge / Oxfam / UK

Discussion

The full involvement of disabled people in the entire CBR process was a constant point of emphasis throughout the workshop. Without such involvement, development becomes superficial - CBR jargon is employed but no real development occurs in the lives of the disabled people in the project. The word 'empowerment' was used frequently by a number of workshop participants. Some contested the suggestion that people - including the disabled - can empower others, believing that it is only possible to empower oneself. Others felt that with a change in attitude, health professionals could contribute significantly to the empowerment process. CBR is the process of finding better ways of enabling disabled people to improve their own lives. Many contributors emphasized the role of health care professionals in listening to the needs of disabled people before attempting to solve their problems. The process of establishing CBR programs was similar in many countries. In one example, Proyecto Projimo in Mexico, disabled community health workers were chosen from the villages initially because they were available. Subsequently, these health workers were found to be the most successful in reaching disabled people partly because their own experience gave them an understanding of the needs of the disabled and partly because the health worker's participation helped to overcome the stigma of being disabled which can be an obstacle to the expression of needs, including health needs. As a natural extension of this experience, CBR programs run by disabled people go on to challenge the way society functions in relation to disabled people and then how it functions in relation to other

oppressed groups - women, ethnic minorities, black people etc. This in turn leads to links between these groups and, consequently, their increased strength.

While some participants suggested that CBR then acts to bring these same disabled people into full integration, others disputed this - do disabled people simply want to be integrated into a poor, unjust society? The group agreed that while integration was useful as a starting point for CBR, ultimately disabled people must challenge the injustices within all sectors of society, working as part of the struggle to forge a more equitable structure. There was agreement that the obstacles which deny disabled people the right to a full life represent a human rights issue, demanding a political as well as social response.

The question of whether CBR constituted the best response to the needs of disabled people, or was merely a second-class service, was discussed at length. It was concluded that in developing countries CBR is often seen as a low-cost option, but that this is appropriate where disabled people are poor and inexpensive appliances and aids can be made available to them. Also, David Werner emphasized that often the appliances made by and for disabled people are better than factory - so called "high-tech" - appliances. David Henley pointed out that moves are underway to introduce CBR into Sweden. The crucial issue is who controls the shape and nature of the programs. Where these are run by bureaucracies keen on saving money, then these programs will provide only cheap second class options. However, when they are run by, and for, disabled people they can be the best approach to addressing their needs and desires.

This took us on to the question of 'what is CBR?', to which many definitions emerged. Most people felt that CBR should be considered a process and not a program - of learning and listening - which is different in every community - hence there is no consensus. However, Pam Zinkin emphasized that CBR has two related but distinct components - provision of skills and appliances to enable the disabled person to address their particular needs in abilities, and also a social change so that the

community listens and alters in response to the expressed needs of disabled people.

RECOMMENDATIONS

1. Community based rehabilitation should involve the active participation of disabled people and their families in every level of the program.
2. CBR must involve both a response to the individual needs of the person with disabilities in a way that promotes their maximum autonomy and dignity, but also a community response to the discrimination experienced by disabled people in our communities.
3. CBR can be hijacked by bureaucratic governments and implemented vertically as a cheap second class service to the poor. However, if CBR is controlled by disabled people it can be the very best response to the needs and desires of those with disabilities.
4. We should ensure that whenever we write or translate the word disabled, that we use accurate translations of the words so that words like 'less-valued' or 'invalido' are avoided.

WORKSHOP: COMMUNITY PARTICIPATION AND EMPOWERMENT

Moderators: Francis Baum/ Flinders University/ Australia
Martin Reyes / Proyecto Projimo / Mexico
David Sanders / Natal Medical School / South Africa

Discussion

This workshop was attended by approximately 40 participants. After the opening discussion, the workshop split into three streams. The general discussion is summarized below, with the recommendations for each stream presented.

Frances suggested that the aims of the workshop were two-fold: to explore the gaps between rhetoric and reality in participation in health care, and to reaffirm the importance of participation and empowerment in health.

In projects that address community health promotion we often lose sight of those who should be involved. Martin presented a set of slides to stimulate discussion on how to involve the child in the process of community health development. The child-to-child program involves the transformation of the child's personal circumstance into an opportunity for individual and collective growth. It is common to find children in the difficult position of caretakers of younger siblings. The child-to-child program views the child as a powerful resource for effecting family health. Martin documented several ways in which this done. Questions were raised as to whether these types of programs were effective in a home setting or on the street, as opposed to merely in a school setting. It was established that child-to-child programs had proved successful in both these alternative settings, in a number of countries.

Bruce Hobson commented that child-to-child is often described as a program rather than as an approach, but it is not simply a matter of organizing a group of children around a program. Much of the structure is determined by activities that children ordinarily perform. There are very few community projects in which the child-to-child approach would not be appropriate.

Fran presented a brief slide presentation on the WHO Ottawa Charter - Healthy Cities Program, showing potential strengths and weaknesses in what has become a popular development movement. She emphasized that such programs are not politically neutral, but rather become ideologically charged in either a reactionary or progressive way depending on whether the health professionals involved in implementing such programs view the community as the object of intervention or as the central resource for development and change.

Community empowerment is central to a meaningful project. Fran identified economic rationalism, individualism, and misplaced professionalism as threats to achieving healthy cities and recommended the avoidance of such pitfalls as key to a progressive, democratic and collectivist project. At this point, the workshop broke into three working groups to discuss different aspects of participation and empowerment.

RECOMMENDATIONS - 1

This group discussed how professionals can move toward participatory empowering practice. The group discussions produced the following:

1. We recognize that physicians and other health professionals often play a disempowering role in the community.
2. We recommend that efforts should be made to reduce the dichotomy between community health workers and professional health workers.

3. We recognize that higher learning institutions contribute to the problem by perpetuating the role that professional health workers play in disempowering communities.
4. We recognize that the struggle for health is an interdisciplinary one. Training must go beyond the biomedical model to include economic, social, and political factors affecting the health of the community.
5. In certain communities, to be effective, the professional health worker should live in the same community which s/he is serving.
6. Community based work should be part of the medical curriculum. Until institutions and curriculae change, training professionals in local communities is recommended.
7. We recommend that funding should be routed, whenever possible, through the community so that the health professionals become directly accountable to the community.
8. Dependency of the community on the health care professionals and their institutions should be eliminated by the creation of a mutual partnership.
9. We recognizes that health professionals alone can not make changes and that female community health workers have a unique role in community health empowerment.
10. Technologies should be consciously selected for their efficacy and appropriateness. Every effort must be made to identify technologies which demystify treatment and which are culturally and socially acceptable to the community.

RECOMMENDATIONS - 2

This group discussed which factors contribute to the successful participation of marginalized groups leading to empowerment/control over the health process. They were identified as:

1. Trust in the process of building through community involvement and confidence in the community should be promoted.
2. Accountability of health workers to the community.
3. Community self-awareness and identification of problems. Community-based diagnosis should be used in all strategies for change.
4. Local resources should be identified for problem-solving, emphasizing community involvement at every level from planning to evaluation.
5. In-depth awareness of the community structure should be developed.
6. Self-esteem among community members should be increased and linkages made among community resources.
7. Community health workers should be trained from the local community.
8. Liaison between community health workers and professionals in the community should be ensured, and a two-way referral and screening system maintained.
9. Self-reliance should be promoted.

RECOMMENDATIONS - 3

The third group discussed obstacles to successful participation. They agreed that there is too much rhetoric about participation and not enough action.

1. Effort must be made to overcome the reluctance to address adequately social issues, particularly those related to women.
2. Members of the medical profession (particularly specialists) must better understand the concept of primary health care, and must have more confidence in the competence of non-professional community members.
3. Doctors should assist community health workers rather than the other way around.
4. There should be further involvement of local people in the health care process.
5. People working in a community must have detailed understanding of power structures within the community and the culture.
6. Primary health care ownership must become multidisciplinary and be truly representative of the community.
7. Professionals from outside the community should train local people and then withdraw.

WORKSHOP: CENTRALIZATION/ DECENTRALIZATION

Moderators: Umaiye Khammash / UPMRC / Palestine
Marina Rosanda / Italian National Health Services / Italy
Allam Jarrar / UPMRC / Palestine

Discussion

The workshop explored the many different experiences of countries in their search for a balance between the centralization and decentralization of health care structures. It was agreed that each country's particular circumstances can radically alter the implications of where power is located within the structure.

Overall, the struggle for democracy in health pushes us all towards decentralization as long as this means popular participation. Decentralized structures, especially those which actively encourage NGOs to be in touch with the grassroots, can give health care creativity and promote new initiatives which can sensitively meet the needs of the community.

However, this must mean development in both service provision and power over finances, administration, planning and evaluation. Otherwise, decentralization can be used by cost-cutting governments to off-load their responsibilities. The extent to which this happens is not always clear, and a lively debate is ongoing in almost all countries about this balance.

It was also agreed that certain functions require a certain amount of centralization, including immunization programs, standard setting, data collection, water and pollution. Additionally, central government can redistribute resources within a country to ensure access to care. It was suggested that the extent to which a community trusts their central

control is a reflection of the extent of people's real power in a democratic system.

Cautions against wholesale decentralization were given by many, some because strong local powers can be set up to resist the redistributive power of central government, as in the case of South Africa, and also because there is a fear that central governments will try to off-load financial or policy responsibilities on to smaller local communities.

It was agreed that it is difficult to strike this careful balance between democratic decentralized units which give a clear role for NGOs, and the proper distribution and coordinating role of central government. Good decisions cannot be imposed from outside that country.

RECOMMENDATIONS

1. Since decentralization intends to increase democracy and the participation of the people in health it should be encouraged. However, there is a role for central government in redistributing resources and coordinating policy and practice around the country, which should be considered.
2. Reactionary forces, which are likely to encourage the decentralization of services without power over resources, should be resisted.
3. Each country must strike a unique balance between decentralization and centralization which will depend on cultural, social, and political, as well as health factors. No set prescription for this balance in each country exists.

WORKSHOP: POPULATION CONTROL IN THE GUISE OF FAMILY PLANNING

Moderators: Heider Hussein / Family Planning Association / Palestine
Ricardo Loewe / Clinica Popular: Prodesep / Mexico
Zafrullah Chowdhury / Gonosasthya Kendra / Bangladesh

Discussion

Family planning that meets the contraceptive needs of couples is important for the health and well-being of women. It empowers women, men, and children when it is used in the spirit of women's free choice and their right to make informed decisions about their own bodies and their lives. However family planning, in the past and at the present time, has been used as a population control strategy. In a coercive and manipulative way, birth control is imposed on women by foreign governments and their agents who want to limit the population of poorer countries. It is also imposed on women by the elite who want to limit the population of the lower classes or of certain racial, gender, or ethnic groups within the same country. Not only is this violating basic human rights and alienating health workers from their own communities, but it is endangering the physical and psychological health of women. The use of selective methods may have dangerous side effects, particularly in a context where implementation and follow-up is difficult and inappropriate.

RECOMMENDATIONS

1. The above-described utilization of family planning must be condemned. Those who practice population control in this manipulative way, or who link other benefits such as loans to population control, either in an overt or covert manner, should be pressured, by all who care about women's rights and well-being, to change their policies. Any attempt to reduce

birth rates in order to promote the welfare of women should also ensure that structural adjustment policies that disempower women and worsen the chances of their children's survival must be resisted.

2. Family planning which empowers women should be only one factor among many which aim to assist women to realize their full potential. Improving economic and social conditions (or political, as in the case of Palestine) has proved more effective in reducing family size than programs which see women only as reproductive entities.

3. Education (formal, informal, training, health education, consciousness-raising etc.) is an essential element of development programs for women and should be participatory.

4. Family planning should be an integral part of the women's health program within a primary health care system. It should include gynecology, screening, prevention and management of infertility treatment, care and adoption facilitation, counselling, and mother and child health. Health education should include nutritional counselling, child care, and consciousness-raising for adolescents, as well as adults, about such issues as gender bias.

5. A range of family planning methods should be made available and freely accessible to women and men and should be accompanied by complete information. More scientific research should be a priority particularly into contraceptives for men and barrier methods for women.

6. The many difficulties that arise from cultural, language, geographical differences, should be recognized. Those who live in countries where family planning methods have been forced on people, differ, in their views, from those people who work for the organizations trying to implement family planning.

7. Relevant government agencies and manufacturers should be held responsible, and compensate women for the suffering caused by the side effects of contraceptives especially where the users were not advised of

the possibility of such side effects, eg. with hormonal and genetically engineered drugs.

8. Finally, while it is difficult to generalize about family planning, each program should be adapted locally and regionally according to the real and self expressed needs of those women concerned. Once there is equality and justice in this world in the distribution of resources, humane and sensitive family planning will be a natural outcome with or without 'advanced' family planning programs.

WORKSHOP: HEALTH AND ENVIRONMENT

Moderators: Mantovani Adriano / WHO/FAO Collaborating Center/
Italy
Aftim Saba / Berkley School of Public Health / Palestine /
USA

The 15 participants in this workshop debated a range of global environmental issues which impact on health, directly or indirectly.

RECOMMENDATIONS

1. That the IPHC form a special committee to gather data, study the short and long-term health effects and identify the various chemicals (such as tear gas) used by occupation and oppressive forces mainly in the South - in the Occupied Territory of Palestine, against the indigenous peoples of Guatemala, and against the people of South Africa.
2. We recognize the importance of land ownership and land redistribution to local communities as a necessary step to prevent the forcing of the poor onto marginalized lands and into critical biological regions such as the rain forests. Land ownership and redistribution is a factor in preventing and perpetuating the degrading cycle of poverty.
3. We recognize that poverty lies at the root of the uncontrolled growth of cities leading to the growth of shanty towns, with poor sanitation and low quality housing.
4. That war and militarization be recognized as major contributors to environmental pollution and degradation particularly in the countries of the South. Specifically, we condemn the continued proliferation and all testing of nuclear weapons. We condemn the use of chemical defoliants in forests by occupation forces acting against national resistance movements, as in Vietnam, Guatemala, and Namibia. We also condemn the

clearcutting of precious forests by reactionary forces and governments in order to finance war against liberation as experienced in Namibia and Guatemala.

5. That the subject of occupational health be considered at all levels of development projects, including grassroots and cottage industries.

6. That environmental and occupational health be included in all health education curricula in medical, nursing, and health worker schools.

7. That any environmental programs considered for implementation should recognize and consider local needs, knowledge and experience, that traditional and local methods are used whenever possible.

8. That the safest toxic chemicals are used when necessary, and that they be accompanied by clear and adequate instructions for safe use such as active demonstration and education, writing, and audio-visual aids. We condemn the sale to the southern community of pesticides and herbicides that have been banned from use in northern industrialized countries.

9. That traditional land management practices - small farms and use of local seeds - be promoted instead of the proliferation of large farms owned and operated by absentee landlords and multinational companies geared toward the production of cash crops for export. These large farms contribute to poverty, hunger, high energy use, and pesticide use.

10. That the role of local unions be strengthened so they are able to deal with health issues, particularly health education, prevention, and data gathering with regard to occupational health such as mining hazards and pesticide use.

11. That development theory be critically evaluated in the light of its deleterious effects on the environment as it is practiced by capitalist and socialist ideologies and states.

12. That South-South ties between NGOs and governmental sectors be strengthened as they relate to the environment. We also recommend South-North ties with regard to appropriate technology, technical training, educational aids, and advocacy.

13. That the recent trend of dumping toxic wastes, pollutants and nuclear waste produced by northern industrialized countries into areas of southern countries and poor communities be condemned.

14. We recognize the destructive effects of the tobacco industry on southern communities and vigorously oppose the aggressive marketing of tobacco products. This action is a form of large scale drug trafficking, being practiced by industrialized nations. We recognize the ill effects on passive smokers, especially innocent children living in households with smokers. As health workers we must assume our responsibilities to be healthy role models, and we call on our host, the UPMRC, to set an example locally in this regard.

WORKSHOP: RESOURCES AND COMMUNICATIONS NETWORKING

Moderators: Lusani Nevhutalu / National Progressive Primary Health
Care
Network / South Africa
Suzanne Fustukian / ARTAG/ UK
Mark Taylor/ Canada

Discussion was based on the recommendations for networking and the action plan from the IPHC meeting in Nicaragua in 1991. The question asked, in the light of these, was how to go forward. Subjects of focus included: types of information and resources needed; different methods of networking; and proposals for building a communications strategy.

Discussion

Any discussion regarding networking must take into account the availability of human resources and funds for this purpose. The orientation of the IPHC network is specific; the exchange of information to facilitate demystification and democratization.

The IPHC document highlights the need to share information, resources, and materials, yet we do not want to network just for the sake of networking and therefore we need to be selective and clear about the role that information has in organized collective action. Information is an integral part of our long-term goals and regular information sharing is a means of building solidarity.

This network aims to support movements and individuals in situations of oppression and to promote exchange between these groups. We recognize that many health networks exist, the aim of this network is not to duplicate these efforts but to complement them through providing a specific political component.

With regards to the dissemination of information on health workers' role and experiences in Third World liberation struggles, it was pointed out that the network should interact with existing human rights/solidarity networks in widely publicizing human rights violations as well as highlighting responses and innovative experiences in dealing with violence and oppression from which others can learn. In this way the IPHC network aims to bring attention to struggles that the international media ignores.

All the groups agreed with the recommendations as outlined in the IPHC meeting of 1991 and added the following to them.

RECOMMENDATIONS

1. That the IPHC set up a working group made up of those with experience in information exchange and communication to consider the following suggestions and draw up appropriate strategies of action:

- That there be a national and regional focus for coordination activities.
- That the working group encourages and advises members on local information and needs assessments.
- That a mailing list and information about member organizations be prepared and made accessible for information sharing.
- That communication channels be set up (such as a newsletter, e-mail links and conferences) and that northern NGOs with facilities and experience act as channels between countries with no direct communication links.
- That IPHC explores ways of sensitizing groups involved in other areas of social justice to the broader perspectives of the political economy of health

- Among subjects about which information should be shared are: repressive laws that inhibit health activities; ideas on how to communicate at local levels when exchange of printed communication is illegal; how to educate health workers to motivate communities to participate in the liberation struggle; how to exchange information and ideas at the grassroots level; and ways of sharing information regarding progressive health policies which have been implemented in specific countries and analyses of their effectiveness.

2. Clarification should be made regarding membership in IPHC, its structure, responsibilities of its members, implementation of recommendations, and determination of future policy.

MARIA HAMLINÚZ NIGA

CONFERENCE SUMMARY STATEMENT

The IPHC was first conceived in Nicaragua in 1991. Now many months later we feel we are giving birth. Here we are in Bethlehem, in Jerusalem, giving birth. I want to use an idea that we have used in popular education. When we talk about structural adjustment or power we are talking about what the elites of the world, wherever they may be, are doing to all of us. Some come from the East and the South, but most come from the North. They are a very close community. They work out their strategies together, they go to conferences every week. In fact, they are in constant communication and making decisions about what is going to happen in the rest of the world.

SECTION FOUR

CONCLUDING STATEMENT

There are some of us who are talking about what these elites are saying without being really involved. The middle classes have tried to be involved in elections and tried to change the policies of their governments or coalition partners. However, most people of the world are far removed from the elites. We speak different languages, we are from different cultures, but we are all concerned about the health of our people. So health has united many of us across the world - which is why we are here today.

We know we are talking about a wider concept of health, one that includes justice, dignity, and equity. We know these are revolutionary words. The elites do not like us to talk in this way. That is why they work against us, they threaten us, and they kill us. Zairelish is a case in point, and the cases we have heard about in Nicaragua are common throughout the world.

Health is a right of all people. If we are going to achieve this right, we have to have alternatives within our cultures and within our programs so that we can make a real impact on our communities. With our communities, our brothers and our sisters, we can work for health.

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There are some of us who are a little closer to what these elites are saying without being really involved. The middle classes have tried to be involved in advocacy, and tried to change the policies of their governments and of multinationals through boycotts or different kinds of coalition action. However, most people of the world are far removed from the elites. We speak different languages, we are from different cultures, but we are all concerned about the health of our people. So health has united many of us across the world - which is why we are here today.

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Health is a right of all people. If we are going to achieve this right, we have to have alternatives within our cultures and within our programs so that we can make a real impact on our communities. With our communities, our brothers and our sisters, we can work for health.

Now, the elites create and use the whole idea of the mass media. This tells us what is happening around the world. All we have to do is look at CNN and we can see how much of what is happening in our lives, and around the world, is distorted. And when we come together in this conference we know there is much more that unites us than divides us.

The philosophy of the IPHC is based on the belief that people who have similar struggles in very different places should link themselves together. We must link ourselves together in our own neighborhoods, in our own countries, regions, among our ethnic and language groups, and then we must make links across our continents. We must build these communications links. We must take these recommendations back to our own groups, discuss them, and then move on to the kind of networking that is necessary. The IPHC will find a way of facilitating this. It begins with us, and the commitment that we are prepared to make in order to carry out what we have discussed today. I believe that the spirit of people is such that it will really enable us to do this. I think that one of things that this conference has demonstrated very clearly is the solidarity that exists between groups and people involved in grassroots movements.

We say different things in different languages, someone here talked about the spirit that has been let out of the bottle and cannot be put back in. In Central America we talk about the explosion of a volcano. The spirit is there, even if it gets beaten down. In this room there is a lot of spirit that wishes to work towards the kinds of things we believe in.

The kind of research that is done in the world that is sponsored by donor groups, foundations, and universities, must be informed by those with whom we are working. It should be planned, executed, and disseminated, to give support to marginalized people. What usually happens with research done in the Third World, is that we never see it. How many documents sit in the offices of donor agencies, never having been read because there simply isn't time. Somehow none of this ever gets back to us especially if we have a 'strange' language like one of the 800 languages of India or one of the 23 languages of the Guatemalan Indians. We need

feedback about the research, the people have provided the information, they have a right to know what is being said about them, so they can act upon on it. We also need to create alternative media so that these things are known in the world.

We do believe if there is a thing called partnership, it goes two ways. There is a lot of talk about partnerships, and the strong partner from the North acts as if they are giving money. In fact most development aid is given with the aim of getting more money back into the North. We feel strongly that it is necessary for those working in the needs-based countries to be consulted more about how aid money is spent around the world. We do not want the hollow rhetoric of partnership, we want real partnership. So those of you here today, go back to the donor agencies from the North and create a real dialogue, so that we can present a counterfront. We want not only that accountability be demanded of us, but also that donor agencies be held accountable for what they are doing throughout the world.

We also believe there are lots of agendas. We are expected to change our priorities to meet the donor's agendas. Let us make our own agenda and let them support us in our agenda because we know what is going on in our part of the world.

Antia said something very beautiful; he recognized the role of women. Women are the main carers and health providers, and the majority of health workers in the world. They also suffer the greatest burden of ill health. We all have a responsibility to learn about women's health and problems, their perceptions and their struggles, and to recognize that the struggle for women's health is a major component in the entire struggle for health. We have to build bridges across the traditional barriers that have separated us, bridges between the various struggles of women, minority groups, indigenous people, disabled people, and other exploited and oppressed people in this world. In just a few days [November 1992], one of our compañeras, an indigenous woman from Guatemala, Rigoberto Menchu, will be given the Nobel Prize for Peace in Oslo. This woman is a close friend of many of us and her father was a community health worker.

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He was assassinated. Next year [1993] is the year of indigenous people, of the struggle of the indigenous people. We would like to ask that this movement celebrate the struggle of indigenous people next year.

Finally, we need to share insights and solutions, and we need to share errors. You know some people think that revolutionaries aren't supposed to make mistakes because they are revolutionaries. But we do make mistakes. We need to share our mistakes, across our borders, across our countries and across our continents. We need to respect the sovereignty of each local and national struggle and their ability to fashion a concrete strategy from the experiences that they are living.

The international conference of the IPHC hosted in Jerusalem by the UPMRC, celebrates and shares with pride the recognition given to Zafrullah Chowdhury and his organization. The award of the alternative Nobel Prize - the Right to Livelihood Award - was rightly conferred on him for the exemplary contribution to people-oriented health care and Bangladesh's drug policy. We note with dismay the concerted campaign mounted in Bangladesh by local and international vested interests to discredit Zafrullah and his work. This conference totally condemns these unfounded and orchestrated allegations and attacks. It declares its complete support for and solidarity with Zafrullah and his co-workers and demands that the perpetrators of these untruths and their motivation be exposed and action taken.

CONFERENCE PARTICIPANTS

NAME	ORGANIZATION	COUNTRY
Abd al-Rahim, Farouq	Doctor's Union	Palestine
Abd al-Shafi, Heidar	Palestine Red Crescent	Palestine
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Abu Shararah, Abdullah	UPMRC	Palestine
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Giacaman, Rita	Birzeit Community Health Unit	Palestine
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Mansour, Ali	Save the Children	Palestine
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Massarwi, Ahmed	Association of Israeli-Palestinian Physicians for Human Rights	Israel
Mazali, Rela	Association of Israeli-Palestinian Physicians for Human Rights	Israel
Mbah, Jonathan A.	Medical and Health Workers' Union of Nigeria	Nigeria
McGaughey, Rita	Health for Minorities	Israel
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Odeh, Jumana	UPMRC	Palestine
Persson, Ulrike	Diakonia	Sweden
Qutteineh, Malek	UPMRC	Palestine
Reyes, Martin	Proyecto Projimo	Mexico
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Shaheen, Muhammed	Center for Development in Primary Health Care	Palestine
Shilongo, M.N.	Namibia Development Trust	Namibia
Shiva, Mira	All India Drug Action Network	India
Sibeko, Frank	South African Health and Social Services Organization	South Africa
Skold, Margareta	World Council of Churches	Switzerland
Soutar, Douglas	Christian Aid	England
Sutton, Ann	South Bank University, School of Education	England
Tamimi, Abd al-Rahman	Land and Water Establishment for Services and Legal Studies	Palestine
Tarazi, Jamal	UPMRC	Palestine
Taylor, Mark		Canada
Téllez, Dora María	Faribundo Marti Liberacion Nationale	Nicaragua

Concluding Statement

Terris, Lillian	World Council of Health Worker Organizations	United States
Terris, Milton	World Council of Health Worker Organizations	United States
Tom, Mvuyo	South African Health and Social Services Organization	South Africa
Tseheridis, Kristos	Panhellenic Federation of Public Hospital Workers	Greece
Van Duppen, Dirk	Medical Aid for the Third World	Belgium
Werner, David	Hesperian Foundation	United States
White, Joanna	Save the Children	England
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Zúniga, Maria Hamlin	CISAS, Center for Information and Advisory services in Health	Nicaragua

Concluding Statement

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THE INTERNATIONAL PEOPLE'S HEALTH COUNCIL

WHAT IS IT?

The IPHC is an informal network of socially progressive groups and movements committed to working for the health and rights of disadvantaged people. Its function is to facilitate the sharing of information, experiences, methods, and resources among a wide range of persons, groups, and coalitions involved in community health work oriented towards empowerment and self-determination.

The goal of IPHC is to contribute towards 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 advance towards health for all people - viewing health in the broad sense of physical, mental, social, economic, and environmental well-being.

We believe that:

- Health for all can only be achieved through the strong participation of people in the decisions that affect their lives.
- Major improvements in a population's health are best achieved through participatory democracy (decision-making 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 towards a healthier world order must be spearheaded through a world-wide grassroots movement that is strong and well-coordinated enough so that 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 social 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?

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 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 growing numbers of poor and disadvantaged people in 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 existing coalitions, umbrella organizations, and national or regional associations of people's health and development initiatives.

The IPHC 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.

While the main focus of the IPHC concerns health, we hope that the network can be intersectoral and to some extent, 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 all certainly impact on health. At least between the umbrella groups in these diverse areas, links need to be made, so that we are all 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 planned for several years.

Most participants came from countries now in socio-political turmoil or transition. Represented were: South Africa, Zimbabwe, Bangladesh, India, Palestine, El Salvador, Guatemala, Nicaragua, Panama, Mexico, the Dominican Republic, and the USA. Most of us who were at the meeting have 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 world-wide crisis are the structural adjustment policies imposed by the International Monetary Fund 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 devalue local currency, free prices whilst 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 of 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 rich who (at least temporarily) benefit from these 'economic adjustments'. It is the poor who are hardest hit. Far from promoting economic recovery as designed, in many poor countries structural adjustment has contributed towards drastic deterioration in living standards and health, especially for the already disadvantaged.

Adding to the defenselessness of exploited people 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. Often, when WHO and UNICEF try to defend the interests of disadvantaged peoples, these conflict with the interests of big business, and 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 reduce child mortality slightly. But with poverty and hunger escalating as wealth continues to flow from poor to rich, health indicators for the swelling ranks of destitute people in many countries (including the USA) show relentless deterioration.

Participants at the Managua meeting stressed the colossal obstacles of the 1990s to any people or nation struggling for liberation from these overpowering forces. The world-wide conversion to 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 own 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 1990s. 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 world-wide solidarity. We must join hands across conventional barriers: across oceans and continents, across races and creeds, across special interests and social classes. Only through global grassroots solidarity is there much hope for making the present self-seeking and ultimately suicidal power structure accountable to the poor and to 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 IPHC

To try to build up the progressive health network in different parts of the world, six provisional regional coordinators have been chosen, plus one overall coordinator and an interim president.

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NEAR EAST & FORMER SOVIET BLOC

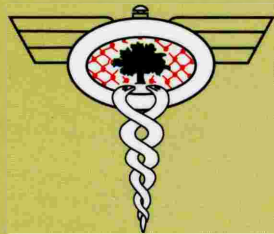
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