Empowerment

United for health

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Foreword

Empowerment. Look it up on the internet and you will find a wide variety of definitions. Some people associate it with self-confidence or autonomy, others with participation or mobilisation, and still others with liberation. But what do you think is most surprising? Only very few of the definitions refer to "power", and we found this intriguing. Some years ago, we had described the essence of our work as "empowerment for the right to health". And now it appears that this terminology is open to interpretation, to say the least.

The term "empowerment" crops up in various historical examples of collective social struggle against injustice. Nowadays, the term is increasingly used to refer to individual change, far removed from its original concept of political change.

Some have doubts about whether there is any point in reclaiming the original meaning for this term, but we think there is. First of all, we need a term that incorporates the word "power". Secondly, it is also a way of ensuring that the debate about how change really happens is kept alive and intense.

Our many years of experience with partners in the South who use empowerment as a strategy in their fight for the right to health have been, and continue to be, hugely inspiring in building our vision of empowerment and social change. Based on that experience, we would like to describe our vision of empowerment in this document.

This brochure combines all these insights, illustrated with practical examples provided by our partners in Congo, the Philippines, Palestine, Latin America and Cuba, as well as some fascinating examples of social struggle elsewhere in the world.

Empowerment is essentially about power relations and developing strategies to alter these and to formulate alternatives for a more socially just society. This brochure contains concrete examples of how our partners tackle this issue, but the context in which the fight for social justice takes place is important and can differ hugely from place to place. And so there is no "magic recipe" for empowerment. We suggest a few basic ingredients but everyone must flavour the dish according to their own local circumstances.

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Health: a right

1. Health for all, really?

Good health is not something we can take for granted; no-one has absolute control over it. So what is the right to health? No, it's not the right not to get sick. That would be absurd, as it is impossible to achieve and not all illnesses and diseases can be prevented.

So what is it then? If we talk about health as a right, that says something about our vision of human beings and society. Health is largely determined by the circumstances in which we are born, grow up, live, work and grow old. We are all entitled to living conditions that enable us to lead as healthy a life as possible. Political choices influence these conditions. That is why health is the responsibility of the State and hence a right that we can claim.

And this right is universal; it is recognised by the United Nations as a human right and more than 50% of UN member states have incorporated the right to health into their constitution.[1] That is important, for human rights have a place in international law and have a special significance:

- **Human rights apply to everyone,** regardless of race, religion, political opinions, sex or status. Everyone is entitled to them equally and without discrimination. Everyone has the same right to health.

- **Human rights can be claimed.** For where there is a right, there is a duty. A human right means that you can and may also expect someone else to fulfil this duty. But you should not expect to wait until it is handed to you on a plate.

- **Human rights become the responsibility of the State** as soon as a treaty has been signed. Under these treaties, the State is obliged to comply with minimum standards and procedures so that citizens can benefit from their rights. There are three levels of obligation: to respect, protect and fulfil these rights.

Talking about the right to health is not merely a philosophical argument or fancy words. It also has consequences

1 Heymann, Jody, Adèle Cassola, Amy Raub and Lipi Mishra, "Constitutional Rights to Health, Public Health and Medical Care: The Status of Health Protections in 191 Countries". *Global Public Health* 8, no. 6 (July 10, 2013): 639–653. doi:10.1080/17441692.2013.810765.

for how we intend to tackle the problems. There are important differences between a rights-based and a traditional approach to health and development. To make the differences clear, we use various perspectives: a right applies to everyone and is not something that can be replaced by selective aid or charity, a right can be claimed, a right has to do with justice, not with laws that serve vested interests.

A right applies to everyone

Human rights apply to everyone, without distinction. If we refer to health as being a right, then this, too, applies to everyone, without distinction. We cannot accept that some people should have more right than others to healthy living conditions, or more right to health care. Yet for billions of people, the reality seems to be very different. We all know that the realisation of the universal nature of this right remains elusive.

But do we not find it too easy to accept that not everyone can enjoy the right to health? That, in practice, we do have this right but many others do not? During workshops on the right to health, we sometimes challenge participants to consider that no-one chooses where he or she is born. You cannot take credit for being born in Brussels; nor is it a personal failure to grow up in a poor part of Kinshasa. So why shouldn't children in both of these places have the same right to a decent life?

In the Middle Ages, there was the birthright. You inherited rights based on where in society you happened to be born: as a prince or princess, as the son of a goldsmith or as a serf, bound to the lord of the manor. But why, in

a globalised world, where we get our fruit from southern countries, our toys from Asia and our Belgian medicines are sold worldwide, should we still be talking about something like this as a "birthright"? Opting for universality is a conscious choice, even though it is also an enormous challenge, for in reality there is huge inequality.

Children are born everywhere, but they do not live long, happy lives everywhere. Marie, born in Brussels, is 42 times more likely to reach her fifth birthday than Charles, who is growing up in a poor district in Kinshasa. In Congo, 168 children out of 1,000 die before the age of 5.[2]

Things would be very different if Charles were to grow up in a well-to-do family in Kinshasa: his life expectancy would increase considerably. A viable family income doubles a child's chances of survival, and in well-educated families they are even trebled. In this scenario, Charles' chances of survival are actually higher than Marie's if she grows up in a poor immigrant family in a deprived suburb of Brussels.

2 Democratic Republic of the Congo: health profile (WHO): http://www.who.int/gho/countries/cod.pdf

However, other factors also play a part. If you have been to Kinshasa you will know that, as evening draws in, there is no escaping the mosquitoes and then just about everyone is at risk of catching malaria. Or maybe not everyone?

You can take precautions and cover yourself with insect repellent, but you can only buy that at a Western-style department store in the city centre. You will not find it in the local pharmacies in areas where millions of poor Congolese live. You can also take preventive medicines, but a monthly dose of malarone costs around 90 euros, more than the average income of a Congolese family. Or you can sleep in a protected, air-conditioned room, but that is impossible for most families in Congo, where there is no electricity much of the time. So, the risks are not the same for everyone.

The traditional approach to health care seems simple enough: someone has a health problem and we need to put it right. The health of poor people in Sub-Saharan Africa clearly leaves a lot to be desired. Something needs to be done here – African patients need to get well again. Africa and its poor people are suffering deprivation in terms of health, and this needs to be redressed.

If we take a rights-based approach to the same situation, we see these poor people not as the needy suffering deprivation, but as excluded and exploited people whose rights have been violated. We therefore need to concentrate our efforts on social justice. Most people die of diseases that are easy to prevent or cure. We know everything about these diseases and there is absolutely no - or hardly any - need for expensive research on them. Diarrhoea and pneumonia are two of the major causes of death worldwide, yet they can be eradicated so easily by giving people access to clean water and by providing them with a job, healthy working conditions, sufficient income to buy basic provisions, and decent housing.

Rights are the responsibility of the State

The State has a special role to play where there is a rights-based approach to development and health. If we recognise that someone has a right, then we must also recognise that someone else has a duty. In the case of the right to health (just as with many other rights), this duty and responsibility is primarily borne by the State, as laid down in international treaties. So, with a rights-based approach, we turn first of all to the State to claim those rights.

But what do we expect from the State? In 1976 the strongly medicalised health care world was shaken by Halfdan Mahler, Director-General of the World Health Organisation (WHO) at the time. He argued: "Health for all implies the removal of the obstacles to health - that is to say, the elimination of malnutrition, ignorance, contaminated drinking water and unhygienic housing - quite as much as it does the solution of purely medical problems".[3]

Mahler's words did not come out of thin air, but were based on concrete examples. In Costa Rica, a poor country in Central America, public health improved spectacularly in the 1970s. The development of universal social security and a sound primary health care system meant that even the poorest had access to proper health care. Health workers went to the most remote villages to offer their services, ranging from vaccinations, family planning and other preventive activities relating to hygiene and sanitation

3 H. Mahler and WHO. World Health Organization, *The Meaning of "Health for All by the Year 2000": Reprinted from World Health Forum, Vol. 2,* World Health Forum no. 1 (World Health Organization, 1981): http://books.google.be/books?id=papVGwAACAAJ.

(safe drinking water, housing, toilets) to support activities like health education and community health programmes.[4]

Mahler's ideas were embraced thanks to the zeitgeist of the 1970s, a period when social justice was high on the international agenda.[5] A number of developing countries had shaken off the shackles of colonialism and were making remarkable social progress. International organisations such as WHO were seeking alternatives to the selective approach to certain diseases, an approach that had prevailed during the 1960s.[6]

In 1978, spurred on by Mahler, WHO and UNICEF brought together 3,000 delegates from 134 governments and 67 international organisations in Alma Ata, Kazakhstan. The conference's final declaration was an impassioned plea for "Health for all by 2000", a goal that was deemed possible by investing in primary health care. The proposed strategy went distinctly further than health care and also involved governments tackling the underlying social, economic and political causes of health problems. The Alma-Ata declaration expressly stated that, in addition to the active role of the health sector, coordinated efforts were also needed in all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors.[7]

Rights are not negotiable

If we recognise that someone has a right, then we must also recognise that someone else has a duty. If someone's rights are violated, someone else is violating them. That is why we cannot remain neutral if we take a rights-based approach to health.

4 L. Saenz, "Health Changes During a Decade: The Costa Rican Case" in *Good Health at Low Cost*, ed. S. Halstead, J. Walsh and K. Warren (New York: Rockefeller Foundation, 1985).

5 "WHO | Primary Health Care comes Full Circle. An Interview with Dr Halfdan Mahler", *WHO*, accessed 28 August 2012: http://www.who.int/bulletin/volumes/86/10/08-041008/en/index.html.

6 "WHO | Consensus during the Cold War: Back to Alma-Ata", *WHO*, accessed 28 August 2012: http://www.who.int/bulletin/volumes/86/10/08-031008/en/index.html.

7 "Declaration of Alma-Ata" (WHO, n.d.): http://www.who.int/publications/almaata_declaration_en.pdf.

A horrific birth story

In 2012 there was an outcry from the Filipino women's movement after a 28-year-old, Jane, gave birth to a son after a Caesarean section was performed with... a kitchen knife. This shocking story is a harrowing illustration of the lack of an accessible and efficient health system for the poorest people in the Philippines.

There was fierce protest from Gabriela, a Filipino women's organisation and a partner of Third World Health Aid. No mother should ever have to go through such a horrific experience in a health system that puts the health of mothers first. Jane's story was reported in the press, but in rural areas in the Philippines there are thousands of women who have to give birth in the most wretched circumstances, just like Jane.

It is therefore high time for radical reforms to the health policy. According to Gabriela, however, the government also needs to tackle fundamental issues such as unemployment and poverty. Poor women are the first to fall victim to complications that are easily

If we sympathise with the millions of poor people in the South, we have to take sides. Starting with the sources we consult to analyse the issue: reports written by experts who are paid directly or indirectly by multinationals will not be the same as the accounts given by the farmers who are the victims of a conflict of interests. In the Philippines, landless farmers are banding together to claim land. They are clashing with major landowners who systematically portray the farmers' representatives as "terrorists" against whom they have to defend themselves. The Philippines is notorious for political killings perpetrated by the army or State-financed militia who escape prosecution and go unpunished.

Something may be perfectly legal but not necessarily just. Until 2012, the Congolese people paid 50 million dollars every month to Western banks for debts run up by the dictator Mobutu in the 1970s. This was completely legal

preventable, but due to lack of money they have little or no access to health care, and this situation is being exacerbated as a result of the government's privatisation policy. In 2012 the government had plans to privatise 26 of the biggest regional hospitals. Clearly, profit-oriented hospitals will not be focusing on the poor majority of the population.

Gabriela is critical of the government: "However you look at the situation, the government is not fulfilling its duty to guarantee the well-being of its citizens. This is evident from the drastic cutbacks in the health budget. Fewer health care professionals mean less health care per Filipino. It's a death sentence for millions of women who can barely cope with the crisis of unemployment, poverty and rising cost of living. If the government really wants to meet the goal of reduced maternal mortality, it should halt its health-sector privatisation schemes immediately. Instead of encouraging health workers to go and work in other countries, the government should hire more nurses and midwives, promote health education in the community and upgrade the knowledge of traditional birth attendants so that they can prevent pregnancy-related complications. All this is a question of policy choices." ■

and involved regular summons to international courts when the Congolese government failed to deliver the money on time. Legal, but is it fair for poor Congolese people to be paying to enrich Western bankers?

We cannot be indifferent when it comes to the basic rights of the majority of the population; those rights are not negotiable. We cannot endorse analyses and arguments that legitimise large social groups being deprived of basic rights. We are not responsible for the problems created by an inadequate system, but it is our duty to exact social justice. Analysing the problems in their wider context therefore means, first and foremost, taking sides.

Filipino researchers side with social struggle

In 2005 the source of income of the Rapu-Rapu islanders became severely compromised when the Australian mining company Lafayette discharged tonnes of mine tailings and litres of waste water into the rivers and sea. The incident illustrates the devastating consequences of large-scale mining operations on vulnerable ecosystems, livelihoods and public health, but also the chronic poverty and lack of social services on the island.

Lafayette Philippine Incorporate (Lafayette) is an Australian mining company that embarked on polymetallic mining in Rapu-Rapu in April 2005. The government had provided the company with the necessary licences without any proper consultations or a thorough environmental impact report. Furthermore, the company was granted economic zone (ecozone) status, meaning that it did not have to pay any taxes for six to eight years in exchange for its investment in the area. This became the flagship project of the national mineral policy and shows how aggressively the government tries to attract foreign investment in mining activities.

Together with a number of non-governmental organisations and the Church, farming and fishing community leaders protested against the presence of the mining company and tried to refute the alleged economic benefits of the project.

With this aim in mind, research was carried out to ascertain the impact of the mining operations on their income, their health and the environment in Rapu-Rapu and Prieto Diaz.

In February 2007 a team from the Philippine research centre IBON conducted a study on the consequences of the mining project in Rapu-Rapu and the adjacent municipality of Prieto Diaz[8]. The result is a story about people who are fighting for their island and the future of their children, about people who became caught up in a long and bitter battle. A battle that they are still fighting despite attempts by Lafayette to spread dissension among the people and the smoke screen put up by the Philippine government to protect the company.

Making themselves heard

The research team was composed of three IBON employees and a local ac-

8 IBON is a Philippines-based research centre that acquires expertise for the benefit of the Filipino people's movement in its struggle for rights and social justice.

Photo: Arkibon Bayan

tivist. The study showed that around 4,473 families in Rapu-Rapu and 2,898 in Prieto Diaz suffered losses from Lafayette's activities. These were mainly the families of farmers and fishermen who are dependent on the sea for their livelihood. The tax exemptions granted to companies under the terms of the 1995 Mining Act, and also the ecozone status, also caused a sharp drop in revenues for local and national government.

Even today, the Rapu-Rapu Polymetallic Mining Project is having an impact on the income of the island inhabitants, as well as on those of Prieto Diaz to some extent. Poisoning of fish, shellfish and marine organisms as a result of mining operations results in a weekly loss of earnings of between 33.3% and 89%. The research shows that people's incomes have been affected not only by the depletion of marine fauna, but also by the pollution of the water available for farming. Many inhabitants have had to adapt. Some go fishing more frequently, others try to supplement their income with all sorts of community work or move to other areas in the

hope of finding casual work, for example as carpenters or rickshaw drivers.

People living near the mine also reported that children and fishermen are affected by a variety of skin disorders. The inhabitants of Tinopan complained of breathing problems when the wind blew from the direction of the mine.

Failed attempt to divide the population

The Rapu-Rapu study supplied valuable information, despite the difficulties and threats that the researchers were subjected to by the military personnel in the area. The research also backs up IBON's analysis about the impact of private mining companies on the local population in poor countries such as the Philippines.

The research team was witness to the efforts made by the company to get the inhabitants onside. Meetings were organised to draw attention to numerous socio-economic projects. The promised economic development was supposed to dispel the inhabitants' distrust. Researchers also witnessed how the company management tried to divide the community by making promises about work and electricity. They recorded how the inhabitants of Malobago, a community near the mine, where a number of Lafayette's workers lived, were watched by a company employee during one of the group discussions.

Thanks to the field study, the dispute in the area took on a human dimension. The variety of opinions, perceptions and experiences shared by people who were clearly familiar with their environment made the discussions very productive. The research data and the inhabitants' stories helped environmental activists and many other types of organisations to bring the situation in the area to the attention of national and international forums. In that way, they supported the people's organisations in their struggle.

The debate in practice: are we fighting to reduce maternal mortality or to improve women's health?

Maria Zuñiga works for the Movimiento para la Salud de los Pueblos de Latinoamérica (MSP-LA), the regional network of the People's Health Movement (PHM) in Latin America. One of the main issues for her is whether we see women as "patients" requiring treatment or as active participants who are fighting for their right to health. Are we dealing with women living in misery or with victims of social injustice? Her many years of experience with primary health programmes in Central America provide us with an interesting glimpse of the trends over the past few decades. Her story also shows how the debate in the higher echelons can have an effect at grassroots level. Are we fighting to reduce maternal mortality or to improve women's health? It is a vital distinction that has everything to do with how we look at human beings and society.

From mission worker to brigadista

Mission workers, usually women, were often responsible for developing primary health programmes in Central America. Inspired by liberation theolo-

gy, which regarded poverty as a consequence of oppression, social inequality and economic injustice, they travelled in the 1960s to the poor indigenous farming communities. They developed primary health programmes there against a backdrop of dictatorship and repression. Public health care was practically non-existent, apart from a few family planning and nutrition programmes, often US initiatives.

In the 1970s the health programmes expanded to cover the whole region and in 1975 the Regional Committee for the Promotion of Community Health was established as an umbrella organisation for the different initiatives. This Committee is still part of MSP-LA today.

Maria: "Right from the start, we've worked with the community leaders, both men and women. We trained them in primary health care so that they could look after their own health and that of their community. They're not professionals, and often they don't speak any Spanish, only their own indigenous language. When the progressive Sandinista movement in Nicaragua ousted the dictator Somoza in 1979, we became active in public health campaigns.[9] Women and young people became pioneers in their communities. The results were phenomenal: in a country with 3 million inhabitants, 10% of the population, i.e. 300,000 people, were trained as health workers.

"Regimes in countries like Honduras, Guatemala and El Salvador feared that the success of the Sandinistas in Nicaragua would also inspire revolutionary movements in their countries so they stepped up repressive measures against their own people. In 1981 there was a massacre in Honduras in a farming community with an active regional committee. Many of the people we worked with there at that time were women. Since then, we've been focusing more on the specific problems facing women in Central America."

Change of focus from "mother and child" to sexual and reproductive rights and gender-based approach

In 1987 the regional committee sent 35 female delegates from Central American farming communities to the International Women's Health Meeting

9 The Sandinista National Liberation Front (Spanish: *Frente Sandinista de Liberación Nacional, FSLN*), also called "the Sandinistas" in English and Spanish, is a social democratic political party and former revolutionary movement in Nicaragua. The FSLN ruled Nicaragua from 1979 to 1990 and has been back in power since 2006. (based on Wikipedia)

in Costa Rica. Maria: "Despite living through turbulent times, we managed to rally these women in the community to present to the public, for the first time, the regional committee's work on promoting primary health care. This was a significant step, as our organisation had been semi-clandestine up until that point, due to the nature of our work and the people we were working with. We worked hard to broaden the traditional, narrow focus on the health of mother and child to gender-based topics and women's health throughout their entire life. We also wanted to expand the focus on family planning to a broader campaign for sexual and reproductive rights. The 1990s were a fruitful period for the women's network, a time when we got support from local and national governments and donor agencies to develop our agenda for women."

Women's health reduced to maternal mortality

After Hurricane Mitch in 1998, which badly affected Central America, the regional committee also began to think about climate change and disaster preparedness. Attention shifted, first and foremost, to the vulnerability of poor communities and of women in particular. Maria: "In our regional network we started to look at topics that were unfamiliar to the women and farming communities we were working with, such as globalisation, neoliberal policy and privatisation of public services, in the health sector and elsewhere. We broadened our work on sexual and reproductive rights to a wider rights-based approach, although still from a feminist perspective."

While the women's organisations were seeing their rights from a broader perspective, the opposite trend was observed among international institutions and governments. Maria: "From 2000 on, we became caught up in the millennium development goals, which were a step backwards compared to the 1978 Alma-Ata declaration with its 'health for all' demands. The millennium development goals actually put the emphasis on 'illness', thus reducing women's health to women's illnesses, maternal mortality, HIV/AIDS, and so on. But why do we talk about death instead of life whenever the issue of women's health is raised?" ■

Social determinants of health

2. Good health begins with a proper diagnosis

If we recognise health as a right for which the State is responsible, what does this responsibility entail exactly? Is there any policy that will guarantee the right to health for everyone? What affects our health and why are there such big differences in health between countries and even between different groups of people in the same country?

In 2005 the World Health Organisation established a commission to investigate these questions. Chairmanship of this Commission on Social Determinants of Health (CSDH) was entrusted to Sir Michael Marmot, a British public health expert with an impressive research record.[1] When he accepted the post, he announced that the commission would seek out the "causes of the causes" of disease and death.

Marmot surrounded himself with 18 commission members from all over the world, all with very different backgrounds. In turn, the commission members called upon many different "knowledge networks", groups of experts on various key subjects. Based on their reports, the commission published a sensational final report in 2008.

The report opens with the statement that our children have completely different life expectancies depending on where they are born. In Japan they can expect to live to the age of 80; in Brazil, 72; in India, 63; and in a number of African countries, less than 50. In general, rich people have better health than poor people. In other words, the differences in health are avoidable, unjust and unacceptable. The commission therefore came to the conclusion that: "Social injustice is killing people on a grand scale".

Differences in health are, therefore, the consequence not so much of biological differences between people but of the circumstances in which people are born, grow up, live, work and grow old. These circumstances are, in turn, determined by deeper social factors: social policy, economic relations and political measures. Living conditions and deeper social factors are the social determinants of health. Marmot & co are clear in the introduction to their report: "This toxic combination of bad policies, economics and politics is, in

1 WHO Commission on Social Determinants of Health (2005-2008): http://www.who.int/social_determinants/thecommission/

large measure, responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible".[2] In other words, anyone who believes that health and politics are two different things is very much mistaken.

The wide disparities between countries are not the only problem. There is often a huge gap within the same country, even in rich countries. We often speak about the gap between rich and poor but the report qualifies this and talks about a "social gradient". If we divide up the population of any country into equal parts according to social status, then we see that those at the bottom of the social ladder will have the worst health indicators. The health status of the group on the rung above will be better and that will be the pattern until we reach the top rung of the social ladder.

Even in the affluent West, social origins determine our opportunities and social position: you are "just" a labourer or a humble white-collar worker and you should "know your place". In addition to the poorer working conditions, this inferior treatment is, in itself, a factor affecting health. Life expectancy differs sharply between various population groups in the same country. You can cycle from Somers Town, in central London, to Hampstead, a wealthy area north of the city, in 25 minutes. In less than half an hour, you have gone from a neighbourhood where men live for 70 years, on average, to one where the average is 80 years. In Washington DC you can take the metro from the centre to Montgomery County, in the north of the city; there is a 20-year gap in life expectancy between poor blacks in downtown Washington and well-off whites in the suburbs.[3]

It is worth noting that what we are seeing here is inequality in rich countries, where it cannot simply be explained away by poverty. To illustrate this, reference is often made to the Whitehall studies, a large-scale investigation into the health of British civil servants. All had jobs with a fixed, decent salary yet the researchers found huge disparities among the civil servants themselves. The higher they climbed the adminis-

2 *Closing the gap in a generation: health equity through action on the social determinants of health: Commission on Social Determinants of Health final report* (Geneva, Switzerland: World Health Organization, Commission on Social Determinants of Health, 2008).

3 Michael Marmot, "Health in an Unequal World", *The Lancet* 368, no. 9552 (December 2006): 2081–2094, doi:10.1016/S0140-6736(06)69746-8.

trative ladder, the longer they lived.[4] As you move down the ladder, each social class below is a little bit less healthy than the one immediately above it. The higher up the social ladder you go, the better your health indicators become, step by step.

In their book, "The Spirit Level"[5], Richard Wilkinson and Kate Pickett, British researchers who have been investigating health inequality for years, present a convincing argument for how important social equality is for the health and well-being of the population. Countries with greater social equality score better on a range of social indicators. Equality is a relative concept, however: poor people in the US will earn more than the middle-classes in Ghana, yet will be less healthy because of their inferior social position.

The differences between the highest and lowest rung of the social ladder can change, as history shows: in 1970 child mortality in Greece and Portugal was higher than in Egypt or Mexico in 2008. However, a few decades later, these southern European countries were topping the league table with hardly any more infant deaths than Iceland, Japan or Sweden. Yet the reverse can also apply. In the former Soviet Union, health status has declined since the fall of socialism and the "shock therapy" that followed, involving the rapid dismantling of social programmes and a switch to neoliberal capitalism. The lower social classes, in particular, experienced a dramatic decrease in life expectancy.

How the gap was formed

The Marmot report links unequal health status between countries to policy choices and power relations, thereby cautiously calling into question the global system.

If we look at inequality in health on a global level, it is tempting to think that the world was always divided into the rich, developed countries in the North and the poor, underdeveloped countries in the South. Peoples and regions have always developed at different rates, of course, but the issue of inequality was very different in the past. There were regional differences but, by and large, global developments were on a similar scale.

It was not a superior religion, values or ideas that made Europe so strong, but

4 M.G. Marmot and M.J. Shipley, "Do Socioeconomic Differences in Mortality Persist After Retirement? 25 Year Follow up of Civil Servants from the First Whitehall Study", *BMJ* 313, no. 7066 (November 9, 1996): 1177–1180, doi:10.1136/bmj.313.7066.1177.

5 Richard G. Wilkinson and Kate Pickett, *The spirit level: why equality is better for everyone* (London; New York: Penguin Books, 2010).

its capacity and willingness to resort to organised violence at certain moments in the past. What was known as "triangular trade", based on the slave trade, would give Europe a crucial head start. Ships crammed with slaves set sail from West Africa for North America or the Caribbean; these African slaves were sold in America to work on the plantations. Ships laden with luxury goods such as sugar, rum, coffee, silver and tobacco left from North America and the Caribbean heading for Western Europe.

The industrial revolution would then lead to the development of thousands of companies, with smaller businesses quickly being swallowed up by their larger competitors. Large monopolies came into being, which dominated national markets and also looked beyond national borders to boost their profits. The most dynamic companies in the markets gained a critical competitive edge over the others and became genuine multinationals.

In the late 19th century, these multinationals began to spread their wings over the whole world. Financial institutions sought new investment opportunities in the South. New technologies and the opening of the Suez Canal in 1869 brought a sharp increase in imports and exports. The agricultural economy of the colonies was exploited for the sole benefit of the colonial powers. The production of food for local markets made way for the cultivation of crops for export.

It is easy to imagine how this affected the well-being of ordinary people in the colonies. Travellers and diplomats who visited El Salvador in the mid-19th century reported no famine or poverty. It was only when the large-scale coffee plantations began to produce for export, in the 1870s and 1880s, that the situation changed. To ensure sufficient manpower was available for the plantations, land rights were revised and access to common land was abolished, resulting in poverty and hunger.[6]

This was a pivotal moment in history when the world was divided between rich and poor countries. Granting formal independence to the colonies would not change anything. The economic gulf between nations remains huge and is growing larger in some cases. Only now, in the early 21st century, are we seeing "emerging economies" in the South, which are trying, in their own way, to keep pace with rich Western countries. China is one of these "pioneers".

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6 L.A. Avilés, "Epidemiology as Discourse: The Politics of Development Institutions in the Epidemiological Profile of El Salvador", *Journal of Epidemiology and Community Health* 55, no. 3 (March 1, 2001): 164–171, doi:10.1136/jech.55.3.164.

China and our world view

In the West there is a prevailing belief that we owe our progress to our enlightenment and knowledge and that we must help other countries that are lagging behind to catch up. However, the modern history of China turns our traditional world view upside down. “China is a much richer country than any part of Europe,” wrote Adam Smith, one of the pioneers of the capitalist economy, in 1776.[7]

In 1800 more than half of the goods in the world were produced in China and India. Gross national product (GNP) per capita of the population in Asia and Europe was more or less the same. By the early 20th century, China and India’s share of world production had fallen to 8%. GNP per capita was two to three times lower than in Europe.[8] Colonial plundering had considerably weakened these countries, and China had been torn apart by war and occupation.

Today, thanks to its restored sovereignty, China is once again a world nation and is gradually overtaking most major economies. Nowadays, global development dynamics are co-determined by China and its economic relations with the countries in the South. Although the country is heavily criticised for its poor social conditions, global poverty reduction results would be a great deal worse without China’s achievements. It is true that there are a lot of immensely rich people in China, but many farmers’ incomes have also doubled in the past ten years. China has lifted hundreds of millions of people out of poverty. This does not alter the fact that China is facing huge challenges, but let us not forget that the industrialisation process in western Europe was also very brutal, involving radical measures that created unprecedented social and ecological problems. In China, the process involves five times as many people and is moving four times as quickly.[9] ■

7 Adam Smith, An Inquiry into the Nature and Causes of the Wealth of Nations, 1776.

8 Philip Golub, “Retour de l'Asie sur la Scène Mondiale”, Le Monde Diplomatique, October 2004, http://www.monde-diplomatique.fr/2004/10/GOLUB/11551

9 Marc Vandepitte, Tikt een sociale tijdbom in China? (2013): http://www.dewereldmorgen.be/sites/default/files/attachments/2013/07/04/china_sociale_tijdbom.pdf

And how the gap is steadily widening

It is often said that globalisation and liberalisation of world trade are fundamental to progress and prosperity. But this is by no means true for everyone; on the contrary, social inequality is increasing on a worldwide scale. Although the world has never produced as many goods and services as it does today, the disparity between rich and poor has doubled. In 1960 the richest 20% of the global population owned 30 times more than the poorest 20%; by 1997 it was already 74 times more.[10] The richest 10%, half of whom live in the US or Japan, owns 85% of global wealth.[11] The richest 1% in the world has as much as the poorest 57%, or, in other words: the fewer than 50 million richest people have as much as the 2.7 billion poorest people.[12]

How is this possible? The paradox is that, as companies make more profits, poverty and hardship increase; profit and prosperity are not necessarily linked. Every company is locked in a competitive battle with other companies. Shareholders want the greatest possible return on their investment. Companies that are unable to achieve healthy profit margins inevitably lose investors to more profitable companies and sectors. Every business applies similar mechanisms in order to achieve profits. One of these is "modernising", which comes down to more production with fewer people or cutting wages or the number of employees. Companies that can do so move their production base to lower-wage countries or flood these markets with cheap products.

Poultry farmers in Kinshasa have first-hand experience of this. A few years ago they came into conflict with multinationals that have a greater turnover than the national economy of some countries in the South. Franco-Belgian capital groups invested in industrial poultry farming in Brazil. They exported chicken breasts to Europe and chicken wings to Kinshasa at dumping prices that forced the local farmers out of the market. Poultry farming has now all but disappeared in Kinshasa. And all this is done in the name

10 United Nations Development Programme, *Human development report 1999* (New York; Oxford: Oxford University Press, 1999).

11 James B. Davies and World Institute for Development Economics Research, *Personal wealth from a global perspective* (Oxford; New York: Oxford University Press, 2008).

12 B. Milanovic et al., *Decomposing World Income Distribution: Does the World have a Middle Class?*, Policy Research Working Papers (World Bank, Development Research Group, Poverty and Human Resources, 2001): http://books.google.be/books?id=RW_KRkaOLbEC.

of "free trade"': multinationals claim the right to drive local farmers out of business and entice buyers with their cheap products.

Investors are always looking for opportunities to maximise the return on their capital. Social sectors such as health care or water distribution can also be profitably managed, but only by those who are prepared to sell out on social justice. The pharmaceutical industry, for example, is particularly keen to deliver impressive annual results to its shareholders and would therefore rather invest in a new diet product for which there is a ready market than in malaria treatments. Although a treatment for malaria would help millions of people, often they have no purchasing power to pay for it, meaning no increase in profits for the pharmaceutical companies. The pharmaceutical industry argues that it needs these profits for investment in research, but in actual fact spends more on marketing than on research.[13]

The gap between rich and poor is also expanding in developing countries. The growing debt burden of these countries prompted the International Monetary Fund (IMF), which is dominated by rich countries, to put pressure on governments in the South to make sweeping savings and privatise public services. National health systems came under pressure and many health sector departments were transferred to the private sector. Commercialisation of health care led to growing social inequality. The poor majority of the population had to rely on the remaining underfinanced public health services or no longer had any access at all, as they could not afford to pay. The savings and privatisation programmes in other sectors, including education, social housing and infrastructure, also had catastrophic social repercussions. An object lesson in how inequality between and within countries goes hand in hand.

Who is responsible?

Although people are often aware that the system is structurally flawed, many also believe that the responsibility of the developing countries themselves cannot be played down. Why do their leaders not do more to break this vicious circle? Why do they not do more for the well-being of their people? Corruption, poor governance and lack of democracy often seem to be the obvious answers to these questions.

13 Gagnon, Marc-André, and Joel Lexchin, "The Cost of Pushing Pills: A New Estimate of Pharmaceutical Promotion Expenditures in the United States", *PLoS Medicine* 5, no. 1 (2008): e1. doi:10.1371/journal.pmed.0050001.

Many of these problems are undeniable, of course, but are more likely a consequence than a cause of the unequal relationships between North and South. Corruption, for example, works both ways; for every corrupt leader there is someone who corrupts. A good example of this is Mobutu, the Congolese (formerly Zairean) leader. The very model of corrupt and undemocratic behaviour, Mobutu sold off his country's national assets in exchange for a substantial percentage of the profit. And who were the buyers? Companies in countries like Belgium, France and the US. By way of thanks, Mobutu was entitled to buy country estates in Europe using his small percentage of the profits and open Swiss bank accounts. There was nothing left over for his people, except a country that was sinking deeper and deeper into debt.

Mobutu did not come to power by chance; leaders who advocated a more independent and democratic Congo, such as Patrice Lumumba and Pierre Mulele, were systematically murdered, with help from the North. When President Thomas Sankara announced in Burkina Faso in 1987 that his country would not pay back its debts, he immediately added: "If Burkina Faso alone were to refuse to pay the debt, I wouldn't be at the next conference". Indeed, he was murdered shortly afterwards. There is no mercy for those who choose the interests of their people over the interests of "Western democracies".

Despite the rhetoric, foreign political interference does not guarantee progress in democracy or social justice. When fundamental decisions are not taken in the country itself but, directly or indirectly, in Washington, London or Paris, such nations can hardly be described as democracies. Even if decisions are taken in the country itself, this does not guarantee democracy, though it is a basic condition for its development. Moreover, the people of that country can put more pressure on their political leaders to be accountable for their decisions.

Clearly, no-one benefits more from a drastic improvement in the social determinants of health than the population itself, which is why it is so important that the fundamental political decisions for a country are made in that country. Besides, this is precisely what many social movements in the 1960s and 1970s were demanding: the right to decide for oneself. Algerians wanted their policies to be made in Algiers and not in Paris, and Iranians wanted Teheran rather than Washington to determine how their country was run. The US, however, resorted to all sorts

of methods, including coups and dictatorships in Latin America, in order to avoid that. The sovereignty of a country is one of the UN Charter's basic principles, and for good reason. Sovereignty is still a troublesome issue for many social movements in the South today, but we will come back to this point later.

Unhealthy interference

Today, some people consider sovereignty as an outdated concept. But it is no coincidence that our partners in Congo and Palestine regard their lack of sovereignty as a very important reason for their poor health status. Look at Palestine: how can those people ever hope for a healthy life while the Israeli occupation is destroying civil infrastructure, including schools, hospitals, homes and factories, as well as wastewater and drinking water plants in a country where water shortage is one of the most serious problems? The people of Congo and Latin America want to have a voice when it comes to the exploitation of their natural resources. And instability in eastern Congo makes even building drinking water plants practically impossible.

The sovereignty and stability of some countries are undermined in very different ways. Sometimes directly, for example by military intervention, or indirectly, through unequal trade relations, application of economic pressure, sanctions, coups d'état, support for the opposition or even internal destabilisation using terrorist groups. With coups against Mossadegh in Iran (1953), against Sukarno in Indonesia (1965) and against Allende in Chile (1973), the US succeeded in subduing these countries without the use of armed intervention. More recently, we have seen orchestrated coups in Honduras (2009) and Paraguay (2012).

Below are a few examples illustrating the impact of direct and indirect political intervention on the right to health.

Military interventions

Military interventions are often justified by Western countries as being humanitarian intervention in the interests of human rights and democracy, hence in the interests of the local population.[14] In practice, however, armed intervention is very destructive and makes it impossible for the population, even after intervention, to develop good policies of their own. It also has a direct impact on health and on the social determinants of health. The

14 J. Bricmont, Humanitarian Imperialism: Using Human Rights to Sell War, New York: Monthly Review Press, 2006.

increase in the number of birth defects and cases of cancer and leukaemia in Iraq is a sad example of this. Military intervention also causes large-scale destruction of the infrastructure of a country, even hospitals. The use of chemical or toxic weapons, including by members of NATO, not only affects a lot of ordinary citizens, but also pollutes the drinking water, the air and the soil. Although armed intervention is often justified as being humanitarian intervention in order to help the people on the ground, academic research has shown that this action considerably increases the number of victims.[15] At the start of the NATO bombing campaign in Kosovo (1999), intended to "stop ethnic cleansing", the number of Kosovan refugees soared.[16] Moreover, after the war, ex-soldiers from the Kosovo Liberation Army began to drive Serbs from their land. In 2011 there were calls for humanitarian intervention in Libya because Colonel Gaddafi's forces was reported to be about to commit a massacre in Benghazi. It was subsequently reported in The Guardian that the death toll before intervention was around 1,000-2,000 and after intervention, between 10,000 and 50,000![17]

Free trade

Free trade agreements can also pose a serious threat to a country's sovereignty and the well-being of its people. There is nothing wrong with trade per se; the same cannot be said where trading is carried on between unequal trading partners and only in the interests of a small elite.

When it comes to trading relations, the economic clout of developing countries can hardly be equated with that of the United States or the European Union. Yet the EU and the US are seeking to use free trade agreements to impose all kinds of conditions on developing countries. This can often be taken literally. For example, in April 2013 Europe informed Botswana, Namibia, Cameroon, Ghana, Ivory Coast, Kenya and Swaziland that unless they ratified free trade agreements quickly, it would impose tariffs on their exports to the EU.

15 Reed M. Wood, Jacob D. Kathman and Stephen E. Gent, *Armed intervention and civilian victimization in intrastate conflicts,* Journal of Peace Research, 20 12 49: 647: http://jpr.sagepub.com/content/49/5/647.full.pdf+html

16 A. Roberts, NATO's "Humanitarian War" over Kosovo, Survival, vol. 41, no. 3, Autumn 1999, pp. 102-23, The International Institute for Strategic Studies: http://www.columbia.akadns.net/itc/sipa/S6800/courseworks/NATOhumanitarian.pdf

17 S. Milne, If the Libyan war was about saving lives, it was a catastrophic failure, The Guardian: http://www.theguardian.com/commentisfree/2011/oct/26/libya-war-saving-lives-catastrophic-failure

Colombian farmers organise themselves agaist free trade agreements (In Spanish: Tratado de libre comercio or TLC)

Development clearly comes below economic interests on the EU's list of priorities.

For the EU and the US, free trade agreements are an instrument for consolidating their competitive position and giving multinationals easier access to foreign markets for export, production or purchase of cheap raw materials. This is why many free trade agreements insist on liberalising access to natural resources and to the strategic sectors of these countries, with the result that national governments lose control of them. Often these agreements even provide for dispute resolution procedures, whereby multinationals can prosecute local governments if they, in the interests of their people, fail to listen to them properly. Consequently, multinationals have a greater say in local politics than the local population.

It is also no coincidence that these free trade agreements are often highly disadvantageous for the local population. They are thus a threat to local development in the countries concerned, since, for instance, the average Colombian or Peruvian farmer is clearly unable to compete with subsidised European producers. Eberto Díaz Montes, president of the biggest farmers' union in Colombia, explains the impact of the free trade agreement between Colombia and the US and the impending consequences of an agreement with the EU: "At the moment we're going through a severe crisis; many small and medium-sized businesses are struggling to stay afloat. The free trade agreement with the EU threatens 600,000 families of dairy farmers who won't be able to compete with the European milk producers. This will therefore lead to mass unemployment with a knock-on domino effect. Not only dairy farmers will be affected, but also producers of rice, maize, soya and other food crops. Bulk imports of agricultural products increase our dependency and are a threat to Colombian food sovereignty."

Free trade agreements also have political consequences. Eberto Díaz Montes again: "The Colombian constitution will have to be changed in order to enter into the free trade agreement with the EU. The agreement negotiated with the US also resulted in amendment of the constitution in favour of multinationals like McDonalds, Cargill and Monsanto." What is this all about? Free trade agreements often mention what is euphemistically referred to as "better protection of patents and intellectual property rights". One condition of the free trade agreement with the US was that farmers may no longer use unregistered seeds. This led to the destruction of 77,000 kg of rice seeds in Campo Alegre, Huila, by the agency responsible for monitoring agricultural activities in Colombia – at the request of… Monsanto. No-one would ever have known about this without the documentary "9.70" on YouTube. The outcry was unprecedented: Colombia, a country where people are starving, allows the destruction of so much food in order to curry favour with a greedy profit-seeking multinational. A farmer producing his own seeds is suddenly an outlaw.[18]

Free trade agreements such as this are also damaging to health care. Opening up the health sector to the private sector will lead to further privatisation. In the interests of its pharmaceutical industry, Europe is insisting on extending patents and property rights

18 V. Coteur, Colombiaans boerenverzet tegen vrijhandelsakkoorden: http://www.voedselteams.be/colombiaans-boerenverzet-tegen-vrijhandelsakkoorden

to medicines, thus paving the way for monopolies and higher prices. As a result, the poor risk losing their access to health services. Often these agreements also harm the environment, another important determinant of health. As well as increased exploitation of natural resources, the economy tends to focus more on exports. Monoculture of products for export is encouraged, including palm oil, which is used as a biofuel. For this purpose, whole swathes of forest are felled and local food security is compromised. Finally, free trade agreements represent an indirect threat to political and social rights. Liberalisation and privatisation intensify social differences and, where there is an increase in social inequality, the number of human rights violations also rises. This is the very opposite of sovereign and sustainable development.

The pharmaceutical industry is an extremely profitable sector with a powerful lobby. In 2000 the ten biggest pharmaceutical companies reported sales in excess of 250 billion euros. In the negotiations for a free trade agreement between the EU and India, the pharmaceutical industry, with support from the EU, is fighting a hard battle to prevent India from continuing to produce generic medicines. In the medicinal products sector, India was reproached for "cheating" because it invested in cheap generic medicines and was not too concerned about the intellectual property rights on some medicines.

Health and sovereignty go hand in hand in the Democratic Republic of Congo

On 20 November 2012, when armed Rwandan-backed M23 rebels occupied the eastern Congolese city of Goma, the inhabitants no longer had access to water or electricity, schools were closed, food was scarce and there was real and immediate danger. Although M23 withdrew on 1 December, everyday life continued to be hazardous. The local section of Viva Salud's partner, Etoile du Sud (EDS), and its health committees reported that the instability and lack of security had a direct and indirect effect on the health and well-being of the local population. The most direct effects were of course the murders, the lootings and the rapes of women and children. For a long time, the inhabitants of Goma feared nightly attacks by armed groups in the city.

The instability has, however, also hampered everyday life indirectly in many ways; in Kivu, for instance, issues with fresh water are particularly acute. The experience of one of the core groups of the Goma health committee shows what lack of security means, in practice, for access to water. The inhabitants of a village, who are dependent on the vast Lake Kivu for their water, only have one supply point, situated about 2½ km from the village. In many places, access to the lake is extremely dangerous, if not impossible. The next supply point is more than 4 km away, a good hour's walk. The pump that used to convey the water from the lake to the village is broken, so the villagers have to go there themselves to fetch water. This means taking a route that is currently very hazardous.

The instability, mainly caused by Rwandan intervention, combined with the Congolese authorities' lack of control over the region, are severely curbing the development of an infrastructure that can provide the local population with drinking water. The infrastructure problem is not limited to the conveyance of water, however; the supply point is used both by local women to wash their laundry and by cattle farmers to water their livestock. The resulting pollution of the drinking water is a direct threat to the health of the users. Together with the people affected, EDS is lobbying the authorities and organising awareness campaigns for the women and cattle farmers. But EDS is also stressing the fact that the installation of a new pump is essential to avoid local conflicts, to reduce long

and dangerous journeys for the population and to prevent children drowning in the lake while they are collecting water. Naturally, the development of a sound infrastructure first of all requires restoration of the Congolese authorities' sovereignty and control over their own territory. ■

Palestine: Health rights under occupation

One of the most flagrant examples of how a sovereign state has been undermined is the decades-long occupation and colonisation of Palestine, which began in 1948 when Palestinians were driven en masse from their villages in what is now Israel. When Israel occupied the West Bank, Gaza, the Golan Heights and East Jerusalem in 1967, it was, as the occupying power, required by international law to provide, among other things, health services for the Palestinians in the areas under its occupation. However, this only happened to a very limited extent. The Palestinians themselves had no funds to organise health care on that scale and there were huge shortages of staff, hospital beds, medication and essential specialised services.

The 1993 Oslo Accords did not create a sovereign Palestinian State, but Israel was able to pass a large share of the responsibility for and cost of health care and other services to the newly established Palestinian Authority (PA), particularly in the areas that came under the PA's jurisdiction. However, more than 60% of the occupied territories remained under full Israeli control. With the support of massive funding from international donors, the Palestinian Ministry of Health has managed to develop health services, but they are still very fragmented as a result of the division of the territories into different zones, of which the PA only controls a fraction. In Area C (62% of the West Bank), there is unequal access to health care for Palestinians compared to that for Israelis living in illegal settlements there. While Israel is freely able to build a health infrastructure in the area for Israeli settlers, the PA has no authority to do the same for Palestinian residents. The network of checkpoints and barriers also makes it very difficult for Palestinian health organisations to reach the inhabitants. The closest hospitals for Palestinians in the Jordan Valley (Area C) are in Jericho and Nablus. However, the checkpoints mean that it is not always possible for them to get the help they need in time.[19]

Restrictions on freedom of movement are also preventing Palestinians in the West Bank from getting to hospitals in East Jerusalem, even though that is where most specialist hospitals are located. Every year, thousands of Palestinian patients from the West Bank and

19 Aimee Shalan, An Unhealthy Accord: 20 years of Oslo and preventable Palestinian aid dependency: http://www.newstatesman.com/2013/09/unhealthy-accord-20-years-oslo-and-preventable-palestinian-aid-dependency

Gaza are unable to reach the hospital in Jerusalem because they are not granted permits to go there.

The health care situation in Gaza is the most distressing. Since the blockade of the Gaza Strip imposed by Israel in 2007, health services in that area have been steadily deteriorating. The blockade means a constant shortage of essential medicines, renders medical equipment useless due to a lack of spare parts and impedes patient transfers to hospitals outside the Gaza Strip. Moreover, hospitals are not being run properly as a result of constant power cuts and contaminated water coming from poorly operating water treatment plants. According to a United Nations report, water, electricity and health problems are so severe that Gaza will be uninhabitable by 2020 unless immediate action is taken.[20]

The situation as regards health care applies equally to other sectors that have an impact on the Palestinians' right to health, such as housing, decent work, education, agriculture, the economy, social services, etc. Despite the existence of the Palestinian Authority, it has little or no scope to pursue its own policies and hence to be held accountable by its own people. Israel controls both imports and exports and levies taxes that it is then supposed to pass on to the PA. In fact, Israel can use this as a lever against the PA: the money is not passed on when it is politically expedient for Israel. The PA is also largely dependent on foreign aid and must comply with the conditions imposed by funding agencies. The 2006 elections won by Hamas provide a striking example. This outcome did not go down well with the "international community", in other words the US and Europe, and consequently the aid was withdrawn and diverted through Palestinian NGOs.

Until the Palestinians can pursue their own policies, genuine development and democracy will remain an illusion. ■

20 Gaza in 2020: A liveable place?, UNWRA, 2012: http://www.unrwa.org/newsroom/press-releases/gaza-2020-liveable-place

Social justice

3. A question of political will

Inequality is not inevitable; nor are violations of the right to health. States have a duty to tackle the social determinants of health and they can do so, if they want to and if they are given the opportunity. Just imagine if Thomas Sankara had been allowed to do that in Burkina Faso!

The People's Health Movement (PHM), of which Viva Salud is part, brings together a wide range of health activists and organisations. In 2012, at their third People's Health Assembly (PHA3) in Cape Town, South Africa, around 800 representatives from every continent gathered to exchange analyses and experiences of their own struggles. PHM pays particular attention to the results achieved by countries introducing progressive health systems that challenge the traditional methods of the World Bank and the International Monetary Fund. Thailand's experience was discussed at PHA3 and Dr Suwit Wibulpolprasert from the Ministry of Health gave a talk on the impressive reform of the health system over the past ten years. Suwit proudly recalled how, to the fury of the pharmaceutical giants and the US, Thais are using any means available to break the monopoly of multinationals and to import cheap medicines or make them themselves. But Thailand is not the only example of how the State can make a difference.

Healthy revolutions

The difference that the State can actually make is often most obvious during times of social upheaval when people are calling for a new system. This is when a country's whole political, social and economic system is turned upside down, and also when people often reject interference by other countries and claim the right to make their own decisions about their future. When these upheavals succeed in establishing a new type of State, there is often a major impact on health.

In 2008 the Bulletin of the World Health Organisation described how, after the Chinese revolution in 1949, China's "barefoot doctors" became a source of inspiration for the primary health care conference in Alma Ata.[1] Central government declared in 1951 that basic health care should be provided by health workers in villages. By 1957 there were already more than 200,000 village doctors across the nation, en-

1 Cui W: China's village doctors take great strides, *Bull World Health Organ* 2008, 86(12):914-915.

abling farmers to have daily access to basic health services, both at home and at work. The expression "barefoot doctors" only became popular in the 1960s as a result of the reform of medical education. In areas lacking health services or doctors, would-be village doctors were given brief training – three months, six months or a year – before returning to their farms and villages to farm as well as practise medicine.

Although the ideology of the Iranian revolution was completely different to that of the Chinese, there, too, the mass mobilisation of the population led to better health for many people. In 1979 the Shah, the Iranian dictator who came to power with Western support, was expelled from the country by a coalition of local political groups that were very hostile to Western imperialism. After the revolution, rural doctors started up prevention programmes, thanks to which child mortality dropped from 122 to 28.6 per thousand between 1970 and 2000. Deaths of children under five decreased from 191 to 35.6 per thousand during the same period. A family planning programme was also introduced. Over a period of about twenty years, the average number of children born per woman went down from 6.2 to 2.1. Literacy rates for boys rose from 59% in 1976 to 81% in 1996; girls showed even more spectacular progress: from 35% in 1976 to 74.5% in 1996. In 1986 there were only 167,971 university students; by 2001 the figure had soared to a one and a half million.[2]

In Costa Rica, a poor country in Central America, the health status of the population improved dramatically during the post-war years. The gradual introduction of universal social security and a robust primary health care system meant that even the poorest had access to proper health care. Health workers went to the most remote villages to offer their services, ranging from vaccinations, family planning and other preventive measures relating to hygiene and sanitation (safe drinking water, housing, toilets) to support activities like health education and community organising.[3] Yet the success of Costa Rica would never have been possible without years of investment in education, primary and secondary education having been free since 1949. It is no coincidence that the 1940s in Costa Rica were years of hard social struggle. Compared to neighbouring countries, the women there are still better educated. This also helps explain the spectacular decline in infant mortality.[4]

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2 T. Coville, Iran, La révolution invisible, Paris, La Découverte, 2007, pp. 130-132.

3 L. Saenz, "Health Changes during a Decade: The Costa Rican Case", in *Good Health at Low Cost*, ed. S. Halstead, J. Walsh and K. Warren (New York: Rockefeller Foundation, 1985).

4 L. Rosero-Bixby, "Infant Mortality Decline in

Cuba is also attracting attention. The social revolution in 1959 made health care accessible to everyone, even the poorest. Although the island was not exactly prospering during the 1960s and 1970s, the redistribution of wealth ensured that the social status of the poorest improved and they were able to meet their most pressing needs. As a result of this, during the 1980s, health indicators for the Cuban population reached a level comparable with that of industrialised countries. Here, too, we see that political choices were fundamental to success. Cuba opted for a health system that is accessible to everyone, and for health services at grassroots level, including prevention and health education. The socialist government also made education a priority, which almost entirely eradicated illiteracy. At the same time, campaigns were launched to give everyone access to safe drinking water and sanitary facilities.

So, despite the American economic embargo, health results in Cuba are comparable to those of developed countries.[5] Vaccination rates are among the highest in the world and life expectancy is 78 years, the same as in the US. Child mortality is 5 per 1,000 live births, lower than in the US. The doctor-patient ratio is very high, with one doctor for approximately 1,000 patients. The Cuban health system, known as *medicina general integral* (comprehensive general medicine), focuses on preventing diseases and treating them as rapidly as possible.[6] Health education forms part of the compulsory school curriculum. Every community has a health centre. Doctors live in the neighbourhoods they serve and therefore know their patients and their patients' needs very well. Yet the government does not spend more on health care than other countries. In 2011 it invested 430 dollars per inhabitant, i.e. 10% of GDP.[7] The same year, the American government spent 8,608 dollars per inhabitant, equivalent to 17.9% of GDP.[8]

Even now, we are still seeing the impressive results of revolutionary upheaval of this type. Hugo Chavez also focused on the social determinants of

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Costa Rica", in *Good Health at Low Cost*, ed. S. Halstead, J. Walsh and K. Warren (New York: Rockefeller Foundation, 1985).

5 Edward W. Campion, MD, and Stephen Morrissey, PhD, "A Different Model — Medical Care in Cuba", N Engl J Med 2013; 368:297-299 January 24, 2013 DOI: 10.1056/NEJMp1215226: http://www.nejm.org/doi/full/10.1056/NEJMp1215226

6 Don Fitz, Why is Cuba's Health Care System the Best Model for Poor Countries?, MRZine, 2012: http://mrzine.monthlyreview.org/2012/fitz071212.html

7 Cuba country profile: WHO: http://www.who.int/countries/cub/en/

8 USA country profile, WHO: http://www.who.int/countries/usa/en/

health, such as education, inequality, work, health care, food security, etc. He increased social spending to 60.6%, a total of 772 billion dollars.[9] This policy reduced inequality by 54%. Poverty was reduced from 70.8% in 1996 to 21% in 2010, and extreme poverty from 40% in 1996 to 7.3% in 2010. Chavez used the revenues of the State-owned oil company PDVSA to invest in infrastructure and social services. Within the space of ten years, by levying taxes, the government had collected 251.7 million dollars (more than the annual oil revenues) and redistributed this wealth. Chavez invested 6% of GDP (gross domestic product) in education. Schools became free from nursery right through to university. Unemployment fell from 11.3% to 7.7%; social security covered twice as many citizens; the national debt was reduced from 20.7% to 14.3% of GNP (gross national product); and annual economic growth rose to 4.3%.

The FMLN (Farabundo Marti National Liberation Front) came to power in El Salvador in 2009.[10] Since then, the Ministry of Health, which reaches 80-85% of the population, has guaranteed the free provision of numerous health services. In 2006, 47% of Salvadorans still had no access to health care. Child mortality rates have since dropped and the country has met the millennium development goal for reduction of maternal mortality. The budget of the Ministry of Health has risen from 1.7% to 2.5% of GDP. Primary health care, prevention and public health lie at the heart of this reform. Dozens of new hospitals have been built in the poorest and most rural areas. These are managed by Community Health Teams, which make outreach visits locally in order to find out about the health needs of individuals, families and whole communities.

9 The Achievements of Hugo Chavez. An Update on the Social Determinants of Health in Venezuela, Counterpunch, 2012: http://www.counterpunch.org/2012/12/14/the-achievements-of-hugo-chavez/

10 Amanda Bloom, Universal Health Care in El Salvador, Global Health Check, 2013: http://www.globalhealthcheck.org/?p=1318

What does this say about "the State"?

Clearly, there is no such thing as a typical "government" or a typical "State". They are different from one country to the next. Even within the same country, the State can take on very different forms and evolve. There is one constant: the State is never neutral. The State takes sides. Let's take some very different examples: Congo, Cuba and a few other Latin American countries.

Congo: a State in transition

The Democratic Republic of Congo has a turbulent past. Our Congolese partners are very experienced at dealing with the authorities, and have had to adapt to changes in circumstances many times already.

Our partner Etoile du Sud developed from the municipal activities organised in Mfumu Nsuka, a working-class district of Masina, a municipality of the capital Kinshasa. EDS has been active since the 1990s and has already been through a lot. Throughout all these years, the core of its operations has been a "reflection group", which read up on many topics and made people more aware of their rights.

Under the Mobutu regime and during the Sovereign National Conference (1980-1996), Mfumu Nsuka was plagued by military raids. The army was no longer getting paid by Mobutu and was seeking its "wages" by stealing anything of any value from poorer neighbourhoods. Spurred on by the reflection group, local young people formed a self-defence committee in order to stand up to the lootings. When the army attacked, it came up against popular resistance.

After the fall of Mobutu in 1997, the reflection group organised a debate on popular democracy in order to have genuine, locally elected "administration of and for the people" in their district. The fight was to ensure that the district was run in a truly democratic manner and to act against local demagogues who wanted to appropriate power for themselves.

Under pressure from the West, these local administrations were abolished in 2003 and preparations for "normal" parliamentary elections got under way again. After the elections, President Kabila launched an appeal for the country to be rebuilt via "the five building sites of the republic" (referring to the government's infrastructure projects).

Since then, the district committee has been working on rebuilding the country and, together with Viva Salud, it has launched a campaign for the right to health. It fully supports the reconstruction and modernisation of the country, but also demands that this should happen in a way that reflects social needs, which is certainly not the case at the moment. By creating a national movement based on the recognition of rights and by seeking allies within the government, its aim is to have a greater say in policy matters. ■

Cuba: participation in health promoted by the State

In Cuba, the authorities actively promote the right to health. Health policy has been designed so as to encourage participation, and equality and accessibility are paramount. The local health service closely involves popular organisations and local administrative bodies in health initiatives. One aspect of Viva Salud's approach is to increase local community involvement in the Cuban health system. No-one knows the problems better than local people themselves, which is why it is important for them to have a say in health policy. But this does not always happen as a matter of course.

Consider the case of Malby Gonzalez, a young woman of 30. All the problems in her district have destroyed her enthu-

siasm: “I didn’t want to hear any more about the district or the municipality or all the organisations or people I considered to be responsible. Especially the government, which I’ve actually always been opposed to. I was sickened by all the injustices and the lack of any sense of responsibility the workers of this country have to contend with, over which no-one is apparently losing any sleep or looking for a solution...”

One day, Malby went to a general meeting of her district committee where locally elected officers had to give account of their work to the voters. Malby listened to what they had to say and then asked if she may be allowed to speak. She then talked about all the things she thought were going wrong and which were in conflict with the law, and which the government was not doing anything to rectify.

When the meeting was over, Doctor Mayda, director of our partner organisation, sought her out. Malby thought that she was in for a scolding for her criticism, but to her astonishment, Doctor Mayda asked if she would like to take part in a planning workshop. “To be honest, I said yes because the workshop was going to last three days and I’d be able to miss work for three days,” she admits, “and also because our meals would be provided by a good restaurant.

“It was a real shock for me to be sitting in that workshop alongside government representatives and official delegates – people I’d been criticising for so long and had never wanted anything to do with. We worked together for three days and I felt very much at ease with them. Gradually I began to understand where the real root causes of our problems lay and the best ways of dealing with them. I could never have imagined that you could work so hard while having so much fun. I realised that, in a very short time, I had made friends and had learned how to work as part of a group and show appreciation for the work of others. I discovered that it’s possible, even in a small district, to find people willing to give up their time, every day, to help others. I also learned that everyone has the right to criticise, provided that if you do so, you must also do what you can to change things. This year I’ve been elected as a representative for my community. That’s not something I could ever have imagined.”

Latin America: an ongoing role for social movements

When leaders who are relatively favourable towards the right to health are elected, this does not always automatically mean that the State will pursue a policy that is good for the majority of the population.

Women of Defensora de la pachamama assert their rights towards local authorities.

Although Venezuelan workers could count on the formal support of the then president, Hugo Chavez, they saw time and again that they would have to continue to defend their claims. Consider, for example, the renationalisation of the multinational Sidor in 2008. This company refused to negotiate a new collective agreement with its workforce. When the workers went on strike for their right to decent working conditions, Sidor received support from the Minister for Employment, who condemned the strikes. The workers, who had already been fighting for years, eventually forced President Chavez to take action himself against the multinational. Chavez nationalised Sidor and removed the minister from office.[11]

Nor, in Ecuador, did Rafael Correa's election victory mark the beginning of a State that would only follow the right path from then on. Even after he came to power, it was only the pressure exerted by the social movement that forced the government to tackle the multinational Chevron-Texaco. When the company discontinued its operations in the Amazon, it failed to get rid of its toxic waste. This material was dumped and left in the rainforest for 30 years, thus contaminating the indigenous community for many generations. A movement was formed against the multinational comprising more than 30,000 people from local organisations, farmers and five indigenous communities. The movement was named the Amazon Defence Front. In 1993 it instituted legal proceedings against the multinational,

11 http://g3w.be/news/sociale-bewegingen-wanneer-het-volk-zich-laat-gelden

an example of an incredibly unequal contest. But the movement never gave up, despite the company's economic and political power, its cunning and the lack of support from the government. It continued to put pressure on the judicial system: demonstrations were organised in Quito, buildings were watched day and night to prevent fraudulent contact between judges and the company's lawyers, and money was collected to pay legal fees. In 2012 the company finally lost the case and had to pay more than 9.2 million dollars in damages.

Since 2001, there have been many protests in El Salvador against the privatisation of health care. This led to the creation of a citizens' alliance, which is an umbrella organisation of NGOs, trade unions, health organisations and social movements. Through their campaigning, which became increasingly harder to ignore, they have made people aware of their rights. Salvadorans therefore succeeded, with campaigns such as these, in stopping the process of health care privatisation during two successive presidential terms.

Many times they were able to bring the country to a standstill in order to publicise their demands. In 2002 health care workers and social security officials went on strike for nine months. The aim of the strike was to stop the privatisation and to inject new life into the social movement. It was a success: an agreement was signed with the government in June 2003.

"We're aware that we haven't achieved everything we wanted, but it's a good start because we've wakened people up, people who will now be opposed to privatisation of the water supply, education and public works," said Cordero del Cid, a Salvadoran surgeon.[12] The alliance is now an integral component of the reform of the health system. Their participation is reflected in their presence on the National Health Forum, set up by, but independent of, the Ministry of Health. The forum ensures social monitoring, participation in government policymaking and evaluation of the system. Three members of the Movimiento para la Salud de los Pueblos de Latinoamérica (MSP-LA), a Viva Salud partner organisation, have been nominated for senior positions in the Ministry of Health.

12 El Salvador – Les neuf mois de grève contre la privatisation de la santé ont pris fin, Alter-Infos America Latina, 2013: http://www.alter-infos.org/spip.php?article1181

Encourage participation: CPPE in Cuba!

Now suppose that the government was not reluctant to acknowledge the right to health; how would you encourage the population to play its part?

The Dragones project, started by Viva Salud in the late 1990s in a working-class district of the same name in the heart of Havana, brings together local volunteers to analyse the health situation in their neighbourhood and to plan activities. For instance, one of the streets has been transformed into a local "green lung" with a children's playground, pitches for street sport (baseball, football, basketball, etc.), and exhibition space where local and other artists can display their work. Cleaning façades, growing plants, painting, hygiene training and preventive medicine: all of this was possible with the assistance of many volunteers. The project gathers together people who are active on the district committees, women's organisations, the party, the police, but also prominent, informal community leaders, key figures in sport, youth welfare, care of the elderly, etc.

This approach is based on the "comprehensive participatory planning and evaluation" (CPPE) method, devised by Belgian doctor Pierre Lefèvre, who works at the Institute of Tropical Medicine in Antwerp. The method, which is now taught to facilitators, has four distinct stages:

- identify the problems in the district
- draw up an action plan together
- implement this plan
- subsequently evaluate the plan and make adjustments if necessary

First of all, a group must be formed of formal and informal representatives of the same community. These may come from the police, the ministry or a women's organisation, or they may simply be charismatic individuals who are respected in the community. These people will then meet to discuss the topic "health in the community". As the whole community is represented, no problems slip through the net. After this, the group must find solutions to each problem and draw up a one-year action plan clearly defining each person's role. The final stage is the evaluation of the action plan. One year after the launch of the action plan, the participants reconvene at a general meeting and evaluate the results. The CPPE can then be repeated on the basis of new problems that have been identified in the meantime.

The results of the method in Havana were so spectacular that the initiators want to share their experiences with others. Over the next few years, this method will also be used in other parts of cities in Cuba (Havana, Cienfuegos, Las Tunas, etc.) and in other South American countries, such as El Salvador and Ecuador.[13] ■

13 P. De Vos, M. Guerra, I. Sosa, L. del R Ferrer, A. Rodríguez, M. Bonet, P. Lefèvre and P. Van der Stuyft, Comprehensive Participatory Planning and Evaluation (CPPE), Social Medicine, Volume 6, Number 2, June 2011: http://www.socialmedicine.info/index.php/socialmedicine/article/view/593/1132

Strong social movements

4. No social justice without social struggle

In the previous chapter, we saw how different states place public health high on the political agenda and accept their responsibility for the right to health. But why do some states do this and not others?

Is economic growth a factor here? Of course, it cannot be denied that industrialisation in the rich countries of the North has had a positive impact on public health. Research also shows, however, that economic growth does not lead automatically to greater well-being and prosperity for all. Political choices play a part that is just as fundamental. Take Chile, for example. After he brought down progressive president Salvador Allende in a coup in 1973, Augusto Pinochet embarked on a reign of terror in the name of economic growth. Services were privatised, trade was liberalised and social security provision was reduced. Although Chile's gross national product (GNP) did, in fact, grow, inequality also increased exponentially.[1] In other words, only a small elite benefited, while most people were facing unemployment and unhealthy living conditions.

Poverty, inadequate access to social welfare, to water – all this is linked to a system that generates inequality. So the answer cannot be simply economic growth. Historian Simon Szreter explains that, throughout history, progress in public health has been mainly a question of political choices, choices that were made due to social pressure from below.[2] In Britain, for example, he states that "Significant health improvements only began to appear when the political voice and self-organisation of the growing urban masses finally made itself heard, increasingly gaining actual voting power from the late 1860s onwards (a process not completed until 1928)." When they could make their voice heard by the urban elite, the new generation of civic leaders used the massive revenues of local utility monopolies as a new source of funding for an extensive programme of investment

1 Juan Eberhard Eduardo Engel, Decreasing Wage Inequality in Chile, 2008: http://web.undp.org/latinamerica/inequality/docs/distrib_chile_ee_061008%20Engel.pdf

2 Wim De Ceukelaire, Pol De Vos and Bart Criel, Political will for better health, a bottom-up process, Tropical Medicine and International Health, Vol. 16, Issue 9, 2011: http://www.be-causehealth.be/media/12579/viewpoint_political_will.pdf

in municipal health amenities and social services.[3]

The same analysis can be made for the emergence of the welfare state elsewhere in Europe. In post-war France, waves of strikes brought about more social advantages, the minimum wage and a shorter working week (Borrel 2004). The same tendency is evident in countries in the South. When social revolutions in China, Cuba and Iran put health and social demands on the agenda, they often achieved impressive results. In Latin America, too, social struggles in countries such as Brazil (Elias & Cohn 2003), Costa Rica (Unger et al. 2008) and Nicaragua (Garfield & Williams 1992) led to greater political attention being paid to public health.

Social struggle also helped to beat cholera and tuberculosis in Belgium. Ghent historian Isabelle Devos[4] explains how labour movements and doctors convinced the government to preventively eradicate deplorable social conditions. In order to tackle tuberculosis, the miserable living conditions in the cities needed to be improved. Working-class houses near factories were small and overcrowded. There was a limited water supply and barely any sanitary facilities. Devos writes: "The impoverished slums were an ideal breeding ground for infectious diseases such as cholera. Following the severe cholera epidemic of 1866, there was an extensive clean-up programme, and, in several cities, work began on filling in ditches and canals and installing sewage systems and water supply networks." She also points out that the construction of public baths by the authorities, the development of a system of public water distribution and public washhouses would prove fundamental in the battle against infectious diseases. Of course, social movements take different forms in every country, but there is no doubt that a powerful movement for the right to health is fundamental.

3 Simon Szreter, The Population Health Approach in Historical Perspective, Am J Public Health, March 2003, 93(3): 421–431: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449802/

4 Isabelle Devos, De evolutie van de levensverwachting in België, 18de-20ste eeuw, Chaire Quetelet 2005: http://www.leeftijdenwerk.be/html/pdf/devos_levensverwachting.pdf

The impact of international aid on the Palestinian social movement

In Palestine we have been working with the Union of Health Work Committees (UHWC) for many years. UHWC was set up in 1985 on the initiative of a number of doctors, nurses and other health workers, who travelled to remote villages and worked as volunteers, providing badly needed health care to the Palestinians left to fend for themselves in those territories occupied by Israel. Over the years, UHWC has become one of the biggest health organisations, remaining active after the Palestinian Authority was established.

UHWC came into being at a time when large numbers of Palestinians were forming "popular committees" out of sheer necessity. Using their own vision and resources, they developed services that are usually the responsibility of the State, such as education and health care. These well-organised popular committees also played a crucial part in the first intifada, the major Palestinian popular uprising against Israeli occupation, which began towards the end of 1987. This involved the mobilisation of the whole population, men, women, young people and children, who took part on a scale never seen before. The people themselves took things into their own hands and united around a common aim, which was to bring an end to the occupation and set the Palestinians free.

It is estimated that in 1993 some 50% of secondary and tertiary care in the occupied territories was provided by NGOs, while primary health care was largely the work of several independent Palestinian organisations, most of which were considered illegal. With the advent of the Palestinian National Authority (PNA), a result of the Oslo Accords, massive amounts of international aid arrived to build the infrastructure of the occupied territories. While we were working in Palestine, we saw how large international NGOs and the World Bank gained influence over local Palestinian organisations due to the latter's financial dependence.

Gradually it became apparent how the Oslo Accords and the ensuing "peace process" have had a dampening effect on empowerment, which had been so dynamic in the 1980s. People's attention was drawn away from the root causes of the conflict towards a "peace process" that has now dragged on for more than 20 years.

This does not mean that all Palestinians let themselves be diverted from the real root causes. Palestinian NGOs found themselves caught in a difficult position between international funding agencies on the one hand and their own constituencies on the other. Benoît Challand described how the local popular committees of the 1980s, which represented and served local interests, evolved into professional NGOs in the post-Oslo period, which were well-connected with international donors but lost ground with their own constituencies. For these post-Oslo NGOs, the occupied Palestinian territories were a "post-conflict area", not an area in active conflict where the interests of the occupying power were antagonistic to those of the people living under occupation. International agencies took on the role of so-called neutral mediators, ignoring the root causes of the conflict and its colonial nature. Local NGOs in-

fluenced in this way lost their legitimacy with the local population.

Although our partner organisation also benefited from foreign aid in the building of its health infrastructure beginning in 1993, the UHWC never forgot the root causes of the conflict and the crucial role played by people's organisations for democratic, social change. When the organisation reformulated its strategic goals, it devised a new foundational principle that "health work cannot be effective unless it is part of a larger social change". One of the organisation's pioneers and its former director, Dr Ahmad Maslamani, reminded us that: "The right to health implies the need to challenge the interests of the major forces [...] and the need to have a drastic change of political and economic priorities, first of which is for us Palestinians to have our unbending basic rights fully achieved, most important of which is the right of return in accordance with UN resolution 194."

UHWC also puts these words into practice. A striking example is what happened after the election victory by Hamas in 2006. The European Union promptly refused to continue providing financial support to the Palestinian Authority, and said it would channel this aid through Palestinian NGOs instead. Even in those dire circumstances, UHWC took the lead in taking a principled stance and refused the aid that the EU wanted to channel through them. Instead, they urged the EU to respect the democratic choice of the Palestinian people and to resume sending aid to the PNA, enabling it to fulfil its obligations to secure the health and human rights of the Palestinian people. They also held the Israeli government – as an occupying power – legally responsible and held the international community morally responsible. ■

Social struggle and aid

Those who reap the benefits of inequality will never question the system. The philanthropy of certain patrons is no exception. Some even describe it as a plaster on a wooden leg. Peter Buffett, son of magnate Warren Buffett, is himself very harsh about the ever-growing charity industry. While lives and communities are destroyed by a system that creates vast amounts of wealth for the few, the charity industry mainly serves to "launder" the conscience of those who are more fortunate: "Inside any important philanthropy meeting, you witness heads of state meeting with investment managers and corporate leaders. All are searching for answers with their right hand to problems that others in the room have created with their left."[5]

In 2004 the Indian author Arundhati Roy bitterly denounced the NGO aid inundating her country. In her opinion, so-called development aid is not intended to help, but rather to conceal social disintegration and to paralyse any resistance to it.

"In India, the funded NGO boom began in the late 1980s and 1990s. It coincided with the opening of India's markets to neoliberalism. At the time, the Indian State, in keeping with the requirements of structural adjustment, was withdrawing funding from rural development, agriculture, energy, transport and public health. As the State abdicated its traditional role, NGOs moved in to work in these very areas. The difference, of course, is that the funds available to them are a minuscule fraction of the actual cut in public spending. Most large funded NGOs are financed and patronised by aid and development agencies, which are, in turn, funded by Western governments, the World Bank, the UN and some multinational corporations. Though they may not be the very same agencies, they are certainly part of the same loose, political formation that oversees the neoliberal project and demands the slash in government spending in the first place.

"Why should these agencies fund NGOs? Could it be just old-fashioned missionary zeal? Guilt? It's a little more than that. NGOs give the impression that they are filling the vacuum created by a retreating State. And they are, but in a materially inconsequential way. Their real contribution is that they defuse political anger and dole out as aid or benevolence what people ought to have by right. They alter the public psyche. They turn people into dependent

5 Peter Buffet, The Charitable-Industrial Complex, The New York Times, 2013: http://www.nytimes.com/2013/07/27/opinion/the-charitable-industrial-complex.html?_r=0

victims and blunt the edges of political resistance...”

Arundhati Roy also talks about the creation of an image: the umpteenth poor Afghan or Sudanese refugee who reinforces the image of the enlightened West, which must help the poor people of the world and give them direction.[6] The world of development cooperation is at the very least a slippery slope. It is easy to become involved in well-intentioned but poorly considered philanthropy and efforts to “help the poor”, which, one realises a few years later, have achieved nothing in the long term.

Above all, it comes down to asking the right questions. “How can I help people in the South?” is often not the most important question. Rather we should investigate what process of liberation and social emancipation is taking place in a country and who is taking the lead, playing a dynamic role, in that struggle. Only then does the question arise: “What can we do to support this struggle in a truly effective way?” The question we ask says a lot about the view we take of people: are we addressing “the poor” or are we siding with “the oppressed” in society? The latter choice suggests a dynamic: whoever is oppressed will react sooner or later, whereas the poor tend to resign themselves to their fate and have to be helped.

6 Arundhati Roy: Les périls du tout-humanitaire, 2004, Le Monde Diplomatique: http://www.monde-diplomatique.fr/2004/10/ROY/11569

Power for justice

So change does not happen automatically. People who benefit from exploiting and oppressing others will not relinquish their power of their own accord. Moreover, large companies and multinationals bring enormous pressure and influence to bear on policymakers. For the former, access to political power is often not too difficult. But if exploitation, exclusion and social oppression are ever to change, we also need a counter-power. Social movements will have to build that power in order to put fundamental changes on the agenda and exact social justice. American sociologist Saul Alinsky described it as "the power of money against the power of numbers".

Alinsky is considered to be the founder of the "community organising" movement in the US. He was active in the emerging popular movement in major American cities such as Chicago and analysed how the poor and the blacks fought for their rights. In the context of the social struggle in US cities, he identifies two sources of power: power comes from money or from numbers, or "they have the money, we have the people", as he once said in a public address. This is a rather simplistic, but interesting way of analysing power. The richest 1% of the population can use money to garner power; on the other hand, however, there is the remaining 99% of the population. They have no money but that does not mean they have no power. If they join together and organise themselves, they can assert the power of their numbers. With this idea, Alinsky is also going against the accepted and narrow definition of poverty, i.e. a "lack of resources", adding that poverty is primarily a "lack of power". Here, too, our definition is critical to our strategy for tackling the problem.

Thanks to the capital at its disposal, a multinational like Monsanto has the power to bend the world to its will. In her book, "The World According to Monsanto", investigative journalist Marie-Monique Robin describes how Monsanto was able to develop and consolidate a position of power.[7]

Monsanto has acquired a monopoly in agricultural seed and is the largest global distributor. Anyone who wants to be involved in industrial agriculture will inevitably come within the multinational's sphere of influence. All over the world, hundreds of thousands of farmers are forced to buy their seed from Monsanto and effectively become subcontractors of the company. "If you buy our products, we own you", is the multinational's unofficial motto. The farmers are bound by exclusive contracts and Monsanto

7 Marie-Monique Robin, The World According to Monsanto, The New Press, 2010

Indian farmers oppose Monsanto *(Photo: Skasuga, Flickr)*

employs an army of lawyers and detectives to ensure compliance.

Monsanto protects itself by forging political ties and being on good terms with a whole bunch of US senators. The company has a particularly good relationship with the Pentagon, for which Monsanto manufactured the notorious "Agent Orange" defoliant during the Vietnam war. The use of Agent Orange caused thousands of children to be born with spina bifida or other spinal deformities. The power acquired by Monsanto is based on social injustice and increases this injustice at the same time.

If we are championing the cause for social justice, it is clear that we must base our power on other resources. Alinsky advocates the power of numbers. Socially oppressed people can only acquire power by organising themselves and standing up for their collective interests, together. But this is far from simple. Empowerment is the quest to increase, by many different processes, the strength of certain population groups; it is a creative process of trial and error and must be viewed as a continuous learning curve.

Clearing the way for change

If you want to influence the State, you need sufficient support for your demands. Building this support and keeping your followers enthusiastic is an ongoing process. A good example of this is something Etoile du Sud experienced in Lubumbashi.

For some time, the Etoile du Sud health committees in Lubumbashi had been asking the authorities to invest in a proper drainage system alongside the main road passing through their district. The poor condition of the drainage channels, which were blocked, meant that waste water could not drain away. This was causing serious hygiene problems in the districts. The "neighbourhood chief" claimed he could not do anything, because the coffers were empty and the provincial authorities were ignoring his requests for extra funds...

Etoile du Sud therefore decided to do something about it themselves. Working with members of Usahidizi, a youth organisation in Lubumbashi, they organised a survey in the district to document the problems people encountered in their daily lives. In this way, the interviewers reached 80% of the local population. Next, they organised an action day, a "health day", during which they themselves set a good example. All the committees mobilised the local residents and together they cleaned up the main road. Hundreds of people set to work, doing what the authorities really ought to have done. At a press conference, they explained their actions and publicised people's grievances. Miracle of miracles: soon after this, work to repair the drains started. The "neighbourhood chief" had finally found some money! ■

TOOLBOX: Theory of change

Developing a strategy and making a difference

In 2012, at the international meeting of the People's Health Movement in Cape Town, South Africa, Viva Salud brought together its partners to develop the outline of its next strategic plan.

Each of the partners was asked to come up with a "theory of change" for their country or region and for their organisation. The result was a colourful mosaic, painting a picture of how change can happen in a society.

Phase 1: What is our dream?

It all begins with us learning about ourselves: why does an organisation exist? What do we want to change in society? What is "our dream", the dream we want to realise?

Phase 2: What is our lever for change?

You cannot realise a dream in 10 or 15 years, but you can work towards it by helping to develop a lever for change. In doing so, it is important to examine in what ways we as an organisation differ from other social actors and what specific contribution we can make (otherwise, it would be better to affiliate with an existing organisation).

Thousands of small - and not so small - grassroots organisations exist in Congo, but these mainly concentrate on

survival issues and take the form of co-operatives or mutual aid organisations. There are very few social organisations that organise and mobilise people for policy change. Our Congolese partner, Etoile du Sud, is committed to helping to create a social movement for the right to health so that the Congolese can learn to fight for their rights in this specific area. It looks set to be a long, hard battle.

Phase 3: Who are our allies, our potential supporters and our opponents?

Once we know clearly what our dream is and what we can specifically do to realise it, the next step is to look for social actors that can influence the change we are seeking. The various actors can be divided into three groups: civil society stakeholders who are inclined to take a positive stance on the change we are striving for, our potential allies, and those who will definitely oppose the desired change.

First and foremost, this exercise teaches us something about ourselves and our shortcomings: if, for example, we regard young people as interesting and promising social actors, why do we not devote more attention to getting them actively involved in our organisation? It also teaches us patience: if the local authorities are a possible ally, we should try to approach them in a positive manner and not seek confrontation.

Phase 4: What role can we play as catalyst in this social farrago?

Based on our unique nature and our potential and limitations, we can think about how we might mobilise as many social actors as possible with a view to changing things. We can seek out specific topics that have an impact on health (social determinants), where we can be the driving force and, at the same time, establish a broad-based alliance.

Our Philippine partners, for instance, highlighted the fact that national and international mining companies are having an extremely adverse impact on the environment in many regions. As health organisations, this is an interesting issue for them because it enables them to unite farmers' organisations, local authorities and environmental organisations and mobilise them to stand up for the right to health.[8] ■

8 M. Botenga, Empowerment en recht op gezondheid, 2013: http://g3w.be/news/empowerment-en-recht-op-gezondheid

From resistance to alternatives

We were discussing Latin America earlier. Venezuelan, Bolivian and Ecuadorian social movements are currently key players in the political landscape. They were forged in the 1980s and 1990s in the heat of the battle against the neoliberal measures imposed by the International Monetary Fund (IMF). Gradually, they succeeded in getting their voice heard and bringing about political changes.

In Venezuela, the social movement was established in the 1980s in response to the privatisation and liberalisation measures of the government of Carlos Andres Perez, acting on the recommendation of the IMF and the World Bank. The government cut social spending and privatised public services. As a result, the cost of living skyrocketed. Social mobilisation already existed, but it was not until 27 February 1989 that a wave of mass protest began, known as the "Caracazo". In response to a steep increase in bus fares by 200% that day, people in the capital Caracas took to the streets in force. The uprising was violently put down. Various sources estimated the death toll at between 300 and 3,000. That day went down in history as the starting point of a national movement that sought to put an end to government corruption and bureaucracy.

After more than 20 years of opposition to neoliberalism and privatisation, the social movement in Bolivia won its first major victory in 2000. In the city of Cochabamba, where the water supply had been privatised, a popular uprising succeeded in getting rid of the multinational responsible. "The social movement of one of the poorest countries on the continent administered the first serious defeat for globalisation," commented Oscar Olivera, the leader of the Coordinating Committee for Water and Life.[9] The events split the right-wing government, which had suppressed the demonstrations with deadly force. For the first time ever, the social movement had succeeded in winning the argument against a State-sponsored company and asserting its interests. Gradually, through large-scale and ever-more frequent protest actions, the popular movement became a key player in Bolivian politics.

The social movements in Bolivia alerted the population to the importance of having sovereignty over their own country's natural resources. Indigenous peoples also became aware of their right to participate in political decisions. As a result of the actions of these movements, two governments

9 Walter Chavez, L'abc de la crise politique bolivienne, 2005: http://risal.collectifs.net/spip.php?article1290

fell, in 2003 and 2005, and there were calls to renationalise gas and oil companies and recognise the interests of the indigenous population.

Social movements are therefore not forever relegated to the sidelines; they can have a significant political impact. In 2006, for instance, Evo Morales won the Bolivian presidential elections thanks to strong social mobilisation. Only a few months after he came to power, he nationalised the oil industry and saw to it that all contracts with foreign companies were renegotiated. His government focuses on combating poverty and recognising the rights of indigenous communities.

In Venezuela, the Caracazo movement created fertile ground for the advent of Hugo Chavez on the political scene. He was able to mobilise the masses into a real, organised social movement. In 1999 he was democratically elected following a campaign that portrayed him as "the plague of the privileged class and the hero of the poor". After his election, he launched what was called his "Bolivarian revolution", which translated into the organisation of participative popular democracy, economic independence, equitable distribution of wealth and an end to political corruption. The goal of the Bolivarian revolution was to give more power to the people, provide them with the opportunity to get organised and to fight for their rights.

In Ecuador, the citizens' movement deposed four right-wing presidents between 1997 and 2005. The rebellion was actually directed against the neoliberal model, the corruption of the political system, the use of economic mechanisms that exacerbated poverty (such as dollarisation[10]) and the lack of attention for indigenous interests. When Rafael Correa ran as a candidate in the 2006 elections, the popular movements pinned their hopes on him as someone who would really pay heed to their rights and bring genuine change to Ecuadorian politics. His election as Head of State therefore meant a *de facto* victory for the Ecuadorian social movement. The indigenous movements' support for his candidacy was important. Correa's "citizens' revolution" was enshrined in the new constitution in 2008, which recognises the multinational State, the rights and customs of indigenous communities, and natural rights. This was a victory for the indigenous movements after 50 years of fighting for recognition of their rights.

10 Dollarisation is the process of aligning or replacing a country's currency with the US dollar. In so doing, the government relinquishes control of the interest instrument, making it impossible to put a brake on or stimulate the economy by means of monetary policy, since interest rates are determined in the US, where the priority will be its own economic situation.

Former president Hugo Chavez at a memorial of 'Caracazo', the mass protest against privatisation and liberalisation in 1989 (Photo: chavezcadango, Flickr).

The "pitchfork and broom revolution" in Colombia

For years the Colombian government has pursued a free trade policy with the United States and the European Union that has made life virtually impossible for poor farmers. Thousands of people have been badly hit because they cannot compete with international dumping prices. In desperation, the farmers have switched to growing coca, which has met with opposition but without any viable alternative being offered.

Moreover, 0.4% of landowners hold 61.2% of the land in Colombia. Eight million hectares (80,000 km², more than 2.5 times the size of Belgium) have been acquired by major landowners and multinationals through systematic, illegal dispossession of small farmers - all with the support of paramilitaries.

Farmers are ruined by multinationals that force them to move, using violence if necessary, by buying up land for large-scale mining projects (Colombia has 4.5 million internal refugees). It has all the makings of a classic tale, except

that the farmers refuse to put up with it any longer and launched their "pitchfork and broom revolution" in August 2013.

It began in the Boyaca area, where thousands of peasant families rose up in protest. The revolt quickly spread to other regions. Road blocks were the weapon of choice of the insurgents, as they are highly effective and very flexible. No sooner had the army or the police cleared away a barrier than another would spring up a few kilometres away. Hundreds of thousands of people were actively involved in the protest, paralysing economic life.

The discontent also boiled over into other sectors, which joined in the fight for better living conditions and against the unbridled sell-off of the nation's wealth. Some 300,000 workers downed tools. Miners, truck drivers, coffee planters, dairy farmers, teachers and young people came out in support and the general-strike weapon was wielded. Even the Archbishop expressed solidarity with the farmers – unprecedented in elitist Colombia.

The government responded with repressive measures: 12 people died, 485 were injured and 262 were arrested, including the vice-president of Colombia's largest farmers' union, Fensuagro.[11] But this only served to fuel the protest. Faced with such strength in numbers, the army and the police were unable to gain the upper hand. The government therefore tried to sow discord by making some concessions to farmers' organisations locally. Vague promises about agricultural subsidies were supposed to appease farmers. In the meantime, however, the revolution had also gained strength politically. Social organisations put forward a programme that would democratise society through and through and make it more social. They demanded strict measures against the multinationals and protection of agricultural areas. The strike paralysed the country for more than a month, and eventually brought down the Colombian government.

The farmers' struggle is taking place in the context of peace negotiations between the government and FARC (Fuerzas Armadas Revolucionarias de Colombia), in which land use and land division are the key issues. So the battle is certainly not over yet. The regime in Colombia is one of the most repressive in the world. But the popular movement has taken a huge step forward and has significantly disrupted the balance of power.

11 Source: Oidhaco Report July-August 2013

The water war in Bolivia

In Bolivia, in the late 1990s, the multinationals Bechtel and Suez Lyonnaise turned their attention to water. In 1999 they hiked up water prices to finance their investment in the construction of a new dam. People with an average monthly wage of just 70 dollars were forced to pay up 20 dollars a month for water.

The inhabitants of Cochabamba, the third-largest city in Bolivia, took to the streets in force to protest against the high water rates and against the privatisation of this public service. Farmers from outlying rural communities, who needed water to irrigate their fields, marched on the city and rallied in marketplaces and main squares. The protest spiralled into a general strike that brought the entire city and region to a standstill for four days. The movement rebelled against the government, which ordered the mass arrest of protest leaders and declared a state of emergency. Various social groups, including teachers and even police officers, joined the protest. In several major cities, students and young people also gathered to show their support. The demonstrators eventually won their battle: the government broke the contract with the multinationals.[12]

Not everyone was pleased with this turn of events. The then President of the World Bank, James Wolfensohn, expressed the view in 2000 that subsidising the water supply was a bad thing and could only lead to overconsumption. "The biggest problem with water is the waste of water through lack of charging."

What is interesting about the Bolivian experience is that Indian farmers were the biggest driving force. They were hardest hit by the asocial policy, but were also most strongly organised in farmers' unions. It was they who drew other, less organised groups, such as market stallholders and craftsmen, into the uprising. The activists celebrated their victory and pursued their battle on the political front. Farmers' leaders unified their efforts within the Movimiento al Socialismo in the fight for a fairer society. One of the most prominent spokesmen was Evo Morales, who was elected President of Bolivia in 2005.[13] ■

12 Bolivia's War over Water, The Democracy Center: http://democracyctr.org/bolivia/investigations/bolivia-investigations-the-water-revolt/bolivias-war-over-water/

13 Emma Strother, On Water Scarcity and the Right to Life: Bolivia, Council on Hemispheric Affairs, 2013: http://www.coha.org/on-water-scarcity-and-the-right-to-life-bolivia/

Empowerment in action

5. Strength in numbers: empowerment stories

The struggle for the right to health by building counter-power will not be won overnight, as is now obvious.

It is often easier and more motivating to get quick results with a specific project that has a positive impact on the lives of a small group of people. But if such a project is not part of a broader struggle for fundamental change and leaves the existing balance of power unchanged, a question mark also hangs over its durability. What's more, the project may be held up as a shining example of progress, even though that "progress" is confined to a small group, while the majority of the population continue to be denied a better and decent life. And when projects like this, however well-intentioned they may be, give the State carte blanche to retreat from sectors such as health and education, they may even be counterproductive.

Nevertheless, we often hear the reaction "fundamental change is all very well, but many people need a solution now to the dreadful situation in which they are living". This is true, of course, but empowerment, or building counter-power, is not just a strategy for long-term change. Empowerment processes also make tangible differences in the lives of people and communities, both individually and collectively.

How can we be so sure about that? Not really based on statistics, figures or indicators, and certainly not from pure gut feeling, but because of people's own stories. This may seem simplistic, selective and not very scientific, but it tells us a lot about the quality of the changes in people's lives, which cannot always be inferred from figures.

For the past few years we have been using a method called the Most Significant Change technique to identify tangible changes based on personal narratives. One key finding in many of the stories we collected using this technique is that change does not just refer to material changes in living conditions. Whenever we ask people to talk about what they think is the most significant change since they joined forces in a collective fight for rights and social justice, it becomes apparent that collective action boosts self-confidence and increases awareness of the fact that their situation is not inevitable, but that, together with others who think the same way, they can actually do something about it themselves. This chapter contains a few examples of these powerful stories.

TOOLBOX 1: Most significant change[1] (MSC)

Learning from stories of change

Those who get involved in campaigns for social change are sometimes asked: "That's great, but what results do you achieve? What actually changes?" These are legitimate questions, but can be frustrating for anyone working on change processes that are intensive, long term and non-linear. There is no phased plan taking you from A to B to C. In empowerment processes, you have to be willing and have the courage to make detours and take a roundabout route. There are no shortcuts. It is just as important to be vigilant when it comes to these detours, and that requires openness and a receptive attitude.

A near-obsessive attention to tangible results has just the opposite effect, however: it makes us focus on one

1 Rick Davies and Jess Dart, The "Most Significant Change" (MSC) Technique. A Guide to its Use, 2005: http://www.mande.co.uk/docs/MSCGuide.pdf

aspect, preventing us from properly hearing and seeing what is really happening. Our early experiments with the MSC technique stemmed from this frustration.[2] The technique is simple: people tell their story. These stories are enriching, precisely because you learn more about the detours that can lead to change. At the same time, people who tell their story become more aware of change that often goes unnoticed. By discussing the stories in a group context, the technique can also become an enriching collective experience from which lessons can be learned.

How does the technique work?

1. Arouse interest and remove barriers: we can all tell a story.

This first step is vital to give people self-confidence. Everyone tells stories every day, but the context in which this happens is important. An informal chat is not the same thing as asking someone to tell a story that illustrates the most significant change in their life since they made a commitment to get involved. So it is useful to first ask people to talk about what they remember about the past week or about a specific activity. Why did that particularly stick in their mind? In other words, you first create a setting that resembles an everyday conversation.

2. What change? Define your focus.

With the MSC technique, we want to hear stories about change, but not just any change. In this second step, we try to clearly define the context of the change. When people become active in a social organisation, they usually have a good reason for doing so, a problem that affects them personally. Ask people what their commitment has changed in their personal situation, what it has changed in terms of their problem, or in terms of their perspective of their problem. This sometimes yields surprising insights.

Besides changes in people's personal situation, commitment also has an impact on personal capabilities and skills that have hitherto lain dormant or undiscovered. You can also ask them what changes they have noticed in their community and in their relations with the community since they became committed. Sometimes, these things only emerge when you ask people to tell a story that illustrates how they perceive and experience change. Defining the domain of change can also centre on specific topics, such as how their com-

2 Most Significant Change. Monitoring empowerment for the right to health, 2010: http://g3w.be/news/wat-veranderen-onze-partners-het-zuiden

mitment and the collective action have influenced gender patterns.

3. Define the period in which change occurred.

This step is important because it can be difficult to recall one story or illustration of change if the question is not specific enough. So explain clearly to people what period you mean, for example the past year or since they became active.

4. Collect the stories.

There are no strict rules for collecting stories. The way in which it is done depends on what might deliver the best results. It is important for people to feel at ease while they are telling their story, that there is an atmosphere of trust. The stories can be documented in various ways: in the form of a conversation (interview) or during a group discussion; alternatively, people can write down their own story.

Here are a few elements that are important for the story:

- the question must be specific: what, when, for whom, where? For example: "Looking back over the last month, what do you think was the most significant change in people's lives in this community?"
- information about who documented the story
- a description of the story itself (ask additional questions if necessary)
- the significance to the storyteller: why is this story an illustration of a change that the storyteller thinks is most significant?

5. Which change is significant? Organise a group discussion.

Once stories have been written down or told in a group situation, it is important to discuss them collectively, together with the people who told the stories. This makes it a mutual learning experience, which is both motivating and inspiring. Not all changes are necessarily positive; sometimes the stories highlight matters that can be a source of valuable lessons in terms of organisational improvements, better relationships, etc.

Sharing the stories within a group also makes it possible to verify them: do they tally? Did everything happen as reported? Once all of the stories have been presented, a decision must be made as to which one illustrates the most significant change, and why. This often leads to fascinating discussions during which people learn how change happens. ■

RAT

The journey east: individual and collective power in Congo

In 2009 Etoile du Sud (EDS) was active in about twenty working-class districts of Kinshasa with local committees. At the end of that year, when the people of Goma once again suffered attacks organised from Rwanda, the EDS local committees decided that verbal protest and displays of solidarity with the victims were not enough: it was time for action. For the first time in its history, the organisation embarked on a solidarity campaign. The children's committees with which EDS works organised fund-raising activities in the local community, which brought in about 1,000 dollars - an enormous sum for the poor population EDS aims to help. With additional support from Belgium, they were able to buy humanitarian supplies and plan a mission.

Ferdinand Mudjene, a doctor working with EDS, was responsible for coordinating the mission. That initially meant looking for organisations in Goma with which EDS could forge lasting ties and collaborate. Dr Mudjene organised several conferences for students and NGOs on the right to health and the Etoile du Sud campaign.

This was how he came across the farmers' umbrella organisation, Codic, which was very interested in the way EDS worked. Contact was established and Codic invited EDS to give training courses within its network. With help from Codic, EDS set up an office in Goma and began an awareness-raising campaign in the five provinces where Codic members are active. The office has also established contact with the university and colleges of higher education in the region and has taken on around 30 students on work placement to help organise the training. Many young people continue to be active after their placement by setting up committees in Goma and in rural areas.

Starting from a simple campaign of unity and solidarity, EDS has taken a huge step forward in building a national organisation fighting for the right to health. EDS attributes this to the fact that the right to health is a subject very close to the hearts of the Congolese. The idea of not only getting organised in order to produce together, but also fighting together for fundamental rights, has caught on quickly among the farmers. At a meeting, members even reproached local leaders for "not talking about it sooner".

“I no longer rely on God to do it for me”

Monique Muwele, member of the popular health committee of Etoile du Sud in Kimbangu, Congo

The right to health is a concept that drew my attention. At EDS, I’ve learned what it really means. Apart from the health care you need when you’re ill, good health is also linked with other factors such as access to safe drinking water, electricity, education for children, and so on.

The reason I’m still active on behalf of EDS is that I’ve noticed that we don’t have any problem keeping our neighbourhood clean any more. It’s something everyone takes for granted now and that’s all down to EDS and its army of cleaners. These days, I can also distinguish my rights from the obligations of the government. Even if we haven’t yet succeeded in conducting a campaign that has delivered tangible results, we know that it’s now possible to take action to win our case. I no longer rely on God to do it for me. And that’s really something totally new for me - a turning point in my life. I used to think that everything bad that happened to me – illness, lack of electricity, water and education for my kids - was pre-ordained by God.

The first spark of empowerment is often when people realise that change is something that you can and must contribute to yourself and that you cannot expect your situation to change as a result of external “aid”. Many development aid initiatives ignore this basic principle, with the result that people are gripped by a feeling of powerless expectation. ■

I learned to think critically about everything we hear in the news"

Khaled, active student member of the HWC youth network in East Jerusalem

I got to know about the youth network of the Health Work Committees during a university course about the right to health. I didn't have many friends but after each session I would leave with a few new friends with whom I could discuss the topics that had been raised.

Before I did the course, I was very shy, especially when girls were around or when I had to speak in front of a group.

As time went on, I became more confident in speaking. That had a lot to do with other discussions that we had about communication and how we could build a group. I now feel self-assured enough to express my opinions and that's changed a lot of things for me. I've since become chairman of the student council.

During the course and the various activities, I also learned a lot about our history and our situation as Palestinians in Jerusalem. I learned to think critically about everything we hear in the news. I used to be impressed by all the activities that young Israelis organised at the university and with other universities in other parts of the world. I was frustrated that we had no such organisation that did the same for Palestinians. Since I found out about the HWC and became active in the youth network, I've seen what we can do together. I got the chance to meet young people from different places and we're now putting together material ourselves and organising activities to tell our story, the reality of our situation. The film we made about Silwan (in East Jerusalem) is one of the tools we use to show people what's happening there.

Khaled's story shows how education triggered an individual change process and encouraged him to get organised and take responsibility within the youth network. He also found a solution to his feelings of impotence and frustration through the collective sense of power he experiences by taking initiatives as part of a group. His story also highlights the power of the media and the need to create a space where people can form their own opinions and make their own analyses. The restrictions that Israel imposes on Palestinians' freedom of movement have created not only a geographical division between Palestinians in the West Bank, Jerusalem and Gaza, but also psychological alienation. This intensifies the challenge for the Palestinian social organisations to strengthen unity among the Palestinian people, which is so essential for building counter-power. ■

Stronger together: The experience of the Filipino women's organisation Gabriela

Since its inception, the Filipino women's organisation Gabriela has seen very little change in the situation of poor Filipinos: poverty is still rife and fundamental rights are still being violated. But over the years Gabriela has also accumulated a wealth of practical experience and learned some valuable lessons.

One of these is that promoting women's right to have access to health care starts with emancipation, by increasing their awareness and by organising and mobilising them to take collective action. Awareness-raising usually takes place outside the private sphere and is the first step in the emancipation process. By coming into contact with other women in their community, women can break out of their isolation at home and within their immediate family circle. By sharing views and ideas with other women, they can overcome their feeling of impotence when faced with the problems life throws at them. The bond formed with other women gives them individual strength.

But the emancipation of these women is impossible without addressing their specific problems. Domestic violence and health problems are therefore Gabriela's primary concern. As part of the services it offers, the women's organisation is committed to tackling specific, urgent health needs and the problem of violence against women. Through free clinics and medical missions, Gabriela volunteers have already helped thousands of women and their families.

Local women's organisations establish health committees made up of volunteers and organise village pharmacies. Hundreds of women receive extensive health training. Awareness-raising goes further than training a health team, however. Via community workshops on first-aid or herbal medicine, the teams also reach a wider group of women. These workshops supplement Gabriela's seminars on women's rights. As women's awareness about their health situation and the underlying causes grows, they are more likely to take part in local actions for the right to health. Active participation in health programmes also forms the basis for educating female activists and leaders.

By offering health services in places where the government fails to do so, Gabriela has become very popular with local women. The health programmes help bolster the local sections and

boost the volunteers' motivation. This has resulted in concrete victories during health campaigns and has generated support for the organisation.

By providing community health care, the volunteers are placing the health programme in a wider context of social, economic and political factors that impact on the health of women and their families. This is why the Gabriela volunteers primarily regard themselves as women's rights activists who raise women's awareness and focus their attention on their right to health and protection against violence and discrimination, as well as on issues such as employment and housing. The link between social and economic problems is also very explicit in the Philippines. Domestic violence often stems from the frustration of men who cannot provide for their families due to unemployment or income insecurity.

Thanks to its efforts to tackle problems affecting poor people, such as housing, Gabriela has also managed to help women who would otherwise be difficult to reach.

In Manresa, a poor community in the city of Manila, the residents are under constant threat of eviction. Nere Guerero, a local resident, was the victim of domestic violence when she decided to become an active member of Gabriela. Her husband, a truck driver, hit her on a regular basis. Yet this was not what made her turn to Gabriela; she came because they were in danger of losing their home. Nere knew that Gabriela campaigned about this issue, but she was not aware of her rights as a woman. Subsequently, she learned more about her right to housing and why some people enjoyed this right but many did not. Through contact with other women at Gabriela, she also became more aware of her rights as a woman. Together with them, she fought for her home but also, little by little, against the violation of her rights in the conjugal home. Initially she learned how to physically defend herself; later she also lost her fear of being beaten by her husband. She no longer saw herself as a victim. Other women in the community confronted the man about his behaviour and helped him realise that his wife had rights, too. He stopped hitting her.

Gabriela repeatedly demonstrates that collective action relies on individual resilience, but also that individual resilience is strengthened by campaigning as a group.

"By forging unity with other women, I've found inner strength"

Bing, active member of the women's organisation Gabriela in the Philippines

Before Gabriela had its women's health programme, it was not a particularly dynamic organisation. Now it attracts attention from various quarters, including local government. Before that, Gabriela didn't really appeal to me; I preferred to get involved in activities for the Moro people. But its health approach immediately caught my eye. It was a good way to encourage other Moro women to get actively involved in the women's movement and learn about social problems related to their own problems.

I took part in Gabriela forums and mass demonstrations, a training course on violence against women and workshops helping people to get organised. Since then, we've succeeded in setting up seven Gabriela sections in Moro communities. The training and activities organised by Gabriela are important for my personal development and commitment, and the same goes for the other women in the communities. Gabriela manages to unite Moro women with other women around issues that connect us. By forging this unity with other women, I've found inner strength.

The Moro are an indigenous Muslim community living mainly in the southern Philippines, on the island of Mindanao. They often suffer discrimination, and have greater difficulty finding work or accommodation. On Mindanao, Gabriela is active in General Santos, where its members work with women from the indigenous population as well as with other women. Thanks to its work on a specific problem that concerns all these women alike, namely access to health care, Gabriela has managed to unite women from the various communities. Gabriela also makes it clear to the women that their internal disunity is an obstacle to changing their situation. Their shared problem is that both Moro and non-Moro women are oppressed and exploited.

People often talk about "community organising", but Bing's story demonstrates that this can manifest itself in different forms. There is a "natural" community, which may be bound together by ethnicity or religion. But what we mean by community is unity based on common social interests, transcending minor differences between people.

Toolbox 2: Initiating the process

Arouse, organise, mobilise

Social change requires social action, which is not something that happens by itself. People are not prepared to take to the streets with placards and banners for no reason. They have to grow in self-confidence, develop their capabilities, learn how to campaign, how to work together… This is a difficult but instructive and fruitful process that encompasses three activities: raising awareness, organising and mobilising. It is not a simple, straightforward phased plan from point A to point B; instead it involves trial and error, and taking two steps forward and one back.

Yet there are some valuable lessons to be learned, based on our partners' practical experience, such as how the Filipino women's organisation Gabriela goes about creating a new local group. Note that the relationship this organisation has with its target group is completely different to that of relief workers with their target group. Gabriela is not there to "help", but seeks rather to discover the potential of people in the community and help to develop it.

Step 1: social investigation
Social investigation, a class analysis and a gender analysis are conducted to find out a community's specific situation. This step occurs before any other action is taken to get people organised. The community's characteristics are identified, a plan is put together outlining methods and ways of raising awareness, organising and mobilising, it is investigated which members of the community could be brought together to form a group, who can help with this and which topics are important.

Step 2: make contacts
Contacts are made during the social investigations, by getting women from outside the community actively involved and through training (awareness-raising activities).

Step 3: put together a core group
Potential leaders should be considered when putting together a core group so as to ensure a solid foundation. In selecting the core members, it is important that they should be affected by the problem that has brought the women together, that they have a good reputation in their community or region, and that they believe in the need for social change and social development.

Step 4: educate the members of the core group
The core members educate themselves by studying the problems in their community in greater depth, working together to identify the underlying root causes, at local, national and international level. They adopt a unified approach to the strategic direction and objectives of their group. They acquire skills for leadership, organising women and organising activities.

Step 5: form local sections
An ad hoc committee is created and a date is set for the annual general meeting, during which the organisation is launched.

Step 6: mobilisation
Collective action is mounted to address the community's immediate and long-term problems.

Step 7: monitoring
Monitoring of the organisation, the situation and the mobilisation of the women.

Step 8: consolidation and expansion

Strengthen the organisation in order to continue the work. ■

Tips for health workers in community-based health programmes in the Philippines

Community-based health programmes in the Philippines have been set up all over the archipelago to provide farmers and ordinary men and women with basic medical training; these skilled "barefoot doctors" can then treat the most common ailments in their communities. Working closely with social movements in their country, they help people to claim their right to health from the government. These programmes are now coordinated by the Council for Health and Development. Based on many years of experience, they apply a few basic principles that may also be useful for other health workers committed to change processes addressing social justice.

- One must realise the basic difference between community-oriented health care coming from elsewhere and community-based, and eventually managed, health care. The former promotes dependence while the latter empowerment. Remove health professionals from the clinic and go to where the people are. Equip them with the knowledge, skills, and attitude for community practice.

- Acquire a deep understanding of the socio-cultural-economic-political context of health issues. This can be done by integration, social investigation, and actual integration in the lives of people in the community. One becomes a health service provider, a teacher, an advocate, a coordinator, a leader, manager, and a student of the people.

- As a primary health care practitioner, we must give emphasis on disease prevention and tap the potential of the people, as well as their wealth of experience. We must look at the people not as beneficiaries but as partners in development. Solutions must come from the people after they recognise and understand their problems. An empowered community realises its own strength politically, economically, socially, and culturally. Encourage participatory learning, consultations, small group discussions, informal sessions wherein they can also be provided with information.

- Participatory learning and community organizing are the keys to community-based health care.

- The concept of simple living, dedication, sacrifice and patience and the openness to undergo a great humbling experience.

- Community-based health work is biased for the poor, deprived, oppressed, in need and are willing to change their conditions.

- Learning may take the form of social awareness building, discussion of their issues (skirting around is not empowerment), training of health workers to become trainers, developing capacity of leaders to lead, facilitate and manage. Allowing them to plan, implement, monitor and assess by themselves their own activities based on their analysis of their problems, resources and capabilities.

- Class based community organizing is the strongest basis of unity and allows for consolidation. This allows the people to move cohesively and broaden their network of supporters struggling for a common goal (equity/freedom from powerlessness and oppression). Sustainability must be ensured in terms of it being economically sound, must work with the environment, has the power to defend its gains and managed well to protect it from problems. The holistic approach to health care can then be realised because it is the peoples organisation, which will ensure the implementation of the health plan and where all the other determinants of health will be ensured, struggled and fought for (land, employment, cultural preservation, social services).

In conclusion

6. Empowerment: a few dilemmas

Viva Salud regularly organises training on empowerment as a strategy for the right to health, aimed at young people who are interested in or want to become active in the development cooperation sector. Trainees are faced with various dilemmas about the nature of empowerment and about what contributions and strategies are sustainable for long-term change. This leads to some fascinating discussions in which young people - some with experience, others with none - express their opinions and justify their viewpoints. It is also an opportunity to take stock of the situation.

We feel there is no better way to conclude this brochure than to present some of these dilemmas to you. Feel free to try and answer the questions yourself first. The answers given here are a summary of what the young people who took part in our training had to say about empowerment. We were pleasantly surprised!

Deal with urgent needs or change the balance of power?

Empowerment is a strategy for achieving sustainable change and is based on the potential of people in the South to develop the inner strength to demand their rights and go beyond their dependence on aid. Empowerment centres around changes in power, in contrast to the traditional development cooperation approach, which focuses on meeting needs. However, this does not prevent organised communities from addressing specific, urgent needs, for example by training local health workers. This approach also persuades people in difficult situations to get involved in the fight for fundamental change. They come into contact with a social organisation because they need health care, but then also start campaigning against the privatisation of health care in order to tackle the root causes of their problems.

Communities in the South do not suffer a “disadvantage” that must be eradicated by the efforts of the West. Empowerment assumes a change in the balance of power between North and South. Conventional development theory simply ignores the fact that the South finances the North through cheap raw

materials and manpower. International solidarity must therefore support the empowerment of social organisations in the South and help alter the balance of power between North and South.

Start up my own project or get involved in an existing initiative?

Changing the balance of power happens from within and from the bottom up: communities form organised groups to claim their rights and have intimate knowledge of the problems that need to be tackled. The best option for anyone who wants to work on change is therefore to get involved in an existing process of change. This means being open to the dynamism of communities and of the countries themselves, and having an eye for the potential that exists at local and national level. It does not mean acting in lieu of local people, but rather working on the basis of the needs that they themselves articulate.

Work towards tangible, short-term results or long-term change?

Empowerment is a lengthy process and therefore requires long-term commitment. The process of acquiring power from the bottom up is a combination of awareness-raising (what is going wrong and what we can do about it), organisation (how we can ensure sustainability) and mobilisation (what action and what changes we can undertake). Abilities such as creativity, willingness to listen and flexibility are needed to continuously galvanise this process. The first step is to develop a strategy that realistically identifies what changes are desired and feasible. It is important to win small but tangible victories that improve people's lot in the short term. But this must be part of a long-term struggle for social justice to ensure lasting results and rights for all.

Knowledge is power, but where do we get our information?

Listening to people with knowledge and experience and using it as a starting point is essential in the empowerment process. Knowledge is power and, as such, can be used or abused. The social elite can perpetuate its power because it "knows better" and so can intimidate and manipulate ordinary people by diverting their attention away from the crux of their problems. There is therefore a need to invest in the development of know-how, analytical skills and expertise at grassroots level through alliances and networking. Empowerment also means constantly strengthening the capabilities of social organisations, for instance by providing access to expertise that gives priority to the interests of the majority of the population.

Develop alternatives or compel political change?

Empowerment at local level can sometimes lead to inspiring and innovative models. But if our aim is sustainable change for everyone, we should not assume that the government will automatically adopt these models. On the contrary, there is a real danger that we will create a local island of justice in a sea of injustice. We must therefore go one step further and not limit ourselves to what people try to make us believe is feasible, namely change at community level. We should also have clear views on how we want the government to take the models of an alternative society to the next level. Local change is rarely sustainable when the balance of power remains unchanged at regional and national level. We therefore need to combine forces at all levels, local, regional and national. Fighting for social justice is a political issue.

Can we help while remaining neutral?

Where there is justice, the flip side is inevitably injustice, and at that point we have to decide which side we are on. The struggle for the right to health and social justice is therefore not a neutral activity. Social injustice stems from an unequal balance of power, so remaining neutral means maintaining this status quo. The aim of empowerment processes is to shift this balance of power

in favour of the majority of the population in an existing context of social and democratic injustice. This means increasing the power of broad sections of the population (those who will benefit from such a shift) at the expense of those who derive power from their wealth and social status (those who try to maintain the status quo in power relations). Once we have completed our analysis of how injustice works, we will have no option but to take sides.

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