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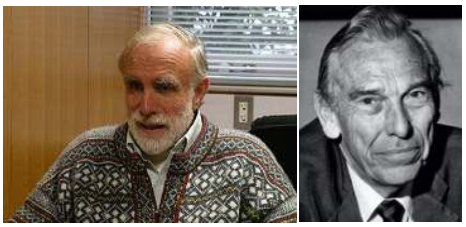
The return of Health for All



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with a contribution by Halfdan Mahler
Director-General, World Health Organization, 1973-1988

Editor's note

'Politics is medicine writ large' said the politician, pathologist and founder of social medicine Rudolf Virchow. Next month the World Health Organization World Health Assembly (WHA) will convene. This and next month *World Nutrition* looks at the big picture that confronts us all, which WHA delegates from the 194 WHO member states need to perceive.

The prevailing global politics and economics, with their consequent impact on health and food systems, have failed, are broken. Yet the most powerful world institutions persist in imposing capital-intensive, resource-greedy policies and programmes on populations that have already often been dispossessed and demoralised by such 'top-down' technical 'fixes'.

Here David Werner, the author of this commentary, and Halfdan Mahler, who as WHO director-general steered the Alma Ata 'Health for All' Declaration, who both have deep experience of what people need, enlighten us. Their news is of good medicine derived from the realities of communities and populations. This now needs to be perceived as the basis of rational policies and effective actions that protect the people and also all life on earth.

Yabasta!



The new generation.The WN cover picture above is of some of the students who come to Haiti, organised by Partners in Health, to understand the social and political determinants of health

Now, in the second decade of the 21st century CE, we live in a different and more endangered world than in the past. The current economic system centred in the United States, dominated by transnational banks and corporations, has placed the collective health and nutrition, and the very survival, of humanity in deeper danger than ever before. This system now threatens the well-being and the existence of our species, because of the problems and crises that it has created. These include the growing gap between rich and poor, the prospect of never-ending wars both conventional and even nuclear, and the threat of genetically engineered crops. Add to this, the turning of our environment into a carcinogenic pool by nuclear and chemical waste that we cannot dispose of, and the global warming ever-lurking crisis.

The enormity and the interaction of these crises create either a 'pandemic despair', or rage and violence. Yet the world's most powerful politicians, who seem to be bought off or intimidated by the transnational banks and corporations, have no apparent interest in taking, or perhaps any ability to take, the radical steps that are needed.

But there are hopeful signs. In this commentary I focus on Latin America, where my work and home has been since the 1960s. Here there are a growing number of communities and populations, and now even new movements and governments, who after enduring centuries of colonial and then neo-colonial oppression, have begun to rise up all together, saying *'Yabasta!'*. ('Enough! No more!').

The push can come only from below. It is time for the world's people – like the populations, communities and citizens in a growing number of Latin American countries – to stand up and cry '*Yabasta!'*. But outcries are only a beginning. What is also needed is a global groundswell of solidarity and organised action.

The People's Health Movement, at local, national, and global level, has a central role in this process. With many thousands of members from all over the world, of all ages and classes, a diversity of national and regional programmes, and numerous watchdog groups, PHM already influences the World Health Organization, *other leading organisations* concerned with health, equity and justice, and policy-makers and decision-takers in many WHO member states. The people who speak for PHM speak for the people, and lead by example. Many other social movements, some small, some huge, are also central players.

We have struggled, sacrificed and learned. We have done some things well. We have made mistakes. Now we look to young people to learn from both our successes and our failures, and to carry the movement forward. We need to recognise and empower young people who believe in and embody the essential goodness of humanity. Many are empowered without our help! What is needed now is a whole new way of governance in which everybody genuinely can take part – as the rallying call of the World Social Movement affirms yes, another world is possible. This now must be so.

For too long, the dominant concepts of development and progress have been tethered to the capitalist paradigm of unlimited growth through the exploitation of people and the unbridled extraction of resources from the environment. But this acquisitive approach to development – as if the Earth belonged to us, rather than us to it – is now rebounding on us all. Ultimately, what our common struggle comes down to, in Latin America and worldwide, is Health for All or Health for No One.

Box 1

David Werner

Born in 1934, David Werner is, with Cicely Williams , David Morley and Derrick Jelliffe, and of a younger generation Paul Farmer, and others celebrated in this commentary, one of the modern pioneers – and many will say heroes – of people- and community-based health care, of which nutrition is central. He has worked for half a century in the global South, especially Mexico. For decades he was facilitator and advisor to *Project Piaxtla*, a Mexican villager-run programme that has helped in the conception and evolution of people-based primary health care. He has worked in more than 50 countries. He has been a consultant for the UN Children's Fund (UNICEF), the World Health Organization, the UN Development Programme, and various national and state governments, including India and Iran as well as Mexico. He has a 'genius award' from the MacArthur Foundation, and many other formal recognitions. He is a founding member of the International People's Health Council and of the *People's Health Movement*, launched in 2000 at the first People's Health Assembly in Bangladesh.

His first book, written from his experience in rural Mexico, and published in 1974, is *Where There Is No Doctor.* His second book published in 1982, is *Helping Health Workers Learn.* Both of these are available from *Hesperian Health Guides* and can be downloaded free of charge (or preferably with a donation). His third book published in 1997, co-written with David Sanders, is *Questioning the Solution: the Politics of Primary Health Care and Child Survival.* This is available from *HealthWrights* and also can be downloaded free of charge, again preferably with a donation.

Sumak Kausay

When we speak of Health for All, 'all' does not mean only us hairless apes. We humans are a small part of a planet where everything is interwoven as a vibrant living whole. We are a thread in the web of life, a participant in the ecological balance of all biologic and non-biologic things, a part of Earth, Air, Fire, and Water, of Warm and of Cold, of Yin and of Yang, of which the cosmos is composed. Unless and until we learn to live in balance and compassion with one another, and with our endangered ecosystem, local and global, good health for any of us will become a bygone dream.

This larger vision of unity and empathy for all is the essence of the ancient Ecuadorian concept of *Sumak Kausay* or *'BuenVivir'* (good living). It is heartening that Ecuador, with its history of indigenous wisdom, has built into its most recent 2008 Constitution the affirmation of the rights of nature as part of holistic living.

Why have so many struggles for liberation slipped back, with new batches of tyrants rising to the top? The key lesson is that revolution without evolution doesn't change much – or at least not for long. Radical change of governance first requires radical change in the way people see themselves in relation to other people and the natural world. If we are to advance towards a healthier, kinder, more sustainable social order, we need to start with ourselves, and with our children, and their children.

Box 2

Bill de Blasio

It is often supposed that peoples' movements are mainly for and from the dispossessed and helpless. Not so. The lessons learned during the hard times summarised below are now being applied by new generations of leaders. An example is the 52 year-old mayor of New York City Bill de Blasio, elected last November with a landslide majority. He is below with his wife Chirlane McCray, who traces her ancestry to Ghana, and their children. During his campaigns it became well known that as a young man (smaller picture) he was a health worker with the Sandinistas in Nicaragua. (See Box 4). He acknowledges this experience as a guiding influence. His initiatives in New York emphasise the need to reduce social and economic equities, for universal free kindergartens, and to transform access to health care.





The Latin American experience



Medical students from the US, now studying social medicine, universal primary health care systems and basic causes of disease and health, in the Latin American Medical School in Havana, Cuba

I have been reflecting on what we can learn from the community-based primary health care movement in Latin America, in the second half of the 20th century. We can learn a lot, including lessons that can ground us in strategies of organised action.

The period from the 1960s – when my own work began in Mexico – to the 1990s, was exciting but difficult. Grassroots actions in many countries were countered by the ruling classes and their agents with fierce repression. This included torture, disappearances, mass murders identified even as genocide, and other violations of human rights and international law. But for all the suffering and setbacks, this was a time when some very positive, deep-seated changes also took place. Dictatorships and repressive regimes were ousted. Foundations were laid for the more recent dramatic shifts in the region towards representative government and participatory democracy now evident in an increasing number of countries and areas within countries. The suffering has not all been in vain, and it may be that hard times are the forge for increasingly equitable societies. Community-based health care played – and plays – a central role in liberating, bottom-up struggles for Health for All.

Beginning in the late 1950s, in various parts of Latin America, small non-government health programmes emerged in the poorest, most under-served rural areas and urban slums. The combination of social injustice, poverty-related ills, and minimal public services led to spontaneous generation of community health programmes. Many of these projects were started by concerned outsiders – such as priests, nuns, doctors, nurses, social workers – committed to serving the poor.

As the community-based, primary care programmes evolved and became more participatory, the *promotores* (health promoters) and villagers began to discuss and analyse the underlying causes of their health-related problems. Then they began to organise to overcome their common problems, at least at the local level. Out of these collective efforts grew organisations: of mothers, landless farmers, day labourers,

share-croppers, even street children and youth, all seeking a greater voice in the decisions that affected their health and their lives. In this way, many community-based programmes evolved from a focus on curative care, to preventive measures, and finally to socio-political action.

These community initiatives began to mobilise people to address the root causes of ill health and malnutrition. In doing so, they were seen as threats by the local power structure: landlords, public authorities, loan sharks, medical professionals, and others whose routine exploitation of the poor contributed to hunger and poor health.

As a result, many of the non-governmental programmes that were at first welcomed as inoffensive charities became blacklisted by the local authorities and then by national governments. Increasingly harsh rules and obstacles were imposed, and, in some countries, health workers or participating midwives were arrested – or worse. In response, many persecuted health workers went underground and joined resistance movements. With their valuable health and organisational skills, some become leaders in the growing liberation struggles against tyrannical rule.

In this way, grassroots community-based health care in Latin America came to play a key role in the mobilisation of marginalised people in the struggles that contributed to the emerging process of genuine democratisation in Latin America. Below I give some examples that I am familiar with, from my own work in Latin America.

But first, in the following two pages is the statement made by former World Health Organisation director-general Halfdan Mahler, to the World Health Assembly in 2008, the 30th anniversary of the Alma Ata Health for All Declaration. This responded to work like ours all over the world at the time, and rallied us. It rallies us now. It should remain in the minds and the hearts of delegates from WHO member states present at the World Health Assembly in May 2014.



Social movements are growing a new democracy. The students' movement in Chile has influenced the ousting of an industry-friendly President and the new election of centre-left Michelle Bachelet

Box 3

Halfdan Mahler on Health for All

This is an edited extract from the address of Halfdan Mahler to the WHO World Health Assembly in 2008, the 30th anniversary of the 'Health for All' Declaration of Alma Ata. It is as relevant now as it was in 2008, and Health for All remains a fundamental call.

Milan Kundera has written: 'The struggle against human oppression is the struggle between memory and forgetfulness'. Remember the transcendental beauty and significance of the definition of health in WHO's Constitution: 'Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity.' Then: 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition'.

Unless we all become partisans in renewed local and global battles for social and economic equity in the spirit of distributive justice, we will indeed betray the future of our children and grandchildren. The World Health Assembly had this in mind when, in 1977, it decided that the main social target for governments and WHO in the coming decades should be the attainment of what is known as 'Health for All', meaning the level of health that will permit all the people of the world to lead socially and economically productive lives. When people are pawns in an economic and profit growth game, that game is lost for the underprivileged.

To make real progress we must stop seeing the world through medically tainted glasses. We need to realise that a strategy of initiating social change is as potent a tool in promoting health, as is knowledge of medical technology. In some countries health management has to be considered along with such things as producing more or better food, improving irrigation, or marketing products. Getting food, or a piece of land, or house, or an accessible source of water, must come first to make other things meaningful.

Conventional or medical wisdom has done little to provide scientific and political credibility to the importance of individual, family and community participation in health promotion. These concerns prompted a study by WHO's Executive Board in 1973 which stated 'There is a wide gap in health status between countries, and between different groups within countries; rapidly rising costs without visible meaningful improvement in service; and a feeling of helplessness among populations, who feel that the health services and the personnel within them are on a path of their own which may be satisfying to the health professionals but which is not what is needed'.

This study led to the decision by WHO, with UNICEF, to convene 'The International Conference on Primary Health Care' in Alma-Ata, then in the USSR, in 1978. I repeat with awe and admiration, the concept of primary health care in the Declaration of Alma-Ata:

> Primary health care is based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, at a cost that the community and the country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination. It forms an integral part, both of the country's health system, of which it is the central function and main focus, and of the social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Primary health care also includes education on prevailing health problems and how to prevent and control them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

So my challenges now to all nations represented here include these. Are you ready to:

Address yourselves seriously to the existing gap between the health 'haves' and the health 'have-nots' and to adopt concrete measures to reduce it?

Ensure the proper planning and implementation of primary health care, to promote health as indispensable to the quality of life of every individual, family and community?

Make preferential allocations of resources to the social periphery an absolute priority?

Mobilise and enlighten individuals, families and communities to ensure identification with primary health care, and their participation in its planning, management and application?

Introduce reforms to ensure the availability of relevant human resources and technology, sufficient to cover the whole country with primary health care at a cost you can afford?

Introduce, if necessary, radical changes in the existing health delivery system so that it properly supports primary health care as the overriding health priority?

Fight the political and technical battles required to overcome any social and economic obstacles and professional resistance to the universal introduction of primary health care?

Make unequivocal commitments to adopt primary health care and to mobilise international solidarity to attain the objective of health for all?

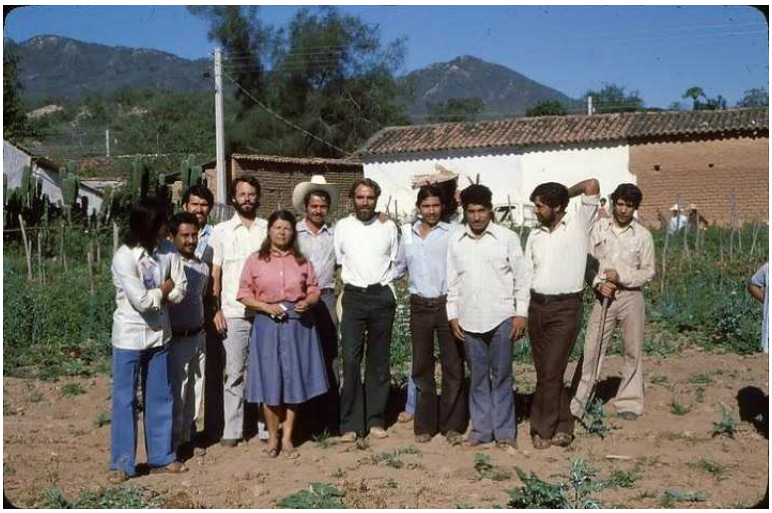
Alma-Ata reflects a famous truism: 'The health universe is only complete for those who see it in a complete light, it remains fragmented for those who see it in fragmented light!"

Let us remember that the inspirational energies and the evidence base have come from developing countries themselves. Financial support from so-called donors was essential to carry out studies, in appropriate technology, human resources development, infrastructure development, social participation, and financing in order to integrate the Alma-Ata vision into heavily constrained local contexts.

Most donors, after an initial outburst of enthusiasm, quickly lost interest or distorted the Alma-Ata vision and strategy, with the ominous name of 'selective primary health care' which reflected the biases of national and international donors and not the needs and demands of developing countries. But in spite of these brutal impediments, many countries have shown courageous adhesion to the Alma Ata principle of equity in local and global health. Civil society movements have also been prime shakers and movers in these admirable efforts.

Being an inveterate optimist, I believe that the struggle between memory and forgetfulness can be won in favour of the Alma-Ata 'Health for All' vision and its related Primary Health Care Strategy. Visionaries have been the realists in human progression.

Rising up in Latin America



Here I am (black trousers) with my companions, friends and co-workers in Piaxtla in rural Mexico in 1970, soon after the beginning of my work in the community. This is where my learning began

My own involvement with the struggle for health and justice began in Piaxtla, a villager-run health programme in Mexico's Sierra Madre Occidental. It is from this experience with Piaxtla, which I helped to start in 1965, that the books *Donde No Hay Doctor* (*Where There is No Doctor*) and *Aprendiendo a Promover la Salud* (*Learning How to Promote Health*) were born. Also, and many years later, *Cuestionando la Solution: laspolíticas de atención primaria en salud y la sobrevivencia infantil.* (*Questioning the Solution: The Politics of Primary Health Care and Child Survival*). Like many grassroots health programmes, Piaxtla evolved as always in three stages. One, medical treatment and care. Two, preventive measures. Three, social and political action.

Mexico



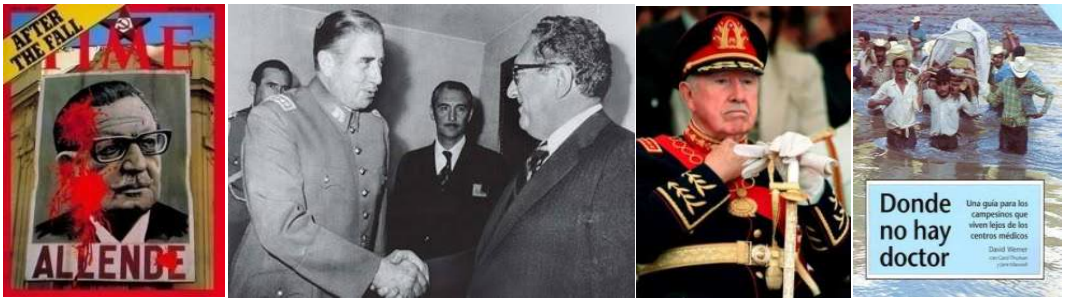
In Mexico, there have been many turbulent periods since independence from Spain, then dependence on the US. Above, its great 19th century president Benito Juarez, and depiction of peasants uprising

The Mexican Constitution, which grew out of the revolution of 1910, provided for a more equitable distribution of land. But much of the revolution was betrayed. Half a century later the best farmland was still illegally held by large landowners, who sharecropped small parcels to landless farmers at exploitative rates.

Hardship, hunger and malnutrition were inevitable. A survey we took in the mid-1960s showed that one-third of the children died before the age of 5 years, mostly from diseases related to undernutrition. This taught me a lesson that all those concerned with the nutrition of communities need to know. This is that treatment of malnutrition alone can of course save the lives of the children who are treated, but will make no difference to the general condition of the community. That can be treated only by ways in which communities and populations are enabled to lift themselves out of poverty and misery. This means direct action.

As the programme evolved, the *promotores* brought their fellow villagers together to analyse the root causes of poor health, and to explore solutions. People began to organise and demand their constitutional land rights. It was a long battle. Several health workers were killed. But in the end, the *campesinos* (peasants) succeeded in invading and reclaiming over half of the illegal large parcels of land, which they distributed to landless farmers. In just over a decade, child mortality dropped to under one fifth what it had been. Maternal mortality fell to less than half. The population as a whole appeared happier, healthier and more self-determined.

Chile



In Chile the democratically elected socialist government of Salvador Allende was overthrown by Augusto Pinochet (above being congratulated by his US sponsor). Yet our work managed to survive

In Chile, the elected government of Salvador Allende (left above) was overthrown by the military junta led by Augusto Pinochet. The dictatorship that followed was funded and sponsored by successive US governments, as indicated by the picture (above) of Pinochet being congratulated by US secretary of state Henry Kissinger. There followed a ruthless and reckless imposition of so-called 'free market' political and economic policies masterminded by monetarist economist Milton Friedman of

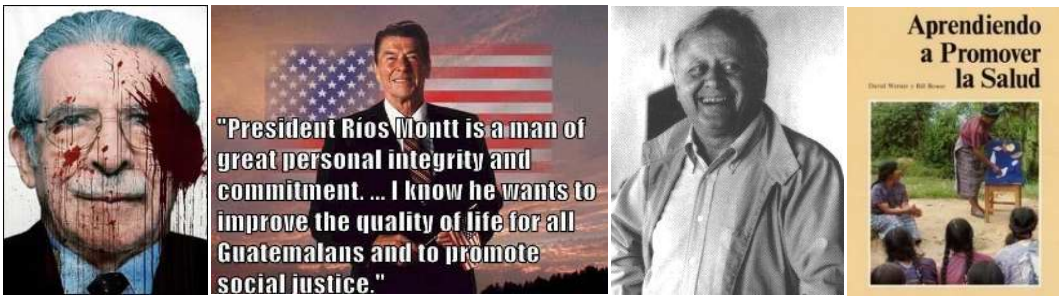
Chicago University, and his followers including Chileans known as the 'Chicago Boys', and the then follower of Milton Friedman, the economist Jeffrey Sachs.

These policies ripped out publicly owned or protected industries and services and privatised the Chilean health service, and continue to pauperise a large proportion of the population without the resources to pay for health insurance or for private medicine. During the dictatorship *Donde No Hay Doctor'* (*Where There is No Doctor*) was banned by the military authorities. However, the publisher of the Chilean edition, *Editorial Cuatro Vientos*, took the government to court. Amazingly the court sided with the publisher and lifted the ban.

During this time of violent repression and vast unmet needs, a radical community health programme called *Educación Popular en Salud,* or People's Health Education,was born in the impoverished districts of Santiago and Concepcion. As part of its health education, EPES promoted the *concientización* (awareness-raising) and mobilisation of people around the root causes of poor health.

This *empoderamiento popular* (people's empowerment) played a critical role in the groundswell of resistance that eventually led to the end of the military regime, the restoration of democracy in Chile, and then also more recently to the profoundly significant student and young people's movement that has helped to restore the current centre-left democratic socialist government of Michelle Bachelet. Like Salvador Allende, she is a physician whose education specialised in public health in the tradition of the radical 19th century physician and politician Rudolf Virchow, one of whose statements is that epidemics are symptoms of sick societies.

Guatemala



In Guatemala, US-backed dictatorships involved mass murder of rural populations. Even so, community-based health leaders like Carroll Behrhorst (second from right) survived and persisted

In Guatemala, one of the earliest and most influential community-based health care programmes was started in the highlands of Chimaltenango by a visionary physician originally from the US, Carroll Behrhorst, to serve marginalised and cruelly exploited indigenous communities. This was one of the first programmes to train local

promotores de salud. As they began to help the villagers to analyse the underlying determinants of health and take collective action to improve their situation, the military government began to see the community programmes and its workers as subversive, which indeed from their point of view, they were. Some *promotores* were murdered or 'disappeared'. In the years of the 'scorched earth' 'pacification' abominations of the early 1980s, perpetrated under the dictatorship of Efrain Rios Montt (above, left, and as feted by US president Ronald Reagan) which amounted to genocide of indigenous populations, entire villages were burned to the ground. One such village was San Martín, where I took the cover photograph for *Helping Health Workers Learn (*above, right), which shows a *promotora* teaching a group of mothers.

Projimo, a programme dedicated to meeting the needs of disabled children, grew out of Piaxtla in Mexico. During the late 1980s and early 1990s, *Projimo* arranged secretly to bring severely disabled guerrilla fighters from Guatemala to their programme where they were provided free rehabilitation and physical support.

El Salvador



In El Salvador, protests against the murder of pro-people archbishop Oscar Romero in street art (left) and young people rose up. Courageous health workers like Charlie Clements (right) survived

In El Salvador in the 1970s and 1980s, within impoverished areas, a number of community based health programmes arose out of enormous unmet needs. Widespread unrest was on the rise. As measures of social control became more oppressive, complete with death squads, community health programmes and workers increasingly aligned themselves with the *Frente Farabundo Marti para la Liberación Nacional.* As elsewhere, *promotores* played a key role in mobilising resistance to the US-supported military dictatorship.

As this resistance to organised repression became more militant, health workers increasingly found themselves in sympathy with the guerrilla uprisings for social justice and self-determination. Some worked directly with them. Among the best known on the medical front was the North American physician Charlie Clements (above in front of a picture of the US pro-people writer Howard Zinn) whose experiences are recorded in his book *Witness to War*. In like manner, a young Mexican

physician, Carlos Miyazaki, spent three years in El Salvador during the 1980s, volunteering in the embattled and liberated villages. There, he trained over 300 health promoters, and provided each with a copy of *Donde No Hay Doctor*.

Nicaragua



In Nicaragua the Somoza dictatorship, sponsored by the US (above left) were overthrown by the Sandinistas led by Daniel Ortega, supported by now New York City mayor Bill de Blasio (right)

In Nicaragua during the time of the brutal US supported Somoza family dynasty that ruled the country from 1936 to 1979, the poor majority lived in deplorable conditions. Many community health initiatives that emerged to respond to the many unmet needs were assisted by foreign non-government organisations or by charitable religious groups that had no political agenda. But the pervasive 'diseases of poverty' they encountered were clearly the result of an unjust social order, and many community health workers began to facilitate organised action at the local level. Thus the *promotores de salud* gradually became agents of change – and were soon branded as outlaw subversives.

The informal network of community based programmes expanded. In response, the Somoza-regime National Guard, and paramilitary groups, increasingly targeted grassroots health workers as well as union leaders and community organisers, and harassed, imprisoned and murdered them. This led many to go underground and join the growing Sandinista resistance. As collective punishment, the government cut off water, food, and other basic supplies and services.

In response, the grassroots communities that supported the Sandinistas set up civil defence committees that acted in effect as local governments. In these communities food, water, and other essential supplies, and also basic health services, were supplied and distributed. Local health volunteers known as *brigadistas de salud* were recruited and trained. In this way, the grassroots network of community-run health initiatives played a vital role in the broad-based awakening and mobilisation that eventually led to the overthrow of the Somoza dictatorship in 1979.

Box 4

A young health worker

Not all US citizens supported their government in Latin America. In the spirit of the direct action against the invasion of Vietnam, some young people from the US supported the people of Nicaragua. One as indicated above in Box 2, was Bill de Blasio, now mayor of New York City. Here is an edited extract from the New York Times:

Bill de Blasio studied Latin American politics at Columbia University in New York City, and was conversational in Spanish. He grew to be an admirer of Nicaragua's ruling Sandinista party. The Reagan administration denounced the Sandinistas as tyrannical and Communist. Their liberal backers argued that after years of dictatorship, the Sandinastas were building a free society with broad access to education, land and health care.

In 1987 he was hired as a political organiser, soon after he finished graduate school at Columbia. He worked inside the Quixote Center's Maryland office and oversaw efforts to solicit and ship millions of dollars in food, clothing and supplies to Nicaragua. He also proved to be a skilled provocateur, twice being arrested during rallies against United States foreign policy that were held in the Washington area.He became an ardent supporter of the Nicaraguan revolutionaries. When he was asked at a meeting in 1990 about his goals for society, he said he was an advocate of democratic socialism. Seeing the efforts of the Sandinistas up close strengthened his view that government should protect and enhance the lives of the poor.

In 1988 he distributed food and medicine in Nicaragua. He took notes on encounters with farmers, doctors and revolutionary fighters. He returned to the US with a vision of an unfettered leftist government. His time as a young activist was more influential in shaping his ideology than previously known, and far more political than typical humanitarian work.

In a health clinic in Masaya, a small Nicaraguan city, he had an epiphany. It came in the form of a map posted on the wall, which showed the precise location of every family in town. The doctors used it as a blueprint for door-to-door efforts to spread the word about the importance of immunisations and hygiene. The idea was simple, but he saw it as a symbol of what a robust government, extremely attuned to community needs, could achieve. 'There was something I took away from that – how hands-on government has to be, how proactive, how connected to the people it must be' he said.

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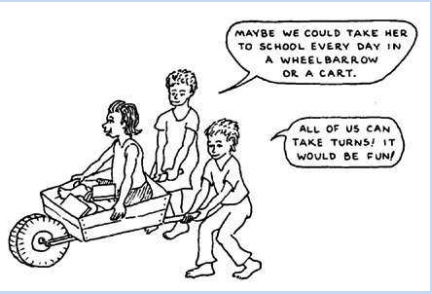
Thus the country in Central America where the liberation struggle appeared most successful was Nicaragua. The victory demonstrated that an alternative model to the one advocated by the global elites could work well and provide far superior health, nutrition, welfare and educational opportunities to the people.

This was seen in the US as having far-reaching subversive potential. So the Reagan administration initiated economic embargoes and counter-revolutionary terrorism carried out by what became known as the *Contras*. Eventually the institutionalised terrorism perpetrated by the United States, the embargo, and more sophisticated strategies of social control took their toll. In 1990, the Sandinistas were voted out and a conservative party, propped up by the US, took power**.**

Box 5

Child-to-child





David Morley (above left). And (right) how child-to-child care works – children work out how to enable a disabled friend to get to school, and in this way they make a game meaningful

One of the most exciting developments to emerge out of the people-centred struggle for health is the child-to-child initiative. The concept grew out of an international gathering of health educators in 1979, convened by David Morley (above), a British paediatrician with long experience in rural Africa, and a leading pioneer in primary health care in least resourced environments.

The idea for child-to-child emerged from the fact that in very poor families older siblings, especially girls, are often kept out of school, because they are needed to care for younger children while their mothers are working. A variety of child-to-child 'activity sheets' were developed to help children learn preventive and curative skills. Early activities addressed diarrhoea, lowering fever, getting enough to eat and to drink, cleanliness, and prevention of accidents.

As it was developed in Africa, child-to-child was effective, but in some ways conventional Health workers and educators in Latin America helped to transform it into a liberating learning experience which encourages children to make their own observations, draw their own conclusions, and take collective action to solve problems in their own homes and communities.

Since its modest start, the concept of child-to-child expanded in a number of ways. It is now practiced in more than 70 countries. And the range of activities has grown to include such diverse activities as tree planting, recycling garbage as fertiliser, and caring for the elderly.

Latin America has contributed to child-to-child by helping to transform it from a useful but fairly orthodox teaching tool to a liberating learning experience. The transformative potential should not be underestimated, either for children or for schools. Child-to-child, in its more liberating form, encourages children to make their own observations, draw their own conclusions, and take collective action to solve problems in their own homes and communities. When practiced in schools it can help make schooling more relevant.

Actually, the children begin by doing their own community diagnosis. This helps them look at the larger picture of sickness and health in their community and to visualise how the various health problems are linked together. Often, based on their findings, the children choose which health problem about which they want to learn first, and about which they want to explore possible solutions.

In the chain of causes leading to death from diarrhoea in children living in poverty, malnutrition is often the most pernicious link. In Latin America, the child-to-child activity titled 'Helping children who are too thin' takes a discovery-based, learning-by-doing approach. This actively engages the children in the entire problem solving process, from measuring the severity of the problem to planning and implementing solutions.

Clearly, the health and nutrition needs of infants in impoverished, marginalised families will not be resolved by groups of schoolchildren. To do away with hunger, the underlying determinants of malnutrition (social, cultural, economic and political) must also be collectively addressed. The long-term transformative potential of the child-to-child approach to education should thus not be underestimated. Its influence both on the children involved and on the school system can be far-reaching.

Building the movement

In the first years of *Project Piaxtla* we had no idea that any similar programmes existed. We were in an isolated mountain area without electricity, and with only mule-trails connecting the villages. When I first wrote *Where There is No Doctor* in the early 1970s, we never imagined it would be used beyond the Sierra Madre. But somehow news of the handbook began to spread to other grassroots health programmes I'd never heard of, in Mexico and then in other countries. Little by little, different programmes began to communicate, share ideas, and eventually exchange visits.

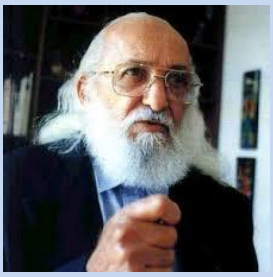
A process of networking and solidarity-building, within and between countries, has been an important strategic outcomes of what became the community-based health care movement. The network grew stage by stage in an organic, bottom-up way.

Largely through the informal distribution of *Donde No Hay Doctor* in the 1970s, *Project Piaxtla* in Mexico made contact with community health programmes in Latin America. In 1975, a group of us from Piaxtla took a study trip through Mexico, Central America, and the northern part of South America, to visit and exchange ideas The trip, and the publications that grew out of it, such as the second book *Helping Health Workers Learn*, catalysed the networking process.

We visited nearly 40 rural health projects in nine countries. These programmes were on a continuum from community-supportive to community-oppressive. Community-supportive programmes encouraged responsibility, initiative, decision-making and self-reliance. Those that were community-oppressive were fundamentally authoritarian, paternalistic and encouraged dependency, servility and unquestioning acceptance of outside regulations and decisions. Interestingly, it was often the non-governmental programmes, usually operating on a shoestring budget, that were more community-supportive.

Box 6

Paulo Freire





Paulo Freire (above), the Brazilian educator of the people, has taught community workers how to raise the consciousness of themselves as well as of the people that they work with

The methods we learned and used in Mexico, which now also are used in communities throughout the world, have been influenced and encouraged by the thinking and practice of the Brazilian educator Paulo Freire (above). His book *Pedagogy of the Oppressed* has revolutionised the methodology of information sharing and awareness raising, in community-action movements worldwide. He describes two of kinds of education. First, is the 'banking' approach where an all-knowing authority deposits ideas into pupils' empty heads. The second is the 'liberating' approach where the facilitator pulls ideas out of the heads of the learners, and helps them build on their own observations and experience. People collectively assess the situations in which they live and develop strategies for change.

Different programmes have used different methods to help people analyse their health- and nutrition-related needs and to explore solutions. To engage groups of farm workers, mothers, or schoolchildren in a situational analysis, many *promotores* begin with a community diagnosis. The group identifies their common health- and nutrition-related problems, which they label according to frequency, severity, contagion, and duration. Next, they look at which problems contribute to others, and how. Finally they discuss which problems they should try to attack first, and try to develop a plan of action. Because the activity is so visual and hands-on, nearly everybody gets involved. It is an eye-opening, action-oriented learning experience … and lots of fun. (See the picture above, right).

One widely used method to help people learn about interrelated causes of different health and nutrition problems uses storytelling, followed by a 'But why?' game, and the creation of a 'chain of causes'. First, a true story is told, perhaps about the recent death of a child. Into the story is built a whole series of causes, one leading to the next. After the story is told, the learning group retells it, and each time a cause is stated, everyone asks, 'But why?' thus progressively getting from the more immediate to the more structural causes. Physical, biological, cultural, economic, political and environmental causes pop up spontaneously from the community, are all examined, and appropriate problem solving procedures are proposed. The game aims at what we would today say is ultimately exploring the social determinants (or more properly, the social determination) of preventable ill-health and malnutrition.

The 'chain of causes' is one of the many methods we health and nutrition educators use. We call it 'discovery based learning', an approach pioneered in the communities in Latin America and elsewhere.

As we went from programme to programme, we gave special attention to the roles that were assigned to the local village health (and nutrition) worker. We found that if the village health workers were taught a substantial range of skills and were encouraged to think, learn, and to take initiatives, they made a major contribution to their community and won the people's confidence and love. This is as valid today as it was then.

But in places where potential change agents were feared, village health workers were often taught a pathetically limited range of skills. They were not trained to think, but to follow a list of instructions or 'norms'. Such health workers had limited impact on health and nutrition and very little on the growth of the community.

Building a worldwide movement



The 1986 'revolution of flowers' in the Philippines, which displaced the corrupt US-supported Marcos regime, was helped by community health workers in communities throughout the country

Over time, the regional committees for community health promotion gradually expanded to include more countries of the Caribbean and representatives from programmes in South America. They also began to have exchanges with like-minded programmes and networks in other parts of the world.

Thus in 1980 Martin, one of the lead village health workers of Piaxtla in Mexico, had a chance to visit India for an international health conference titled, 'Let the Village Hear'. As one of only a few actual villagers present at the conference, he stressed the need for more villagers to have a chance to speak up, rather than to just be talked about. The conference closed with an official decision to change its theme from 'Let the Village Hear' to 'Let the Village Be Heard.'

The following year, in August 1981, a group of health workers from programmes in Guatemala, Honduras, and Mexico travelled to the Philippines, where they exchanged ideas with health workers in the countrywide network of community based health care programmes there.

In the Philippines, the despotic US-supported president Marcos government was overthrown in 1986 in the massive, largely non-violent, popular uprising called the Revolution of Flowers. The community-based health care movement, which had by then become an international organisation, whose health workers in the Philippines reached nearly every town and village, played a strong underground role in mobilising and preparing the people for this revolution.

Similar scenarios played themselves out elsewhere. In the Philippines after Marcos, and in South Africa after liberation from apartheid rule, people's hope for radical change was high. But within a few years, reversals took place that moved back to the top-down model of the delivery of health care which brought back the polarised social order of before. Even for a revolutionary as visionary as Nelson Mandela the overarching power of the globalised plutocracy was just too much.

The International People's Health Council

In 1990, an international meeting organised by a group of community health pioneers in various parts of the world, was scheduled to take place. The purpose of the *Symposium on Health in Societies in Transition*, as it was called, was initially to focus on positive transitions toward more equitable, health-promoting governance. However, in view of some of the current negative transitions, the decision was made to focus on strategies to preserve what gains had been made, before the tides turned back to ignorance, repression and immiseration.

This symposium in Managua, Nicaragua, broke new ground. There was penetrating analysis of the similar problems people from diverse locations were experiencing, and solid proposals for local and international action were made. Towards the end of the meeting, the group agreed that the exchange that had begun needed to continue and expand. To this end, they formed a new intercontinental coalition, called the International People's Health Council.

During the 1990s, the IPHC arranged periodic international gatherings, held in South Africa, Palestine, Europe, and Australia. Conjointly it facilitated short courses on topics such as health education for change, child-to-child activities, grassroots organisation, and other action-oriented topics.

The People's Health Assembly



A vivid celebration of the People's Health Movement and of Health for All, organised in Latin America. Regional and local meetings of the PHM are now held in countries all over the world

In the 1990s, people in the International People's Health Council, and many others in similar national and international health networks, began to plan a turn-of-the-century global conference, named the *People's Health Assembly*. This was held at Gonashasthaya Kendra in Bangladesh, in December 2000. Over 1400 health workers and activists from more than 70 countries participated. Out of this groundbreaking Assembly has emerged the *People's Health Movement,* which is dedicated to inform and empower professionals and citizens all over the world. Like other social movements, the PHM is also becoming prepared to play its part in a whole new system of governance from, by and for the people.



The People's Health Movement is for people everywhere of countries, classes and ages. Here, children introduce a PHM conference in 2012, held in Karachi. Pakistan. This is the way to a new world



Porto Alegre, Brazil, March 2014. Students meet to discuss SUS, the Brazilian public national universal health service, and to become more aware of its failings and its value for all the people

The founders of the People's Health Movement are older now than we were when we planned the first People's Health Assembly, and many of us are now much older than we were when we first became active. My own story goes back half a century. In many ways the threats to world health faced now are worse than those we faced. But all over the world now they are being faced by a new generation many of whom are young, brilliant, brave and energetic. So we can have hope.

Box 7

Who is WHO for?



Next month the World Health Organization World Health Assembly convenes in Geneva. Here are some of the delegates from the 194 WHO member states at the 2012 WHA. Some of them look bored or distracted. Some seats are empty. We believe that there are other voices that upholders of health – yes, Health for All – will learn from. These voices, of the people as a whole, are well represented in and by the Peoples Health Movement.

The People's Charter for Health



This People's Health Movement (logo above) Charter for Health, available from the People's Health Movement, is the outcome document of the first PHM Assembly held in Bangladesh in 2000. It is as relevant now as then – more so.

In 1978, at the Alma-Ata Conference, ministers from 134 member countries in association with WHO and UNICEF declared 'Health for All by the Year 2000' selecting Primary Health Care as the best tool to achieve it.

That dream never came true. The health status of Third World populations has not improved. In many cases it has deteriorated further. Currently we are facing a global health crisis, characterised by growing inequalities within and between countries. New threats to health are continually emerging. This is compounded by negative forces of globalisation which prevent the equitable distribution of resources with regard to the health of people and especially that of the poor.

Within the health sector, failure to implement the principles of primary health care, as originally conceived in Alma-Ata, has significantly aggravated the global health crisis. Governments and the international bodies are fully responsible for this failure.

It has now become essential to build up a concerted international effort to put the goals of 'Health for All' to its rightful place on the development agenda. Genuine, people-centred initiatives must therefore be strengthened in order to increase pressure on decision-makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality.

Several international organisations and civil society movements, NGOs and women's groups decided to work together towards this objective. This group together with others committed to the principles of primary health care and people's perspectives organised the People's Health Assembly which took place from 4-8 December 2000 in Bangladesh, at Savar, on the campus of the Gonoshasthaya Kendra or GK (People's Health Centre). 1453 participants from 92 countries came to the Assembly, which was the culmination of eighteen months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross-section of people who have been involved in thousands of village meetings, district level workshops and national gatherings.

The plenary sessions at the Assembly covered five main themes: health, life and well-being; inequality, poverty and health; health care and health services; environment and survival; and the ways forward.

People from all over the world presented testimonies of deprivation and service failure as well as those of successful people's initiatives and organisation. Over a hundred concurrent sessions made it possible for participants to share and discuss in greater detail different aspects of the major themes and give voice to their specific experiences and concerns. The five-day event gave participants the space to express themselves in their own idiom. They put forward the failures of their respective governments and international organisations and decided to fight together so that health and equitable development become top priorities in policy-makers' agendas at the local, national and international levels.

Having reviewed their problems and difficulties and shared their experiences, they have formulated and finally endorsed the People's Charter for Health. The Charter from now on will be the common tool of a world-wide citizen's movement committed to make the Alma-Ata dream a reality. We encourage and invite everyone who shares our concerns and aims to join us by endorsing the Charter.

Preamble

Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health For Alll means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed.

This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organisations and corporations.

Vision

Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world – a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives. There are more than enough resources to achieve this vision.

The health crisis

'Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us' (A voice from Central America)

The planet's natural resources are being depleted at an alarming rate. The resulting degradation of the environment threatens everyone's health, especially the health of the poor. There has been an upsurge of new conflicts while weapons of mass destruction still pose a grave threat.

The world's resources are increasingly concentrated in the hands of a few who strive to maximise their private profit. Neoliberal political and economic policies are made by a small

group of powerful governments, and by international institutions such as the World Bank, the International Monetary Fund and World Trade Organization. These policies, together with the unregulated activities of transnational corporations, have had severe effects on the lives and livelihoods, health and well-being of people in both North and South.

Public services are not fulfilling people's needs, not least because they have deteriorated as a result of cuts in governments' social budgets. Health services have become less accessible, more unevenly distributed and more inappropriate.

Privatisation threatens to undermine access to health care still further and to compromise the essential principle of equity. The persistence of preventable ill health, the resurgence of diseases such as tuberculosis and malaria, and the emergence and spread of new diseases such as HIV/AIDS are a stark reminder of our world's lack of commitment to principles of equity and justice.

Principles

The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class.

The principles of universal, comprehensive Primary Health Care envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating policies related to health. Now more than ever an equitable, participatory and intersectoral approach to health and health care is needed.

Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay.

The participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.

Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

Health as a human right

To combat the global health crisis, we need to take action at all levels – individual, community, national, regional and global – and in all sectors. The demands presented below provide a basis for action. Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns.

This Charter calls on people of the world to:

Support all attempts to implement the right to health.

Demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health.

Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.

Fight the exploitation of people's health needs for purposes of profit.

The broader determinants of health

Economic challenges

The economy has a profound influence on people's health. Economic policies that prioritise equity, health and social well-being can improve the health of the people as well as the economy.

Political, financial, agricultural and industrial policies which respond primarily to capitalist needs, imposed by national governments and international organisations, alienate people from their lives and livelihoods. The processes of economic globalisation and liberalisation have increased inequalities between and within nations.

Many countries of the world and especially the most powerful ones are using their resources, including economic sanctions and military interventions, to consolidate and expand their positions, with devastating effects on people's lives.

This Charter calls on people of the world to:

Demand radical transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In particular, such transformation must include intellectual property regimens such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.

Demand the cancellation of Third World debt.

Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.

Demand effective regulation to ensure that transnational corporations do not have negative effects on people's health, exploit their workforce, degrade the environment or impinge on national sovereignty.

Ensure that governments implement agricultural policies attuned to people's needs and not to the demands of the market, thereby guaranteeing food security and equitable access to food.

Demand that national governments act to protect public health rights in intellectual property laws.

Demand the control and taxation of speculative international capital flows.

Insist that all economic policies be subject to health, equity, gender and environmental impact assessments and include enforceable regulatory measures to ensure compliance.

Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognise environmental constraints, the fundamental importance of equity and health, and the contribution of unpaid labour, especially the unrecognised work of women.

Social and political challenges

Comprehensive social policies have positive effects on people's lives and livelihoods. Economic globalisation and privatisation have profoundly disrupted communities, families and cultures. Women are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.

Public institutions have been undermined and weakened. Many of their responsibilities have been transferred to the private sector, particularly corporations, or to other national and international institutions, which are rarely accountable to the people. Furthermore, the power of political parties and trade unions has been severely curtailed, while conservative and fundamentalist forces are on the rise. Participatory democracy in political organisations and civic structures should thrive. There is an urgent need to foster and ensure transparency and accountability.

This Charter calls on people of the world to:

Demand and support the development and implementation of comprehensive social policies with full participation of people.

Ensure that all women and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious choice, to education and to freedom from violence.

Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalised groups.

Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.

Demand that the activities of public institutions, such as child care services, food distribution systems, and housing provisions, benefit the health of individuals and communities.

Condemn and seek the reversal of any policies, which result in the forced displacement of people from their lands, homes or jobs.

Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of women, children and minorities.

Oppose sex tourism and the global traffic of women and children.

Environmental challenges

Water and air pollution, rapid climate change, ozone layer depletion, nuclear energy and waste, toxic chemicals and pesticides, loss of biodiversity, deforestation and soil erosion have far-reaching effects on people's health. The root causes of this destruction include the unsustainable exploitation of natural resources, the absence of a long-term holistic vision, the spread of individualistic and profit-maximising behaviours, and over-consumption by the rich. This destruction must be confronted and reversed immediately and effectively.

This Charter calls on people of the world to:

Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.

Demand that all development projects be evaluated against health and environmental criteria and that caution and restraint be applied whenever technologies or policies pose potential threats to health and the environment (the precautionary principle).

Demand that governments rapidly commit themselves to reductions of greenhouse gases from their own territories far stricter than those set out in the international climate change agreement, without resorting to hazardous or inappropriate technologies and practices.

Oppose the shifting of hazardous industries and toxic and radioactive waste to poorer countries and marginalised communities and encourage solutions that minimise waste production.

Reduce over-consumption and non-sustainable lifestyles both in the North and the South.

Pressure wealthy industrialised countries to reduce their consumption and pollution by 90 per cent.

Demand measures to ensure occupational health and safety, including worker-centred monitoring of working conditions.

Demand measures to prevent accidents and injuries in the workplace, the community and in homes.

Reject patents on life and oppose bio-piracy of traditional and indigenous knowledge and resources.

Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.

War, violence and conflict

War, violence and conflict devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector.

This Charter calls on people of the world to:

Support campaigns and movements for peace and disarmament.

Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms, including all types of landmines.

Support people's initiatives to achieve a just and lasting peace, especially in countries with experiences of civil war and genocide.

Condemn the use of child soldiers, and the abuse and rape, torture and killing of women and children.

Demand the end of military occupation as one of the most destructive tools to human dignity.

Oppose the militarisation of humanitarian relief interventions.

Demand the radical transformation of the UN Security Council so that it functions democratically.

Demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression which can damage the health of civilian populations.

Encourage independent, people-based initiatives to declare neighbourhoods, communities and cities areas of peace and zones free of weapons.

Support actions and campaigns for the prevention and reduction of aggressive and violent behaviour, especially in men, and the fostering of peaceful coexistence.

A people-centred health sector

This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this.

This Charter calls on people of the world to:

Oppose international and national policies that privatise health care and turn it into a commodity.

Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access.

Pressure governments to adopt, implement and enforce national health and drug policies.

Demand that governments oppose the privatisation of public health services and ensure effective regulation of the private medical sector, including charitable and NGO medical services.

Demand a radical transformation of the World Health Organisation (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organisations in the World Health Assembly, and ensures independence from corporate interests.

Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.

Support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care.

Demand changes in the training of health personnel so that they become more problem-oriented and practice-based, understand better the impact of global issues in their communities, and are encouraged to work with and respect the community and its diversities.

Demystify medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people.

Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people- and public health-oriented, respecting universal ethical principles.

Support people's rights to reproductive and sexual self-determination and oppose all coercive measures in population and family planning policies. This support includes the right to the full range of safe and effective methods of fertility regulation.

People's participation for a healthy world

Strong people's organisations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people's civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

This Charter calls on people of the world to:

Build and strengthen people's organisations to create a basis for analysis and action.

Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.

Demand that people's organisations be represented in local, national and international forums that are relevant to health.

Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world.

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Status

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