THE STRUGGLE FOR HEALTH:

PROBLEMS AND SOLUTIONS

REFLECTIONS FROM THE SOUTH

Philippines

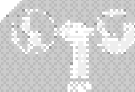
Ecuador

India

Zimbabwe

Argentina

South Africa



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Introduction

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The continuing relevance of Alma-Ata

The year 2003 marks the 25th anniversary of one of the most important documents in international health, the Alma-Ata declaration on Health for All. The declaration set a deadline of the year 2000 for achieving a level of health that would enable all of the world's people to "lead a socially and economically productive life." The strategy to achieve the goal would be the implementation of primary health care, with its emphasis on community participation, and tackling the underlying causes of diseases, such as poverty, illiteracy, and poor sanitation. The declaration was drafted by WHO and UNICEF and signed by over 130 health ministers (including those from the developed countries) and called for a New International Economic Order to benefit the developing world, and the diversion of money spent on arms to investments in health. It seems slightly unbelievable today that rich nations and international agencies could have put their names to such a radical declaration. However, despite promises, very often the Declaration was not put into effect: Health for All by the year 2000 was patently not achieved.

But this does not mean we should throw away the Declaration. It has continuing, and even heightened relevance for the world today. Alma-Ata was an evidence-based Declaration, which sprung from the lessons learnt in the many community-based projects working in health and from the performance of some of the high achieving developing countries such as Costa Rica, Malaysia, Cuba, China and Sri Lanka. The emphasis these countries placed on reducing social and economic inequalities and providing broad based education, health, water and social security services, showed that good health could be achieved in even very poor countries, if the political will was in place. Although these problems are challenging, experience shows that they cannot be ignored.

Challenges

Since Alma-Ata parts of the world have undergone a 'health reversal', and many of the contributions to this booklet show the consequences. Health systems have come under unprecedented stress, as Dr. Sanders shows in his analysis of the situation in sub-Saharan Africa. New diseases (and old ones) have flourished,

and public health has deteriorated in many countries. Dr. Unnikrishnan highlights the intolerable burden that health care costs place on the poor: it is a perverse world in which the actual costs of health care can push people into poverty, but in many places they routinely do so.

Globalisation and the expanding role of the market have also frequently damaged health and health care. The new world of free trade in goods and capital has led to greater instability in the global economy, with dire consequences for health, as Dr. Monsalvo reveals in his analysis of the Argentinian situation. Global trade agreements, as Dr. Sanders shows, have prioritized trade concerns over public health. At a deeper level, the emphasis on introducing markets in health care has had an unhelpful influence on fundamental values such as co-operation and solidarity, and affected the ability of countries to re-distribute income from richer to poorer segments of society.

Alternatives

Dealing with these global problems, as well as those at the national and community level is a complex and tiring business for health activists. The experiences of the Council for Health and Development in the Philippines show how positive health interventions can be set back by the actions of governments and the military. However, even in dire situations bravery and tenacity can win through. In Latin America, Dr. Monsalvo describes the efforts of health professionals and others to envisage a new Argentina (and a new world!) through practical health interventions and policy debate. Dr. Quizphe shows how in Ecuador, health activists have composed their own 'Health Charter' with a list of demands to government. All such efforts bear testimony to the values encapsulate in the Alma-Ata Declaration.

All over the world, people concerned with health are trying to focus the attentions of governments and international agencies on the promises they signed up to 25 years ago in Alma-Ata. Recently, the People's Health Movement, with which International People's Health Council and Health Counts are closely involved, has been formed to focus attention on these goals and to mobilize activities. We hope that this booklet will be part of that process and that people concerned with health will join us in the ongoing struggle for 'Health for All'.

* IPHC is a worldwide coalition of people's health initiatives and socially progressive groups and movements committed to working for the health and rights of disadvantaged people - and ultimately of all people. The vision of the IPHC is to advance toward Health for All—viewing health in the broad sense of physical, mental, social, economic, and environmental well-being.

The IPHC maintains that:Health for All can only be achieved through: ***participatory democracy*** - decision-making power by the people***, equity*** - in terms of equal rights and everyone's basic needs, and ***accountability*** of government and industry, with strong input by ordinary people in the decisions that effect their lives.

The International People's Health Council – IPHC - is one of the groups that helped to organize and coordinate the People's Heath Assembly held in Bangladesh in December of 2000.

If you want to learn more about the IPHC and the People's Health Movement as well as future plans for action, please contact:

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** Medact is a UK-based organization of health professionals undertaking education, research and advocacy on the health impacts of conflict, poverty and environmental degradation. Medact is a member, with the Dutch NGO Wemos and the Finnish NGO Solidar, of the Health Counts consortium which calls for economic policies which respect equity and the right to health. website: www.medact.org e-mail mikerowson@medact.org

CRY MY BELOVED COUNTRY

By Dr. Unnikrishnan PV

The picture below shows Endramaya (60), a migrant casual labourer carrying on his back his wife, Lakhamma (50), her broken right leg in a plaster cast. Lakhamma is also a migrant worker, and she was injured in an accident in the outskirts of Bangalore two weeks earlier. The couple came to the city from Raichur in the northern dry belt of Karnataka state, where a farm and market crisis make local people migrate in search of work elsewhere in the country. State capital Bangalore, one the best technology hubs in the world, "the Silicon Plateau of India", is a favourite destination for many migrants.

I was on my way to office when I spotted the couple. Endramaya had already walked for over two hours along the two km stretch of Mahatma Gandhi Road in the heart of the city, carrying Lakhamma on his shoulder, occasionally resting on the roadside.

Endramaya made several attempts to get his wife medical treatment. His first stop was the government Primary Health Centre (PHC). But the PHC did not even have the basic facilities to take an X-ray or to put a plaster cast on the patient's leg. Endramaya then took his wife to several private hospitals and clinics, but they would not treat her. He did not have enough money to pay. After several days, once he was able to mobilise some money, Endramaya took Lakhamma to a private clinic for treatment. Needless to say, the couple ended up spending most of the money they had. They had just enough for the bus fare to Raichur. After treatment, they spent the night on the pavement and it was raining. Around midnight, Endramaya started walking towards the Central Bus Station located in the heart of the city. He walked over 7 km, almost unnoticed in a City that is home to six million people, thousands of them employees of top firms, including several Fortune 500 companies. He tried several times for a free lift, waving at cars, some of them latest models, four-wheel drives and auto rickshaws passing by. It did not work. Perhaps after several days on a hospital trail and a sleepless night he did not look quite presentable.

Endramaya would walk slowly, after every few yards letting his wife sit on the kerb, so that he could stretch his hands and try to flag down some vehicle. Moments later he would continue his journey.

It was morning peak hour. Several vehicles slowed down, those driving them staring at the couple in disbelief, but they proceeded to catch their deadlines as if nothing had happened. I was upset and angry. Running towards them, I pulled my camera out of my backpack. I paused and started clicking. Then they told me their story. I joined the duo, waving hands at vehicles. Two cars stopped, their occupants willing to help. We all pooled in some money and helped the couple get a taxi to the bus station.

That evening at the photo studio I was waiting for the prints to come. A curious clerk at the cash counter asked me about the photograph. I was still upset, so I talked a bit loud about it all. Overhearing our conversation, a gentleman patted me from behind. "It is a good shot, but you should have used a wide-angle lens,''

the professional photographer said, leaving me speechless. As a medical professional, I should have told him about the ‘rigor mortis’ of the private sector health care and the numbness of citizens in general. As a humanitarian professional, I should have told him that medical expense is the second largest contributing factor for rural indebtedness in India after dowry, an equally unacceptable social evil.

A leading national newspaper flashed my photograph of Endramaya’s journey on the front page of their city edition the following morning. The caption said how callous the city could be towards its “guests” like migrant workers. They said it was “reality and not virtual,’’ probably referring to the virtual reality shows at the city’s annual international IT fare that concluded the previous day. It did not have space to discuss larger issues - mounting medical expenses and an insensitive health policy that denies even basic facilities to the poor. A day after the news report, I was giving a class on humanitarian action at a leading medical college in the city. I waved the newspaper featuring Endramaya’s journey on the front page. One of the senior students said: “It is a multiple fracture of tibia and fibula.” Quite a professional remark! By that evening I had one more professional remark, from a photographer: “It is a very good picture, but we missed the story.” Sad.

These professional reactions are the signs of our times. The present health care system has become super-efficient, and it is going fast forward, at least in terms of technology and innovation. But it has lost touch with social realities, and it is losing its human element.

By the time you finish reading this note more than 15 people in India will have died of tuberculosis (TB). Every minute one person dies in India because of TB. Treating TB is no rocket science. A nutritious diet, sanitation and basic public education can cut down TB toll. This year we have even seen reports of “alleged starvation deaths” from two belts in India, a country that has a surplus of food grains. In a country where a large percentage of women are anemic, this sounds like a riddle.

Around the same time Endramaya was walking his way of the cross in Bangalore, experts were discussing the proposed new Health Policy in New Delhi. The last National Health Policy was announced in 1983. Compared with that, the new policy draft looks like a sell out. “The new policy (draft) is more eloquent where it is silent,” says a critique. It omits the very basic concept of comprehensive and universal health care. For example, one of the salient features of the 1983 document was its commitment to the Alma Ata declaration. It said: “India is committed to attaining the goal of ‘Health for all by the year 2000 AD’ through the universal provision of primary health care services.” The new policy (draft) is silent about it.

The new policy is also silent about the role of village health workers, the frontier guards of public health, who keep the pulse of this country ticking. The new policy has just a few lines about the women's health, without any specific plans to improve their health - a betrayal of half the population. The policy does not care about children. It does not even have a separate section for children's health in a country where 70 out of 1000 children die prematurely.

Endramaya's desperate walk in one of the fastest growing cities in Asia is symptomatic of the sickness of the health systems in a large part of the developing world where they fail to cater to the needs of the poor. India's experience of dealing with the health needs of its majority, especially the poor, has not been very impressive. In fact, the health care system has worsened in the last decade, which has seen comparatively good economic growth.

Critics argue that neo-liberal policies related to trade and commerce, as part of the World Bank- and IMF-imposed Structural Adjustment Programmes, have left a long trail of ill health. The cost of medicine, including that of essential drugs, has shot up. In the last 10 years, the price of drugs used even for killer diseases like malaria and TB have been decontrolled to boost the health of the pharmaceutical industry at the cost of human lives.

Public health investment in India is one of the lowest in the world and it fell from 1.3 per cent of the GDP to 0.9 per cent during the 1990s. The new policy recommends an increase to 2.0 per cent by the 2010. This still falls much short of the 5.0 per cent benchmark demanded by the People's Health Movement, several health and social groups and the WHO long back.

The new draft policy projects that by 2010 public expenditure will be 33 per cent of the total health expenditure. But even 33 per cent will be lower than the government expenditure of some of the most privatised health systems in the world.   At present India spends an average of around Rs.160 (less than US $ 4) per person per annum on health care. That is roughly the price of three hamburgers, going by the standards of the new economy. No wonder that Lakhamma had to go from pillar to post before finding place in a private clinic.

In contrast to the cut in health care sector, the defence budget has shot up. This is an insult to the people of India, where 200 million people (1/5th of the total population) do not have access to safe drinking water and 600 million who do not have access to basic sanitation. Moreover, India pays a huge amount every year to the World Bank by way of debt servicing - much more than what the country receives every year. "Our programmes are like medicine. Some of the medicine has harmful side-effects, and there are real questions about what the dosage ought to be," says Michael Mussa, Chief Economist at the International

Monetary Fund. "The best that can be hoped for is that we are prescribing more or less the right medicine in more or less the right dosage." Thebitter pills prescribed by the World Bank have worsened health problems in many countries. For example, Bank loans for agriculture, dams, mines and power plants often cause health problems as a side effect of environmental devastation. Bank-financed dams around the world have increased the incidence of water-borne diseases like malaria and schistosomiasis because the stagnant pools of water in dam reservoirs breed vectors such as mosquitoes and snails- an additional burden on the already crippled health system. Further, structural adjustment programmes have often meant drastic cuts of social safety measures. Often poor people have ended up paying more for products and services, further cutting their limited food budget.

As a health and humanitarian worker, my attitude should be positive. I should explore the possibility of saving and rebuilding lives in disaster, war and epidemic situations. This note may sound pessimistic. But it reflects the mood of our times.

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Globalisation, Health and Health Services in Sub-Saharan Africa[1]

by Dr. David Sanders
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Health is in a state of crisis in Sub-Saharan Africa (SSA). While at an aggregate level health status has improved in SSA over the last fifty years, these improvements have been slower in SSA than in other regions of the world. For example, between 1981 and 1999 IMR has decreased in SSA from 126 to 107 as compared with 78 to 57 for the world as a whole. The respective percentages of decline for this period are 15.1% and 26.9%. Furthermore, in 1999, seven of the 48 SSA countries had a lower life expectancy (LE) than in 1970, while eight countries have seen an increase in infant mortality rate (IMR) between 1981 and 1999. Life expectancy in 17 of 48 countries has declined between 1981 and 1999[1 2 3]. In addition, young child malnutrition has worsened significantly over the past decade in SSA[4].

In the past two decades there has been an alarming resurgence and spread of "old" communicable diseases once thought to be well controlled, for example cholera, tuberculosis, malaria, yellow fever and trypanosomiasis, while "new" epidemics, notably HIV/AIDS, threaten last century's health gains[5].

To aggravate matters, a number of African countries are experiencing an "epidemiological transition", with cardiovascular diseases, cancers, diabetes, other chronic conditions and trauma, replacing communicable diseases in some social groups, but in others, co-existing with them[6].

Access to health services improved considerably during the period 1980 – 1990, but has worsened since then as shown by Expanded Programme on Immunisation (EPI) coverage data. EPI coverage data for SSA in 1999 show declines in coverage of all routinely administered antigens[7]. This occurred despite the intensive polio vaccination campaigns and the regular measles vaccination campaigns.

The above declines in health status and health sector performance are the result of the combined impact of economic decline and adjustment, the HIV/AIDS epidemic which now affects 28 million Africans, approximately 70% of the total of HIV infected people globally[8], and conflict and violence which involves 13 of 48 SSA countries.

The serious economic situation is summed up by the startling statistic that 28 of 48 countries had an average per capita income of less than $1 per day in 1999 compared to 19 of 36 countries in 1981[9]. Furthermore, there is evidence that the income gap between rich and poor within countries has increased dramatically over the past decade. In addition, most SSA countries still spend less than an average of US$10 per person per year on health care, an amount that is 20-40% below even that required to cover the basic package of health services advocated by the World Bank[10].

The above situation is the result of a number of factors, some historical and others contemporary, the latter being ultimately linked to various aspects and instruments of globalisation.

In Africa, amongst the most important components of the recent phase of globalisation have been Structural Adjustment Programmes (SAPs), which have had the effect of further integrating countries into the global economy through the imposition of stringent debt repayments and liberalization of trade. SAPs have also resulted in significant macro-economic policy changes and public sector restructuring and reduced social provisioning, with negative effects on education, health and social services for the poor. A recent review of available studies on structural adjustment and health for a WHO commission states: 'The majority

of studies in Africa, whether theoretical or empirical, are negative towards structural adjustment and its effects on health outcomes'[11].

More recently, other instruments of globalisation have further undermined the ability of developing country governments to provide health care for their populations. For example, the development of agreements under the World Trade Organisation (WTO), notably Trade-related Intellectual Property Rights (TRIPS) and its interpretation by powerful corporate interests and governments, have already threatened to circumscribe countries' health policy options. The best known case relates to the recent legal battle around the attempt by South Africa to secure pharmaceuticals, especially for HIV/AIDS, at a reduced cost. In 1997 Nelson Mandela signed into legislation a law aimed at lowering drug prices through "parallel importing" – that is importing drugs from countries where they are sold at lower prices – and "compulsory licensing", which would allow local companies to manufacture certain drugs, in exchange for royalties. Both provisions are legal under the TRIPS agreement as all sides agreed that HIV/AIDS is an emergency. This was confirmed during the WTO meeting in Doha in 2001. The USA administration did not bring its case to the WTO but instead, acting in concert with the multinational pharmaceutical corporations, brought a number of pressures (e.g. threats of trade sanctions and legal action) to bear on the South African Government to rescind the legislation. This followed similar successful threats against Thailand and Bangladesh[12]. However, an uncompromising South African Government, together with a vigorous campaign mounted by local and international AIDS activists and progressive health NGOs, forced a climb-down by both the US Government and the multinational pharmaceutical companies[13].

Notwithstanding this important victory, the provisions of the WTO, particularly TRIPS and the General Agreement on Trade in Services (GATS) hold many threats for the health and health services of developing countries[14].

Accompanying neoliberal reforms of the macro-economy have been health sector reforms (H.S.R.). Key components of HSR include decentralisation of management responsibility and/or provision of health care to local level, improvement of national ministry of health's functioning, broadening health financing options through, for example, user fees, insurance schemes and introduction of managed competition; and rationing of health care through the identification of public health and clinical "packages", comprising a set of (often limited) interventions.

The combined effect of the above interventions together with the impact of HIV/AIDS on the health workforce has resulted in a significant reduction in public provision of social (including health) services in SSA, and there is mounting

evidence of a general decline in access to health services, affecting particularly the poor. This is starkly illustrated by immunization coverage, a sensitive marker of health service coverage, which has fallen during the 1990s. [15].

In recognition of the growing global health divide between North and South, the crisis imposed by HIV/AIDS and the resurgence of TB and malaria, as well as the inability of both for governments and increasingly cash-strapped multilateral (UN) agencies to invest in health services, a number of Joint Public - Private Initiatives (JPPIs) have been recently launched. The best-known of these in health are GAVI (Global Alliance for Vaccines and Immunisation) and the GFATM (Global Fund Against Aids, Tuberculosis and Malaria).

The first disbursements of the GFATM have still to be made, but those for GAVI, made for 2000/2001, totaled USD 150 million from initial commitments totaling USD 1.03 billion. Of this initial disbursement 90% was allocated for the introduction of new vaccines and single use injection materials, while only 10% went to strengthen immunization services. Anita Hardon has commented: *"The emphasis on the introduction of new and under-used vaccines in GAVI reflects a more general shift away from equity towards technological innovation and disease eradication in global health programmes. This appears to indicate a fundamental move in vaccine policy from the values of the Post-Alma Ata (PHC) era."* [16].

Further, it is emblematic of the current emphasis of health policy and the influence of the private sector partners, that, notwithstanding the clear inability of health systems – particularly in Africa – to sustain "delivery" of robust, effective and tested technologies, such as the standard six vaccines, that the focus is on the pursuit of new technologies, rather than the resuscitation of delivery systems. Without a shift in currently dominant neoliberal thinking and a consequent change in macroeconomic policy and its reflection within the health sector, the future for Africa's health is bleak.

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TAKE TIME GIRLS

By Fortunate Kahari
Mwanza Secondary school
Zimbabwe

Let me take this opportunity
To warn you my fellow sisters, teenage girls.
Before attempting to do anything
Think of the four Ps first
That is Purpose, Plan, Perseverance and Price
Nowadays, there is AIDS.
Do not rush to be parents
Those boyfriends lovers of your are liars
They tell you that they have cars
Where as they are fathers
They tell you that you are as sweet as sugar
But imagine girls can you be put into tea
They tell you that your eyes are stars
But do you really know what exactly a star is like
They can even tell you that you are a rose of Sharon.
But why did not they plant you in their gardens.
Take time to know the one you desire in life
Do not rush
And you girls are sometimes foolish
When you hear that, you think that they genuinely love you
But no they are only after your bodies
They are only there to vacate you
You agree to the proposal and have sex with them
After that, they spit you like unsweet bubble gum.
Take time to know what you are doing
Do not rush
Some young girls are involved in such activities
Just because they are blessed at a young age.
Some even, wear cloth that attracts boys
But I tell you; you do not need to show off your body to catch a boy's eyes.
Their eyes dance every time a boy whistles.
Girls are stopped in streets like commuters.
Girls why not wait like a boutique;

These are not like flea markets
For many people enter in a flea market and a few in a boutique.
Wait until the right time comes and the right one takes you.
Some of you girls have vanished and come are regretting.
Ignore those silly boys and concentrate with school first, lastly boys

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Story of a community health worker from the Philippines:

Developing Self Reliance in Health

Nang Vicky's story

Nang Vicky Undangan is a peasant woman from a mountain village in Surigao del Sur, which is home to landless farmers in this northwest province of Mindanao in the Philippines.

When the *Community Based Health Program* (CBHP) *of Tandag* reached *Nang* Vicky's community in Camam-onan, San Isidro, she was among those chosen by her community members to be trained as a *community health worker* (CHW). With the existence of *CBHP Tandag*, the training and developing of CHWs in Surigao del Sur has been a community effort. Normally, one per 10-15 families is chosen to be trained as a CHW.

Aside from training CHWs, the health program undertakes community organizing and health services delivery, which includes assisting referral patients and conducting medical missions. The trained CHWs are deeply involved in such activities not only in their communities, but also in nearby communities as needed.

Attending health skills training was never simple for any CHW. This would mean leaving their children at home, foregoing a day's work in the farm and finding extra food to bring and extra money for transportation.

When the CHWs of San Isidro had a 6-day training on Anatomy, Parasitism and Tuberculosis, *Nang* Vicky resolved to attend the training at any cost. Only at that time, the challenge was even harder for her. For three weeks, her husband then had been suffering from a kidney infection with occasional bouts of vomiting and fever. The situation made her think twice. She presented her problem to her family groups, which had offered to look after her husband and children while she was training.

The importance of community health services

Nang Vicky finished the scheduled training and went on to serve her community as a health worker. She belongs to the over 3,000 CHWs of the 57 CBHP members of the *Council for Health and Development* (CHD). The CBHPs directly serve marginalized sectors in Philippine society, namely, the peasants, farmers, fisher folk, workers and indigenous peoples in 2,000 villages spread out in 67 provinces in the Philippines. (The country is comprised of 75 provinces).

Most CHWs like Nang Vicky now recall common experiences of carrying sick members of their communities in hammocks down the mountain trails for a day or two to reach help. Most of them suffered from tuberculosis, malaria or diarrhea. The children were malnourished. People died as they were being brought to the nearest doctor. These deaths happened because health services were inaccessible and unaffordable.

They are one in saying that "We have learned so much since that time". As products of CBHP training programs, the CHWs have been trained in basic health skills such as prevention and treatment of common diseases, first aid, use of herbal medicine, dental hygiene and tooth extraction. And from the basic line of prevention, the knowledge and skills of the CHWs were raised to a higher level. They were given trainings on basic anatomy and physiology, history-taking and physical examination, acupuncture and acupressure. The trained CHWs multiplied themselves by training new CHWs.

In undertaking such trainings, *Nang* Vicky, as well as many of her co-community health workers, are able to find new directions in life after being introduced to the CBHPs. With limited education and seemingly no hope in the communities to be employed decently, many of them regain their confidence because they realize that they can acquire skills that can be of productive use.

Military threats

Many communities of *CBHP Tandag* were never before visited by government health care providers. When the whole province was put under massive military operations against insurgency, soldiers were everywhere in the province—the town hall, the plaza, the market place and in the fields. People were driven away from homes and from their sources of livelihood. Women and children alike were caught in the crossfire.

The CBHP communities, including San Isidro where *Nang* Vicky lives, became the subject of undue suspicion from the military and were subjected to tactical interrogations. The CHWs were also favorite targets for intimidation and harassment, just like leaders of people's organizations. The intense military

harassment demoralized many CBHP communities, forcing the program to cease its operations.

A decade after, *CBHP-Tandag* was back on its feet again, working closely with the diocese of the catholic church. Because of the CBHP's long and effective history, there was much work that needed to be done. Memories of the turbulent period were still poignantly vivid for the communities. However, the tremendous help the communities have gained from the CBHP outweighed the fear they had for themselves.

Although, *Nang* Vicky and the other CHWs of San Isidro like *Nang* Dolor were met with malicious suspicions and even threats from the military, they were never afraid to let the military know that they were CHWs. In the case of *Nang* Dolor, her regular visitors during those days were not her family groups asking medical help, but the military looking for subversive documents like her training manuals in acupuncture, herbal medicines and the likes. Thus, before any military personnel could rummage through her belongings, she would hide her training manuals at the back of her house.

After a painstaking period of recovery, *CBHP Tandag* continues to operate in 33 villages from different municipalities, making people aware of their capacity to help alleviate their situation by working together as one community. And the likes of *Nang* Vicky, *Nang* Dolor and the rest of the CHWs have once again proven their worth as many times before in contributing their share in developing self reliance for an alternative health care system that CBHPs promote.

The story of *Nang* Vicky and *CBHP Tandag* that she worked with is only reflective of what is now 29 years experience of CBHPs in the Philippines. Evolving from the first mobile-paramedic training health team in the 1970s to actually laying the foundation for an alternative health care system, CBHPs continue to survive and thrive because they are rooted in a very strong and solid foundation—the people of the community who struggle unceasingly to defend their lives and rights, and to develop their own appropriate health programs. — *[Council for Health and Development, 04 November 2002, Quezon City, Philippines].*

Argentina 2002
Endemic Injustice and Silent

Proposals from Daily Life

By Dr. Julio Monsalvo
Argentine doctor and activist of the peoples Health Movement

"Microbes are insignificant as a cause of disease compared to the illnesses that cause poverty, the social despair, anguish and misfortune of peoples."

Ramón Carrillo (first Minister of Public Health of the Argentine Nation, 1945-52)

The growth of hunger

Angela lives in a poor neighborhood in one of Argentina's large cities. She is 39 years old, mother of four children. In the "Health Center," a young doctor, Alejandra, diagnoses that Angela has anemia. The cause is quite clear. She lacks access to adequate nutrition. Angela is one of nine women over age 35 who have been diagnosed with anemia this week, all due to the same cause. A simple test shows that Angela barely has 8 grams of hemoglobin, as well as low levels of red cells.

In this Health Center, as in most Argentine hospitals, medications with iron supplements have not been supplied for quite some time. This is happening throughout the country, anemia is being detected in all age groups due to a lack of access to food. Numbers are growing of malnourished and anemic children (particularly under age 5), anemic pregnant women, anemic children with low birth weight, and malnourished elderly people. In one province alone, official 2001 data showed 71 deaths from malnutrition, of which 44 were children under age 5 (62%) and 21 people over age 50 (30%).

But our young doctor does not become discouraged. She researches what local plants may be a source of iron and discovers "nettle" (Urticara urens L.) She prepares a nettle tincture in the Health Center and gives Angela this natural treatment for three weeks. The test results improve and Angela feels much better. This encourages Alejandra and other health workers to treat the other women with nettle tincture. The results were successful and the word of the solution spreads. It's an uphill struggle, but also heroic and hopeful. Bit by bit, spread from mouth to mouth, people begin to talk about this possible treatment.

An abundance of food

Argentina annually produces, according to official data, 68 million tons of food. With a population of 35 million, there would be an abundance of food if this were deemed a social good and the production of food was aimed at feeding people instead of increasing the profits of a few corporations. Each person would have 2 tons of food per year, five and a half kilograms per day. Even part of that food would take care of the country's needs, and the system could keep exporting the rest. Instead, over half of the population is living in poverty or outright indigence.

In addition, there are concerns about food quality. Argentina is one of the countries with a large area dedicated to growing genetically modified foods. The use of agrochemicals not only contaminates food sources and soil, but also leads to poisoning and deaths. Animals are subjected to cruelty, fed unnaturally to be fattened quicker, in order to produce "increased economic benefits." The industry uses an abundance of chemicals for coloring, as preservatives, and "authorized" flavoring. On top of the injustice that the great majority is denied the right to feed themselves, we now have food insecurity in a country that has lost its food sovereignty among its many other losses.

Another Argentina, another world

Alejandra, the young doctor in our story, is one of thousands of health workers in this country who silently struggle every day to provide humanitarian answers to pain and misery. At the same time proposals are being made to build a different Argentina!

For many years in cities there has been a food production for consumption program called "Prohuerta." The State provides seeds for vegetables and fruit and farm animals, in addition to training for organic-style production (no agrochemicals or chemical fertilizers are used). Between large cities and smaller communities, up to 400,000 family, school and community garden plots have been registered. These produce about 80,000 tons of food per year for 2.5 million people. It is estimated that the country has 7.5 million indigent people. Instead of supporting and broadening this program, the budget allocated for it has been reduced by 7%. Other State and NGO programs also help people feed themselves. However, these efforts are not encouraged or supported by the State.

Here and there, throughout the country, small groups of women and men farmers produce events with incredible political and transformational voltage: fairs to

exchange seeds from local production and establishing local markets with organic products. There are many examples of healthy food production systems, social and economic organizations based on respect for all forms of life, which translates into healthy relations with the ecosystem that have a positive impact on health.

A change in paradigm and in consumption patterns is urgently needed to roll back the endemic social injustice and immediately bring an end to all cruelty and the denial of access to foods and healthy foods.

Over 50 years ago Ramón Carrillo pointed out that social injustice was the cause of illness. Today in Argentina those social injustices have deepened and spread, and have become ecological injustices in the form of soil deterioration, the disappearance of forests, contamination of rivers and the air. For many years in this country, women farmers, professionals and students committed to health and life have been proving that it is possible to create another Argentina, and another world as well.

Mandate to the new Government

Health for all: Essence of a good Government

Dr. Arturo Quizhpe Peralta
Dean of the Medical School of the University of Cuenca-Ecuador
Coordinator of the International Peoples Health Council, IPHC-South America

"Equity, ecologically sustainable development and peace, are the central focus of our vision of a better world. A world in which a healthy life for all becomes a reality; a world that respects, appreciates and celebrates all life and diversity; a world that allows the flourishing of talents and abilities to enrich all of us; a world in which the voices of the people guide the decisions that affect our lives. More than enough resources are available to achieve this vision." (1)

A sick society

The neoliberal development model in effect is not sustainable; its failure has been extensively proven in countries like Argentina. It cannot even be considered as a model of development, as it is designed to perpetuate underdevelopment and strengthen dependency. We survive in a sick society in which humans have

been sacrificed for the market, where nature is profaned and attacked by the greedy interests of large transnational corporations, where the abuse of power, corruption, intolerance, segregation and injustice rule.

We cannot go on with more deceit and white lies. Health is intimately connected to development, and development in turn, produces health. One cannot speak of health policies for the majority if this does not go hand in hand with an integral reform of the State aimed at the well being of the majority. As Dr. Roses, the new Director of PAHO, has stated: health programs are a reflection of a country's ethical decisions, they reflect the value given to life and human development in general, and even more specifically, the value of the life of each human being, of women and children, of the disabled and elderly.

Poverty must be eradicated

In Ecuador and the other countries of Latin America, poverty constitutes the main cause of illness and death, and therefore its roots are found in the economic and social policies imposed upon us.

Poverty arises from the inequitable distribution of wealth, the society's organizational structure, the unequal trade between nations, the exaggerated power of transnational corporations, and the policies they impose to increase their profits.

As stated in the People's Charter for Health: "economic globalization and privatization have deeply disrupted communities, families and cultures. Public institutions have been undermined and weakened; many of their responsibilities have been transferred to the private sectors, to corporations or other national and international institutions that rarely take on responsibility before the people."

Poverty must be eradicated, not lessened. Attempting to lessen poverty means treating the symptoms instead of the disease. Fighting poverty means redistributing wealth, working for more just rules of trade, generating employment, allocating resources, responsibility and power to the people.

All the countries in the region have included health in their constitutions as a right of all people. However, expenditures on health have been determined and subjected to economic calculations, the decisions of transnational corporations, and market interests, sacrificing the life of millions of men, women, children, and elders.

Human development indicators reflect a degrading reality for human beings: 80% of Ecuadorian homes are poor; 20% are indigent, with no access to education, social security, or basic sanitary infrastructure; maternal mortality (160 to 300

for 100,000 live births) and infant mortality (39 out of 1000) are high and result from preventable causes, the persistence of illnesses associated with poverty such as dengue fever, malaria, yellow fever, tuberculosis, and others.

A variety of organizations and groups from towns in Ecuador working in this area and committed to the struggle for the respect and full effectiveness of this primordial human right, appropriate as our own the points of the People's Charter for Health and set forth the following:

Basic Principles for a Program of Health for all

- Guarantee the universal access to high quality integrated Primary Health Care, according to the needs of the population, not their ability to pay.
- Elimination of cost-effectiveness criteria as a defining factor for the implementation of health care programs and the abolition of cost recovery projects because they generate inequity and obstacles to access to services.
- Stop privatization of public health and social security services, ensuring the effective regulation of the private medical sector including medical charities and NGOs.
- Increase public investment to at least 70% of the national expenditure on health.
- Emphasize the promotion of health, primarily in community organization and participation.
- Strengthen and legally support social participation, intersectoral work, and a multidisciplinary approach to health problems.
- Promote health programs aimed at women, the eradication of domestic violence and fulfillment of the Law of Free Maternity.
- Establish promotion and prevention programs for the health of young people, particularly related to sexual and reproductive rights.
- Adopt measures to ensure occupational health and safety that include oversight of working conditions, particularly for high-risk sectors (for example: assembly plants, flower growing companies, the informal sector and others).
- Regulation of the use of technologies, production and issue of medications, to assure they are subordinate to the needs of the population.
- That research on health – including genetic research and the development of reproductive medicines and technologies – be oriented towards people and public health and respect universal ethical principles.

- To defend harmony with the environment and the protection of ecosystems.
- Invest more, invest better and begin to pay the social debt, giving priority to health and education, reducing military expenditures and payment on the foreign debt.
- Submit economic policies to assessment regarding their health, equity, gender and environmental impact and include regulatory measures to follow-up on their fulfillment.

Health is a fundamental human right, and this is why we tell, beg, and demand that the new government make a serious commitment to Health for All.

Cuenca, November 2002
(1) People's Charter for Health. IPHC. December 2000.

[1] ** This Policy Brief draws heavily upon: Sanders D., D. Dovlo, W. Meeus, U. Lehmann, "Public Health in Africa" in Global Public Health, R. Beaglehole (ed.), O.U.P. (forthcoming)*

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