

# Historical development of the global Health for All movement: conditions, continuities and convergence

By David G Legge

People's Health Movement and La Trobe University, Melbourne

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## Introduction and purpose

PHM aspires to contribute to the strengthening of a global people's movement for health. Notwithstanding the name, "People's Health Movement", PHM is only one small player in a much larger aggregation of civil society organisations and networks around the world working to achieve improved health care and population health. Insofar as this aggregation has some level of self-awareness, shared repertoire, and internal communications it may be identified as a global social movement. To make it clear that we are not talking just about PHM, we are calling this 'the Health for All movement'.

In this study we are reviewing the historical processes through which separate episodes and streams of civil society action around health are coming together (or not) as a global social movement. What does this history tell us about the dynamics and strategies of movement building for 'health for all'? What are the continuities across different streams of engagement, across time

and place, within this movement? How might we analyse this history to draw more specific lessons for organisations and networks like PHM which are seeking to strengthen this global social movement?

While there has been considerable research, theorising and commentary on social movements, including health social movements, there is relatively little previously published research on the issues at the heart of this project: the **conditions** and **dynamics** through which separate passages of civil society action around particular health issues in particular place may converge towards a global social movement for health more broadly and the **strategies** deployed by social movement activists in health to mobilise (around local issues understood in a global context), build solidarity and converge.

## Methods

We are taking an archaeological approach to this history in we are selecting particular ‘episodes’ from different times and places and exploring how the prevailing context shaped those episodes.

However we are also taking a genealogical approach to this history in the sense that both ‘health for all’ and ‘civil society engagement’ are terms which take their meaning from contemporary (21<sup>st</sup> Century) challenges and we are seeking to understand how earlier engagements have contributed to an evolving social project which can be identified as the global HFA movement.

### The ‘episode’ as the primary unit of data collection

Our primary unit of data collection is the ‘episode’, defined as a political engagement contributing to health equity which was located in time and place and which involved social mobilization in some way.

The term ‘episode’ suggests a beginning and an end but all of the engagements referred to in this paper as ‘episodes’ emerged from earlier engagements *and* fed into later engagements. Thus we cite the establishment of the Pholela Health Centre in South Africa in 1940 as an ‘episode’ and we seek to identify *both* the enabling conditions behind its establishment *and* the legacies of Pholela, the channels of influence through which the Pholela experience influenced primary health care in other settings. The episode metaphor is not entirely satisfactory; it could in many cases be replaced by ‘streams of engagement’ including the convergences of particular currents in such streams.

‘Episodes’ defined around health issues are conceptual artefacts which arose out of a much more complex set of cultural, political and economic configurations in particular places and times. We are viewing those more complex configurations through the prism of ‘episodes’ but in a sense; the ‘episodes’ are samples of more subterranean streams of historical change. Accordingly, we need to refer to other forms of historical documentation as part of *making sense* of the episodes; making sense of what they can tell us about the more subterranean streams of historical change. This kind of contextualisation is in some degree provided for in the references we have drawn on in reviewing the stories of the episodes.

Many of the episodes included in this study should be seen as representing a ‘class’ of similar episodes. We have cited several instances of localized community health projects but these have been selected because they are well known. There are thousands of other instances of similar projects. Likewise we have cited the struggle for universal, single payer, publicly funded and managed health insurance in Saskatchewan. However similar struggles have taken place (are taking place) in many other settings.

## ‘Domains’ of engagement

We have selected episodes for inclusion in the study within a series of *domains* of engagement as shown in Table 1, below.

We have selected the ‘episodes’ for inclusion in this study through reference to a small collection of books which provide various histories of the HFA movement globally (including but not restricted to Birn, Pillay et al. 2009, Farmer, Kim et al. 2013 and Baum 2015). We have reviewed and revised our collection of ‘episodes’ of engagement with a small working group of technical advisors who are broadly based expert observers of (and participants in) health-related social movements globally.

Domains of engagement	Episodes(streams) of engagement
Health care	Mutual assistance organisations State run health care in the USSR The UK NHS Primary health care in China Pholela Health Centre, South Africa Jamkhed Rural Health Project Solo health care, Indonesia Chimaltenango Project Guatemala Christian Medical Commission Alma-Ata and the NIEO Health insurance in Saskatchewan Community health centres Community health workers Health PAC The New Public Health Access to medicines
The health of populations defined by identity	The union movement and workers’ health Women’s health Race and health: the civil rights movement in the US and the MCHR (Indigenous health) (Disability rights) (GLBT health care)
Social and environmental determination of population health	Urban sanitation (industrial revolution England) The Framework Convention on Tobacco Control (Social protection) (Breastfeeding)
Human rights	(Universal suffrage) (Civil rights and freedoms) (Land grabbing) (Megaprojects)
Peace, disarmament and conflict resolution	(IPPNW)

**Table 1. Domains and episodes**  
**(Episodes in parenthesis remain to be documented)**

Our team has workshopped two main questions in relation to each of the ‘episodes’ selected for study:

- What were the **enabling conditions** for movement building evident in each ‘episode’?
- What can we learn about **continuities** between ‘episodes’; understood in terms of the formative influences contributing to ‘episodes’ *and* the legacy influences arising from particular ‘episodes’ (and impacting on subsequent work)? What are the **continuities**

across time and space through which the experience of particular episodes is appropriated collectively across broader streams in the struggle for health?

In the original plans for this study we made provision for a selection of a number of 'episodes' in a wide range of domains including human rights and peace, disarmament and conflict resolution. We do not have the resources to complete the analyses of these episodes at this time but they will be included in the next iteration of this study.

### Episodes of engagement and patterns of influence

The 'episodes' of civil society engagement which together trace out the development of the global Health for All movement are very heterogeneous. Our central interest is in the convergence of different streams of civil society engagement into a broader movement for health equity ('Health for All') and as part of this concern we have asked about 'patterns of influence' (legacies, continuities) through which particular 'episodes' have contributed to the development of a broader movement.

On this basis we have developed an alternative way of categorising these different 'episodes' in accordance to patterns of influence (and the process of 'convergence'). Four categories of 'engagement' which have emerged from this analysis of our 'episodes' are:

1. engagements which were or are largely country-specific but have inspirational / iconic status globally;
2. engagements which were nationally focused but which attracted international solidarity (including, in particular, anti-colonial, anti-imperial, pro-democracy struggles);
3. engagements which have been worked through in parallel in many different settings, but have involved the sharing of experience across communities of interest spanning different countries; and
4. engagements which reflect in significant degree common global drivers and call for collaborative strategies globally.

We return to these categories below.

Dates	Country specific engagements which acquired iconic status	National engagements but with international solidarity	Parallel and separate but sharing solidarity, analysis and modes of action	Similar problems with common causes and collaborative strategies	Historical context	Health care technologies
1700-1800		Abolition of slavery			Industrial revolution	
1800-1900	Urban sanitation in UK Revolutions in Paris over bread (1848) Social security in Germany (Bismark 1883) Virchow in Upper Silesia	Opposition to the opium trade (including resistance to the imperialists)	Extending democracy (eg rule of law, universal suffrage) Labour rights Anti-colonialism	Early attempts at building international labour links	Industrial revolution Intensified competition between colonial powers Revolutions in Europe	Germ theory, aseptic technique, artery forceps anaesthetics
1900-1920	USSR (feldshers, polyclinics, focus on public health, government funding)	Philippines (anti-colonial, imperial, feudal)	Extending democracy (eg rule of law, universal suffrage) Labour rights	Occupational health (in the context of employment relations)	WWI Revolution Emerging US ascendancy Monroe Doctrine	Vaccine development
1920- 1960	UK NHS China: PHC, from Ding Xian to barefoot doctors India (Bhore Committee) Pholela in South Africa	Spanish Civil War Chinese revolution Anti-colonial anti-imperial struggles in Africa and Asia	PHC, community health, New public health Public financing, universal access	NIEO and Alma-Ata	Depression, WW2, Cold War, US ascendancy, long boom, decolonisation, UN system	Antibiotics, psychotropic
1960–1980	Jamked, Solo Cuba 1959 USA 1960s (anti-racism, women's and workers' health) Canada Medicare Tobacco, Breast feeding	Anti-imperialist struggles in Latin America Anti-apartheid struggle Faith-based health care	Workers' health Women's health Environmental health Disability rights Indigenous health services	Anti-war and nuclear disarmament (IPPNW)	Bipolar world Cold war Vietnam war Stagflation	Molecular biology
1980–2000	TAC in SA	A2M / TAC in SA		Structural adjustment and debt crisis Ozone hole HIV and treatment access	1970s inflexion: Threat of capitalist crisis → SAPs Rise of the IP agenda	Genomics
2000-now	Bien vivir	Disaster, emergency, war,	Migrant and refugee solidarity	Trade and health Austerity and neoliberalism Food sovereignty	Neoliberalism	Biotherapeutics

Table 2. An Archaeology of the Global Health for All Movement: Timelines and categories of engagement

## Theory of analysis

The analysis of the data assembled here is interpretive and inductive: interpretive in relation to the episodes studied (looking particularly for causal relations) and inductive across the episodes (generalising from multiple episodes).

Many of the descriptions of episodes included in the Findings below are quite brief, particularly where the episodes or institutions are very well known. In other cases we have drawn on one or more principal sources to construct a narrative which provides sufficient detail to draw out the implications for 'enabling conditions' and 'continuities'. In doing so we have been guided by the principles of narrative synthesis as elaborated by Popay and her colleagues (Popay, Roberts et al. 2006).

It would not make sense to claim that our conclusions are 'objective' or 'unbiased'. The world view within which our conclusions are reached is centred on the subjectivity / agency of health activists and is biased by a commitment to health equity. However, we have been careful to ensure that the interpretations and generalisations arising from our analysis are explicated and rigorously challenged through consultation with people from a wide range of perspectives and structured dialogue in the final analysis.

As researcher-activists the ultimate guarantee of the integrity of this analysis arises from our commitment to movement building and social / global change. This calls for an honest scepticism to ensure that our findings are not constrained by the aspirations and assumptions which informed the conception of the project.

## Findings

We are reporting our findings under the 'domains' listed above, in each case in broadly chronological sequence.

### Health care development

#### *Mutual assistance organisations*

The 'friendly societies' (so named in England but also established under different names in many other countries) were among the earliest examples of civil society engagement around access to health care.

Based on locality or on trade the friendly society (also 'clubs') collected a small premium from its members and was thus able to provide mutual assistance in the form of benefits payable for funerals, widow's assistance, and support during sickness. In due course the benefits extended to help defray medical costs. Commonly medical practitioners were contracted to provide care for members of the friendly society and paid on a capitation basis.

The German sickness funds, a similar form of mutual aid, formed the basis for the health insurance arrangements introduced by Bismarck in 1883. This involved making an employer contribution to the sickness fund mandatory for low income workers. This became the core principle of 'social insurance' and has been very influential internationally in the succeeding years.

In 1911 Lloyd George established a similar social health insurance scheme in England, again based on the friendly societies. In 1948 the general practice committees were taken over by the NHS; still funding GPs on a capitation basis.

The concept of 'community based health insurance' about which the World Bank was for a while enthusiastic is based on the same broad principles.

#### *Enabling conditions and continuities*

Financial barriers to health care, particularly dire for low income people, have long been an issue of public concern. The endogenous emergence of structures for mutual assistance reflects a readiness to explore collective solutions. The Bismarck case illustrates how financial barriers to health care can threaten political stability and how concessions may be seen as necessary by the elite to secure the established order.

Among the 'enabling conditions' for the development of this form of mutual assistance we may identify: shared need, an existing culture of mutual concern and trust, and organisational capacity. It may be that the development of mutual assistance organisations was linked to the urbanisation which preceded and accompanied the industrial revolution. As noted above the formative influences included the perception of need, the prior recognition of some sense of community, and existing and evolving organisational models.

The specific institutional model associated with Bismarck, the German sickness funds has been very influential in health care financing in many countries.

#### *State run health care in the USSR*

The Soviet health system was the first modern health system to be wholly publicly funded and wholly publicly delivered. It had a strong focus on primary health care with the polyclinic, the feldsher and close integration of public health and clinical medicine. Collective responsibility for health was the underlying paradigm.

Roemer (1962) has described Soviet health care as he found it in 1962 with brief overview of its history. He quotes Lenin as saying, "socialism will conquer the louse or the louse will conquer socialism". (Perhaps he read Virchow.) His paper includes a useful bibliography.

In her chapter in 'Comrades in Health', Solomon (2013) tells the story of the Milbank commissioned study tour of Newsholme and Kingsbury to the USSR in 1932 and the consequences, particularly for Kingsbury, on return owing to his very positive assessment of the Soviet system.

Two other significant policy figures who were also impressed with the early achievements of Soviet medicine were Henry Sigerist (Duffin 1992) and Milton I. Roemer (Abel, Fee et al. 2008) to whom we will return later in reflecting on continuities and convergences across this global movement for health equity.

#### *Enabling conditions and continuities*

The revolutionary origins of Soviet health care remind us that social movements should not be seen as divorced from or clearly distinguishable from more broadly oriented political movements.

The Soviet model established government funding and publicly delivered health care as a policy model worthy of serious consideration. The early achievements of the Soviet model in public health reflect the capacity of a strong state to act effectively on environmental health issues. However, the abuse of power as a threat to health (including through alienation-linked alcoholism) and the technological weaknesses of Soviet health care later became evident.

Soviet health care was a creation of a socialist revolution inspired by the promises of communism. Insofar as it was born of the revolution it was a reflection of revolutionary mobilisation, although largely a working class mobilisation which had less support among the peasantry.

Soviet health care also played a strategic role in the accelerated industrialisation of the USSR, helping to maintain population health and deliver health care in the most efficient way and demonstrating to the populace that the leadership really cared for them.

Clearly the health conditions of the Russian working class contributed to the case for revolution. The communist vision informed the design of Soviet health care and public health.

The vision of government funded and managed health care and public health has been very influential, perhaps more so in earlier years. The Soviet health model exerted a powerful influence on policy makers and public health advocates from the 1930s onwards, including in the UK, but particularly in the newly decolonising countries in the 1950s and 1960s. The decline and collapse of the Soviet Union suggests that government managed health care depends in large degree on the health of the government.

The subsequent trajectory of the Russian Federation provides instructive comparisons.

#### *UK NHS*

The NHS was established in 1948 along with the reconstruction of infrastructure and morale in post-war Britain.

Most histories of the creation of the NHS present stories of inquiries, policies, laws, ministers, and structures. In contrast, Steve Iliffe's (1983) account of the politics underlying the creation of the NHS traces the pressures emanating from and through the trade union movement and the impact of women's movement after adult (>30) female suffrage had been achieved in 1919. In the lead up to 1948 most of this pressure was being mediated through the Labour Party and enacted in and through government. However, the struggles for universal suffrage, the health concerns of the trade unionists, and the continuing constituency pressure on Labour politicians need to be recognised.

#### *Enabling conditions and continuities*

The NHS has served as a beacon for health policy makers and health activists since it was established. It symbolises universal access, public funding and public service delivery. The institutional mechanisms such as capitation payment for general practice, and salaried hospital staff have been very influential.

The creation of the NHS reflected a strong public demand, informed by and expressed through Beveridge and mediated largely through the political structures of electoral representation. Our focus in this project is on social movements and while public pressure for the Beveridge principles was mediated largely through electoral politics, there was a social movement based in the trade unions, the Socialist Medical Association and the women's movement which informed and expressed much of this pressure.

The conditions for the successful creation of the NHS included the community wide aspirations for post war reconstruction and the strength of the trade union movement and the women's movement. Formative influences included the hopes and promises which had supported Britain through the war as well as the perceived achievements of Soviet health care.

However, by 1948 there had been extensive policy work done including reports, commissions and debates (Pater 1981). The creation of the NHS reflected in part the contribution of bureaucrats and policy makers as well as the political demand.

The structural model which comprised the NHS has been very influential for policy makers and activists in other countries.



The mobilisation around the defence of the founding principles of the NHS in Britain has also been associated with a strong social movement for health access and health equity in Britain.

#### *Primary health care in China*

In 1954 the first National Health Conference adopted four core principles to guide health development in China. These were: serve the people, put prevention first, integrate traditional Chinese and Western medicine, mobilise the people for health work.

The Chinese approach to primary health care was characterised by community involvement in public health campaigns, training of rural health workers (referred to as barefoot doctors from the 1960s) to provide basic medical care and to lead public health campaigns and the cooperative medical scheme to under-write the cost of health care. This model attracted widespread interest overseas (Sidel and Sidel 1975, Sidel, Sidel et al. 1982).

The model adopted in 1954 was based on an approach to primary health care which had been developed by Dr C. C. Chen (Chen Zhiqian) in the 1930s (1932-1937), known as the Ding Xian model (Chen and Bunge 1989).

Dr Chen has commented that the concept of village health workers was not invented at Ding Xian; rather it was building on a tradition of particular villagers acquiring (and being recognised for) special expertise in health and medicine. His contribution was to organise, support and build on this tradition.

#### *Enabling conditions and continuities*

The Chinese approach to primary health care during the period of the socialist planned economy has influenced health policy makers and activists in the global North and global South.

The successful mobilisation of people for public health work (the 'mass patriotic health campaigns') was in part a consequence of the power of the Communist Party of China which from the earliest days of New China extended down to the 'work unit' in both rural and urban areas. However, the Party was in some degree accountable to its mass constituency and in this respect the mobilisation around health reflected an urgent and widely perceived need to provide basic health care and address the environmental determinants of health.

The organisation of the patriotic health campaigns was in part directed through the Party. However, it built upon strong clan structures and community traditions. The formal structures established by the Party drew in significant degree on the hierarchical authorities of imperial China.

As Dr Chen has pointed out the successes of the barefoot doctors reflected in some degree an older tradition of particular community members developing some basic expertise in health and being recognised for this within the community. The focus on getting basic health care and public health to every village was appreciated by communities which had not had access before.

It is important to note the role of the Rockefeller Foundation in supporting Dr Chen and the Ding Xian project within the context of Y.C. James Yen's grassroots Mass Education Movement (MEM) (1926-1937).

The experience of primary health care in China, during the planned economy, has had a powerful influence on policy makers and health activists internationally.

Less widely appreciated are the challenges that Chinese health policy authorities have faced in managing the transition to a market economy particularly after the chaos of the Cultural Revolution.

Particularly salient are the challenges in health care financing, clinical governance and workforce development.

There is a powerful social movement in China today centred on consumer rights in the health care system. Because of the political constraints on the emergence and operations of civil society organisations in China this health movement is dispersed and unorganised but it has a powerful impact on health care nonetheless. Unfortunately the contradictions between exploitative medical care practices and suspicious consumers have damaged trust and slowed reform.

#### *Pholela, South Africa*

The description of the Pholela health services provided by Kark and Cassel in 1952 is worth quoting directly:

*Following the Report of the National Health Services Commission in 1944, the government decided to establish Health Centres in various parts of South Africa. Pholela was considered a useful pilot project in this new service. Medical Officers and other staff appointed to the various newly created Health Centres were first sent to Pholela to gain experience in Health Centre practice and to study the methods evolved there. At the same time it was realized that Pholela could not remain the only teaching and investigation base in a service to be provided for various types of community in South Africa. As a result the Pholela Centre became the rural section of an Institute of Family and Community Health which was established with headquarters in Durban. Established in April 1940, it is the oldest section of the Institute.*

*By this programme the emphasis of the service is modified from what is done for patients to what the family or community does for itself, assisted by the Health Centre staff. The interest of the community has been developed slowly with the result that an increasing number of families is participating actively in improving standards of health.*

*Malnutrition, maladjustment and diseases like tuberculosis and syphilis, are features in the vast majority of patients who seek medical care at the Health Centre. By means of its clinical and health education programme the Centre has been able to make a significant contribution to improved family health. However, the fact that these diseases are so closely related to soil erosion and migrant labour indicates the need for a broader programme of development. A family health and medical care service of the kind described in this progress report should be a feature of this development plan, functioning in close liaison with other services concerned with the general welfare of the community. It would seem that the effective liaison of such a health service with services concerned with agricultural improvements, soil conservation, industry and education offers an opportunity for improving the health of the people, for increasing the productivity of the area and at the same time conserving the soil for future generations.*

See also Kark and Kark (1999):

*This personal historical essay is the story of a pioneer health project in South Africa, and its transformation into health care focuses on communities and their constituent groups. The unique features of a new approach to family and community health care are set against the background of South Africa in the 1930s, the growing racism, the developing consciousness of the socio-economic condition of the Black population, and the emergence of liberal leaders who realized the importance of race relations. The book begins before the first project was initiated in Pholela (KwaZulu/Natal), and follows the development of the health centers*

*during the 1940s and 1950s, through to the ultimate destruction of the movement under the apartheid regime. The authors describe the concept of Community Oriented Primary Health Care (COPC), a unified practice combining individual clinical care with community medicine, and provide a unique insight into many of the personalities who contributed to the development of primary health care in South Africa. The promotion of health and quality of life remains a major objective of health care today. At a time when health services worldwide are casting around for relevant models and examples, this detailed and coherent account of the work of one dedicated couple is particularly relevant.*

Geiger recalls the role of John Grant in directing funding from the Rockefeller Foundation for the Karks and Pholela.

#### *Enabling conditions and continuities*

Pholela has deep significance for the community health centre movement, for the recognition of the social determination of health, and of the role of primary health care in confronting social and environmental conditions as well as providing health care. However, Pholela must also be contextualised in relation to: the exploitation of black labour, including migrant labour, in Southern Africa and the political tensions within the ruling white polity during the 1930s and 40s; tensions which led to the emergence of apartheid.

The conditions which underpinned the development of the Pholela program included government support, committed professionals and the willingness of the local community to enter into partnership with the health centre.

The political role of Anglophone white liberalism seeking to implement liberal reforms in the face of perceived risks to political stability and commercial well being were also part of this story and contrariwise the ascendance of the apartheid regime which led to the closure of Pholela and the departure of the Karks.

While the story of Pholela is not widely known outside South Africa the principles which were developed there including the concern for social and environmental determinants of health and the partnership with community have had a powerful influence on policy makers and civil society activist engagement in health in many countries.

Part of this influence arose from the status of Sidney Kark as a teacher and author of an influential text book on social medicine (Kark 1974). However, it was also mediated through several of Kark's students and colleagues including Sidney Sax who initiated the Community Health Program in Australia in 1973, and John Cassel and Jack Geiger in the USA (see below).

#### *Jamkhed, India*

The story of the Comprehensive Rural Health Project in Jamkhed, Maharashtra is widely known. In brief, a committed physician couple, after four years of clinical experience, undertake further training at Johns Hopkins University (both hospital residency and public health training) and then return to Maharashtra (1970) where they establish a clinic and start to build relationships with the communities they are serving. They provide clinical services but come soon to appreciate the pressing need for food and water. Working in partnership with the communities and working with village health workers they undertake successful initiatives in both health care and on the social conditions for better health. For more see Mabelle Arole and Rajanikant Arole (1975).

### *Enabling conditions and continuities*

Jamked has been a powerful influence internationally on the integration of community development and clinical services in the primary health care setting.

In contrast to the successes of the Jamked project the drive for a more organised approach to health care in India nationally, from as early as the Bhore Committee report of 1946 (Health Survey and Development Committee 1946) has been much less successful. This raises the question of so-called 'scaling up', both scaling up successful models of service and program delivery and scaling up the paradigm of community development in health.

The conditions for the success of Jamked include:

- committed physicians (who access public health training),
- partnership with communities negotiated and deepened,
- the effective and supported role played by village health workers, and
- early support from Christian Medical Commission.

The influences which contributed to the development of the Jamkhed project included:

- the service culture of the Christian Medical College at Vellore where both Aroles studied,
- reflection on international experience during discussions at Johns Hopkins.

The media through which Jamkhed has in turn influenced national and international thinking include:

- its iconic status, including through awards and articles in the professional and lay press,
- its role as an international teaching centre and the associated links with various academic teaching centres,
- advocacy through the Christian Medical Commission through which the Jamkhed project was one of several of critical influence in the development of Alma-Ata Declaration of 1978 (Newell 1975, Litsios 2002, Litsios 2004).

### *Solo*

The story of the Nugrohos (Nugroho 1975) is similar to that of the Aroles. A recently graduated medical couple are assigned by the government authorities to work in a Christian hospital system in Solo, the second largest town in Central Java. They are confronted by pressing medical care needs (vaccination, maternal and infant care, etc) but over-shadowing that is deep poverty, food insecurity and a high prevalence of protein calorie malnutrition.

Gunawan Nugroho tells of how, from 1963, he and his team worked with different village communities surrounding Solo providing nursing and medical care but also working with those communities to increase food supply (50 goats to be shared around the village), to build infrastructure (bulgur for work), to organise community based health insurance.

Nugroho makes no direct reference to the massacres undertaken under the Suharto leadership during 1965 and 1966. More recently more information has come to light (Simpson 2010) reflecting on the role of the US in the destabilisation of Sukarno and the role of the CIA in setting up the Suharto putsch. Aspinall (2010) summarises:

*Drawing mostly on newly declassified archival material ... Simpson explains how, at least after 1960, "the United States committed itself to provoking a clash between army and the PKI [Indonesian Communist Party], on the presumption that the army would emerge victorious over its well-organized but unarmed and basically defenseless opponent".*

### *Enabling conditions and continuities*

The Solo story was a significant influence on the conceptualisation of primary health care in the lead up to Alma-Ata (Newell 1975, Litsios 2002, Litsios 2004) .

However, like Jamked, it raises questions about the relation between individual centres of excellent PHC and whole-of-country health care reform. Like the Guatemalan story, below, it raises questions about the relation between individual centres of excellent PHC and the wider political climate, including the geopolitics of imperialism.

The enabling conditions included:

- Committed physicians,
- Taking a cautious but experimental approach,
- Working in a bureaucracy that had space for creativity,
- Building partnerships with communities,
- Small scale financial support from outside

Sukarno was one of the five founders of the non-aligned movement from 1961 which projected an optimistic outlook on national development following independence. See reference to the NIEO below. This optimism was reflected in a bureaucracy that had space for a primary health care approach as was pioneered by the Nugrohos.

In turn the Solo example influenced the development of Alma-Ata Declaration (see Litsios 2002) although it is not as well known as Jamkhed.

### *Chimaltenango Development Project in Guatemala*

The third of the three case studies that, according to Litsios (see below), were so influential in the conceptualisation of the primary health care model at Alma-Ata, was the story of the Chimaltenango Development Project in Guatemala, told by Carroll Behrhorst (1975) and included in Newell's 'Health by the People' in 1975.

Behrhorst came to work with the Indigenous people of the highlands of Guatemala in 1963, from a general practice in Kansas. Like the Aroles and the Nugrohos he started by delivering medical care but like the Aroles and the Nugrohos he found that it was "something like trying to empty the Atlantic Ocean with a teaspoon".

Behrhorst tells of the initiatives that he and his colleagues undertook to increase food security, training 'health promoters', supporting extension workers, working with the local savings and loans organisation. He emphasises repeatedly the degree to which the project built upon the culture, wisdom and hard work of the Indigenous people and describes the careful and respectful ways in which the partnership was developed.

Behrhorst says little about the wider political economy of Guatemala during his time except for references to absentee landlords who were sitting on uncultivated land while Indigenous people went hungry because they had no access to land. However, it is instructive to reflect on the Behrhorst story in the light of the more recent papers by Hove (2007) and by Flores and colleagues (Flores, Ruano et al. 2009) and by Hochmüller and Müller (2015).

Hove's focus is on the US sponsored overthrow of the democratically elected President of Guatemala, President Jacobo Arbenz Guzmán, in June 1954. He traces the consequences of this exercise in subsequent Latin American history including the careers of Salvador Allende in Chile and Ché Guevara.

Flores and colleagues review the history of repression and violence from colonial times up to the new millennium.

*In the period between 1960 and 1996, Guatemala experienced one of the most violent armed conflicts on the American continent. In a report published in 1999, Guatemala's Historical Clarification Commission (Comisión de Esclarecimiento Histórico, or CEH) estimated that 200,000 persons were affected by arbitrary execution or forced disappearance and that the number of orphans of the armed conflict approached 150,000. The massacres and destruction of villages gave rise to forced displacement of the civilian population internally as well as abroad. The CEH report also estimated that 1.5 million persons were displaced during the critical phase of the armed conflict (1981–1983). These figures indicate that more than one-quarter of the country's total population was affected by the political violence — through assassination, forced disappearance, and kidnapping — or by forced displacement from their dwellings.*

It is admirable that Behrhorst's story contributed to the conception of primary health care and to the Alma-Ata Declaration but as Flores and colleagues note, "In the years following Alma-Ata, more than 650 social leaders [in Guatemala] were assassinated".

The focus of the Hochmüller and Müller paper is on the practices of 'counter insurgency' in the context of the 'global war on terror'. They note how Guatemala served as a laboratory for US counter insurgency strategy which then informed a range of subsequent US interventions across the globe. The sting in their tale is how 'best practices' in counter insurgency are being re-imported back into Guatemala under the rubric of containing 'criminal insurgencies' in the Americas, under the aegis of the Central America Regional Security Initiative. Senior military strategists are quoted as emphasising 'centrality of the civilian' and 'the importance of non-military efforts and actors' for winning the battle by winning the 'hearts, minds and acquiescence of the population'.

#### *Enabling conditions and continuities*

The Behrhorst story has ambiguous implications for discourses of primary health care. On the one hand it is an inspiring story about primary health care and community development and as such contributed to the conceptualisation of the Alma-Ata Declaration (see below).

However, it would be a mistake to attempt to make sense of the ongoing significance of the health promoters in Guatemala (including in Chimaltenango) except in the context of the repression and resistance which Flores and colleagues describe.

The conditions underpinning the very positive outcomes which Behrhorst reports corresponds to those listed for Solo and Jamked above, including:

- Committed physicians,
- Taking a cautious but experimental approach,
- Working in a bureaucracy that had space for creativity,
- Building partnerships with communities,
- Small scale financial support from outside

However, the wider context of the Guatemala case, completely missing from the Newell collection, highlights the limits on this kind of local community development approach. Where hunger reflects inequality, and inequality is sustained by repression and imperial intervention, the solution to hunger needs to be more than local projects.

Formative influences appear to have included the international mission / development tradition of the US Presbyterian Church as well as the US Peace Corps although the chapter in the Newell book does not provide much information on this. Clearly the resilience of the Cakchiquel Indians of Guatemala was part of the story including the commitment of the health promoters and extension workers.

In terms of on-going influence, the contribution of this story to the conceptualisation of PHC in the lead up to the Alma-Ata Conference must be acknowledged (although fortunately the Declaration does not completely ignore the pressures of globalisation and imperialism).

#### *The Christian Medical Commission*

Litsios (2004) describes the influence of the Christian Medical Commission in the genesis of the Declaration of Alma-Ata. He identifies the three projects referred to above as being particularly influential in shaping WHO thinking. These three projects were included in the influential collection, 'Health by the people', edited by Kenneth Newell (1975) and published in the lead up to the Alma-Ata Conference.

The CMC was established in 1968 as one of the outcomes of a significant rethinking of the role of health care in Christian missions. Braley (2014) describes the shift in thinking which was behind the establishment of the CMC; moving away from an assumption that "curative medical practices were a jumping-off point for proselytizing". He comments also that it was necessary for the churches to distance themselves from the historical associations of missions (including medical missions) as part of the colonial apparatus.

John Bryant (Bryant and Richmond 2008) who was part of these early discussions recalls that mission hospitals had become "a factory for repair of things rather than a hospice for the care of souls. The growth of medical specialisation tended to break down the patient into pathological parts so that he is regarded or treated less and less as a whole patient. ... It is only when the Christian community serves the sick person in their midst that it becomes itself healed and whole, suggesting a moral basis for individuals and communities to be involved in any consideration of how resources are to be used to promote their health."

The rethinking of Christian mission was part of a wider rethinking of Church and society, reflected in the rise of liberation theology in Latin America and the Second Vatican Council from 1962-65. See Adriance (1994) for a description of the role of base communities in rural mobilization in Northern Brazil and Norget (1997) for an account of liberation theology and popular mobilization in Oaxaca in Mexico. In both cases health care and addressing the conditions for better health are encompassed in the social change agenda.

Minden (1981, 1989) has taken a detailed look at medical missionaries in China in the early 20<sup>th</sup> century and throws additional light on the contradictions facing Christian missions in the post-colonial era. Missionaries gained access to China as a consequence of the Opium Wars and as part of the 'unequal treaties' and in the early years depended on foreign gunboats for physical protection. This was a continuing barrier to their proselytising and did not endear them to the revolutionaries.

The medical missionaries faced some criticism from the church authorities back home when the original purpose of the missions, to convert the heathens, was diverted into a focus on teaching and practising medicine. However the main lesson from Minden's study has to do with the elite character of the medicine that they practised and taught and the relative neglect of public health interventions which could have had a far greater impact on population health.



When the Communist Party came to power the missions were closed and the leadership looked to Ding Xian and Dr C. C. Chen for a model of health care which gave priority to serving the whole population and implementing basic public health programs.

The PHC model which the CMC urged upon Dr Mahler in the mid 1970s prioritised access to basic health care with appropriate workforce structures, appropriate technology and action on the social determinants of health. In particular, it promoted a partnership model with the practitioners working in partnership with local communities to create health care capacity and to engage in the social determination of better population health.

#### *Enabling conditions and continuities*

The intervention of the CMC in the conceptualisation of Alma-Ata provides a useful focus for reflecting on the variations in, and transformations of, the Christian missionary enterprise, from the height of invasion and colonisation to the diversity of faith-based health involvements in developing countries today.

The conditions underpinning this 'episode' reflected the optimism of the newly independent ex-colonies, of the non-aligned movement, and of the long boom. They also reflect significant changes taking place within the churches and the health care organisations. Formative influences included the politics of independence and liberation theology in its various forms.

The spectrum of faith-based health care organisations operating in developing countries varies widely from the evangelical homophobes to the liberation theology priests and radical health activists working on a range of health equity issues.

Our inclusion of the CMC involvement in Alma-Ata in this survey should be taken as a recognition of this important strand of North South engagement.

#### *Alma-Ata and the NIEO*

The story of Alma-Ata and PHC has been told many times; see Litsios (2004), Sanders (Sanders 1985, Werner and Sanders 1997) and Bryant (Bryant and Richmond 2008). However, one feature of the Declaration which is not so widely commented upon is the reference to the New International Economic Order (NIEO).

The emergence of dependency theory after the Second World War led many developing countries (particularly in Latin America) to adopt import substitution strategies for economic development and to maintain relatively high levels of industrial protection (Hettne 1995). This responded in part to a recognition of the long standing exploitation of Latin America by the European powers and by the USA (Galeano 1997 [1973]).

Dependency theory was very influential within the non-aligned movement (NAM) which was launched after the Bandung Conference of 1955 and was one of the key ideas behind the establishment of UNCTAD which met for the first time in 1964 with Raúl Prebisch (a strong advocate for import substitution industrialisation) as the first Secretary-General. The proposal for a new international economic order (NIEO) emerged from UNCTAD and was adopted by the UNGA in 1974 (UNGA 1974).

Sneyd (2005) describes the origins of the NIEO in the following terms:

*The New International Economic Order (NIEO) was a comprehensive package of multilateral policy options that aimed to improve the position of Third World countries in the world economy relative to the richest states. It came together at the Non-Aligned Movement (NAM) Conference held at Algiers in September 1973.*



*Subsequently, the leaders of the NAM requested a Special Session of the UN General Assembly to address issues associated with international trade in raw materials. At this Session in April 1974 the Group of 77 (G-77) secured the adoption of the Declaration and Programme of Action for a NIEO despite lacking the support of the United States and a small group of advanced industrialized countries.*

Dependency theory, import substitution industrialisation and the NIEO represented a major threat to the TNCs of the global North and the industrialised countries who depended on cheap raw materials and markets for their manufactured goods. The NIEO was demolished with the debt crisis of the 1980s and the IMF's structural adjustment policies.

#### *Enabling conditions and continuities*

The inclusion of the NIEO in the Declaration of Alma-Ata reflects an early recognition of the impact of economic globalisation on population health and the need to contain it through the principles enshrined in the NIEO. In the context of PHC and the concept of practitioners working in partnership with their communities to address the social determinants of health this was an important signal.

While the NIEO was largely a political economic manifesto it reflected assumptions about an interventionist state with responsibilities for social development as well as economic development. Virtually none of the NIEO program was implemented and by the late 1990s the prevailing orthodoxy enshrined in the Washington Consensus ran counter to virtually the whole of the NIEO.

The global tensions around the NIEO versus the Washington Consensus set some of the backdrop to the questions about scaling up brilliant but isolated instances of community development in health.

The NIEO (1974) was considered by WHO's Executive Board in January 1975 and by the Health Assembly in May. The Assembly adopted a number of related resolutions (WHA28.75, WHA28.76, WHA28.77) calling upon the Organization to assure increased assistance and a greater transfer of resources to the developing countries, particularly those most seriously affected by the present world economic crisis (WHO 1975).

In a report prepared for the Assembly in May 1975 (WHO 1975), the Secretariat advised that:

*The Director-General has expressed his views ... that the United Nations system should continue to adapt itself to become a more viable and effective instrument of Member States in the development process. To this end the health sector must necessarily become more integrated with other sectors such as education, industrialization, etc. which also go into forming the totality of development per se.*

The inclusion of reference to the NIEO in the Alma-Ata Declaration reflected in part the commitment of Dr Mahler (elected DG in 1973) with the support of the countries of the Non-aligned Movement who had been instrumental in the development of the NIEO in 1974.

The NIEO was a major intervention in global economic governance in the post-independence period but before the recession of the late 1970s, the closing of the debt trap and the beginning of structural adjustment. It envisaged a global economic regime which in many respects was the antithesis of the neoliberal globalised economic integration which is the dominant paradigm today.

The inclusion of the NIEO in the Declaration confirms that a significant number of developing country diplomats understood the degree to which access to health care and the conditions for population health are shaped by the global political economy.

It is not clear that the inclusion of the NIEO in the Declaration of Alma-Ata has had much influence on health policy makers or primary health care activists. It seems that many people have been persuaded that the process of global economic integration which has been wrought under the aegis of neoliberalism has effectively precluded realizing the vision of the NIEO.

#### *Health insurance in Saskatchewan*

The Canadian province of Saskatchewan played an important role in the development of health insurance in Canada. As in the case of the British NHS most of the policy debate and institutional development took place within the framework of government and electoral representation. However, there was a real social movement behind the government processes.

Taylor (1973) describes how in the early years after World War I rural municipalities in Saskatchewan began to employ physicians on contract to provide GP services and to prepay hospital services through local property taxes and 'premiums' for non-property owners. This system expanded rapidly and by 1948 there were around 100 municipal plans operating. However, by 1948 this system was a significant burden on municipalities and there was pressure for the provincial government to expand the system province wide and assist with the funding (Brown 1983).

In the spirit of reconstruction after World War II the federal government had offered in 1945 to underwrite 60% of estimated costs of provincial health care programs. This offer was the latest in a series of commissions and reports promising a comprehensive health care program (Gelber 1966). However, this 60% proposal did not proceed owing to opposition from the richer provinces.

Meanwhile in 1944 a new left wing government was elected in Saskatchewan and one of the first steps of the new Premier (who was also Minister of Health) was to commission a review into health services by Henry Sigerist, the director of the Johns Hopkins University Institute for Medical History (Duffin 1992). Sigerist, originally from Switzerland, had written about Soviet health care, had supported American public health bills and had endorsed the value of state-funded medicine in the medical literature. He had also visited Canada several times to talk about medical history and health policy. Building on Sigerist's review, in 1947, the Saskatchewan provincial government launched the first compulsory hospital insurance plan in North America.

In the early 1950s Milton I. Roemer came to work in Saskatchewan on the implementation of the hospital program and on the details for a subsequent medical insurance program. Roemer was a leading health system researcher and had written extensively about the Soviet health system. He was also a sometime student of Sigerist at Johns Hopkins. Roemer's period in Canada corresponded to his exile from the USA under the pressure of McCarthyism (Abel, Fee et al. 2008).

Meanwhile, other provinces were following Saskatchewan into single payer, state sponsored hospital insurance and by 1961 the Federal proposal to pay half the costs of inpatient and outpatient hospital services had been accepted by all provinces. In 1962 Saskatchewan took the lead again and expanded the program to cover physicians' bills. Following a doctors' strike it was agreed that physicians could bill patients directly but the government would enrol everyone and would set the benefits.

In 1965 the federal government offered to provide grants to the provinces to cover 50% of national per capita cost in return for the provinces accepting four principles: universal coverage, comprehensive benefits, portability of coverage, and government non-profit administration.

### *Enabling conditions and continuities*

Saskatchewan pioneered single payer, universal, comprehensive, government administered health insurance in Canada and has provided a model which has informed health systems development (such as in Australia) and health advocacy in many countries (not least the USA).

The political drivers worked largely through the institutions of government, the political parties and electoral representation. However, behind the structures of government was a strong concern for access to health care across this dispersed and largely farming community. The electoral pressure was further modulated by on-going policy advocacy from within the medical profession.

The legacy of the municipal health services model which itself reflected the dispersed agricultural economy of the province and the support of the farmers for the Cooperative Commonwealth Foundation (the CCF; later the New Democratic Party) were important drivers.

The widespread appreciation of the Soviet model of health care, including through the direct influence of both Sigerist and Roemer, helped to shape the policy commitment to universality, comprehensive benefits and government administration.

Roemer(1958) attributes the pioneering achievements of Saskatchewan in health insurance to a number of forward looking politicians associated with the CCF; to Dr Fred Mott for his leadership in the administration from 1946 to 1951; and to the Saskatchewan farmers who initiated the municipal health services model in 1916 and through the 1930s and 1940s and who were an important part of the CCF constituency.

Duffin (1992) has explored the conditions which led to Sigerist being employed to do his survey in 1944. Her focus is on the role played by Dr Hugh Maclean, a general practitioner, whose views the premier of the time Tommy Douglas had great confidence in. Duffin suggests that MacLean may have been instrumental in the decision to invite Sigerist to do the review.

Clearly the Soviet health system and the generally rosy picture of the Soviet Union in Left wing circles at that time was also an important influence.

The Canadian model has been widely referred to in health systems policy debate globally and has directly informed health systems development in many other countries (such as Australia, see Scotton and Macdonald 1993). It has had a powerful influence on the single payer movement in the USA.

Roemer personally had a significant influence on health policy through his writings on comparative health systems and undoubtedly promoted the Canadian model.

### *Community health centres*

There are community health centres (CHC) in low, medium and high income countries but their policy significance varies widely. In the global North, the CHC as an organisational form has particular significance as a challenge to state subsidised private medical practice and as a focus for activism around access issues and around the social determinants of health.

Health centres (health posts, primary health care centres, etc) are commonly part of publicly delivered primary health care in the global South but the policy issues are generally somewhat different.

Our discussion of CHCs here is focused largely, although not exclusively on the global North. The International Federation of CHCs (IFCHC 2016) describes CHCs in the following terms.

*Community health centres deliver integrated, comprehensive, people-centered primary health care, through an interprofessional team that addresses aspects of both health and wellbeing. Clinical primary care services at community health centres address aspects of health promotion and illness prevention, as well as curative care and rehabilitation using a holistic frame of reference and are orientated towards the needs of individuals, families, communities and populations. The Community Health Centre care and programs team integrates into its daily activities, attention to the broader causes of illness, and looks at the social determinants of health, addressing them through intersectoral cooperation.*

*Community health centres develop a community-oriented primary care strategy, blending skills for individual health care with approaches focused on public health. Community health centres have a commitment to equity and social inclusion and put emphasis on access to health care (with special attention given to the most vulnerable), and on respect for fundamental human rights. Community health centres place a strong emphasis on community engagement and civic participation in health and health care, which may, but does not necessarily include participation of clients/patients and other community members in governance of the healthcare organization.*

*Community health centres contribute to universal coverage and are strongly committed to being accessible for individuals and families, irrespective of race, religion, social status and other factors, including ability to pay for care. Community health centres engage in processes of continuous quality improvement, starting from the needs of the individuals and patients that they are serving. Community health centres take responsibility for a defined population that can be geographically-determined or defined by population group(s).*

While the general principles which have informed the development of CHCs have been formulated by many thoughtful practitioners three CHCs stand out as inspirational models for policy makers and activists. These are:

- the 'Peckham Experiment' (Pearse and Crocker 1985[1943])
- Pholela (see above), and
- Mound Bayou in Mississippi (Geiger 2002).

The Pioneer Health Centre in Peckham in SE London was opened by another medical husband and wife team, George Scott Williamson and Innes Hope Pearse in 1926. The Centre provided space for a wide range of community activities including swimming, games, workshops and exercise. The Centre was suspended during the War but finally closed in 1950 because it did not fit into the new NHS. However, the Pioneer Health Foundation which operated the Centre continues to exist and to propagate the principles which inspired Peckham. Social Medicine 4(3) includes a number of articles remembering Peckham and affirming the continuing importance of those principles.

The role of health centres as the basic platform for primary care and public health had been urged as early as 1920 in the Dawson report (Anonymous 1920) and in 1943 the Labour Party committed itself to establishing health centres as the basis for primary health care in the new NHS (Pater 1981, p106) but this was not to be, owing to opposition from the medical profession.

While the Pioneer Health Centre is not so well known outside Britain, the Pholela centre in Kwazulu Natal, referred to above, has been very influential internationally. The influence of Pholela has been mediated by its creators, Sidney and Emily Kark, and by their students and colleagues, including in particular John Cassell and H. Jack Geiger in the USA and Sidney Sax in Australia.

In his memoir in Birn and Brown's *Comrades in Health* (2013), Geiger (2013) reflects on his own early activism and the development in his thinking which brought him to undertake a placement in

Pholela as a mature age medical student in 1957. Seven years later as a field coordinator with the Medical Committee for Human Rights (Dittmer 2009) Geiger travelled to Mississippi and was inspired with the vision of realising the principles of Pholela in Mississippi. By 1969 the Mound Bayou Health Centre was established in a partnership between Tufts Medical School (Geiger 2002) and a wide range of individuals and networks in the Delta and funded through the Office of Equal Opportunity (Lefkowitz 2007). Since then Mound Bayou has inspired generations of health activists in the US. Geiger and his colleagues had a direct influence on the establishment of a community health centres program within the OEO and the involvement of both Robert Kennedy and Ted Kennedy in promoting the OEO health centres (Sardell 1988, Lefkowitz 2007).

Over the succeeding years almost a thousand federally qualified health centres were established and notwithstanding the Reagan Administration, most continue operating today, largely serving poor, and otherwise underserved, communities. However, the CHC program does not present a major threat to the dominance of private medical care in the US.

Sidney and Gwen Sax came to Australia in 1960. Sidney Sax had graduated and practised in Johannesburg until 1951 when he moved to Rhodesia and then to Australia in 1960. While Sax did not work at Pholela he was very aware of the Kark's work and acknowledged it as an important influence in his later work in Australia. Sax worked as a geriatrician and health planner in NSW before being invited by the Whitlam Government in 1972 to set up the Hospital and Health Services Commission. The following year the Interim Committee of the National Hospitals and Health Services Commission published a report entitled *A community health program for Australia*. This report took a very non-prescriptive attitude to the development of community health in Australia, setting out general principles and inviting applications for federal funding. States with Labor governments were quick to apply for support for various existing programs but those states with conservative governments generally sought to block community groups from accessing federal funds. Paradoxically it was the opposition of state governments, particularly in Victoria and South Australia, which encouraged community mobilisation around the establishment of local committees to apply for funds and build and manage their own health centres. By the end of 1975 (when Whitlam was dismissed) around 600 projects had been funded under the Community Health Program (Whitlam 1985, p343). These included generalist CHCs, community mental health centres, workers' health centres, women's health centres and Indigenous health centres (Baum, Fry et al. 1992). There have been a number of case study collections documenting and analysing some excellent vignettes of primary health care in action including both health access programs and community development in health programs (Community Development in Health and Victorian Community Health Association 1992, Butler and Cass 1993, Butler 1994, Legge, Wilson et al. 1996, Legge, Wilson et al. 1996).

The Australian Medical Association was fiercely opposed to centres having salaried medical officers and many of the 'CHCs' which were established were restricted to having community nursing and allied health staff and were expected to provide support to local private general practitioners. Nonetheless in Victoria and South Australia there were a number of generalist health centres with multidisciplinary staffing, including salaried medical officers, and strong community involvement, including in governance. Many of these centres had strong community development programs addressing the social determinants of health as well as access issues. In subsequent decades under the neoliberal ascendancy, the structures for community involvement have been greatly weakened and the generalist CHCs have been reduced to clinical services, largely non-medical.

It is the Indigenous health centres which have stayed closest to the principles of primary health care including strong community involvement in governance and rich programs around access,

appropriate clinical services and action around the social determinants of health, including racism and the colonial legacy (Fredericks and Legge 2011).

Canada has around 800 CHCs, which is almost as many as in the US. There was a significant funding increase for team based care in 2004 much of which flowed to community health centres.

#### *Enabling conditions and continuities*

There have been a range of drivers for the establishment of CHCs in the rich countries of the global North. These include public policy concerns:

- around the quality and efficiency of private general practice where it is conducted in a largely unidisciplinary mode; hence an argument for facilities which can support multidisciplinary teams;
- about the maldistribution of primary care resources owing to a clustering of private medical practices in the more affluent areas; hence an argument for CHCs in underserved areas;
- about the individual and episode focus of much private primary medical care with less attention paid to personal preventive services and much less attention paid to social determinants of health; hence a (less often heard) argument for multidisciplinary teams and salaried staff and provision for close community involvement.

In many countries the organised medical profession has been quite opposed to CHCs because of fears regarding clinical and operational autonomy and income expectations. The continuing encroachment of corporate medicine often with very significant constraints on autonomy and income may lead to significant changes in mainstream medical opinion.

The case for CHCs has been advocated by community advocates of access and health justice, by a range of health equity activists and by progressive (public health oriented) medical practitioners and medical organisations. These groups have seen CHCs as an important strategic target in the struggle for access and equity and meaningful action on the social determinants of health.

In some respects the promises of community health activists have not been fulfilled. Certainly CHCs have reached into underserved communities with culturally appropriate models of care and strong public health programs.

Community health centres have served as a focus for local health activism in many countries but this has remained largely local in many cases. Insofar as the social determination of health chances is shaped by politics at the national and global levels the potential for building a global social movement for health equity remains unfulfilled. Certainly, the community health lobby has not been able to prevent the rolling impact of neoliberal austerity in the North, nor has it developed strong bands of solidarity with people in the global South who have been marginalised by and excluded from the transnational global economy.

The history of community health in the North reflects a fascinating dialectic between the bottom up activists struggling around the health of their constituencies and the policy oriented rationalists who see a practical logic in the CHC. While a vision of a more equitable and inclusive society has motivated the activists the practical rationalists have steered much of their effort into ameliorating the injustices and exclusions of the neoliberal transnational regime.

We have presented a chronological narrative which privileges the inspirational influence of Peckham, Pholela and Mound Bayou. However, while these cases provide a vision, the national and local contingencies which are the concern of state/provincial/national policy makers have been of comparable importance in driving what has been achieved.

The community health sector attracts health care practitioners who are looking for a more equitable as well as healthier world. The stories of Peckham, Pholela and Mound Bayou will continue to inspire them. However, the pressures of need within local communities create a certain inward looking orientation in which global analysis and international solidarity can lapse.

#### *Community health workers*

While community health centres have been more contentious in the North than the South, the reverse is true regarding community health workers. While CHWs have been deployed in some high income countries the main focus of policy and implementation has been in low and middle income countries where severe workforce shortages have constituted a barrier to accessing clinical care and to implementing effective public health programs.

Walt and her colleagues (1990) have provided an excellent overview of the evolving conceptualisation of CHWs in relation to changing narratives about 'development', population, the 'medical care model' and community involvement. Walt and colleagues explore the debates between those who view CHWs as 'extenders of health services' versus those who see them as 'agents of change'. This debate was framed by Werner in 1981 as 'lackey or liberator'. Walt et al highlight the contrast between inspiring case studies (Jamked, Solo, Pholela, etc) created and sustained by charismatic leaders and the challenges of 'scaling up' in the form of national programs. In this context they review some of the on-going debates regarding implementation (eg payment, employment, gender issues). They explore the different roles which have been assigned to CHWs (clinicians, aids to clinicians, interpreters, educators, mobilisers) and discuss the kind of support functions which are needed to successfully implement such programs (support, supervision, supplies). They review the relations between CHWs and community development workers, agricultural extension workers, traditional practitioners and with community organisations. They also review some sources of local resistance to the CHW role including from nurses and other professionals and local elites.

The overview provided by Walt and colleagues in 1990 still applies in general terms although more recent experience, research and commentary helps to sharpen some of their conclusions.

Haines and colleagues in 2007 reviewed a number of trials demonstrating substantial reductions in child mortality, particularly through community based case management and the delivery of preventive interventions. However they emphasise that 'community health workers are not a panacea for weak health systems and will need focussed tasks, adequate remuneration, training, supervision, and the active involvement of the communities in which they work'. More recent studies such as that of Puett and colleagues (Puett, Sadler et al. 2013) studying community based management of severe acute malnutrition in Bangladesh and a systematic review (Arshad, Salam et al. 2014) of the role of CHWs in the prevention and control of TB treatment bear out Haines and colleagues' report regarding cost effectiveness.

Our interest in this project concerns the relations between CHWs and the 'health for all' movement; what Werner captured in his article on the village health worker as lackey or liberator. One of the most striking additions to this debate has come from the Mitani program in India. Nandi and Schneider (2014) have undertaken a qualitative comparative study of projects in two districts of Chhattisgarh, one on malnutrition and the other on gender-based violence. They summarise their findings thus:

*Action on social determinants involved raising awareness on rights, mobilizing women's collectives, revitalizing local political structures and social action targeting*



*both the community and government service providers. Through these processes, the Mitans developed identities as agents of change and advocates for the community, both with respect to local cultural and gender norms and in ensuring accountability of service providers. The factors underpinning successful action on social determinants were identified as the significance of the original intent and vision of the programme, and how this was carried through into all aspects of programme design, the role of the Mitans and their identification with village women, ongoing training and support, and the relative autonomy of the programme.*

Zanchetta and colleagues (2014) report on a program of Freirian workshops provided for community health agents in three Brazilian cities. They report that the community health agents were already committed to a social movement for health equity to 'catalyse a more equitable distribution of social goods, promote social inclusion, and liberate communities' but that the workshops contributed to enhancing their awareness of the social determinants of health and the need for major structural change to sustain meaningful health promotion initiatives.

In a less optimistic vein Druetz and colleagues (2014) explore the use of CHWs in the implementation of case management of malaria. They argue that community based case management of malaria reflects a medicalisation of CHWs and a deprioritisation of health promotion: 'Far from serving as promoters of social change and community empowerment, today we expect them to act as front-line clinicians'. They argue that the principle of 'task shifting' needs to be managed carefully to avoid this shrinking of the primary health care vision.

The experience of China with village health workers (village doctors, barefoot doctors) during its economic transition is salutary (GHW3 2011). From 1949 to the late 1970s the Chinese health system emphasised access to essential clinical and preventive services based largely on equitable distribution of and community support for the barefoot doctors.

By the 1990s with urbanisation and the development of a larger middle class there emerged increasing community demand for graduate level doctors. However, the medical workforce inherited from the period of the 'socialist planned economy' was dominated numerically by diploma level doctors which the educational institutions continued to produce in large numbers.

As the production of graduate doctors increased from the mid 1990s they were largely absorbed into the tertiary hospital sector and increasingly the diploma level doctors were restricted to rural institutions and to the primary care institutions in the cities. However, the government's attempts to re-establish a strong primary health care capacity has faced significant obstacles in part due to community aspirations for the higher technical competence which is presumed to be associated with graduate level doctors and the hospitals from which they practice.

While China remains famous for its pioneering of primary health care in the 1950s and 60s in the present era the re-establishment of PHC remains a work in progress.

#### *Enabling conditions and continuities*

The tensions between CHWs as promoters of social change versus front-line clinicians and extenders of sparse professional staff, will not be resolved any time soon. The lack of health service resources, and the logic of CHW programs, reflect a particular set of power relations, locally, nationally and globally, and the elites will not take kindly to programs which explicitly set out the challenge such power relations. Only where the CHWs themselves are committed to social change, as with the Mitans or the Brazilian community health agents, and where they have significant



community support will such programs be able to contribute to meaningful social change and meaningful 'empowerment'.

Such commitment is a necessary but not sufficient condition for CHWs to undertake the mobilisation needed to address the social and political circumstances that reproduce the health needs of their communities. The administrative, professional and educational support emphasised by Haines and colleagues is also quite critical and points to the responsibility of policy makers and program planners.

Walt and colleagues have highlighted the contrast between the local case studies led by charismatic doctors and the challenges of 'scaling up' the concept. This points to the important role which can be played by (professional) primary health care practitioners in supporting the development of CHW programs and the need for policy makers and program planners to leave space for significant local leadership in the development of programs.

In relation to the project of building a global social movement for health equity the role of CHWs and other primary health care practitioners and the support of their communities, are quite critical. The groups who might help to drive the development of more emancipatory CHW programs include enlightened policy makers, progressive primary health care practitioners and managers, and community activists.

A range of contending purposes weave their way through the debates around CHW programs and help to determine whether such programs play any role in social mobilisation around health and any convergence towards a global movement for health equity.

The 'development assistance for health' organisations are looking for improvements in their outcome indicators. The ruling elites behind the big donors are seeking to shore up the perceived legitimacy of an unequal and unsustainable global economic regime. At the national level, policy makers and planners are facing the challenges of delivering modern health care and public health with a severe lack in the necessary human resources and weak health systems. In such circumstances and the logic of using CHWs as physician extenders has significant appeal. At the local level there are various practitioners, organisations and community fractions who for various reasons have reservations about the CHW program.

Walt and her colleagues have commented that the models which have informed/ inspired such advocacy fall into two categories: national programs such as the Chinese 'barefoot doctors', and individual local case studies such as Jamked, Solo, Pholela and the health promoters of Central America. In the modern period the Mitanins of Chhattisgarh might be added to this list. These are truly inspiring episodes with great potential to contribute to movement building. However, such enthusiasm needs to be tempered by the lessons referred to above:

- the barefoot doctors model arose in a very specific context and it was not without limitations;
- the 'scaling up' of brilliant local models faces many difficulties;
- the field is highly contested at many different levels;
- institutional support from within the wider health system is critical.

The vision of CHWs working with their communities to support access to appropriate health care and public health programs, including action on the social determinants of health, will continue to inspire.

Hopefully future initiatives will also be informed by the experience of programs to date, mediated through ongoing policy debate and research. The role of 'counter-hegemonic knowledge production' as discussed by Carroll (2015) and referred to above is critical in this project.

### *Health PAC*

The 'new left' came into salience in the global North (most flamboyantly in the US) during the 1960s. The qualifier 'new' reflected a distancing from the 'old (communist party associated) left'. However the descriptor 'left' reflected a renewed critique of capitalism and imperialism, US imperialism in particular. The rise of the new left in the 1960s reflected radicalisation arising in the growing opposition to the (US involvement in the) Vietnam War. It corresponded to the final decade of the 'long boom', with high levels of economic growth and expectations of security. Finally, although the Cold War continued unabated, the influence of McCarthyism was waning.

Our case study of the 'new left' in health activism is the Health Policy Advisory Centre (and Health PAC Bulletin) in New York and is taken largely from Chowkwanyun (2011).

From 1968 to the mid 1970s Health PAC was a base for activism around hospital politics in New York and from 1968 to 1994 the Health PAC Bulletin produced a sharp and penetrating critique of the 'American health empire' (or the 'medico-industrial complex'). Collections of articles appearing in the Bulletin were published in book form in 1970 (Ehrenreich and Ehrenreich 1970) and 1976 (Kotelchuck 1976). John Ehrenreich's 1978 collection, *The Cultural Crisis of Modern Medicine* also owed much to the Health PAC platform.

Health PAC was started through a partnership between Robb Burlage (one of the founders of Students for a Democratic Society or SDS) and left wing Fabergé philanthropist Samuel Rubin. The objects of the Health PAC critique included health insurance, racism and sexism in health care and profiteering associated with private medicine. A major focus of Health PAC was the disparity between well-resourced private hospitals (and medical schools) and cash strapped and neglected state and municipally owned hospitals.

Much of Health PAC's on-the-ground organising was around a policy of New York City of 'affiliating' municipal hospitals with private medical schools (the 'empires'); the sharpest conflicts arose in relation to the affiliation between Lincoln Hospital (a municipal hospital in the South Bronx) with the Albert Einstein College of Medicine. The core of the issue was whether the medical school was primarily interested in accessing 'teaching material' rather than service delivery. Another long running exposé focused on the problems at Chicago's Cook County Hospital.

Chowkwanyun describes how the prevailing analysis within the Health PAC group evolved with increasing appreciation of the challenges involved in 'community activism' and in the later years a certain 'crisis of purpose'.

### *Enabling conditions and continuities*

Health PAC and the Bulletin contributed greatly to elaborating an analysis and critique of the 'medico industrial complex'; the institutional configuration of medical schools, hospitals, insurance companies and other supply industries and the class, gender and race relations which was expressed in the 'American health empire'.

While the major focus of Health PAC's organising and analysis was on the US situation the wider political economy of US's global role was also a recurring focus of critique.

The conditions which allowed Health PAC to flourish included: the zeitgeist of 'the 1960s' (including SDS, the anti-Vietnam War movement, the civil rights movement, second wave feminism,

etc), the presence of a philanthropist willing to support radical activists in health, and the extreme inequities exhibited in the US health care.

Formative influences included a rising critique of US imperialism in the context of the Vietnam War and the re-emergence of class analysis, but linked to parallel analyses of race and gender (and later of disability and sexual orientation). The focus on the medico industrial complex was a direct reference to the critique of the military industrial complex (of which the US was warned by Dwight D. Eisenhower in 1961).

Robb Burlage was working in the Institute for Policy Studies (IPS) when he undertook his analysis of the NYC 'affiliations' policy in 1967. One of the founders of the IPS was Richard Barnett who with Ronald E. Müller published *Global reach: the power of multinational corporations* in 1974.

The Health PAC Bulletin (and the books which were produced) nourished thousands of young health activists in the US and beyond for almost 30 years. While the civil rights movement in health (particularly the Medical Committee for Human Rights) and the women's health movement both found other outlets for their analyses and critiques the Health PAC critique was an important influence.

Many of the individuals associated with Health PAC went on to other forms of activism including teaching, research and writing and have shared and built upon the Health PAC critique. Barbara Ehrenreich who was 29 when she and John Ehrenreich edited *The American Health Empire* went on to become an influential women's health activist (see below) and well known writer.

#### *The new public health*

The new public health emerged as a heterodox school of thought within public health in the 1980s. The term 'new public health' was more widely used in Britain and Australia but was comparable in some ways to the emergence of 'social medicine' in the Americas, in particular, the Latin American school of social medicine.

The NPH was broadly characterised by its advocates as a new phase in the development of public health characterised by increasing concern for inequality and the social determination of health. A number of important developments in health policy were brought into the NPH tent including health promotion, the Ottawa Charter, 'the settings approach' (in particular, healthy cities), 'health in all policies', and, in some versions, the Alma-Ata Declaration on primary health care.

In some respects the new public health could be best characterised as a reform movement arising from outside the established institutions of public health. As a reform movement the NPH elaborated a critique against some of the prevailing assumptions and practices of (the 'old') public health (eg positivism, disregard for qualitative research, and preoccupation with specific causation without regard to social context). It also denounced the unproblematised and unrecognised class, gender and racial affiliations of the established public health. For a comprehensive coverage of the program of the new public health see Baum (2015).

Some of the heat has now gone out of these debates. Much of the NPH critique has been accepted by and integrated into the established institutions and communities of public health. Whereas health inequalities were once neglected by the establishment they are now recognised as a key priority (although the US establishment insists on calling them disparities rather than inequities). A whole new field of 'social epidemiology' has emerged, a recognition that in many countries 'epidemiology' had become primarily preoccupied with method.

A concern for the 'social determinants of health' has been recognised in WHO reports and resolutions, although the Latin American insistence on the 'social determination' of health has been hardly noticed in the Anglophone world.

Nevertheless, the positivist assumptions and top down indicator strategies remain prevalent in many sub-disciplines. The class, gender and racial affiliations of the established public health remain poorly recognised and often unaddressed.

In some degree the rise of austerity and instrumentalism in health policy has sapped the constituency that was most active in the debates

#### *Enabling conditions and continuities*

The new public health movement put equity on the research agenda in public health (social epidemiology) and the policy agenda (for example, through the Commission on the Social Determinants of Health). It has helped to challenge to the perceived legitimacy of the prevailing global regime, for its contribution to and tolerance of, health inequity.

It has provided a theory of practice for many PHC and community health practitioners and in this degree has contributed to the global social movement for health equity.

Perhaps the main significance of the NPH has been in its theoretical and ideological challenge to the complicity of the institutions of public health in the project of the ruling elite and the hidden presence of such assumptions (pointed out by Tesh in 1988).

However, with some exceptions, new public health advocacy has not been strong on political economy (in particular the application of class analysis in the globalised context) and has not generally elaborated a far going critique of neoliberalism and its impact on global health.

The theoretical critique and equity oriented advocacy associated with the NPH are still urgently needed; a deeper political economy analysis is also needed including globalisation and class and the debate needs to be taken out of academia into the clinic and community (as is happening in Latin America).

The conditions for the emergence the NPH in the Anglophone world included the expansion of academic research in public health and the entry of more qualitative and non-medical researchers; the emergence of a constituency in the community health movement; and the increasing focus of policy analysts on the conditions for better health; and their recognition of the limitations of bureaucratic (regulatory) public health in this work.

The Latin American school of social medicine reflects a different genealogy, including as it does, many academics who are or were closely affiliated with revolutionary forces (Waitzkin, Iriart et al. 2001). Accordingly it has a much stronger political analysis and community links than the NPH in the Anglophone world.

The need for a new public health was identified in different contexts in different countries but the common pattern was the rising challenge of 'life-style diseases' in the global North. The initial policy response involved behaviourally focused social marketing. However, as more academics, policy analysts and practitioners (eg in community health centres) became involved the limits to simple behaviouralism and the absence of useful theories and effective strategies became more obvious. The social distribution of illness and injury pointed clearly to the experience of poverty, powerlessness and alienation as important and fundamentally social factors driving much of the life style disease epidemic and was widely understood as explaining the limits to behaviouralism (often

referred to as 'victim-blaming'). However, a focus on social determinants and social change does not sit well with the political elites (nor the academic nor professional elites).

In this context the work of Thomas McKeown (McKeown 1979) was widely referred to as justifying a focus on environmental factors, indeed in some cases to the exclusion of access to health care from policy concern.

Trevor Hancock and Ilona Kickbusch brought health promotion to the world stage with the Ottawa conference on health promotion in 1986 and the Ottawa Charter which arose out of this (World Health Organisation, Health and Welfare Canada et al. 1986). It is significant that the Ottawa conference was co-sponsored by the European region of WHO, the Health and Welfare Canada and the Canadian Public Health Association. The Ottawa Charter gave an important fillip to the new public health in those jurisdictions where it had currency.

The Ashton and Seymour book, *The New Public Health*, in 1988 and later Fran Baum's *New Public Health* (2015, 3rd ed) have given further currency to the term and provided it with a more comprehensive theoretical base.

The heat has gone out of the debates; many of the slogans of the NPH have been taken up by the establishment. Marmot's work in the Whitehall studies (Marmot 1993) and later on the social determinants of health (Commission on Social Determinants of Health 2008) represents great progress since Thatcher tried to suppress the 1982 Black Report (Black, Morris et al. 1982). Marmot himself has argued cogently (Marmot, Allen et al. 2012) for the need for a global movement to address inequities in health.

Nevertheless, the veil of ideology continues to obscure the dynamics of injustice in health and possible strategies of challenge. While there is an appearance of consensus in some branches of public health the old positivism and instrumentalism continue to prosper in certain parts of epidemiology and in health economics.

Much of the controversy raised by the new public health was limited to somewhat restricted academic and professional circles. This is unfortunate because the critique needs to be more widely known. However the critique itself needs to expand to include a much stronger political economy perspective than hitherto.

#### *Access to medicines*

There is a wide range of issues associated with access to treatment including weak health systems and the lack of financial protection from the costs of health care.

However, our focus in this section is the global social movement which has emerged around the barriers to treatment arising from high prices of medicines due to high levels of intellectual property protection in the TRIPS Agreement and various bilateral and plurilateral trade agreements (PTAs).

Anti-retroviral treatment (ART) became available in the mid 1990s, just a short while after the conclusion of the WTO negotiations and the entry into force of the TRIPS Agreement ('t Hoen 2009). The international pharmaceutical industry had been intimately involved in the push for the inclusion of intellectual property protection in the Uruguay Round and the producers of the early anti-retroviral drugs were not backward in taking advantage of the newly strengthened IPRs to charge high prices for ART.

To many, including Dr Nakajima, it seemed that access to treatment would remain out of reach for the overwhelming majority of those living with AIDS in developing countries. Around this time the

originator companies were selling ART for around \$10,000 per treatment year while Indian generics manufacturers were selling it to MSF for \$350 per treatment year. In 1997 the South Africa parliament passed a new law for the procurement of medicines; sourcing brand name drugs internationally through cheapest supplier (parallel importation). In February 1998 39 pharmaceutical manufacturers sued South Africa arguing that the law contravened its obligations under TRIPS. From 1997-1999 there was continuing pressure on the South African Government including from the Clinton Presidency in the USA.

Meanwhile there was a growing mobilisation under the Treatment Action Campaign in South Africa (Heywood 2009, Robins 2010) and in the US under the leadership of ACT UP. During 1999 ACT UP dogged the Gore campaign over the Clinton administration's support for big pharma and against treatment access. From September 1999 US support for Big Pharma started to wane under this pressure. ACT UP and many other civil society organisations were active in 'battle of Seattle' around the meeting in that city of the Ministerial Council of the WTO. In 2001 Medics Sans Frontiers launched global petition against Big Pharma's lawsuit which collected 250,000 signatures.

In March, 2001 TAC was granted 'friend of court' status. TAC was at this time working closely with both MSF and Knowledge Ecology International (KEI) which were maintaining the campaign outside South Africa. In April 2001 Big Pharma withdraw their lawsuit and agreed to pay the government's legal costs.

In December 2001 the Ministerial Council of the WTO, meeting at Doha, affirmed that trade considerations should not over-ride public health and reaffirmed the legitimacy of compulsory licensing and parallel importation, the so-called TRIPS flexibilities.

Heywood describes the strategies and experiences of the Treatment Action Campaign (TAC) between 1998 and 2008. He describes how the TAC mobilized people to campaign for the right to health using a combination of human rights education, HIV treatment literacy education, demonstration, and litigation.

*As a result of these campaigns, the TAC was able to reduce the price of medicines, prevent hundreds of thousands of HIV-related deaths, but also to force significant additional resources into the health system and towards the poor.*

The access to medicines campaign has mobilised in many countries since 2001 including over the Europe India free trade negotiations (Bhardwaj and Lofgren 2012), the AIDS treatment movement in Thailand (Ford, Wilson et al. 2004, APN+ 2009) and Brazil (Nunn 2009) and the continuing debates around the proposed Trans Pacific Partnership (TPP) agreement (MSF Access Campaign 2012) and the Transatlantic Trade and Investment Partnership (TTIP).

The access to medicines (A2M) movement comprises many different policy streams and organisations in many different countries. Further sources include: (Smith, Correa et al. 2009, Archibugi and Filippetti 2010, Williams 2012)

#### *Enabling conditions and continuities*

The TAC and the A2M movement are extremely significant in tracing the emergence of a global Health for All movement. They exemplify:

- very local level struggles which are played out with full appreciation of the global dimensions of those struggles;
- the power of community involvement, most dramatically in the achievements of the treatment literacy movement;

- international collaboration of civil society organisations across many countries;
- the use of modern information and communications technologies; and
- the productive coming together of mass demonstrations with high level policy analysis.

The conditions which gave rise to the TAC and A2M appear to include:

- the devastating impact of AIDS in Sub-Saharan Africa and within the gay communities of many nations;
- the popular mobilisation traditions of democratic revolution in South Africa, including the role of health organisations in the anti-Apartheid struggle;
- the capacities of modern ICT technologies.

In terms of formative influences Heywood highlights the power of the human rights discourse in the TAC and the power of strategic litigation. The human rights discourse has also been prominent in the health care struggles of gay activists.

In terms of legacy influences the TAC remains iconic in terms of international solidarity in binding a global movement for Health for All (Basu 2010).

### Episodes around the health of populations, defined by shared identity

In this section our focus is on episodes and movements focused on the health of identified populations, arising from and contributing to a shared identity. Our focus in this section is restricted to comment on the labour movement, the women's movement and the civil rights movement in the US. (In a future version of this analysis we hope to include discussion of Indigenous health services in Australia, the disability rights movement, the struggles of the LGBTQI movement for access to appropriate health services and the research and commentary around inequalities (or 'disparities') in health.)

The emphasis in the commentary below is on the power of, and limitations, of identity based social movements. We draw some conclusions about the building of solidarity across difference as well as within a particular identity.

#### *The union movement and workers' health*

The union movement is one of the oldest examples of the social movement. The union movement as an aggregation of individuals and organisations who are committed to bettering the working and living conditions of workers through empowering workers to confront managers and employers regarding pay and conditions by organising workers in unions. Success in achieving such objectives depends on solidarity among members and on the workforce having real sanctions over employers, ultimately the withdrawal of labour.

The health risks associated with different kinds of employment are many and varied: injury, disease, alienation and poverty (low wages or unemployment). Unions have been critical in identifying the hazards of work and demanding safety and health protections including appropriate regulation.

As a social movement which has and is contributing to the emergence of a global social movement for health equity the history of union action is made up of many thousands of different 'episodes'. 'Episodes' such as black lung (Berman 1978), asbestos disease (Peacock 2009), repetitive strain injury, HIV and migrant labour, Bhopal, Fukushima and Rana Plaza evoke a sense of the magnitude of the health issues which are at stake as well as the barriers to a closer convergence between labour and other social movements for health equity.



Fantasia and Stepan-Norris (2004) insist that the labour movement is a social movement despite its highly institutionalised organisational forms. In certain circumstances leaders of the union movement seek to downplay tendencies to behave with the spontaneity and autonomy which is characteristic of a social movement. Thus the organisational expression of the movement both depends upon the collective identity but seeks to control, contain and steer that expressions. Further they insist on a relational perspective which recognises the context in which the labour movement operates and particularly the oppositional movement of the employers.

*On the basis of what we have learned about the labor movement, we would recommend that analysts of social movements focus less on the bounded social movement group per se, and more on the group's relationship to the larger configuration of institutional relations of power from which the movement develops and to which the movement therefore owes a good deal of its shape and character.*

This is an important insight.

#### *Employee risk is shaped by the power relations between capital and labour*

In many industries and work places there are sharp contradictions between profit and safety. Workers who are easily replaced with short induction periods are generally those who are least protected against injury and disease. Employees who have scarce expertise or who carry valued experience and corporate history can expect to be better protected and better cared for.

Union power is a threat to shareholder profit and a major responsibility of management is to discourage unionisation and to curtail union power. This includes lobbying (or blackmailing) governments for a legislative and judicial regime which restricts union power. The restructuring of mass employment as individualised contract labour has greatly weakened the power of organised labour.

Social democratic political parties with union links have played an important role in containing the employers' legislative agenda although this is complicated by the conflicting accountabilities many union officials face, arising from the close relations between union leaderships with their associated social democratic parties.

#### *Globalisation and ICTs: weakening the power of organised labour*

It has always been the case that some industries are harder to organise than others; for example, physically dispersed employment in the rural sector.

However globalisation and the developments in information and communications technology have greatly strengthened the hand of mobile capital over locally anchored labour. Trade and investment agreements since 1994 (properly called economic integration agreements) have greatly facilitated the growth and reach of transnational corporations with the capacity to source labour and other inputs from a range of different countries and to use the promise of investment to elicit concessions and subsidies from governments. Countries and workers are forced to compete for jobs and investment which greatly limits the capacity of unions to insist on adequate wages and safe working conditions.

With globalisation and increasing monopolisation of various industries transnational corporations have increased control over global value chains and an ability to force contract suppliers (and their workers) to compete with each other for diminishing margins.

Modern ICTs have strengthened the power of management over the production process vis a vis shop floor labour and have created new opportunities for exporting jobs and for dispersing workers.



In the context of jobless growth (crisis of overproduction) workers in different countries are forced to compete with each other.

*Estimating and managing the hazards of work involves managing uncertainty*

Some of the variables about which there may be uncertainty include: source of hazard, safe levels, exposure levels, chance and vulnerability, regulatory compliance, etc. Occupational health and safety specialists working for the employers often have greater access to knowledge about such matters than employees and unions. This is part of the power imbalance.

Government officials often have better access than workers and unions to such information but are not always able or willing to share it. Independent and academic researchers have sometimes played a crucial role in providing information to unions.

Union members would sometimes prefer to take danger money and gamble on risk rather than pursue prevention. For low income workers the immediate certainty of an increase in pay versus the more distant and uncertain possibility of safer work is a no brainer.

*The health and safety of the unemployed, informal workers and precariously employed*

Unions are not so good at looking after workers in the informal sector, the unemployed or the precariously employed who may move between jobs including periods of unemployment. The threat of withdrawal of labour is not strong in such circumstances.

Lee (2014) describes how the implementation of neoliberal policies in South Korea has fragmented, stratified and marginalised labour in both the market and the political sphere. An 'insecure class' has emerged, consisting of irregular workers and the low-income self-employed with precarious labour conditions, bare social protection coverage, and frail organizational/political representation.

*Strategies*

International unions have existed for a long time but have limited power vis a vis transnational corporations. This is partly because of the challenges of building transnational solidarity but partly because workers in different countries are being actively forced to compete with each other (Bieler, Hilary et al. 2014).

Choudry (2014) has argued that in the context of debates over trade and investment agreements there is a need for stronger alliances between the union movement and other social movements. This has been described as social unionism.

However, Hilary (2014) argues that:

*the predominant stance of European trade unions has been to support the free trade agenda promoted by the European Union, while calling for social conditionalities to offset its most negative impacts.*

Hilary concludes that the strengthening of transnational labour solidarity will remain unrealised as long as “the instrumental priorities of trade union structures are allowed to drown out the expression of a more transformative class politics”.

Zamponi and Vogiatzoglou (2015) describe the impact of austerity and the wider neoliberal global order on unions and the political power of labour in Italy and Greece. They recognise the weakening of the unions and loss of trust but highlight some projects which might point to different ways of working.

Hurt (2014) explores the complexities involved in developing some kind of global social movement unionism through a case study of COSATU in South Africa. Hurt points to ambivalence regarding global free trade versus preferential South-South trade at both the national and international levels which limits the development of both social unionism and South-South union solidarity.

#### *Enabling conditions and continuities*

The health implications of work, both positive and negative, are huge. Organised labour has a critical role to play in the struggle for health equity. The labour movement also has a critical role to play in any convergence around health equity globally. Many unions have played a powerful role in struggles over social and environmental issues as well as pay and conditions including health and safety at work. The vision of a powerful global social movement around health equity is significantly dimmed if it does not include the organised labour movement.

The impact of globalisation and modern ICTs on the industrial and political power of labour underscores the importance of building transnational solidarity and forging new alliances between labour and other social movements.

The union movement also provides an important case study of the relationship between a social and a political movement. The achievements and difficulties of the union relations with social democratic and other political parties has lessons for social movements generally.

The conditions for successful action on health and safety through the labour movement involve first the conditions for successful unionism and second the conditions for effective action on occupational safety and health.

The conditions for successful unionism include: democracy, political freedoms, legislative protection of labour rights, and union bargaining power (stemming from a robust demand for labour and the capacity to deploy the ultimate sanction of withdrawal of labour).

The conditions for effective action on occupational safety and health include access to information, a well trained union based cadre of occupational health and safety experts including medical, legal, hygienist, and shop floor representatives.

Labour mobilising, including around occupational safety and health, is able to draw on a rich tradition of analysis and struggle. The representative 'episodes' cited earlier illustrate the range of industrial dynamics shaping workers' health and many of the strategies which have helped to address the health hazards of employment.

The traditions of labour organising, nationally and internationally, industrially and politically, and around workplace issues and broader social issues, will continue to inform health activists in the labour movement.

However, there are big challenges facing the union movement associated with globalisation in particular and the analyses and strategies to address these will need to draw on experience from beyond as well as within the labour tradition.

#### *Women's health*

The special relevance for women, of health care and the conditions which shape population health, are well laid out in Fee (1983) and Murthy and Smith (2009) amongst many others.

Fee structures her collection around: women's health care experience (papers on convenience induction of labour and iatrogenic vaginal cancer); women in the health care labour force; women as

workers (pay, conditions, occupational hazards); health care and social control (birth control, patriarchal violence); and the social construction of knowledge.

Murthy and Smith structure their collection around:

- gender based violence, conflict, discrimination, terrorism and trafficking;
- economics and human rights;
- health problems specific to women, including chronic disease and global burden;
- cultural practices, environment and migration; and
- challenges and progress.

Reproductive choice was a central demand of first wave feminism from early on. Angela Davis quotes an 1850s essay by Sarah Grimké, one of the early US feminists, in which she argued for a 'right on the part of woman to decide when she shall become a mother, how often and under what circumstances' (including the right to sexual abstinence).

The rights of women at this time were constrained by their exclusion from electoral politics and hence the campaigns of the suffragettes (see, for eg, Whitfield 2001) and by the legal doctrine of coverture which enshrined the ownership of the wife by the husband. Charles Reid (2013) describes the role of the early feminists including Mary Wollstonecraft (1759-1797) in England, and Sarah Moor Grimké (1792-1873) and Elizabeth Cady Stanton (1815-1902) in the US in campaigning for equality and women's rights. The struggle for legal equality was a necessary strategy to address the issues of reproductive choice and freedom from violence.

The development of the international women's health movement is traced by Desai (2005). Desai recalls how women's health organisations (and a broader women's health consciousness) grew out of second wave feminism in the 1970s in the global North while in the global South women were playing an increasing role in nation building and development in the optimism of the long boom. However, these were somewhat different movements with limited interconnections.

Three iconic publications symbolise the revolutionary changes being driven by the women's health movements in the global North. These are *Our bodies ourselves* by the Boston Women's Health Collective (Boston Women's Health Book Collective 1973, Heather and Zeldes 2008) and two pamphlets by Barbara Ehrenreich and Deirdre English: *Witches, Midwives, and Nurses: A History of Women Healers* (1972) and *Complaints and disorders: the sexual politics of sickness* (1973).

Dorothy Broom (1991) has provided a political history of the development of women's health centres in Australia which captures the development of the movement and the establishment of an alternative sector of health care delivery. Wilson and her colleagues (1998) have documented some of the community development projects implemented during this time; addressing the social determinants of women's health before the term was coined.

Meanwhile as Desai tells it women's health activists in the global South were working in a range of settings from the community development projects described above, to campaigning for democratic rights, to policy reform in access to birth control and education.

This separation of women's health movements in the global North and South was to change with the International Decade of Women from 1975 and the women's world conferences in Mexico City (1975), Copenhagen (1980) and Nairobi (1985). These conferences provided the opportunity for women's health activists from around the world to 'debate as well as share meanings and strategies'. Desai describes how richer communication links and networking emerged, focusing in

shared issues such as reproductive rights and violence. The Women's Global Network on Reproductive Rights was formed in 1978 and the International Women's Health Coalition in 1984.

During the 1980s and 1990s the activists and organisations which supported the global advocacy of the international women's health movement were increasingly active around the UN in conferences and declarations. Particularly important were the Cairo conference on population and development in 1994 and the Fourth World Conference on Women in Beijing in 1995.

Very significant achievements were gained during this time, in both the global South and North. However, the debt crisis of the early 1980s and the brutality of the IMF's structural adjustment policies had a devastating impact on women (as well as men), particularly in the poorer communities in the global South. The impact of structural adjustment on food costs and the drive to privatise health care both had a serious impact on women's health. Meanwhile the rise of neoliberalism in the global North was leading to some similar outcomes with privatisation of health care, economic stagnation and austerity.

Neoliberal globalisation sets the background to the current concerns of the international women's health movement. Many scholars have commented on the implications of globalisation for women's health.

Leslie Doyal (2005) discusses globalisation in terms of the 'dramatic increase in the volume and speed of economic, financial, technical, and cultural interchanges between different countries'. She emphasises the importance of the global restructuring which is accompanying these interchanges. She notes that much of the work on globalisation has been gender blind and proceeds to review, first, the ways in which gender relations shape the impact of globalisation on human health; and second, how globalisation of health affects gender relations.

Wamala and Kawachi (2006) recognise both positive and negative effects of globalisation on women's health but emphasise the inequitable distribution of such impacts across women in different countries and groups. They conclude that the 'need for gender-equity-oriented macroeconomic, trade, and labor market policies remains an urgent priority for the future course of globalization'.

Razavi and her colleagues (Razavi, Arza et al. 2012) focus on employment and social protection in their discussion of the gendered impacts of globalisation. They discuss

- trends in women's employment; labour markets as gendered institutions and constraints to improved labour market outcomes for women
- the impact of policies associated with globalization (including financial liberalization, inflation targeting, trade liberalization, public sector reforms)
- a broader development agenda that enhances gender equality (including policies and practices to improve labour market outcomes for women; social protection policies and programmes aim to address workers' living standards and economic security; improvements in social insurance design and financing and social assistance programmes)

The focus of Mohindra and her colleagues (Mohindra, Labonté et al. 2011) is on the impact of the global financial crisis on women's health. They review the gendered impact of financial crises over two decades and find that national and international policy settings can magnify or mitigate the gendered health-negative effects.

#### *Enabling conditions and continuities*

The women's health movement constitutes a major component of both the women's movement generally and the Health for All movement at both the national and international levels.

In many ways it is a paradigmatic case of a social movement: a community of individuals and organisations, held together by a sense of shared identity (to some degree), shared concerns (in some degree), a shared analysis (to some degree) and with rich communication links. Our project, learning from the history of the health equity movement has much to learn from the history and experience of the women's movement.

Feminist theory (see for eg: Weedon 1987, Smith 1990, Alcoff and Potter 1993) has much to offer the analyses and strategies of the health equity movement. One set of powerful insights are centred around the mutually constitutive relationships between a patriarchal ideology which normalises male privilege; a set of institutions, which realise, reflect and reproduce male privilege; and the speech and practices of everyday life, which sustain those institutions and which reproduce and are framed by the ideology. The institutions of health care and the speech and practices of health care have played a powerful role in reproducing patriarchy and the ideology of male supremacy.

Ferree and Mueller (2004) point out that patriarchy and gendered roles and relationships also characterise many social movements and suggests that part of the feminist agenda is to challenge such assumptions and practices.

Desai's account of how the women's health movements of the global North and the global South converged in an international women's health movement is a useful precedent in terms of thinking about the convergence of a global health equity movement.

The changing face of feminism offers several useful insights. The transition between the singular identity of early second wave feminism and the later politics of difference (Young 1990, Gunew and Yeatman 1993, Yeatman 1993, Weedon 1999) has powerfully informed thinking about social movements based on identity. Middle class white women were criticised by women of colour, lesbians and disabled women for projecting a singular subject position which did not appear to have a place for difference. The 'politics of difference' has encouraged more careful thinking about the personal practices involved in working across difference and the theoretical challenges of recognising multiple and fluctuating identities in political analysis and strategy. One of the outcomes of this discussion is a recognition that subjectivity is shaped by social context as well as individual characteristics. The subjectivity which determines practice may be woman in one context, person of colour in another, and professional in another. However, in many situations several of these multiple subjectivities are intersecting in the determination of practice (Yuval-Davis 2006). How the social movement addresses this intersection in its analysis, its culture and its practice, can be critical in determining its success and indeed its survival (Cockburn and Hunter 1999).

Another aspect of the changing face of feminism has been the declining enthusiasm for militant feminism in the middle class constituencies where it was so strong in the 1960s to 1980s. Hester Eisenstein (2010) has written of *feminism seduced* into an acceptance of globalisation and the neoliberal world view.

*In short, the women's movement created a successful 'bourgeois revolution' for women in the United States. While the English, French and American revolutions of the seventeenth and eighteenth centuries replaced feudal relations with the rule of the white bourgeoisie, these revolutions notoriously did not extend to the rights of women, people of colour or those without property. It took the nineteenth and twentieth century women's movements to claim the rights of women as full citizens. This unfinished revolution now seemed complete: women, especially women in the middle class, could escape from the category of 'only' wife and mother into the world*

*of the competitive, individualistic market. ... [T]he dominant mainstream version [of feminism] emphasised women as self-sufficient individuals.*

*... capitalism in its twenty-first-century version within the United States was profoundly welcoming to women. ... The media both absorbed and shaped the ideas of the feminist movement of the 1970s, adapting it to the needs of consumer capitalism. They created the idea of the 'first woman', virtually encouraging the women interviewed as pioneers in male-dominated areas of work to renounce the energies and the political achievements of the women's movement in catapulting them into these new positions. Typically such a woman pioneer was expected to say, in response to interview questions, 'No, I'm not a feminist, I don't burn my bra, I just want to do a good job.'*

The early socialist feminists claimed that patriarchy was irrevocably imbricated with capitalism (see for example, Zillah Eisenstein 1999). However the renunciation of feminism by younger middle class women suggests that class and gender are not so linked; that the achievements of the women's movement have weakened the gender contradictions in the upper and middle classes and perhaps contributed to a stronger class solidarity in those classes (and weakened the potential for gender solidarity with women in the developing world).

What were the conditions for the emergence of the national women's health movements and then for the convergence in the international women's health movement?

First wave feminism is closely linked with the early struggles for democratic rights (and the rights of man, see Reid 2013) including the demand for electoral representation and the right to vote. The struggle for democratic rights (the struggle to contain the privileges of the sovereign) was closely linked with the early stages of capitalism and the struggle for economic freedom for the entrepreneur. For the suffragettes it was a struggle to contain the privileges of the husband and father and the right to control reproduction as well as the right to vote.

The conditions for the success of second wave feminism include: the legacy of women in industry during WWII; the material security of the 'long boom'; mechanisation and automation of work and the rise of the services sector (and employment opportunities); and improved technologies for contraception. The conditions for the development of national women's health movements, as part of the second wave, include the restive sentiment of the 1960s, the increasing power of medical technologies, and the increasing focus of academic sociology on health, partly linked to the move of nurse education from technical colleges to universities.

The conditions for the convergence of national women's health movements into an international women's health movement include the rising power of the post-colonial independent countries of the global South, and advances in communications and travel.

*Our bodies ourselves* had a big influence on the women's health movement in the global North during the 1970s. However, in many ways it was an expression of what was already happening in many different places rather than an original source.

Reproductive choice had been a central demand of first wave feminism from early on. In view of the role of women in health care and the exposure of women to the medical system, it was predictable that as health care technologies developed there would be some specialisation within the women's movement and the emergence of a women's health movement.

Notwithstanding the pessimism of Eisenstein (2010) regarding the seduction of feminism, there remains a powerful feminist presence within the global health equity movement which has not lost its militancy.

*Race and health: the civil rights movement in the US and the Medical Committee for Human Rights*

Contradictions across race have been part of the independence struggle in many parts of the world (discussed further below) but our focus in this 'episode' is on race and health in the global North, through a reflection on the civil rights movement in the US and the role of the Medical Committee for Human Rights (MCHR) in that struggle. It is difficult to generalise from this case / 'episode' to other social movements around race and health; circumstances vary widely across different countries (see, for example, Bourne 2001, who discusses institutionalised racism in Britain through a reflection on the Stephen Lawrence case). Our purpose here is to reflect on the specifics of the civil rights story and explore possible implications for building and converging a global movement for health equity.

*History of civil rights movement in the USA and the role played by the MCHR*

The civil rights movement in the US (McAdam 1982, Morris 1984, Garrow 1989, Dierenfield 2013, Wilson 2013) comprises thousands of different episodes of struggle including the heroism of the activists who returned time after time to face down the vigilantes, police and state troopers in demanding their rights, fully expecting more shootings, beatings and often torture. The movement also includes the community leaders who inspired communities to march, to boycott, to sit in. It includes the lobbying in Washington which put in place new civil rights laws and the advocacy through the courts to lock in the gains.

The movement also includes the mobilising, demonstrating, emergency care and service development of the MCHR and the organisations and individuals who worked with the Medical Committee for Human Rights (MCHR) Dierenfield's (2013) detailed chronology of the civil rights movement from 1865, the conclusion of the Civil War, through to 2003 provides a useful background against which to review the work of the MCHR which operated for 11 years, from 1964 to 1975 (Dittmer 2009).

MCHR started out in 1964 as a group of progressive New York male physicians all of whom had previous engagements with progressive causes. They were responding to the dire need of civil rights workers in the South who were facing on going brutality, murder, prosecutions and threat.

Initially MCHR accompanied demonstrators and provided first aid and a 'medical presence'. Soon they were being challenged to provide basic health care to poor black people in the South. Out of this came the Tufts Delta CHC in Mound Bayou (see earlier) and other OEO health care programs. MCHR had staff in Jackson and other cities who provided first aid but also worked with other civil rights organisations to build community health committees at the local and county level.

One of the specific areas MCHR worked on concerned the desegregation of hospitals both in terms of patients accessing decent facilities and clinical privileges for black physicians. This latter question had been an issue for the (black) National Medical Association for a long time. The AMA's position was any physician who was a member of their state and county affiliates should have clinical privileges. However the AMA took no action in relation to affiliates who refused to accept black physicians as members and therefore could be denied clinical privileges without any AMA objection.

Both the segregated wards and the exclusion of black physicians only changed when the Federal government, under pressure from the NMA, MCHR and other organisations, moved to implement

civil rights laws which would deny federal funds to hospitals, universities, local government and other organisations practising Jim Crow.

The achievements of the civil rights movement have been huge and the MCHR contributed to those achievements.

In a memoir on the transformation of the University of Mississippi Medical Centre deShazo and colleagues (deShazo, Smith et al. 2014) recall the request of the National Medical Association for access to academic facilities at the UMMC, a request which was denied. The UMMC did provide medical care to the sick and injured Freedom Riders, and sit-in and demonstration participants but was slow to desegregate until national controversy over the role of the UMMC in the autopsies of the three murdered civil rights workers Michael Schwerner, James Chaney, and Andrew Goodman. The initial autopsy was reported as showing no evidence of beatings but simply the bullet wounds. When finally an independent autopsy was achieved it showed that James Cheney, the only black of the three had been horrifically beaten. This did not reflect well on the UMMC.

In 1965 the NAACP Legal and Educational Fund lodged a federal civil rights complaint against UMMC noting that UMMC was not compliant with the Civil Rights Act of 1964 in relation to desegregation. This law suit had big financial implications for the Medical Centre for it threatened its federal health care funding and academic funding. deShazo and colleagues describe how the UMMC proceeded to unwind Jim Crow and go on to claim that 50 years later “UMMC has become arguably the most racially integrated academic health center in the United States”.

A less optimistic reflection on progress in race relations in the USA might be derived from a report by Miller in 2013 discussing the hyper-incarceration of black people.

#### *Enabling conditions and continuities*

The US Civil War, 1861-1865, was fought in part around the abolition of slavery. 100 years later a brutal segregationist regime prevailed in the South.

The forces opposing desegregation were very powerful and willing to use extreme brutality to suppress the civil rights movement. Jim Crow would still be in place in the South now if thousands of very brave activists (including health care workers) had not been willing to put their bodies on the line (and scores paid for it with their lives). Employers of black workers feared that civil rights would increase their wages bill. White workers feared that desegregation would jeopardise their jobs. These fears were invested in a cloak of racist stereotypes and hostility dating back to slavery.

The strategic focus of the marchers and demonstrators was not the state governments of the South. It was the Federal Government and beyond it the various constituencies to which the federal government was accountable. These constituencies included the liberal constituency of the North, but importantly also included the political leaders of the newly independent countries of the Third World and of Africa, in particular.

In the end it was federal civil rights laws and the threat of not being able to access various federal funding programs through which desegregation was achieved but it was at the cost of the blood of marchers, sitters-in and voter registrationists.

Northern volunteers, including the MCHR volunteers, played a significant role in challenging the Southern elite and demanding federal action. However, the contradiction between black power and white solidarity, and the rising focus of progressive attention on the Vietnam War, reduced the flow of volunteers in the late 1960s. The radical momentum within the black community reflected an impatience with the strategies of Dr King and the reluctant minimalism of federal legal concessions.



A range of contradictions across identity progressively weakened the MCHR. It started out as a white, male professional movement. Progressively it confronted black professionals in the NMA, nurses and other non-medical health care practitioners, women, and younger radicals. There are clearly lessons here regarding both the culture and practices of 'working across difference'. However, some of these tensions were inevitable insofar as the status and authority of white male physicians (deployed as 'medical presence') was derived through the structures of a racist, classist and patriarchal state.

The sectarian politics which finally led to the end of the MCHR may hold lessons for future movement building in terms of the relation between political movement (in this case various forms of left politics) and the social movement.

The ambivalence regarding the Vietnam War of MCHR leaders and leaders of the NMA, NAACP and the Urban League in 1966 (Dittmer 2009, p145-7) reflects the distance between the civil rights struggle and the struggle in other parts of the world against US imperialism. Dittmer (p146) reports David French, the last black chair of MCHR as saying that the black freedom struggle was what MCHR was all about and that he resented "the group of people who had an additional cause, which would supersede that mission. As far as I was concerned [the Vietnam resolution] was a red herring and not in our best interest."

One final feature of the Dittmer story which is worthy of comment is the significance of individuals as well as organisations. Dittmer provides short biographies of many of the individuals who played prominent roles in the civil rights movement and the health-related struggles, including Bob Smith, Aaron Shirley, H. Jack Geiger, June Finer, Jane Kennedy, and many more. There is an important message here about the agency of the individual as part of the movement.

The conditions for the emergence of the civil rights movement were several but the insufferable poverty, brutality and indignity of Jim Crow stands out. The solidarity of many Northerners, black and white, was a key asset in terms of supporting the struggle and in putting pressure on federal politicians.

The urgency with which the founders of the MCHR took up the challenge to support the movement, including through reform and innovation in the health system, reflects the solidarity of many middle class progressives in the North. The fact that many of the MCHR activists were Jewish speaks to both the culture in which they grew up.

One of the most salient influences on the civil rights movement was the school of non-violent resistance of Ghandi (Chabot 2002). During the period of MCHR activity the rise of Black Power and the New Left greatly influenced the MCHR trajectory. Lessons from the period covered by this 'episode' continue to inform the anti-racist struggle in the US and beyond.

### Social and environmental determination of population health

Under this heading we include a range of more or less specific health hazards or fields where such hazards can arise. In the original scope for this study these 'episodes' included: urban sanitation during the industrial revolution in England, the adoption of the Framework Convention on Tobacco Control, the marketing of breastmilk substitutes, food sovereignty, extractivism, buen vivir, and environmental movements.

Unfortunately it has been possible to complete only the first two of these 'episodes' for this report.

### *Industrial revolution in England*

The living conditions of ordinary people in the cities of industrial revolution England were appalling (Engels 1845/1969) but progressively improved over the following century.

Many different stories are told about the struggle for health during this period. These variously focus on great persons (Chadwick, Snow, Nightingale, etc), the institutional structures of public health (sewerage, clean water, building by-laws, central/local board of health, etc), medical care, and progressive improvements in housing and food supply associated with economic development and rising incomes (McKeown 1979).

The main author who emphasises the role of civil society engagement in the struggle for health is Simon Szreter who links the delay in sanitation to the reluctance of the rising capitalist class to agree to higher municipal rates (associated with their ability to live apart from the filth). However, with the second reform act of 1867 parliamentary and municipal suffrage was extended to many working class men and some women, the sentiment of the electorate turned much more supportive for the construction of sanitation.

Szreter (1988) is the definitive presentation of his critique of McKeown and his alternative analysis to the effect that public health regulation (including housing and food) and infrastructure development (in particular water supply and sanitation) played a major role in the health improvement from the 1870s.

Szreter argues (2004) that the struggle towards universal suffrage was critical in changing electoral sentiment and finally driving the infrastructure needed for urban hygiene.

*After delaying for as long as they dared, from 1867 to 1928, in response to organized male working-class and subsequent feminist political pressure, the British propertied governing class passed a sequence of four major enfranchisement acts which ultimately granted the vote to all adults of both sexes on an equal basis. From 1867 onwards, this began to transform the electoral arithmetic and the politics of the health and social security needs of the wage labour class in society. The shift in political economy occurred first at municipal level. Under its visionary Mayor Joseph Chamberlain, an industrial magnate, the city of Birmingham pioneered a programme of 'gas and water socialism' as its opponents vilified it. Local monopoly services were bought, built and run by the city to provide revenue for an expanding preventive health and social services infrastructure. Once Chamberlain had proved both the electoral and the practical viability of this new political economy, all other major cities and eventually smaller towns, too, followed suit over the next three decades. The towns were beautified but also, crucially, the urban death-rates came tumbling down as local authorities' expenditure on the health and environmental needs of their mass electorates multiplied to the point where in 1905 the total amount spent by vigorous local governments actually exceeded (for the only time in Britain's recorded history) the total spent by central government.*

In Szreter (2003) he provides an excellent overview of the population health approach with mentions of the US and French experience as well as more detail regarding the British experience. He draws useful parallels between the bourgeois resisters of public health regulation and infrastructure during the industrial revolution and the Washington consensus. "Significant health improvements only began to appear when the increasing political voice and self-organization of the growing urban masses finally made itself heard, increasingly gaining actual voting power from the late 1860s onwards (a process not completed until 1928)."

### *Enabling conditions and continuities*

The living and working conditions in 19<sup>th</sup> century English cities and towns and the progressive improvements in living conditions associated with regulatory reform and infrastructure development are widely referred to in the education of public health practitioners world wide. While England was the first to go through such changes the experience of industrialisation in Germany, France, the USA and Russia was comparable in many ways.

The role of the suffrage movement in England in driving improvements in the regulation of work and in urban infrastructure was paralleled by the revolutionary demands of workers in France and Germany. The significance of revolutionary threat in driving Bismarck's social security reforms in the 1880s has been widely noted (Saltman and Dubois 2004).

Szreter comments that McKeown's ideas have been widely deployed in support of the Washington Consensus and neoliberal austerity because they emphasise that economic growth will finally deliver a better life; a variant of 'trickle down' development. This emphasis on economic growth discounts the significance of policy choices (such as regulatory reform) and political dynamics (such as democratic accountability).

(McKeown had argued that health improvement in the latter part of the 19<sup>th</sup> century reflected improved nutrition and housing which in turn reflected gradually improving economic circumstances. It has to be acknowledged that McKeown saw himself as arguing against the hubris of clinical medicine which at the time he was writing (from the 1950s) was seen to be claiming an overwhelming role in health improvement.)

The 'episode' we are considering here can be defined as the struggle for universal suffrage in the provincial cities of industrial revolution England. Electoral reform in turn drove regulatory reform and infrastructure development and contributed significantly to improving population health in the latter half of the 19<sup>th</sup> century.

It is beyond our scope to speculate on the formative influences which shaped the suffrage movement in England and the dynamics of institutional change that this brought about.

As Szreter points out the legacy of this 'episode' remains contested as between the promise of trickle down economic growth versus the agency of social and political movements in driving institutional reform.

### *The Framework Convention on Tobacco Control (FCTC)*

For the purposes of this study we are treating the adoption of the FCTC (WHO 2003) as an 'episode'. The 'conditions' which enabled the adoption of the FCTC are of particular interest in terms of the role of civil society engagement.

The immediate circumstances which led to the adoption of the FCTC have been described by WHO (2009) and by Roemer and colleagues (2005). Initially the WHO Secretariat, under Dr Nakajima, was opposed to the proposed Treaty but when Dr Bruntland was elected she threw her weight behind the Convention.

Yach and colleagues (2006) locate the adoption of the FCTC as a response to the globalisation of the tobacco industry. The global coherence of tobacco industry strategy has been well exposed in the 'tobacco industry documents' (Malone and Balbach 2000, Bero 2003) released variously by a whistle-blowers, Congressional hearings and various court settlements. Bero comments that:

*the documents provide information that is not available from any other source and describe the history of industry activities over the past 50 years. The documents show that*

*the tobacco industry has been engaged in deceiving policy makers and the public for decades.*

#### *Enabling conditions and continuities*

The disease burden associated with tobacco use is widely understood (WHO 2008).

The FCTC as an 'episode' in this study gains added significance as one of only two binding legal instrument adopted under the aegis of the WHO and one of very few international instruments directed at health objectives.

In the context of globalisation (as described by Yach) and the role of the highly processed (and globalised) food industry in driving the NCDs epidemic and the increasing role of trade agreements in making international law (Gleeson, Tienhaara et al. 2015), the precedent provided by the FCTC is highly significant.

A full account of the conditions which enabled the adoption of the FCTC is beyond the scope of this study but we identify in note form some of the main conditions.

At the immediate institutional level the role of Ruth Roemer and other individual champions should be acknowledged including the commitment of the Director-General Dr Gro Harlem Brundtland.

However, the adoption of the FCTC was in effect the culmination of a long and varied struggle over tobacco control in many countries. Without the numerous previous struggles the awareness and commitment would not have been there for the adoption of the FCTC.

One of the critical areas was the biological and epidemiological research which progressively demonstrated the contribution of tobacco smoking to cancer and then heart disease and then the risks of second hand tobacco smoke. Musk and De Klerk (2003) provide an overview of this research.

*Tobacco comes from plants that are native to the Americas around Peru and Ecuador, where it has been found since prehistoric times. It was brought back to Europe by early explorers where it was adopted by society and re-exported to the rest of the world as European colonization took place. Smoking tobacco in pipes of one sort or other gave way to handmade and then manufactured cigarettes, especially during the First World War. Smoking rates increased dramatically during the 20th century in developed countries until recently and rates are still increasing in underdeveloped countries. An epidemic of smoking-related diseases has followed the prevalence of smoking. Scientific knowledge of the harmful effects of active tobacco smoking has accumulated during the past 60 years since early descriptions of the increasing prevalence of lung cancer. The first epidemiological studies showing an association between smoking and lung cancer were published in 1950. In 1990 the US Surgeon General concluded that smoking was the most extensively documented cause of disease ever investigated but governments worldwide have been ambivalent and slow in taking action to reduce smoking. Tobacco smoking is now agreed to be a major cause of a vast number of diseases and other adverse effects. Since the 1980s passive smoking including exposure in utero has also been implicated as a significant cause of numerous diseases. In response, the tobacco industry has managed to forestall and prevent efforts to control this major health problem.*

The dissemination of this knowledge was greatly assisted by official reports such as that of the Surgeon General and by publicity driven by various medical associations. The simple act of

monitoring smoking rates, initially as a research activity but later as part of national statistics, has also contributed to building awareness.

Chapman and Wakefield (2001) have reviewed the Australian experience in tobacco control and identified a wide range of strategies which have contributed to tobacco control including:

- harm reduction strategies (eg measurement and publication of tar and nicotine content),
- progressively more comprehensive advertising bans,
- progressively more graphic pack warnings,
- mass reach campaigns,
- banning smokeless tobacco,
- banning of small packs (“kiddie” packs, < 20 sticks),
- tax increases to drive price disincentives,
- replacement of sponsorship (buying out tobacco sponsorships),
- smoke-free workplaces, restaurants, public transport and domestic environments.

Chapman and Wakefield focus on two of these achievements exploring first, how the move to smoke-free indoor environments was driven, and second, how tobacco advertising came to be banned. Some of the drivers of the smoke free indoor environments included:

- publicity to expert reports on the risks of passive smoking;
- litigation (employees suing employers who conducted smoke filled businesses);
- airlines responding to customer preference;
- opinion polls showing increasing support for smoke free environments.

Among the drivers which led to the banning of tobacco advertising, Chapman and Wakefield list:

- a six year campaign of civil disobedience by health activists involving billboard graffiti
- demonstrations outside tobacco sponsored media events; and
- the buy out of tobacco sponsorship of sporting and cultural performances

Chapman and Wakefield argue that active community involvement in tobacco control has played a relatively minor role compared with professional public health advocacy. However, it would be a mistake to downplay the millions of informal conversations which contributed to changing public opinion (which was instrumental in emboldening the politicians) and the progressive change in attitude and practice, among both smokers and non-smokers, about ‘not smoking inside’. There was an active agency associated with changing community attitudes and practices; not to be reduced to a passive constituency being educated by the advocates.

Changing community attitudes both reflected and contributed to the progressive implementation of tobacco control measures, including the negotiation of the FCTC.

Among the formative influences contributing to the FCTC, the inclusion of treaty making powers in the 1948 WHO Constitution stands out. The FCTC was not the first attempt to use the treaty provisions; earlier attempts were made in relation to the ethical promotion of medicines and the marketing of breastmilk substitutes, but in both cases were defeated.

In the context of the widespread inclusion of investor state dispute settlement provisions in trade and investment agreements (Gleeson, Tienhaara et al. 2012) the legal mandate provided by a binding treaty may prove increasingly important, in particular in relation to the food industry and the challenge of controlling and preventing NCDs.

## 'Episodes' of civil society engagement and movement convergence

We have reviewed a range of different 'episodes' of civil society engagement which together trace out the development across time and space of the global Health for All movement. However, this is a very heterogeneous collection. Our central interest is in the convergence of different streams of civil society engagement into a broader movement for health equity and as part of this concern we have asked about 'patterns of influence' (legacies, continuities) through which particular 'episodes' have contributed to the development of a broader movement.

On this basis we have developed an alternative approach to categorising these different 'episodes' in accordance to patterns of influence (and the processes of 'convergence'). Four categories of 'engagement' which have emerged from this analysis of our 'episodes' are:

1. Engagements which were or are largely country-specific but have inspirational / iconic status globally;
2. Engagements which were nationally focused but which attracted international solidarity (including, in particular, anti-colonial, anti-imperial, pro-democracy struggles);
3. Engagements which have been worked through in parallel in many different settings, but have involved the sharing of experience across communities of interest spanning different countries; and
4. Engagements which reflect in significant degree common global drivers and call for shared strategies globally.

This typology corresponds to a range of other surveys, most notably the work of Smith (2002) in describing the different constituencies involved in the Battle of Seattle in 1999.

### *Engagements which were or are largely country-specific but have demonstrable inspirational / iconic status globally*

In this category we include civil society engagements which were organised nationally (or sub-nationally) and which addressed issues and conditions which were largely country-specific but which have acquired inspirational / iconic status internationally. Their contribution to the global movement for 'health for all' arises from their iconic and inspirational status; iconic because they are well known and commonly referenced; inspirational because they give hope and confidence.

Examples: Pholela, Jamked, NHS, barefoot doctors, the mitanins and BUGA UP.

In many respects country-specific engagement remains the most important mode in terms of delivering HFA. For every iconic episode there are thousands of local struggles based on local activism.

Perhaps the simple conclusion here is the importance of sharing the experience of struggle across boundaries; adding to the collection of icons and inspirational stories, building hope and confidence; moving isolated local struggles into category 3 below: engagements which involve the sharing of experiences across communities of interest, spanning different countries.

### *Engagements which were nationally focused but which attracted international solidarity (including, in particular, anti-colonial, anti-imperial, pro-democracy struggles)*

In this category we have included civil society engagements which were nationally based but which gained international significance through solidarity action.

These engagements included diverse anti-colonial, anti-imperialist, and pro-democratic popular struggles, from the Spanish civil war, to the resistance movements of Central America, to the anti-Apartheid struggle. Health issues were important in all of these episodes.

This sort of solidarity action is critical in building the global Health for All movement. The Birn and Brown collection 'Comrades in Health' (Birn and Brown 2013) provides a very useful source for exploring forms of action which express such international solidarity.

*Engagements which have been worked through in parallel in many different settings, but have involved the sharing of experience across communities of interest spanning different countries*

In this category we have included examples of engagements which have been worked through in parallel in different settings but where there has been considerable exchange and learning from shared experience between activists in different countries. See Giugni (2002) for a more extended discussion of the diffusion of analyses and strategies across boundaries.

Chabot (2002) has described how the strategy of non-violence travelled across time and space from the independence struggle in India to the African American civil rights movement in the 1960s. Hanagan (2002) traced a different form of diffusion mediated by Irish emigration and a cultural tradition of political activism.

In this study the Women's health movement and AIDS/HIV movement are powerful examples of movements in different countries sharing analyses and strategies. This dynamic has not been so strong in relation to health care advocacy.

Supporting this kind of international sharing is an important role for an organisation like PHM.

*Engagements which reflect similar problems, common causes and shared strategies globally*

In this fourth group we are including engagements which address local problems which clearly reflect common global causes and call for collaborative and globally relevant strategies. In this respect they differ from the first group which, at least originally, were largely country specific; they differ from the second group which were international in the sense that solidarity was international but the issues themselves were largely context specific; and they differ from the third group which dealt with similar struggles in different countries, which, while similar, were context specific. This group of engagements truly involves common global problems and shared global solutions (Giugni 2002).

The stronger engagements in this group include access to medicines, tax justice and fair trade activism. These are strong in that the relationships and communication networks are strong; the knowledge base is strong and widely shared; and that collaborative strategies are well developed and honed in practice.

Two engagements which are weak at this stage (in terms of global organisation and collaborative strategies) include privatization, tax justice and extractivism.

## Discussion

In this section we review what we have learned about the *enabling conditions* which support 'episodes' (or streams) of civil society engagement in Health for All and the *continuities or patterns of influence* between and across 'episodes' and domains. These are of course linked in that the lasting influence of one episode may be a formative influence for another.

We embarked on this study with certain assumptions about social movements generally as applied to health. Some of the conditions for movement building which emerged in the academic commentary (reviewed in Annex 7) were:

- recognition of health and/or health care as foci of concern;
- a collective focus, a concern for others as well as for self and family;



- a sense of agency; confidence that personal action / engagement can make a difference;
- transgression; a willingness to break out of institutionally prescribed roles;
- a shared analysis (at least in some degree) regarding causes, objectives and strategies;
- communication channels through which to share concern, analysis, planning and collaborative action;
- a repertoire of various forms of action.

In this discussion section we bring together our reflections on these 'conditions for movement building' derived from the literature *plus* the salient issues which have emerged from the foregoing analysis of particular 'episodes'.

### Conditions for movement building within 'episodes'

We are doing this research because we want to build a global movement for HFA. We are asking *how*. First, what does this history tell us about the movement building dynamic within episodes.

#### *An explicit focus on health*

In some of the cases we have discussed an explicit focus on health gave coherence to the engagement. Examples include the drive for health insurance in Saskatchewan, the various community health projects which informed Alma-Ata, the Mound Bayou health centre and the women's health movement.

However, we have discussed several cases where health was not the primary focus but there were health benefits nonetheless. These include the Szreter analysis of health improvement in 19<sup>th</sup> century England and various revolutions and national liberation movements and human rights struggles where health was on the agenda but clearly subordinate to more radical political goals.

#### *Role of political movements*

Popular concern for health care issues can be mediated through political movements (including through electoral representation and the threat of revolution), other than through identifiable health-directed 'social movements'. The NHS, Saskatchewan, Chinese and Russian experience illustrates. In effect these were driven by *political movements* rather than *social movements*. This raises questions about the relations between social movements (specifically the HFA movement) and wider political movements.

#### *Health gains from the struggle for the vote (and the threat of revolution)*

Following Szreter we have identified the 'episodes', at the heart of improving health in industrial revolution England, as the four major enfranchisement acts adopted between 1867 and 1928. In changing the electoral base progressive enfranchisement changed the electoral sentiment regarding the investment in urban infrastructure. This was not driven by a social movement explicitly directed to better health; it was a political movement focused in the first instance on the right to vote; presumably because of the neglect of urban infrastructure by governments controlled by lords and squires. There is a lesson here about movements which drive health improvement but are not organised explicitly around health. There is a further lesson about the role of political rather than social movements in creating the conditions for health improvement.

#### *A sense of collectivity; shared identity*

The collective focus has been particularly evident in relation to the various struggles for health organised around oppressions associated with class, gender and race and also the revolutions and national liberation struggles.

We have cited the contemporary Chinese experience where protests about health care have been very localized, expressing a sense of collectivity nonetheless, but have not merged into a recognisable social movement. They have been quite influential in policy terms because of sensitivities regarding 'social stability'.

We have also cited the tobacco control example where changing attitudes and practices largely at the individual, family and cultural levels has been critical in progressing the cause of tobacco control but the 'social movement' has been largely driven by professional organisations, academics and bureaucracies.

#### *The power, limitations and risks of identity politics*

Social movements based on singular identity can be very powerful and when they empower previously oppressed or exploited populations they can powerfully contribute to better health and health care. This is clearly the case in relation to the three 'episodes' we have discussed, based on the identities of labour, woman and black.

The limits of identity politics emerge where subordination or coercion, associated with difference, divides the movement (eg patriarchy within the civil rights movement, class within the women's movement) and prevents convergence across movements (eg between labour and civil rights). The power which is deployed in the service of patriarchy in many countries obscures the role of class and caste in reproducing immiseration.

Social movements based on singular identity can also be harmful to health. Examples include various forms of racism, jingoism, chauvinism and xenophobia. The Trump phenomenon illustrates the political power of populist manipulation of shared grievances around a shared identity.

A politics of identity will emerge wherever oppressions are structured around manifest stigmata of identity. Class is a less evident stigma than gender or race. The challenge for activists is to find a balance between the politics of identity and a politics of difference. The politics of difference requires new attitudes and skills to support listening across difference and building solidarity across difference. These are significant challenges. People facing various threats of insecurity find it easier to opt for a politics of identity than risk listening across difference.

#### *Social entrepreneurship and 'scaling up'*

Charismatic PHC practitioners can achieve amazing outcomes in igniting community involvement but 'scaling up' can be difficult. We have cited the Jamkhed, Solo and Pholela cases as iconic instances of primary health care practice, partly because they were influential in the genesis of the Alma-Ata Declaration. However, they also underline the challenges of 'scaling up' to national level. Charismatic leadership is not easily institutionalised, particularly where system-wide support is not available. The concept of scaling up figures in much orthodox policy commentary. Some caution is warranted in extrapolating what can be achieved by social entrepreneurs with donor funding to system-wide policy formation.

#### *Links between local community development and wider denials of human rights*

Inspiring instances of PHC in effect can involve wonderful community development work but not necessarily address the broader determinants of inequality, oppression and exclusion. Again the Solo and Guatemala cases offer sharp contrasts between excellent local community development and wider breaches of human rights. The Mound Bayou instance, with its very strong links to the civil rights movement, provides a useful comparison. In contrast the 'community' activism celebrated by Health PAC did not always articulate closely with any wider movement operating at a more structural level.

### *'Movements' which are largely driven by professionals*

The FCTC 'episode' was built upon a 'social movement' largely driven by professional organisations and professional advocates. However, there is a lesson here also about the agency of the individuals and families who discouraged their children, chose smoke free restaurants and who adopted smoke free protocols in their own homes and workplaces.

The NCDs 'movement' is similarly driven by professional concern but is achieving (some of) its goals through the agencies of families deciding to change their shopping and eating practices. Such changes in family practice contribute to changing political sentiment regarding regulatory strategies.

### *Agency; we can make a difference*

Agency, the perception that I/we can make a difference, would appear to be central to both social and political movements.

Agency needs to be qualified in relation to scale. The various community health development projects have demonstrated how people can be mobilised around immediate grievances and the local conditions shaping their health; developing this sense of agency can be critical in this process. Likewise the agency of families in adopting smoke-free homes has been very powerful in enabling regulatory control of tobacco industry. However, acquiring a sense of agency in relation to large scale issues such as tax justice or fair trade can be more difficult. To many people who are very aware of the reach of these issues, the perception that 'I don't have access to any levers of change' is a significant barrier to activism.

The concept of agency also needs to be contextualised in relation to urgency ('how desperate we are', 'what have we got to lose') and solidarity ('we are fighting together' and 'we have hope'). The sacrifices made in various revolutions and human rights and national liberation struggles for example, or the activists in the US civil rights movement, including the Medical Committee for Human Rights illustrate.

### *Transgression*

Transgression, the breaking out of institutionally prescribed roles, is a prominent feature of several of our 'episodes'. The doctor couples of Jamkhed, Solo and Pholela all illustrated practitioners who had the integrity and courage to break out. The young activists who demonstrated against tobacco sponsorship of sports or reframed tobacco advertising by graffiti-ising billboards in Australia were likewise transgressing against the conventions of their professions. The women and men who transgressed gender stereotypes.

Foucault and Marx before him have emphasized how political control is exercised through established institutions which are constituted by established roles and relationships and reflect established ways of thinking. Transgression in speech and practice can be powerful strategies of challenge.

### *Leadership*

The question of agency is linked with inspiration ('if she can, I can') and leadership ('of course we can').

Inspiration commonly involves identification: 'she has done great things'; 'I can see myself in her shoes'; 'I can do great things'). According to this perspective the stories and images of 'her doing great things' are critical.

Various different facets of leadership have been evident in the cases reviewed including: articulating shared grievances, articulating a clear analysis of causes and strategies, building

solidarity through sharing of experiences and aspirations, and inspiring action through courage and integrity.

#### *Shared analysis*

A shared analysis regarding causes, objectives and strategies clearly contributes to solidarity and a sense of agency. However, where the conditions for solidarity are largely about shared identity there may be limits on the reach of the analysis.

#### *Communication channels*

Various different kinds of communication channels are evident in the 'episodes' we have reviewed. In the various community health projects inspirational leadership combined with community sharing was important. In the women's movement (and the women's health movement) deep sharing associated with consciousness raising was critical. In many of the Latin American examples Freirean methodologies have facilitated sharing and reflection. In the tobacco control movement professional journals and the mass media have played a major role.

These all point to the significance of local practices and media of communication.

#### *Forms of action*

A shared repertoire of forms of action is postulated by social movement theorists as a defining character of a social movement. A wide range of forms of action are evident in the cases we have reviewed, ranging from guerrilla war to non-violent action; from popular education and consciousness raising to research and policy analysis; social entrepreneurship to media advocacy.

It may be that different movements deploy different forms of action but it is likely that the variety of forms of action evidenced reflect the context of the engagements rather than being somehow intrinsic to the movement. Forms of action arise in context; they are not off-the-shelf strategies.

However, it is clearly that the choice of particular forms of action and the skills with which they are deployed contribute to the effectiveness of campaigning and advocacy and indirectly to movement building. This underlines the need for health activists to be aware of the different forms of action which have been previously or are elsewhere deployed; to develop the necessary skills and resources and to apply these to the circumstances of their struggle.

In the context of this study this points to the question of 'influence'; the communication of the experience and lessons across episodes (or domains) of engagement.

#### *Continuities and influences across episodes; within and across domains*

We are interested in building a *global* HFA movement or at least promoting some degree of convergence across episodes (or across the mobilisations that these episodes represent). What are the continuities across time and space through which the experience and significance of particular episodes is appropriated collectively across broader streams of the struggle for health? 'Continuities' includes formative influences, parallel influences and influential legacies: across episodes; across time and space and constituency.

The 'continuities' (mediators of influence, attractors of convergence) that we have identified in the episodes presented may be categorised as follows.

#### *Ideologies, world views and theories*

We all interpret our experiences within preconceived frameworks (ideologies? world views?). Within such ideologies we manage an assemblage of partial stories, theories about different aspects

of the world, which we put together to make sense of our experience and to frame our plans for the future. We act upon the world, experience the impact, and may adjust our theories and even reframe our world view.

World view and theory are fundamental in informing activism. Convergence of social movements will not happen unless there is some convergence with respect to world view and the theories with which we make sense of our struggles.

Some of the clouds of ideas which float through activist health movements include:

- the Enlightenment Project (salvation through science, rationality and democracy),
- liberation theologies, the kingdom of God on earth,
- Marxism, class and imperialism,
- national democratic sovereignty,
- primary health care and the social determination of health,
- the Latin American social medicine movement,
- the NIEO.

World view is part of who we are. The best that we can ask is that we learn to listen for the world view of the 'other' and try to understand where it comes from. However, theory can be verbalized, can be examined, challenged, worked on and improved.

#### *Icons and heroes*

Many but not all in the HFA movement share the same icons and some of the same heroes; icons like the NHS and China's barefoot doctors; heroes like Rudolf Virchow, Salvador Allende and Che Guevara.

Icons and heroes carry the culture; they are the screens on which our aspirations are projected, the clay in which our values are re-created.

#### *Research and publication mediates influence*

Publication is an important medium through which influence travels across different currents of health activism, including books, journals, reports and statements. In this context we may cite *Our Bodies, Ourselves*, *Where there is no doctor*, the Alma-Ata Declaration, the Health PAC Bulletin, the International Journal of Health Services, Social Medicine and Global Health Watch.

#### *Personal relationships mediate influence*

The Kark, Sax, Cassell, Geiger links in relation to community health centres and the Sigerist, Roemer links in relation to Saskatchewan also highlight the importance of personal relationships in mediating influences between 'episodes'.

#### *Organisational networks mediate influence*

Organisational networks with international reach also mediate influence. IBFAN (the International Baby Food Action Network) illustrates an international network which has affiliates and supporters in many countries and which facilitates common and collaborative approaches to their shared objectives.

Other networks with comparable international reach include MSF (Medicins Sans Frontieres), TWN (Third World Network) and many more, including PHM.

## Conclusions

This study has been undertaken as a contribution to the CSE4HFA project. Accordingly we now seek to identify implications for the five main themes around which the CSE4HFA project was designed.

### Movement building

#### *Within particular episodes/currents*

Highlights include:

- organising around and building a sense of collectivity, a sense of identity, is always part of movement building, strengthening the sense of 'we'; however, activists need to be aware of the limits of identity politics and give full attention to working across difference, in particular, listening across difference; this principal points to the importance of interpersonal skills, group work practices and opportunities within which personal relationships across boundaries can develop and flourish
- our review highlights the potential of social entrepreneurship and leadership but the political and institutional challenges of 'scaling up' to system-wide implementation;
- small scale community initiatives can be insulated from or aligned with the wider political challenges arising from inequalities and breaches of human rights;
- it is important to recognize both the potential and the limitations of health 'movements' which are largely restricted to health professionals;
- learning from previous and parallel experiences (eg in group work, popular education methodologies) should be part of movement building.

#### *Convergence across different currents*

Highlights include:

- building organizational relationships, building networks, cannot be done by correspondence alone, or even digital communication; personal contact and the opportunities to develop strong personal relationships are also critical;
- inspirational writings, songs, movies and other cultural activities and resources can contribute to building solidarity and collectivity across boundaries;
- strengthening organisational networks which span different countries and currents is clearly a fundamental part of the convergence project.

### Campaigning and advocacy

Highlights include:

- the potential for learning from previous and parallel experiences in campaigning and advocacy;
- the significance of articulations between the social movement for health and the political movements (including parties) which are engaged in mainstream politics. In many instances securing improved health care and social conditions for health may depend on such articulations.

### Capacity development

Highlights include:

- recognize the role of inspiration and organizational culture in nurturing agency and solidarity;

- accumulate and demystify technical knowledges (eg access to medicines, fair trade activism, tax justice);
- cultivate story telling as carriers of history and theory;
- model transgression
- cultivate leadership.

### Knowledge building and dissemination

The main highlight emerging under this heading is the importance of documenting movement building and campaigning experience and making it accessible. It is useful to note the limits of the 'gray literature' and other evanescent modes of communication (videos, websites, and even books) which may disappear within a few years. Note the benefits of the indexed literature and the importance of progressive academic as vehicles for publishing activist experience.

### Policy dialogue and governance

The main highlights include:

- attention to the articulations between the social movement for health and the various political movements (including parties) upon which improved health care and social conditions for health may depend;
- the challenges of aligning local activism with the dynamics of global power are many:
  - acquiring a sense of agency in relation to big picture issues;
  - accessing arcane technical knowledges; and
  - building collectivity and solidarity across difference and distance.

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