E1 | THE MOVEMENT FOR CHANGE

The People's Charter for Health is a call for action: 'To combat the global health crisis, we need to take action at all levels – individual, community, national, regional and global – and in all sectors.' In this chapter we review the strategies, structures and practices of the People's Health Movement and related social movements in responding to this call. Our review is structured around a series of basic questions:

- How is the global health crisis stabilised and reproduced?
- How does historical change take place?
- What can we do to intentionally shape our collective destiny?
- What are the main strategies which social movement activists can deploy to drive social change?
- How can social movement activists build their capacity to effect social change?

How Is the present regime reproduced?

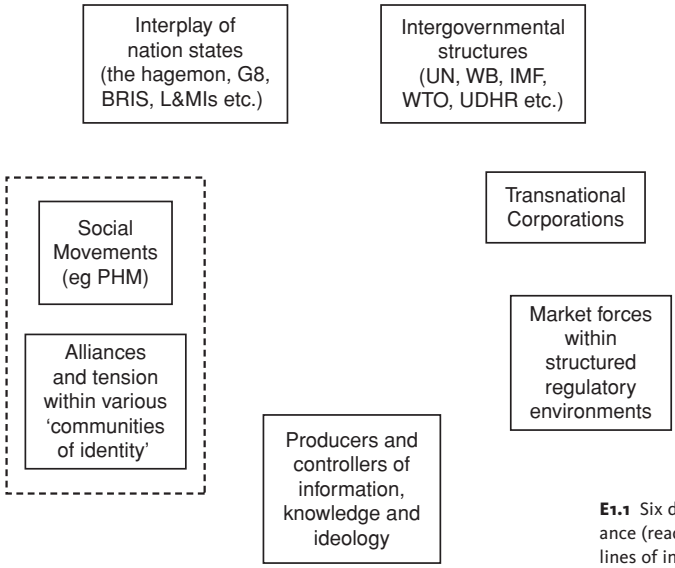
The global health crisis referred to in the Charter has many faces: food insecurity (Holt-Giménez 2008), preventable child and maternal deaths (Hogan et al. 2010), price barriers to accessing medicines ('t Hoen 2009), collapsing health systems (WHO 2007) (many of these we have discussed in preceding chapters). There are enough resources on the planet to provide for 'health for all' but the necessary resources flow instead to overconsumption, military expenditure and obscene wealth for a small elite (Milanovic 2009; Davies et al. 2008). How is this situation stabilised and reproduced?

The fact that resources are not so deployed to address the global health crisis is a consequence of the prevailing governance structures of the globe, and particularly global health governance (GHG). Global health governance encompasses the social determinants of health and health system development.

There is no simple way of representing the structures of global governance. It is necessary to look at it from a range of different but overlapping perspectives: nation-states, intergovernmental institutions, the corporate sector, the marketplace, civil society and social movements and knowledge, information and ideology.

Domains of global governance

Nation-states Global governance, among other dynamics, involves the interplay of nation-states (or their different alliances and blocs). Nation-states project



E1.1 Six domains of global governance (readers are invited to draw the lines of influence)

their power by military and other means. The role of US trade law (Super 301) and the US trade representative (USTR) (Drahos 2001) in pressuring small countries to adopt restrictive intellectual property (IP) policies is an example of the use of the power that nation-states wield (Knowledge Ecology International 2011a).

Intergovernmental structures Also important are the formal institutions of global governance and regulation: such as the UN, the WHO, the World Bank and the IMF; laws and agreements such as the Universal Declaration of Human Rights or the 23 enforceable trade agreements administered through the WTO. The role of the WTO's Agreement on Agriculture in sanctioning dumping of subsidised foods into low- and middle-income country (LMIC) markets, destroying small farmers' livelihoods, illustrates the role of such institutions (Hawkes 2007).

Within this terrain, of increasing importance today are the various global public–private initiatives (GPPIs) which disburse aid and advice, mainly to poor countries. These include the Global Fund for AIDS, TB and Malaria (GFATM), the Global Alliance for Vaccines and Immunisation (GAVI) and over 100 others (Sanders n.d.). In terms of the immediate needs of sick people and poor countries, the funds mobilised by GPPIs are life-saving. In the context of the politics of intergovernmental organisations, the separation of these GPPIs from WHO reflects the ongoing project of the rich countries to contain the influence and reach of the WHO. From a more critical perspective the role of the GPPIs is to shore up the legitimacy of the regime of global governance which reproduces inequality, exclusion and marginalisation.

Corporate sector An obvious big player in GHG is the corporate sector, in particular the transnational corporations (TNCs). Included here is the power of the financial corporations which are 'too big to fail' (Bello 2008; Stiglitz 2009); the pharmaceutical giants and others which shape US trade policy; and the global food corporations which destroy indigenous food systems and force junk foods onto global markets (Schrank 2008). The freedom of the TNCs and their lack of accountability is a consequence of their nation-state sponsors ensuring that the global regulatory environment is TNC friendly (Knowledge Ecology International 2011a). The levers that harness the nation-state in the interests of the transnationals also need to be explored. In some circumstances this is electoral leverage (e.g. the influence of the US auto industry on Capitol Hill); sometimes it involves the purchase of influence (e.g. campaign contributions by big insurance in the US to prevent health care reform and by big oil to prevent action on global warming); and sometimes it reflects a confluence of interests between the corporation and its nation-state host (e.g. highly protected intellectual property, which enables Big Pharma to inflate profits through monopoly pricing and helps to maintain US export revenues and reduce the trade deficit).

The market The market is one of the key structures of global health governance; separately from the power of the big corporations. Markets operate within regulatory frameworks which are erected through national governments and intergovernmental structures. The environment within which markets operate is created through deliberate policy. While individual companies may lobby to be exempt from regulation, equally important are the wider ideological pressures associated with neoliberalism for deregulation, small government and the continuing denial of any limits to growth.

Information, knowledge and ideology The field of information, knowledge and ideology is another domain of global governance. The structures of this domain (including universities, think tanks, publishers and media barons) shape who shall access what information; who shall create or access knowledge and how we shall understand the world we live in. A simple example lies in the role of the financial press in shaping how we understand the global economy and in determining what analyses of the global economy shall be privileged and which shall be discounted (Herman and Chomsky 1988). The control of information is equally powerful; illustrated by the quality of information released by WikiLeaks, which would otherwise have been kept secret.

Civil society Finally we need to recognise civil society as a key domain of global governance (Thompson and Tapscott 2010). This domain is where the People's Health Movement is located, along with familiar civil society institutions such as churches and unions, and sporting and cultural and advocacy organisations.

A social movement is a collectivity that shares a common set of concerns, understandings and claims and a sense of shared identity (Pakulski 1991). It is bigger than but includes formal organisations. Examples include the environment movement, the women's movement and the People's Health Movement (fundamentalist religions are also social movements in this sense).

Within this domain of 'civil society' we need also to recognise the fluctuating alliances and tensions within and across the many diverse 'communities of shared identity' both within countries and internationally (variously analysed in terms of nationality, class, race, gender, income, ethnicity, sexuality, religion, etc).

One of the important dynamics in this analysis is the emergence of a global middle class with a shared interest in consumer goods and the good life and negotiable loyalties to poorer people in their own and other countries. The power of this global middle-class identity may be illustrated by the support among the middle classes of low- and middle-income countries such as India for tariff reductions so that imported consumer goods might be cheaper (Ghosh 2002). The 'free trade' bandwagon would not have made the progress it has without this shared perspective across the global middle class. Unfortunately the sense of shared identity among farmers or workers in different countries is sometimes much looser.

The dynamics of global health governance

This listing of the structural domains of GHG takes us only so far. We also need to understand how they interact to reproduce the prevailing regime and how the health crisis inheres in this regime. We can approach this question through an exploration of the 'access to medicines' case, described in detail in previous GHW volumes (PHM et al. 2005, 2008a).

With the advent of highly active antiretroviral drugs (ARVs) in the mid 1990s the plight of people suffering from AIDS became politically critical. At a time when Big Pharma was selling a year of treatment for $US10,000, the Indian generic manufacturer Cipla was able to supply the same to Médicins Sans Frontières (MSF) for $350. When the South African government sought to procure ARVs through parallel importation (buying them in countries where the prices were lower than in South Africa), Big Pharma, supported by the US, took the South African government to court. After three years of mounting civil society protest in South Africa, in the US and in many other countries, the US and Big Pharma withdrew their suit in May 2001 (and paid costs) (Sen 2001; Raghavan 2001). Later that year the members of the WTO affirmed that trade rules should not be an impediment to public health (WTO Ministerial Council 2001).

The perceived legitimacy of the TRIPS regime (the WTO's Trade Related Intellectual Property agreement) was damaged by this episode, and the US project of further tightening of global IP laws suffered a significant setback.

The setback was only temporary. The Global Fund for AIDS, TB and Malaria and the US President's Emergency Fund for AIDS Relief (PEPFAR) stepped into the breach with massive funding (from 2003 from GFATM and from 2005 from the US (OECD 2011) and a charity model was put in place (as opposed to access at reasonable prices based on a reformed IP regime).

The macroeconomic context of this episode deserves closer attention. With the move of manufacturing from the high-wage economies to 'emerging' economies, the 'post-industrial' economies of North America, Europe and Japan have become increasingly dependent on the export of products with a high IP rent. The US economy has come to depend, more than that of any other country, on rent from intellectual 'property' through royalties, licence fees associated with pharmaceuticals, seeds, software, music and film, consumer goods and arms. In 2007 the surplus earnings from royalties and licence fees (exports – imports) comprised $57 billion, without which the US trade deficit would have been 7.5 per cent greater (WTO 2008). Thus, for the US to maintain national income from the export of products with a high IP rent, two policy objectives became critical. One was to establish and entrench a global IP regime with lax patentability standards. The second was to access the middle-class markets of the 'emerging' economies. The former has been advanced through the TRIPS agreement and the TRIPS-plus provisions in bilateral and regional trade agreements (Oxfam 2002). Opening LMIC markets has been progressed through the continued promotion of the ideology of neoliberalism (universities, media, think tanks, etc.); through the brutality of IMF conditionality; and through the sanctions associated with the dispute settlement procedures of the WTO.

This exploration of the medicines and IP case provides insight into how the structures of global governance work and how global *health* governance is embedded in the wider structures of political and economic governance. The story also shows how such policies and 'truths' can be resisted and alternatives promoted through combinations of nation-state diplomacy, civil society advocacy and social movement activism (such as the AIDS movement in this case).

All kinds of activism, which seeks a fundamental change in the iniquitous social and economic relations that prevail in most parts of the world, need to be rooted in local and national endeavours. However, unfortunately, national (and even local) dynamics are increasingly determined by the requirements of the global regime.

We may take the *human resources for health* crisis as a case study to better understand how this is happening. Health systems in many LMICs are in crisis. There are many elements to this health systems crisis, but problems in the production and deployment of human resources for health care are quite central.

There is much that can be done at the national level, notwithstanding the global pressures. Ministries of health can put in place universal publicly funded health systems (as we discuss in Chapter B1). Ministries of education can struggle for relevant curricula and a workforce mix which meets com-

43 Statue commemorating end of slavery, Goree Island, near Dakar, Senegal (Hani Serag)

munity needs. Social movements need to keep the pressure on governments to eliminate corruption, control moonlighting, contain the export of 'human capital' and adopt appropriate health and education policies.

But there also loom the wider global forces: promoting the ideology of neoliberalism (rationalising the privatisation of health care and education; picturing widening inequality as unfortunate but necessary); the various GPPIs promoting hierarchically controlled vertical health care programmes rather than comprehensive primary health care; and the articulations of the global medical elites (discounting the role of nurses, community health workers and other health professions).

Thus, clearly, the governance of health, at the national and global levels, is complexly embedded in the structures and dynamics of global governance. The challenge before social movements is to find a balance between continuing to struggle for local and national change while also building links with global movements that confront the global dynamics.

How does historical change take place?

Health activism needs to be informed by an understanding of the structures, forces and dynamics which shore up the prevailing regime. Also critical is an understanding of how historical change takes place. There are many different and overlapping dynamics of historical change; these include:

- conflict and military power (colonisation, decolonisation, wars of imperial policing);
- rise and fall of political ideologies (deflation of communism, rise of neoliberalism and religious fundamentalism);
- technological innovation (steam engines, internal combustion, computers, solar energy collectors, dry composting toilets);
- environmental opportunities and limits (desertification, global warming);
- population and migration.

Conflict and military power, in the form of colonisation, have shaped the health chances of most people who are alive today. The role of colonial exploitation in funding the Industrial Revolution, and therefore the privileged health status and health care of the rich world, is mirrored in the continuing challenges faced by the countries that were colonised. The role of conflict and military engagement in national liberation struggles must also be recognised as contributing to progress towards Health For All through the positive role played by newly liberated countries (Metzi 1988). Though, for many countries, the shackles of colonisation were quickly replaced by a new form of subordination through the workings of economic imperialism.

The rise of neoliberalism and the related ideologies of individualism and consumerism have been powerful influences on health over the last half-century. Neoliberalism normalises inequity and with its faith in markets and distrust of government discounts collective control of our future (Kelsey 1995). The doctrine of neoliberalism is a big challenge to the Enlightenment vision of humanity steering our destiny, and it may be that the negativity of neoliberalism has contributed to the rise of various religious fundamentalisms (John and Legge 2011). However, there are different streams of cultural development which avoid the nihilism of economic and religious fundamentalisms. In Latin America an Indigenous Cosmovision is re-emerging as a spiritual framework which can guide the struggle for a better life (Ward 2008).

Undoubtedly, the progressive improvement in human health over the last century reflects in part the impact of new technologies. However, technology without democratic social control, and in the hands of global capital, is a very uncertain bet. The uncertainties regarding the directions and implications of technological development underline the importance of activists maintaining a close engagement in this field. Technology will shape social, economic, cultural and institutional development as well as being shaped by them.

Environmental resources and limits have shaped and continue to shape human development. The Easter Island Syndrome hovers over our future pathways (Diamond 2005). This syndrome refers to a society that destroys its environmental supports (in the case of Easter Island, all of its trees) because its culture does not have the adaptive capacity to understand, predict and change (Rees 2002). Self-evidently humanity has the technologies to move

44 Indigenous People celebrate at the Peoples Health Assembly in Cuenca, Ecuador, 2005 (David Legge)

to a more equitable, sustainable and convivial civilisation. Again the question is whether we will find the cultural competence and be able to create the institutional machinery.

Large-scale migration has been a powerful driver of human history. The health consequences have been varied, from the devastating, for displaced indigenous peoples, to the flourishing, where new technologies in new environments have created new societies. Technologies are at hand to assist in managing the challenges of living in harmony, but the institutions and cultures for wise decision-making are sorely lacking. The issues of population and migration raise particular issues concerning human solidarity which are major challenges for health activists today. (We discuss one such example from Italy in Chapter E2.)

The above are not separate 'dynamics' of change; rather they are interrelated processes. By understanding them, we gain useful insights into the past and ways of thinking about the current challenge.

Projecting scenarios of change

The processes that we describe above can be projected to characterise future scenarios of historical change in terms of optimistic and less optimistic trajectories.

An optimistic scenario (or vision) could be characterised by: rapid development of solar technology and techniques for restoring depleted soils and oceans; democratic and transparent regulation of the global economy; return of confidence in collective decision-making; rejection of competitive consumerism; reducing pressures of migration; fairer distribution of economic resources; and rapid reversal of population growth associated with improved standards of living, etc.

Of course, other, less optimistic scenarios are also implied by this optimistic scenario. Perhaps we have already passed the projected climate change tipping points; perhaps the robber barons will successfully stall effective regulation of the global economy; perhaps the promise of personal salvation through apocalyptic religious fundamentalism will critically weaken the movement towards a more deliberative control over human destiny; perhaps divide-and-conquer strategies will continue to fan communalism, racism and nationalism and distract the democratic sentiment.

The optimistic scenario provides us with a clear vision of the kinds of directions that progressive social movements need to work towards, while also highlighting some of the uncertainties to be negotiated on the way.

The critical insight for the activist is that human agency has a powerful role to play in determining which scenario is realised. This is not a matter of wishful thinking or individual heroics; rather it calls for the building of movements and social institutions that mediate the process of change. We need to ask what we, as individuals, groups, and social movements, can do to *intentionally* shape our collective destiny.

In the following section we discuss social movement activism in terms of, first, the strategies for social change, the logic of activism and, second, the elements of daily practice – what activists do on a daily basis in the pursuit of those strategies.

Strategies focused on achieving social change

Change-focused strategies deployed by social movements, such as the People's Health Movement, include: practising differently; policy critique and advocacy; service system reform and development; institutional reform and innovation; delegitimation; and inspiration. Of course, the naming and separation of these strategies is quite arbitrary; they all work together.

Practising differently We use the idea of 'practising differently' as a way of recognising how the 'big structures' are constituted by the acceptance and participation of 'ordinary people'. Junk food, understood as a regime of production and marketing of low-nutritional-value, high-margin foods, is constituted by the purchasers as well as by the transnational corporations and retail networks. Patriarchy, understood as a regime of unequal power relations, institutional inequality and a set of assumptions and practices, is constituted

by the participation of the men and women whose lives it touches. Global warming is driven by individual and household practices as well as by the corporate interests that profit from carbon-based energies and the culture of consumption.

The idea of 'practising differently' reorients our thinking away from 'behaviour change', which objectifies the people whose behaviour will be changed (while rendering invisible the agents who will 'intervene', as if from outside, to encourage such behaviour change). Practising differently underlines the choices involved in refusing or affirming particular ways of practising. Practising differently is collective as well as individual and is political as well as personal. It involves actively reworking our values and cultures. It involves political as well as personal change.

Examples of 'practising differently' in the struggle for health include: innovation in primary health care practice; primary health care (PHC) practitioners working with communities to resist corporate appropriation; fair trade; patient literacy in the AIDS/HIV movement; alternative technologies (including alternative farming); and gender-neutral language and other forms of anti-patriarchal practice.

Practising differently in primary health care settings is well illustrated by *Health by the people*, published in 1975 by WHO and edited by Ken Newell. This collection of case studies of primary health care from Cuba, China, Indonesia, India, Guatemala, Iran, Venezuela and Tanzania was influential in the framing of the 1978 Declaration of Alma-Ata, which in a sense represented a distillation of the experience of these cases. It is a profound illustration of the ways in which practising differently can change the world.

Unfortunately the PHC example also illustrates the resilience of transnational capitalism in resisting the call for a new international economic order and in continuing to advance stratified models of health care and vertical disease-focused programmes (Sanders 1985; Werner and Sanders 1997). It is clearly inadequate to talk about these different ways of practising differently except in the context of the wider structures of global governance and other strategies of social change.

Policy critique and advocacy Policy critique and advocacy is one of the central strategies of the social movements for change. The struggles over access to medicines and IP policies ('t Hoen 2009) illustrate both the power of social movement policy advocacy and also the resilience of Big Pharma and its nation-state partners.

Some other major policy controversies in which the People's Health Movement has engaged include: the return to PHC and universality (Labonté 2010); the social determinants of health (Anon. 2007); the destruction of people's living environments by big mines and big dams and the role of PHC in working with communities to defend and create healthier environments.

The defeat of Big Pharma in South Africa was achieved through the mobilisation of people living with AIDS and HIV both in South Africa and in other countries (Sen 2001); through international solidarity, which was able to support direct action in the US (e.g. through Health GAP (2011)) as well as in South Africa (Treatment Action Campaign 2011); and through the detailed and timely exposures and analyses of a small number of websites and email lists (in particular, CPTech (now Knowledge Ecology International (2011a) and Médicins Sans Frontières (2011)).

Let us look at environmental struggles for other examples of the role of advocacy by social movements. Community struggles against the destruction of their environments by unregulated mining and the destruction of lives and lungs through working in unsafe mines are one of the sharpest points of conflict between corporate greed, political corruption, the culture of consumption, climate change and community health. A dossier of complaints about the mining giant Vale has been compiled by the International Movement of People Affected by Vale (Fair Deal Now 2011). The dossier includes cases reported at the first meeting of the International Movement, held in 2010 in Rio de Janeiro, with about 160 people from over 100 organisations, unions, social movements and communities from 13 countries and nine states in Brazil. This illustrates a highly focused community-based advocacy action backed up by activists operating at a more global level, such as the website named Mines and Communities (MAC 2011), which provides a searchable data source covering mining in many different countries.

The role of Shell in the Niger Delta has been described in detail in GHW2 (PHM et al. 2008b) – a story of corruption, denial of human rights, extrajudicial killings and environmental disaster. In the Central Indian state of Chhattisgarh, Dr Binayak Sen, a well-known civil rights activist, has been sentenced to life imprisonment on trumped-up charges of terrorism. In fact Dr Sen's crime is his continuing support for the struggles of tribal peoples to prevent their forests and lands from being expropriated (Analytical Monthly Review 2007). Dr Sen has said, 'I am being made an example of by the state government of Chhattisgarh as a warning to others not to expose the patent trampling of human rights taking place in the state' (Sen 2011). The forests that provide the livelihoods of the tribal people cover rich mineral resources and there are many cement and steel manufacturers (national and transnational) and state politicians who are keen to drive the tribal peoples from their lands.

The struggle against environmental destruction and abuse of workers rights illustrates the breadth of the struggle for health and the fact that it is not solely the province of people who identify as 'health activists'. There are many such parallel movements which should be understood as part of the People's Health Movement.

Service development reform

The pioneering examples of early primary health care models (discussed above) illustrate the contribution that service development reform can make to social change. Since the Newell collection (Newell 1975) many further inspiring examples of health care organisations developing new approaches to PHC have attracted attention. Since 2007 the Canadian-funded Revitalising Health for All project has been working with research groups in Latin America, India and Africa and with indigenous health researchers in Canada, Australia and New Zealand to document and analyse contemporary initiatives in PHC (Labonté 2010).

At the national level the health care reforms in Brazil and in Thailand (discussed in Chapter B3) have been inspirational, showing that despite the global pressures for fragmented health systems and widening inequalities it is possible to confront these directly at the national level.

Institutional reform Change is also being driven through institutional reform. Again the IP field provides examples of reforms that are being proposed, such as for new methods for funding pharmaceutical innovation (we discuss in Chapter D1 how these reforms are being contested by the rich countries).

The student-based Universities Allied for Essential Medicines (UAEM) illustrates another approach to institutional reform in this area (UAEM 2010). The organisation started at Yale in 2000 at the height of the South Africa stand-off over the drug stavudine – an antiretroviral drug. The drug had been developed by a scientist at Yale and the university had licensed it to the drug company Bristol-Myers Squibb. The students at Yale launched a powerful campaign at the university (including a 'TB die-in') and managed to persuade Yale and Bristol-Myers Squibb to export the drug at much lower prices than was currently being charged – almost 95 per cent lower. That success inspired students elsewhere in the United States and Canada, and UAEM was set up two years later. Now over 50 universities are involved. Three universities in the United States and Canada have since embedded UAEM's core principles in their university constitutions (numerous others are planning similar measures). Those universities that have signed up still grant exclusive licences to pharmaceutical companies for their discoveries, but written into these licences is the requirement that any drug or medical technology relevant to developing countries be made accessible to them.

The UAEM provides a useful model for thinking about how a focus on systems and institutions can help to drive change, in particular the link between (i) mass action through a concerned constituency (the TB die-in by students); (ii) the detailed analysis of university IP policies (involving considerable legal expertise); and (iii) the value of an inspirational example which can be replicated in other similar settings.

Delegitimation The appearance of legitimacy is a critical defence structure for any governance regime. Habermas discusses the nature of legitimation crisis in relation to the financial crisis of capitalism and the recurring need to divert public resources to prevent collapse (Habermas 1975). Although he was writing in 1973 he could have been describing the global financial crisis of 2008, when banks were too big to fail and billions in taxpayers' money was drawn on to pay their debts. Habermas argues that while the prevailing cultural expectations and narratives naturalise such transfers, legitimacy is secure, but when people start to question those expectations and narratives and government has to act to deliberately shore up its own legitimacy, a legitimation crisis is in place. It is the role of the merchants of ideology to maintain the cultural expectations and narratives that naturalise an unsustainable and inequitable governance regime. These merchants include the media proprietors, the elite universities and the private think tanks.

The collapse of the Soviet Union in 1989 and that of Mubarak's regime in 2011 illustrate how quickly an apparently stable governance regime can crumble when its curtain of legitimacy falls. The transformation of the apparatchiks of Soviet Russia into the oligarchs of present-day Russia reminds us that institutional collapse is not necessarily the forerunner of a better regime.

The concept of legitimation and delegitimation can be usefully applied in the context of global economic and global health governance. It suggests the importance of identifying the cultural assumptions and narratives that are projecting an inequitable regime as legitimate and identifying the merchants of ideology who are promoting those narratives. Delegitimation is a central strategy for social movement activism but it is necessary to be wary of the speed with which the regime governors can respond in terms of shoring up their challenged legitimacy. This is illustrated in the South African medicines case we discussed earlier. Though the perceived legitimacy of the TRIPS regime was damaged, the setback was not permanent.

A similar two-step was danced in the 1980s and 1990s over the IMF's Structural Adjustment Programmes (SAPs). From the onset of the debt crisis in the early 1980s the IMF imposed brutal conditions on governments that were forced to borrow from it as lender of last resort. These included cutting government expenditure and other policy conditions directed solely at forcing governments to pay their debts (SAPRIN 2002). By the late 1980s the impact of SAPs in health was becoming evident, and in 1987 a UNICEF report was published entitled *Adjustment with a human face* (Cornia et al. 1987), clearly implying that the IMF was being inhuman. A similar report was published by WHO in 1992, entitled *The health dimensions of economic reform* (WHO 1992). However, the delegitimation of SAPs led to the World Bank becoming more active in structural adjustment and reinventing SAPs as PRSPs (Poverty Reduction Strategy Papers) with the appearance that countries were designing their own SAPs.

The Alma-Ata Declaration of 1978 and the announcement of PHC as a new paradigm for health development was 'delegitimated' almost immediately by the accusation of unaffordability in the context of the debt crisis and structural adjustment (Werner 1995). Selective PHC was promoted as an alternative 'viable' model. By the end of the 1980s privatisation and safety nets were facing increasing criticism (delegitimation) as part of the general reaction to SAPs and *Adjustment with a human face*. This led the World Bank to commission the 1993 World Development Report *Investing in health* (World Bank 1993), which offered a much more sophisticated version of stratified health care (relegitimation). With the advent of highly active antiretrovirals (ARVs) from the late 1990s and the explosion of global public–private initiatives in the new century (itself partly a reaction to the delegitimation of TRIPS in 2001) a new regime of vertical disease-focused programmes emerged cutting across the stratified health care promoted by the Bank. In recent years this regime has been subject to increasing criticism (and 'delegitimation') because of the fragmenting of health systems, and so the regime governors are responding with a new discourse of Health System Strengthening (WHO 2011).

Delegitimation is a powerful strategy for health activists but must be accompanied by positive policies for institutional reforms which will lock in any gains that can be achieved from such delegitimation. Otherwise the dance of delegitimation will proceed one step forward but two steps back.

Inspiration Delegitimation is in some respects a negative strategy. Anger at injustice is a negative although powerful motivator. We also need to project alternative and inspiring visions; partly to guide our analysis, partly to maintain our enthusiasm, partly to assist people to move from passivity into movement activism.

Alma-Ata is an example of inspiration. Many health workers and policy officials have been inspired by the vision of comprehensive primary health care (CPHC). Such examples can be found in other sectors, such as alternative energy (Rocky Mountain Institute 2011) or alternative farming (Permaculture Institute 2011). These in aggregate constitute a coherent vision of a better world. However, they gain traction only if people see them as achievable. Objectives, strategies and models are inspiring when their underlying logic makes sense, when they offer practical entry points and when they are seen as powerful in effecting change.

Many people have found that the rights framework can be inspiring. PHM's Right to Health and Health Care Campaign (PHM 2011a) highlights the various formal statutes upon which the Right to Health is based (Human Rights Council 2008) and acknowledges that in many situations the legal mechanisms for realising this right are weak. The inspiration that many people derive from the affirmation that their burdens constitute a denial of recognised rights can provide the drive to put in place these necessary institutional mechanisms.

45 Participants at the International Peoples Health University in a march in Dakar, Senegal, January, 2011 (David Legge)

We discuss in some detail the PHM's Right to Health global campaign in Chapter E2.

Conclusions

It is not preordained that humanity at large will avoid the fate of the Easter Islanders. There are trends and projections which suggest that we will not. However, there are very real grounds for hope and determination.

Hope and determination are necessary but not sufficient. We also need strategy, solidarity, mobilisation and activism. Strategy requires an understanding of the dynamics of historical change and the ways intentional action for change can shape outcomes. Solidarity requires that, like the many communities struggling against Vale, we come to appreciate more the shared pain and the common dynamics of the different struggles in different sectors and countries. Mobilisation requires that we have a clear analysis of why the world is the way it is and a plausible account of how it could be changed. Activism requires collective intelligence and hard work.

Above all we need to spend energy in building movements that can channel the hope and determination. We have reserved for another day a discussion on the strategies and tactics that need to go into movement building. The People's Health Movement, like many other social movements, continues to grapple with different options as it endeavours to build a truly global movement. We hope that the analysis provided in this chapter will stimulate debate on this

Box E1.1 The International People's Health University

The International People's Health University (PHM 2011b) provides learning opportunities for people's health activists around the world. Between 2005 and 2010 IPHU, in association with local PHM networks and its funding partners, ran 18 short courses (one to two weeks' duration) for activists in many different countries, mainly in the global South. The IPHU courses are subtitled *The struggle for health* and aim to cover some of the key areas of theory and practice that health activists need. The curricula include: health systems, social and environmental determinants, globalisation, the right to health, working across difference, research for social change, and applications of information and communications technology.

There are some similarities between the IPHU curriculum and conventional public health and global health courses but there are also important differences. Conventional public health training prepares health professionals for a set of existing roles (programme manager, university researcher, project coordinator, outbreak investigator, etc.) which are essentially framed by the prevailing governing structures. They are important roles in which people can do good works, but the concepts of the social movement as an agent of social change and the health activist as part of a grassroots social movement are not well recognised in such training.

IPHU is not just about individual training. There is a focus in the courses on building the people's health movement locally, nationally and regionally and globally. One example is WHO Watch (PHM 2011c), which brings together IPHU alumni in monitoring the WHO governing bodies and advocating for the adoption by WHO of policies, programmes and practices that are aligned with perspectives of the People's Health Movement.

critical aspect of our collective endeavour to effect change that is sustainable, democratic and premised on the principles of equity and human rights.

Many of the ideas and issues that we explore in this chapter form the core of the curriculum of the International People's Health University (IPHU) (see Box E1.1).

BoxE1.2 Changing from within

Challenging the conservatism of italian medical schools As in many other countries in the world, universities in Italy are traditionally conservative and mainly structured around rigid hierarchies – more dedicated to perpetuating their own power and privilege than a commitment to

producing and transmitting innovative knowledge for societal advancement.

In recent years, cuts in public expenditure, exacerbated by the ongoing economic crisis, forced universities – which in Italy are mostly public – to increasingly orientate their activity in a manner that can attract private funds. This necessarily means investing in market-oriented, patentable research, which seldom matches the real needs of the community.

The dissatisfaction with the limits and inefficacy of the biomedical approach, of which most medical schools are champions, has given rise to a desire for change in medical education, often coming from students. Especially in the last decade, in several countries, medical students have been requesting a radical reorientation of their curricula. Global health (GH) – looking at health as a complex issue, scrutinised amid the shaping forces of globalization – is an emerging field that attracts many students. GH recognises the urgency for trans-disciplinary and multifaceted approaches, capable of analysing the root causes of challenges faced by the health sector.

In the experience of the University of Bologna, the need felt by students to widen their academic and conceptual horizons, and the interest shown by a professor in the university, led to the creation of the Centre for International and Intercultural Health (CSI) in 2006 within the Department of Medicine and Public Health.

CSI strongly supports a vision of health rooted in the approach of its broader determinants, as well as a commitment to work with the community, closing the gap between the academic world and society as a whole. In order for this to happen, a cultural change is required that enables professionals to understand and manage the interdependency between the global and the local contexts. Therefore, CSI operates to:

- facilitate students and health professionals in undertaking field experiences and participating in community action-research projects – in Italy and in low-income countries – mainly focused on the social and cultural determinants of health and their impact on health inequalities;
- promote the introduction of new subjects and teaching methods into medical education;
- develop research and training activities in the GH field at local, national and international level.

Presently, CSI is composed of university professors, researchers, PhD and undergraduate students from different fields (medicine, anthropology, sociology, political sciences, law, etc.).

CSI is a laboratory for the integration of disciplines, participation and

peer-led work. CSI has adopted a horizontal and participatory approach in teaching (through peer-led teaching/learning in small groups under the supervision of qualified tutors) and research (through the planning and implementation of participatory action-research projects), as well as in decision-making (discussing and planning all activities through a consensus method). Such an approach allows mutual knowledge exchange between teachers and students, and among students themselves, despite different levels of expertise. Finally, it is different from the hierarchic and rigid university environment, avoiding reproduction of the dominant power structure in favour of a more equal learning and working environment, consistent with the principles and values of GH.

In order to translate its vision into practice, working often against the academic mainstream, CSI actively promotes the creation of networks at local, national and international level, involving different stakeholders (such as university professors and students, health workers, policy-makers, non-governmental organisations, civil society associations). At the local level, networks help connect the university with health institutions, community and civil society organisations, to plan and implement the action-research projects. On a bigger scale, examples of this approach are CSI's participation in the creation of the Italian Network for Global Health Education, as well as a similar European network, which is now taking its first steps. These networks allow collaboration and synergy between social actors and exchange between different experiences.

CSI is an intellectual and a social laboratory for experimenting with new approaches to both medical research and education. When trying to innovate, CSI has faced resistance to change within the university environment (when adopting a counter-hegemonic perspective, you don't expect the 'hegemony' to be supportive!). Adopting an 'activists' attitude' – ethical commitment and a strong correlation between theory and practice – has helped CSI go beyond existing norms and values.

In practice, this allows CSI to face the scarcity of human and economic resources – while addressing innovative, complex and non-market-oriented issues. CSI's orientation involves choosing collaborative rather than competitive approaches, based on common commitment and shared values.

CSI is in many ways a unique experience in the academic world, almost a 'leak in the system'. Nevertheless, it shows that 'another university' is not only desirable and necessary, it is also truly possible.

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Note

1 The People's Charter for Health is the pre-eminent directions statement for the People's Health Movement. It was adopted at the first People's Health Assembly in Dhaka, Bangladesh, in December 2000. See phm.org.

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