SEMINAR
"The Struggle for Health and Participation in the 21st Century: Challenges and Strategies"

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SERIE EDUCACIÓN PARA LA ACCIÓN
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EPES
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Contents

Summary

A collection of presentations from the seminar "The Struggle for Health and Participation in the 21st Century: Challenges and Strategies," held in celebration of the 20th anniversary of Educación Popular en Salud (EPES, Popular Education for Health), this publication identifies political, social and economic elements affecting health advocacy work in Chile. The various articles analyze the current situation of the State's role as guarantor of the right to health, as well as civil participation in influencing public policy and the commitment of churches and other organizations to social justice in their health-related work. Also identified are the problems EPES currently faces and its evolving strategy to meet these challenges.

Presentation

During January 3-6, 2002, *Educación Popular en Salud* (EPES, Popular Education for Health) celebrated its 20th anniversary and its new status as an independent foundation. Created in 1982 as a program of the Evangelical Lutheran Church in Chile, EPES' anniversary marked a new stage in its organizational history. We dedicated the new training room in our Santiago headquarters to the memory of our colleague, Gastón Toledo de Los Santos. We also debated the challenges we face today as we renew our commitment to health and dignity together with the communities with whom we work, our friends and members of the church who have accompanied us and supported us these many years.

As our colleague Karen Anderson, founder and current president of the EPES Foundation, states so well:

> *"Anniversaries are important rituals. They are a time to evaluate where we stand, to reflect on the past and to reaffirm our commitment to the future. Twenty years ago, when we founded EPES in the midst of the military dictatorship, we never imagined that one day we would be here celebrating our twentieth anniversary and looking forward to the challenges of the next twenty years."*[1]

As Karen also emphasized, *"We do not want this celebration to be just a stroll down memory lane. We want to ask the tough questions, to renew and strengthen our commitment to fulfill the promise of life in abundance for all God's people."*[2]

One of the central activities of this anniversary was the seminar, "The Struggle for Health and Participation in the 21st Century: Challenges and Strategies."

This publication contains the speeches presented during the seminar. It is not merely a debt to those who participated in the event, but part of our responsibilities in education and promotion of critical reflection. These presentations contain valuable experiences and reflections on health and participation among those of us who work with the neediest people, whose rights are being increasingly limited and who are threatened by the current emphasis of public policy.

Pastor Lisandro Orlov of Argentina's United Evangelical Church helps us remember the essentially humanitarian nature that should inform our health promotion work in the community. Based on his experience working with people living with HIV/AIDS, he stresses the need for the churches to welcome change and diversity and to renew their methods and to strengthen "the will of this community of faithful to join in solidarity with all those whom society excludes and marginalizes, no matter how crazy this may seem."

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1 Karen Anderson, "EPES celebra sus veinte años trabajando por salud y vida digna," march 2002.
2 Idem.

Valeria García, member of the Llareta Community Health Group, shares her experience as a woman, as a member of the grassroots community and as psychologist. Her brief, but well-chosen words describe the "individual and collective process" of transformation, the personal experiences that nurture the commitment to the creation of different human relations in a better society.

Fernando Leiva, economist in the Department of Latin American and Caribbean Studies, State University of New York at Albany, shares a summary of his presentation at the 2001 meeting of the Latin American Studies Association (LASA) in Washington D.C., in which he analyzed the "politics of participation" of Chile's post-Pinochet transition governments. Fernando describes how the power structure uses "participation" to consolidate its economic and political objectives, and he warns of the challenges that this implies for our work in health.

Dr. María Isabel Matamala, consultant for the Pan American Health Organization's project on Equity, Gender and Health Sector Reform in Chile, applies a gender perspective to the processes of health sector reform in Latin America in the context of an economic model that has deepened social inequalities. Her presentation allows us to perceive these reforms' real impact on the women of our countries, both as users of the public health systems and as providers of health care for their families and communities.

As president of the Canadian Public Health Association, Dr. Christina Mills analyzes the situation of health promotion in the current inhospitable political, economic, social and environmental context of the globalized world. She also explains how new theoretical frameworks and international agreements as well as advances in communications and technology may have a positive impact on health promotion.

Finally, our colleague and founding member of EPES, María Eugenia Calvin reminds us of our roots. She reviews the fundamental principles of EPES' work, based on the social and political context, the urgent need for survival, and the struggle and organizational efforts of the social movement. She describes the victories achieved by some community organizations working from the perspective of comprehensive health and points out several of the challenges that we now face as an institution.

We are grateful for the contributions of these friends of EPES and all our other colleagues and collaborators who have helped us reach this anniversary. We sincerely hope that this document will contribute to the permanent, dynamic process of construction and re-construction which is integral to our work for health and dignity for all.

Rosario Castillo Iribarren
Executive Secretary
EPES Foundation

The Church's Role in Promoting Health

Lisandro Orlov*

First of all, I would like to thank you for considering me part of the EPES project by inviting me to participate in this anniversary and at such an important moment for the institution and the EPES team. Since 1986, the Ecumenical Pastorate and EPES have worked together for a world of greater justice and solidarity. I am so very happy to be here, and I feel right at home. Thank you again for the invitation and the warm welcome.

This event is an important opportunity for reflection, a time to ask ourselves: What are we celebrating in these 20 years? Certainly it is not just the passage of time, but the construction of an identity.

EPES has an identity that is not quite the same as other non-governmental or civil society organizations. But what exactly is this identity? I was just now introduced as a pastor, and this identifies me as speaking from a certain perspective. I also work on AIDS issues; we support people living with HIV/AIDS, and I will also speak from this experience.

Obviously, when churches and their congregations become involved in health issues, they are not trying to compete with other organizations, which often do excellent work. Indeed, we have much to learn from the efforts of government agencies and civil society organizations. However, we must ask ourselves: *Why does the Church become involved in these areas?*

Working with people living with HIV/AIDS has taught us that our commitment to the issue of health has nothing to do with a virus or bacteria or microbes. Rather, our convictions and our actions focus on people's dignity. We have learned that people living with HIV/AIDS are sick and tired of our compassion and our pity. People living with HIV/AIDS are not looking for compassion: what they want and what they need is justice. This is the focus of our commitment to health issues, just as in any other area. The churches and their congregations are committed to people's dignity and to their demands for justice.

That is the identity of the churches in their work in society: to promote dignity and justice for everyone and at all times. But this identity and this commitment is under the constant threat of being transformed into mere works of charity. The worst sin churches commit is to limit their actions and become charities. The focus of our actions should be the social and human advocacy for those who need help to maintain their dignity within society. Social advocacy deeply respects each individual's independence and autonomy and avoids generating any sort of dependency. This objective is clearly expressed in the motto of the 10th Assembly of the Lutheran World Federation, to be held in Canada, July 21-31, 2003: *"For the Healing of the World."*

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* The author is a pastor of the United Evangelical Church in Argentina and the Coordinator of the Ecumenical Pastorate working with people living with HIV/AIDS.

It is truly difficult to translate the English word "healing" into Spanish because no single Spanish word captures all of the rich and varied meanings. A literal translation is limited to the physical plane, to the concept of curing the body. But this would reduce the notion of health to a one-dimensional aspect that robs the Federation's motto of its deeper meaning. In the context of Latin America, "healing" has a much wider and much less individualistic meaning. Our words for "restoring" or "repairing" would more adequately describe the Church's actions of solidarity in health. These actions are quite different from medical interventions because their primary objective is to heal situations of injustice that affect people's quality of life. The overriding concern of Christian communities is to help people to occupy their rightful place of dignity in society.

Through their actions in the area of health, the churches seek to heal situations of exclusion and marginalization. By accompanying those whose dignity has been wounded, we Christians have learned the cruel truth: those who are really ill, those who need to be healed in every sense of the word, are society and the churches themselves. Our work has made it abundantly clear that it is the churches and society that need to be cured of exclusion, marginalization and stigmatization. Our work encourages us to go out and meet with our sisters and brothers. From these encounters, we are learning to listen to those excluded or marginalized and then return and speak out against these realities in our churches and elsewhere. In this effort, we have a very specific model to follow, that of Jesus with the lepers.

In Jesus' time, in addition to being ill, lepers were liturgically impure because they could not take part in the community's religious celebrations. Neither could they enter the synagogues nor take part in any social gathering. Anyone who even committed the simple act of touching a leper was considered liturgically and socially impure and had to undergo a long process of ritual purification before being able to rejoin the community. When He encountered the lepers, Jesus acted in defiance of society and organized religion. Touching the lepers was a very simple gesture, but through this act He, too, became a leper. Through gestures like these, one assumes the social stigma of the individual or the group, taking on the marginalization or exclusion of the *other*. Jesus turned Himself into a leper: through His solidarity and communion He became marginalized and excluded.

This archetypal model of Jesus leads us to question whether or not the churches and Christians are willing to imitate Jesus and embrace all those who are excluded and marginalized in and by our society and our churches. This is the challenge, the lesson that our communities face when they participate in health issues. Embracing those who are excluded, taking on their stigma and becoming one of them – this is the lesson that gives the churches an identity when dealing with the issue of health.

As we recently heard, in this globalized world the only thing that has truly been globalized is exploitation while the benefits of globalization continue to be enjoyed by a select few. In this context, the churches must be a locus of resistance that helps to build a counterculture. It is dangerous when the churches and their pastors are too welcomed and accepted by society. This is a very bad sign. I often tell the members of my parish, my brothers and sisters, that if any of us followed the Scripture word for word and tried to live as Jesus did, our churches surely would have thrown us out long, long ago because this is exactly what the esteemed religious authorities of His time did to Jesus.

Last year, in the United Nations General Assembly's Special Session on AIDS, we witnessed how civil society began to use language in a surprising new way, which undoubtedly reflected a change in mentality. Civil society has shown that it is ready and able to understand vulnerable groups from a perspective that is much more respectful of their dignity and human rights.

But who comprise the vulnerable groups? With regard to the issue of AIDS, the churches are quick to acknowledge only two vulnerable groups: women and children. Focusing their message entirely on these groups makes it very easy to avoid addressing the other vulnerable groups that are problematic for "moral" reasons. By disguising and avoiding the problem, the churches involves themselves in the HIV/AIDS epidemic without paying any of the costs.

Civil society is now willing to talk about male and female sex workers, to address what we generally refer to as prostitution. Civil society is also talking about how to help prevent HIV/AIDS among men who have sex with men, which is a totally new way of describing these many different realities. But are these just new labels? Are we merely changing the names, or is there a change in the mentalities and attitudes that accompany the way we address these realities?

Society is changing, and we ask ourselves what will happen with the churches. *How will we take part in this change of mentality and attitude?* The methods and ideological structures that have been used in the past are no longer appropriate for understanding the realities that the epidemic has revealed and which we are healthily obliged to face. Sadly, our churches are often specialists of the old guard, continuing to answer questions that no one is asking any longer.

The HIV/AIDS epidemic has forced us to sincerely ask the question: *Why are Christian communities working on health issues?* The answer will surely lead us to earnestly consider changes and find the will to carry them out. The dynamics of recent events encourage us to not simply repeat old formulas that have worked in the past. Today, we confront new realities that few of us could imagine before.

Our work with the team of the HIV/AIDS Ecumenical Pastorate in Buenos Aires has challenged us to open our minds and our hearts. Until only recently, we used to say, without fear of any consequences, without guilty consciences, that transvestites or transgendered people were mentally ill. Based on this prejudicial belief, the team decided to only accompany these individuals when they were admitted to the hospitals and not take them into the Pastorate's halfway house. And indeed, this Hostel of Solidarity was not an appropriate space for them. Our decision to exclude these cases was well-grounded in theory, and our consciences were clear.

But our calm certainty was rapidly challenged when we started to hear the life histories of the first transvestites whom we accompanied in the hospitals. As we listened closely to these stories, our protective walls came tumbling down, and we were forced to rethink our entire pastoral action. This process led us to seriously question our concept of inclusion and showed us the poverty of our affirmations born of pure ignorance. Reality in all its complexity forced us to rapidly change our attitudes and our pastoral methodology, to open our faith and our hearts so that our team could become witnesses to the dignity of all people, without exclusion.

We hope that this work in society will lead to a conversion process that will renew the churches both theologically (regarding the nature of the God in whom we believe) and ecclesiastically (regarding the concept of inclusion of the Christian community). Anyone can condemn, marginalize and exclude when they are sitting behind a desk because, after all, these are only theories... But in real life, when this reality has a face, a name and a history, it is quite difficult to exclude.

Today, civil society is talking about drug users; terms like "drug addicts" are no longer used. Words always reveal what is in our hearts, so we must try to perceive this change of vocabulary as part of a mental and methodological change, leading us to act based on real and profound respect for the human and civil rights of all people, in all situations and circumstances.

This new mentality, this new understanding of social problems, demands a renovation of the way in which churches address these issues. In general, Christian communities are tempted to support any methodology that proposes abstinence, be it in terms of sexuality or the use of illegal substances. Our theological traditions have long been suspicious of emotional bonds, sexuality and any conduct that is not "normal." This reality is clearly reflected in the way in which churches deal with addiction. The most common approach has been compulsory abstinence as a condition of any sort of therapeutic or pastoral counseling.

Today, a new way of addressing the issue has appeared: *"harm reduction."* This approach is based on a profound respect for others' different identities, options and lifestyles. It is based on respect for human and civil rights, on considering and recognizing the decisions of others and helping them to endure the least possible harm as a result of their lifestyle.

In some countries, the churches already have begun to employ this new methodology for working in this area. We must ask ourselves: *Where are the Latin American churches? As pastors, how will we take part in this process of harm reduction? What methodological approach best expresses the spirit of the Scripture?* The Scripture always shows us an approach to the real situation of others that is unconditional, free and open.

I suspect that behind certain works of charity or social action undertaken by some Christian communities, there often lies the desire for opportunist proselytism that undermines their good intentions. In this regard, the attitude that I sometimes have noticed in the treasurer of my church when he pays my salary at the end of each month is quite revealing of his attitudes about the work of the deaconate. He has asked time and again: *How many people have been converted through your work supporting people living with HIV/AIDS?* This question clearly evidences a theological and ideological attitude common among many Christian communities in their social activities. To his exasperation, my answer was always the same: only one person has been converted – me.

The principal objective of a Christian community is to incorporate into the church the concerns of individuals who are totally alien to it, those who are completely different. This is called conversion. The action undertaken by the churches in the context of the HIV/AIDS epidemic exposed us to realities that previously had been alien to us. *The real converts are the agents of the pastoral action because the Scripture exposes them to dynamic, changing and unfamiliar realities.* This is the essence of the theology of the Cross that so identifies Lutherans. In Christian communities, the Cross is a sign and symbol that reminds us of and embodies that which is totally alien to the religious community.

Under the shadow of the Cross, action in health in the context of the HIV/AIDS epidemic becomes an action stripped of power relations and hidden with Christ in God. It is the will of this community of faithful to join in solidarity with all those whom society excludes and marginalizes, no matter how crazy this may seem. The marginalization or stigmatization of others is the sole basis for this action of service from the Cross. It is the action undertaken by those who know that they are wounded healers and who heal from their own wounds and experiences of exclusion.

In this context, it is fitting to cite Martin Luther's *Commentary on St. Paul's Epistle to the Galatians*: "If there truly is some good in us, it is not of us but is a gift of God: and if it is a gift of God, we owe it entirely to love, that is to say the law of Christ. And if we owe it to love, I should not use it to serve my own interests, but to serve others. Therefore, my erudition is not mine, but of those who are not erudite: it is a debt that I have to them. My chastity is not mine, but of those who commit the sins of the flesh: it is they whom I must serve with my chastity. And this I do, presenting it to God as an offering on their behalf, interceding for them, excusing them, covering their dishonesty with my honesty before God and the rest of Mankind... Thus, my wisdom belongs to the poor, my justice to the sinners, since knowledge and the rest are *"ways of God"* that we must cast off to bear instead *"ways of servitude,"* because with all of these characteristics we must stand before God and intervene in favor of those who do not have them, as if we wore the clothing of another, just as a priest presents an offering from those around him clothed in ritual attire and not his regular dress. But we must also serve others with the same love against those who slander and oppress them: because this is what Jesus did for us."

Christian communities' action in health is therefore an attempt to take on these *"ways of servitude."*

When the Ecumenical Pastorate's team of volunteers working with people living with HIV/AIDS felt the need for an image that would express their identity, they chose August Rodin's sculpture of two hands joined to create a harmonious space; it is called "The Cathedral." This decision was based on our desire to create just such a space for dialogue and exchange among equals in our work accompanying those living with HIV/AIDS. In this regard, I remember the story shared by a nun who took part in a meeting of volunteers working in HIV/AIDS prevention. She explained that she had tried all night to imitate the hands of the sculpture until she realized that the image requires the hands of two different people. Coming together, which generates a sacred space like that of any cathedral, also requires people to enter into a dialogue in the spirit of equality and mutual comprehension.

The churches' activities in promoting health must always address people as equals. It means sharing our sickness and our health. There are no predetermined roles of those who administer and those who receive care, some in a position of power and others who are needy. This is an experience generated by the collaboration of equals. It is always reciprocal, and that is why we must address health in the broadest sense of the term. Through the World Council of Churches, Christian communities have basic documents that provide an excellent overview of the comprehensive understanding of health that goes far beyond an explanation focused on viruses or microbes[1]. When the churches talk about health, they do so from a perspective that embraces all the factors that influence health and illness.

What do illnesses and epidemics do to vulnerable people? First of all, they focus the issue of health on justice. Injustices result in people being placed in situations of vulnerability. We cannot talk about health without talking about poverty and social, cultural and economic injustice as well. A person living in poverty is more vulnerable not because of an individual characteristic, but because of the context of their life. When we talk about health, we must keep in mind above all the entire social situation. Talking about injustice or poverty also means talking about the changes our societies need in order to heal these realities. Health and illness form part of the social structures that need to be reformed.

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[1] Christian Medical Commission, "Comprehensive Health. The Churches' Role in Health," Geneva: World Council of Churches, 1990.

From this perspective, we can assert that, as a foundation with close ties to the Christian communities, EPES' function is to train those who can dream new, just social structures, to train those who would search for the new star of Jerusalem and who will lead us and reveal new realities of solidarity and dignity. Training health monitors means mentally and emotionally preparing people to dream new, comprehensive utopias, creating promoters of a new society in which relations of equity and justice are evident immediately. This urgent need is clearly expressed in the pastoral concerns of Jesus Christ who called on his disciples to be specialists in the here and now and not escape into the "great beyond" which would allow us to avoid commitment with reality. Christ promises all His disciples that we will inherit heaven and earth.

When we talk about health, we also are speaking of peace. Violence of any sort makes people more vulnerable. Our concept of health must also incorporate the concept of peace in the world, our society and our communities. Battles and struggles between brothers and sisters cause more death and illness than many diseases. We have become used to the media's presentation of war in which everything looks like fireworks and special effects, without any of the realities of the suffering of the wounded and the dying. Statistics are manipulated, and the face of death is hidden. In such situations, conventional medical treatment offers little relief. Through our solid commitment to justice based on peace, Christian communities can make a tremendous contribution in these situations of structural violence.

When we talk about health, we must talk about the interdependence of creation. Atomic weapons and biological warfare continue to be real threats on the horizon of our globalized world. Our ability to destroy one another is not only a theoretical possibility but a reality that conditions the relations among countries. Aside from the nuclear threat is the danger of environmental contamination which underscores how immediate gains can compromise the future. Sustainable development is still only an abstract notion, and the powerful and most highly-developed nations – those that most contaminate nature and export this contamination – block any possibility of an international agreement that would protect the environment so that we could leave future generations a habitable world.

The human race is today an endangered species threatened with extinction. We know that the protection of the human race first demands that we hear the cries of all creation that awaits its liberation.

The churches' commitment to promoting health is part of the call to mission that they all have received, a call that urges them to go out and face these realities and overcome the feelings of complacency in our church ghettoes. The commitment of the churches to health promotion springs from their desire to cooperate with all the civil and governmental organizations in the construction of a more humane world. The identities of these very communities are challenged by their commitment to health.

A church's identity is always an identity in construction and dialogue. If the seed of wheat dies, it cannot bear fruit. The church's role in health is a relationship built on and acquired through cooperating with the society in which the community is embedded.

In the Scripture, the church finds models for action in health, such as when Jesus heals the woman who had suffered from menstrual hemorrhages for more than 20 years, a miracle that took place in fairly strange circumstances. Because of her gender and her nationality, the woman did not feel worthy enough to ask directly to be cured. Because she was a menstruating woman, the customs of Jewish law considered her to be impure, both socially and liturgically. In addition, she was a foreigner.

So she was excluded from the health system for a number of reasons: because of her gender, because she was impure and because she was foreign. Defying customs and norms, the woman dared to touch the hem of Jesus' garment. In the midst of the crowd that surrounds him, Jesus asks a question that must have sounded very strange to his disciples: "Who has touched me?" The woman panics because in her desire for health, she has defied all the norms. Filled with fear, she confesses before the multitude and before Jesus that she was the one who touched him. To everyone's surprise, Jesus praises the woman for transgressing the ritual laws of religion and custom.

This wasn't the first time Jesus had done something like this. Another story recounts the healing of the ten lepers sent before the High Priest to testify to their healing as demanded by the Law of Moses. Only one returns, disobeying the command of Jesus and the ritual or health law. The leper who returned was also a foreigner, and Jesus also praised his transgression.

These stories propose archetypal models for the churches' action in health: going beyond the social concepts of inclusion and exclusion; defying norms and challenging systems of injustice and marginalization, generating possibilities of integration in actions that promote the dignity of all people. We hear the very words of Jesus: "Your faith has saved you." These actions in health are born of faith and challenge and defy the concepts of inclusion/exclusion, of otherness, purity and propriety.

Jesus is a great transgressor, and the churches must also be great transgressors: of laws, of prejudices, of stigma. We know that when Jesus Christ returns, he will sit down with all of us who have been thrown out of our churches and our societies. Action in health makes a space for us at this same table.

Obstacles to Health Promotion in a Globalized World: The Role of the State and Challenges for Community Organizations

Dr. Christina Mills*

In order to address the obstacles to health promotion in a globalized world, I have attempted to cut this rather daunting topic down to size by working through a sort of SWOT analysis – a review of the strengths, weaknesses, opportunities and threats affecting the future of health promotion (HP).

Strengths

First of all, we have solid theoretical frameworks around which there is a high degree of consensus world-wide. In 1986, the World Health Organization released the *Ottawa Charter on Health Promotion.* The following definition and salient points from the Charter are fairly widely accepted, although often honored more in the breach than in practice:

- HP is the process of enabling people to increase their control over, and to improve, their health.
- To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.
- The prerequisites (fundamental conditions and resources) for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources and equity.

The values and definitions of the Charter can be traced directly back to a document published by Health Canada in 1974, *A New Perspective on the Health of Canadians.* Widely known as the Lalonde Report, it became the global touchstone of health promotion theory. Most of you are probably familiar with its general content, but let me remind you of some points I think are particularly relevant to today's discussion. Among other things, the report:

- describes the different groups of determinants which influence health (health fields); in addition to health services, these are the environment, biology and genetic endowment, and behavior (referred to at the time as lifestyle, a term now out of favor because of connotations of victim-blaming);
- highlights the need to intervene in all health fields in order to have a healthy population; and
- identifies reducing inequities as a primary objective of health promotion and community participation as a key operating principle.

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* The author is a physician and president of the Canadian Public Health Association. She is also a founding member of the EPES team.

The Lalonde Report thus established a theoretical basis for an important role of the State in HP, since no one sector possesses all the tools and resources needed for the full range of interventions in all the health fields. (Of course, not all governments recognize and fulfill that role.)

Second, we now have decades of practical experience in widely diverse settings and conditions. Millions of people have been reached by thousands of participants in hundreds of projects and programs around the world over the past quarter century, and the benefits of HP for both individual and social health have been seen. Not all such programs have been as durable as EPES, but that's another story...

Third, there is an increasing body of evidence that validates the process of HP; this serves to inform and improve HP practice and support requests for funding needed to sustain and increase the progress made to date. Research has confirmed many things we once suspected or believed (or merely hoped) – such as, for example, the damaging effects of stress, unemployment and social exclusion on health, and, in the latter category, the benefits of social support and humor.

Weaknesses

The main weakness I want to address is not intrinsic to HP, but is the result of ambiguity in how the phrase "health promotion" is used. It is applied variously to a philosophy or ideology with certain values (such as equity, participation, etc.) and to refer to a set of tools and mechanisms to achieve health gains: community mobilization, capacity-building, popular education, empowerment, advocacy, social marketing and healthy public policy (including legislation, regulation, fiscal and tax measures, organizational change, etc.)

This confusion has led to a false dichotomy between HP and disease prevention. For example, someone once said to me, "Oh, you only deal with diseases; I deal with health." This is a prime example of throwing the baby out with the bathwater! We forget that in order to enjoy health in its broadest sense, we must first be alive, and that people don't die of the absence of positive health, but of very concrete causes, such as AIDS, motor vehicle crashes, cholera, cancer, etc... Maybe the tendency is so extreme in Canada because we are a relatively rich country and think we can afford the duplication involved in maintaining this separation between health and absence of disease, but it leads to inefficient use of resources (financial, human and knowledge), as well as destructive competition for resources between programs directed at disease prevention (e.g. efforts to reduce risk factors such as tobacco use, physical inactivity and poor diet) and "purer" programs which focus on building capacity and social capital.

Threats

The major threats and obstacles I perceive are very much intertwined, but the unifying theme seems to be the environment – not just the physical environment, but also the political, economic and social environment. The domination of neoliberal economics and the primacy of international trade agreements over and above those of all other sectors has led to an erosion of the power of national governments to establish social, environmental and health standards. Results: increasing inequities in income distribution within most countries and internationally, with consequent environmental and social deterioration.

In the name of international competitiveness, governments keep shrinking the public sector, resulting in ever more desperate competition for increasingly scarce resources. In Canada, the values of solidarity and mutual aid that lead us to seek collective solutions to shared problems are in danger of being replaced by US-style individualism under the unrelenting and inescapable barrage of mass media. In the three richest and most populous provinces, right-wing governments are implementing a virtual orgy of privatization. The Canada Health Act, a federal law, guarantees Canadians universal and equitable access to publicly funded and administered health care services, but the range of services, even within health care *per se* is narrow: only physicians and hospital services are covered; neither drugs, nor dental services nor other paramedical professions, such as physiotherapy and psychology, are included. Forget equal access to prevention and HP! Furthermore, under our constitution, the responsibility for actual delivery of health services resides with the provinces, which fiercely resist any attempt by the federal government to introduce new national standards or programs. Their attitude is always, "Just give us the money!"

Advances in genetics and biotechnology also present a challenge for HP, in that they seem to offer a magic bullet to cure all ills. The promise is tantalizing but deceptive; as sophisticated as the bullet might be, the concept is still simplistic, and health problems are more complicated. The challenge for HP practitioners will be to keep prevention and HP on the agenda of politicians and funders dazzled by the glamour of biotechnology.

Environmental degradation constitutes a different sort of challenge. Environmental deterioration accelerated by economic competition can produce intergenerational inequities as great as or greater than those we see now among countries, regions, ethnic groups and classes. The physical, economic and social well-being of our children and grandchildren will be affected by decisions taken today by individuals, communities and governments. We need to make sure that the policies we advocate from the other sectors influencing health (transport, housing, finance, etc.) do not sacrifice the health of future generations for a short-term gain.

Opportunities

In the face of economic globalization, we have what some have termed a counter-globalization but which I prefer to think of as a globalization of solidarity, enabled by modern communications technology. When my son participated in protests against the Free Trade Agreement of the Americas in Quebec City, I was able to follow events throughout the weekend, thanks to a web site set up by a progressive group to share the news not often found in mainstream media. The text of a response to Canada's draft position on one of the agreements was distributed around the word before the news was even reported in the paper. Experiences, lessons, warnings, calls to action, all can be shared in less time than it takes to get them down on paper. This means that, at a relatively low cost, very small organizations can have the benefits of what amounts to a very sophisticated intelligence service, and that they can enter into alliances that go far beyond local or national borders.

This can help address a dilemma described by some activists: that the most effective community interventions are those that are designed, developed and implemented by the community itself, but larger and more powerful organizations are needed to get the attention of those making decisions on the national and international level to complement and support community interventions. The judicious use of information technology can facilitate more flexible and effective links among community organizations as well as between them and national and international NGOs, other sectors and

governments at various levels. The need to establish new kinds of alliances is not unique to HP; it's an issue for all of civil society. We have already seen some the benefits of broadened alliances in the mobilization around international trade deals.

Conclusion

So, now what? We certainly didn't achieve the dream of "health for all by the year 2000" and the competition for scarce funding dollars is more ferocious than ever, now that governments are obsessed with security and counter-terrorism. Someone once said that the test of a creative intelligence is the ability to entertain contradictory ideas simultaneously – and gave as an example the ability to see a situation as hopeless while maintaining the will to keep working to make it different. Not to recognize the magnitude of the challenges facing us would be naive, but we mustn't give in to despair. We need to take advantage of the advances we've made in theory and practice over the two decades, the passion and commitment of those who have accumulated that knowledge and experience, the possibilities for knowledge exchange provided by the Internet and the new alliances that this can facilitate.

I have no doubt at all about EPES's capacity to tackle today's challenges and those of tomorrow, and I feel truly privileged to have walked a small part of the road with you. Thank you so much for inviting me to participate in this seminar and to share your 20th anniversary celebrations – please accept my heartfelt congratulations and best wishes for your future work. To paraphrase Bertolt Brecht,

There are those who struggle for a year, and they are good.
There are those who struggle for a decade, and they are better.
But those who struggle for a lifetime are indispensable.

Dear friends in EPES, in the struggle for health and human dignity that defines health promotion, you are truly the indispensable ones.

The Situation of Women's Health in the Context of Health Sector Reform in Latin America

Dr. María Isabel Matamala*

It is very exciting to be here to share with people from EPES and with the community committed to health in Chile and elsewhere in Latin America, especially among the neediest and most vulnerable sectors of our countries. It is exciting because even though I am not a founding member of the EPES team, I have watched this dream grow, and I have shared in the utopia that this effort implied.

The invitation that EPES sent out for this event contained a quotation from Galeano explaining that utopia always moves away from us and that we must continue to pursue it. I believe that with each step that it has taken, EPES has somehow slowly caught up with this utopia. What we are sharing today – here in this house, in this room named for Gastón[1]– is part of this utopia first imagined 20 years ago by a group of dreamers to whom we now pay tribute.

My task is to speak about women, and I prefer to speak of women in the plural because there are so many of us and each experiences health her own way amid the contradictions and discriminations of different health care systems. Since we have to place women in the context of health sector reform, I want to begin by showing you a table that will help us understand why real reforms are necessary. Although the term "reform" means an improvement, in practice this is not always the case, neither in Chile nor elsewhere in Latin America. This table describes the health care model and the crisis that supposedly requires reform.

As Christina Mills and Lisandro Orlov have reminded us, we must examine the political, social and economic contexts of health and how the sex/gender system influences health through the roles assigned to women and men and the accompanying prejudices and gender-based discrimination. Together with globalization, this socio-political structure, including the sex/gender system, has imposed a model of production and consumption and a type of anti-ecological development that has increased health risks considerably and undermined living standards for most of the population.

Social inequalities of all sorts have grown worse; the benefits of economic globalization are enjoyed by only a small percentage of the population. The great majority have no access to these benefits, and their living standards actually have fallen. We have also witnessed the feminization of poverty: the poorest of the poor are women, especially rural, indigenous and/or elderly woman and young girls.

If we look back in history, we see that under the system of the welfare state, the social contract assumed that the salary of a single worker –then more frequently than now a man– would be enough to support the family. Today, even if there is a man in the household who works, he alone cannot meet all the needs of the family. As a result, women and children have also had to join the labor market and contribute to the family's maintenance.

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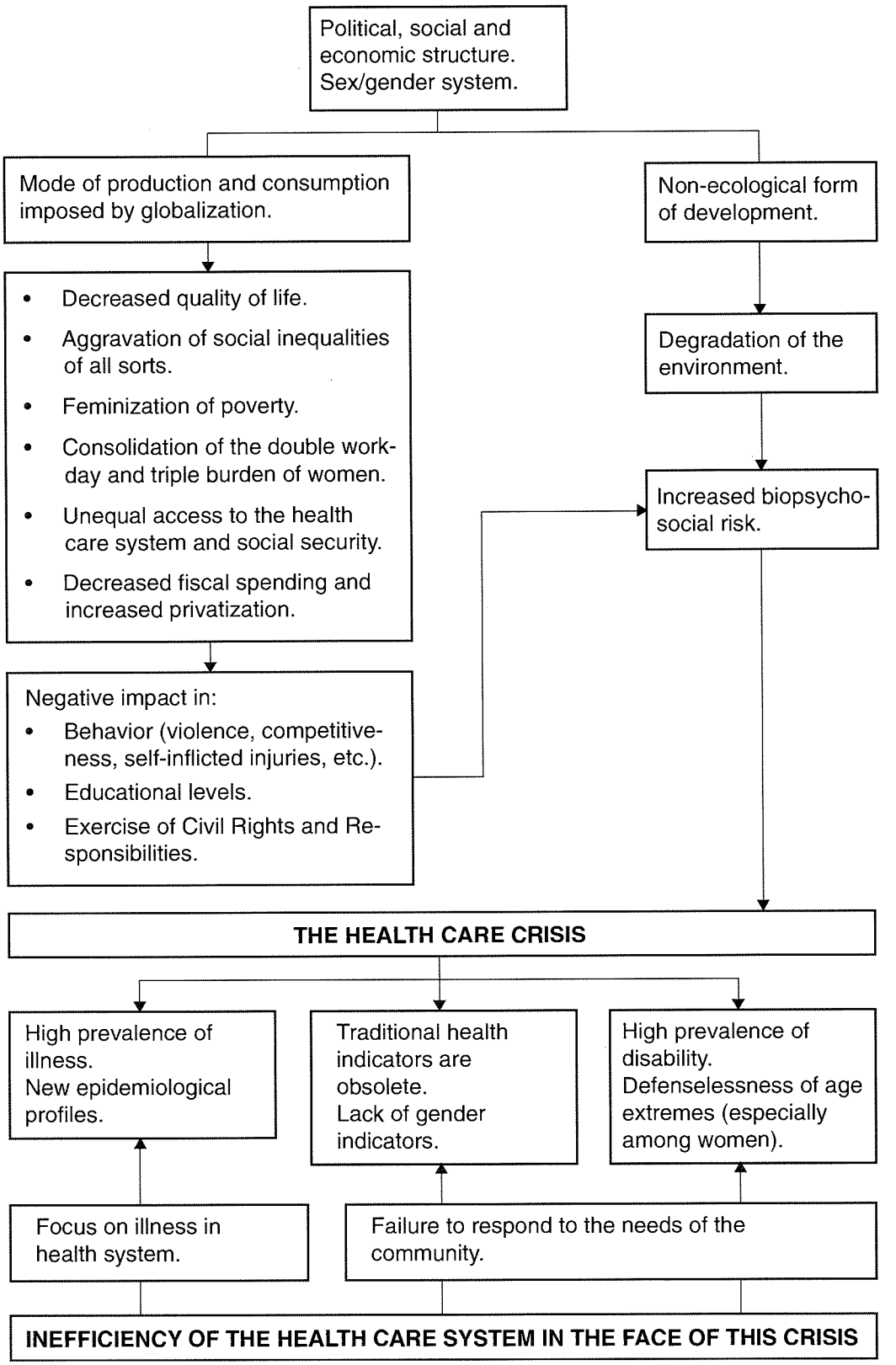
1 Gastón Toledo, a long-time member of the EPES educational team, died November 20, 2001.

THE HEALTH CARE MODEL—THE HEALTH CARE CRISIS[2]



[2] Adapted from M. Costa, E. López, "La Crisis Mundial de la Salud", in *Salud Comunitaria* (Spain, 1986).

One immediate result of this situation is the double and triple workday endured by women. There has been little, if any, change in the situation of women's productive work within the home: women workers, who thanks to the long hours of labor flexibilization dedicate eight, ten or twelve hours to paid work, must return to their homes to shoulder the tasks they still do not share with the other sex. At the same time and in one of the great gender inequities that still exists in our society, these working women have unequal access to health and social security systems due to gender-based wage disparities and because they often must quit their jobs. We all know that in Chile and throughout Latin America, women are paid 60% of men's salaries for comparable work.

Another effect of what has been called the "modernization of the state" is the tendency to follow the recipes of the World Bank and the International Monetary Fund by lowering state spending on health and education and opening these services to the market through new and "inventive" forms of privatization.

These factors also have had a tremendous impact on women because in addition to the double workday, they also face another extra burden: cuts in government health spending, which pass on these costs to the household.

We talk in the abstract about households that have to assume the responsibilities of caregiving and health promotion. But these households are not abstractions: they are the women who take on these tasks. Each time a hospital cuts costs, many homes must take in and care for the elderly, the sick who have been prematurely discharged, or the terminally ill suffering from cancer or AIDS. While we may find the humane aspects of homecare to be important, the realities of our countries mean that the tremendous costs of homecare are shouldered by the women caregivers who have neither the time, the means nor the real possibilities to take on these additional responsibilities.

As a result, within the domestic sphere women are making a tremendous, unseen effort: it is not recognized by those around them and much less by the national and global economies. The model of the welfare state has vanished from our countries, and women have become a buffer zone by providing the care no longer assured by the state through what we have termed the "domestic health care system." As a result, despite the whirlwind of reforms, the fact that health care indicators have remained steady in Chile and in the rest of Latin America is largely due to the monumental effort of women in their own homes.

The negative impact of the reform processes are revealed clearly in the behavior, levels of education and, above all, in the civil participation of the general population. For example, in the case of Chile, the first neoliberal health sector reform – the most orthodox proposed by the World Bank – was undertaken in the 1970s, during the Pinochet dictatorship. Even the country's constitution was changed: the "right to health" became the radically different "right to access" which meant a serious setback for civil rights. The very right of Chilean citizens to participate in and determine public policy was put in question by these World Bank-led reforms.

All of this supposes that what is happening in health today cannot be addressed as it once could have been under the welfare state. The paradigm shift, the cultural change of globalization, has led people to live in a context of competitiveness and anguish, which in turn transforms the type of illnesses suffered by the population. Today, at least in the Southern Cone, people are not as afflicted by transmissible diseases which were the primary cause of mortality and morbidity in past decades. We now find that mental health illness, the so-called "ills of the soul," are more prevalent. However, the system does not diagnose these fundamental problems, and therefore no responses are offered.

As an example, let us look at a situation in Chile that has recently caused a great deal of controversy. The mayor of Santiago decided to dismantle the city's first treatment center for gender-based violence, founded over ten years ago by the municipality and the National Women's Service (SERNAM). The mayor made this decision because the center costs 60 million pesos (about US$86,000) each year. Evidently, there is still not a clear perception of the fundamental problems of violence faced by women (and men, who were also treated at the center). Centers like these for the treatment of violence represent an effort to change our health care responses.

To use the terminology of the health profession, what we are proposing are "new epidemiological profiles." These profiles imply a change in the ways in which the general population lives, becomes ill and dies. However, we continue to measure health with the same indicators as before.

In Uruguay, for example, every eight days a woman dies as the result of domestic violence, and yet we continue to measure health in terms of maternal or infant mortality. At the same time, infant mortality will tell us very little about the situation of girls who have been raped. They didn't die during their first year of life, so it can easily be claimed that the status of girls' health is excellent because infant morality is down. But it so happens that one out of every four or five girls aged one to five are victims of abuse or rape, especially in the most vulnerable sectors, and nothing is being done about it. This is an example of the defenselessness of the elderly and the young, especially in the case of women. Meanwhile, our countries continue to emphasize health services which are really "illness" services: they are not focused on the community; there is no real participation by the community; and the services are unable to effectively respond to the health crisis.

Health sector reforms should aim to resolve this issue, but the debates, discussions and new recipes proposed by the World Bank in response to the failure of the health sector reform implemented in Chile under the dictatorship are all focused on resolving the problems of health system financing. The new reforms seek to guarantee the continued coexistence or "collaboration" between the public and private systems, with one dealing with the poorest and most dispossessed sectors while the other concentrates on profits. Until now, this has been the recipe of the so-called "second generation" of health sector reforms.

The Colombian attempt at reform has been in place for some ten years, the longest of all the efforts in our region. Recently, we heard the opinions of a Colombian physician visiting Chile who shared his opinions on this undertaking. I'll cite just one example: when the Colombian reform was first implemented, 14% of the population had no health coverage, but now, ten years later, 40% of Colombians have no health coverage. We call this "evidence," and in the medical profession, it is very "in" to talk about evidence-based medicine. So we are seeing evidence that as long as the reforms in Latin America do not meet the needs of the population – and fundamentally, the needs of women who are the most affected by the reforms – we will not be able to resolve the real health problems of the population in general and of women in particular.

In conclusion, I wish to emphasize why we insist that women must be a priority in the planning and design of the reforms. First of all, women are the mainstay of the domestic system of health care. As a result, they make the greatest contribution to the production of health services. In addition, they have an added value that we have never been able to evaluate: their work is based on emotional bonds. When an aide, a nurse or a midwife places her hand on your forehead, it does not have the same soothing effect as the hand of your grandmother, sister or mother, and this cannot be measured.

Another aspect that we often talk about when we examine these reforms from a gender perspective is financing. You want to talk about financing? Okay, but we have to describe the economy of health in its totality and not just the mercantile aspect, and this means placing value on women's contribution to the health of the general population through the system of domestic health care.

The women's movement is defending this contribution throughout Latin America. We want women's unpaid work to be recognized in the national accounts, the Gross National Product and the Central Bank of every country so that the entire population is aware of this reality. We believe that this recognition of women's contribution would restore some justice on a macroeconomic level and in the overall panorama of reform policies. This would have positive repercussions for women's health both in terms of self-esteem and social and civil identification. Above all, we do not want any elderly woman to be bereft of health care after a life of caring for others simply because her husband dies or because she has no social security or independent means of support.

I am thrilled that we are working with EPES on this topic in the reform process. And I believe that we must invite all the women and men of Chile to take part in these civil initiatives that will most assuredly facilitate greater justice in health not only for women, but for the entire population.

Finally, I would like to thank you all for giving me this opportunity to speak, in particular the EPES team and the entire community with whom I've collaborated for so many years: among them, Mónica, Valeria and the many other women from the El Bosque neighborhood with whom I worked when I first returned from exile and who have been an example for us all during these many years.

The "Politics of Participation" and Social Control Under Chile's *Concertación* Governments

Fernando Leiva*

I am very pleased to be able to take part in this commemoration of the 20th anniversary of *Educación Popular en Salud* (EPES) and the celebration of the recent creation of the EPES Foundation. Both of these important achievements are the result of the hard work, clarity of vision and commitment of all of you.

I would like to share with you a summary of a paper presented at the 2001 meeting of the Latin American Studies Association (LASA).[1] At this event, health promoter Valeria García, María Eugenia Calvin from the EPES team, Julia Paley and I took part in a roundtable entitled "The Complexity of Participation in Chile: From Social Action to Social Control."

The roundtable questioned whether the current "politics of participation" facilitates new forms of representation or if instead they form part of a new strategy for social control designed to discipline grassroots organizations in our country. The reason for asking this question is very concrete: in Chile as in all of Latin America, we are witnessing a major change in the dominant discourse. It appears as if those in power have discovered that "participation" is the key to ensuring their political and economic objectives. We see the emergence of new policies and a new language among international financial institutions and in the ministries of Latin American governments. Therefore, we are well advised to examine the reasons for this change in discourse, the sort of participation that is being promoted, and the implications for our work. Understanding the nature of official discourse on participation is fundamental for a clear view of the complex challenges confronting EPES and the health promoters in the 21st century.

A New Discourse on Social Participation

In the mid-1990s, the international financial institutions – the World Bank and the Inter-American Development Bank, among others – had begun to thoroughly revamp their discourse. Abandoning their exclusive emphasis on economic policy, these institutions began to stress the importance of "civil society" and "citizen participation." Surprise! After more than a decade of neoliberal policies praising the supremacy of the market and private initiative, these same institutions began to discover that "civil society," "citizenship," NGOs, "partnership" and most recently, the "social capital" of the poor were key for the success of their policies. In light of this new discourse, we must ask ourselves: Are we witnessing a sort

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1 See Fernando Leiva, "'Participation' and Social Control Under Chile's *Concertación* Governments: New Forms of Representation or an Emergent Global Strategy for Disciplining Social Actors?" Paper presented at the 2001 meeting of the Latin American Studies Association (LASA), Washington DC, September 6-8, 2001.

of "conversion on the road to Damascus" on the part of the international financial institutions? Does this indicate a major "paradigm shift" on the part of these institutions and, by extension, on the part of the U.S. Treasury Department, their main shareholder?

The governments of the *Concertación* also reflect this "shift" and, in fact, are at the vanguard of similar changes throughout Latin America. Thus, Chile's third consecutive *Concertación* government has proclaimed that "one of the distinctive traits we have wanted to give to the Third *Concertación* Government is that of **more and better citizen participation**."[2] This objective has been enthusiastically endorsed by the Inter-American Development Bank through a pioneering US$15 million "Program to Strengthen Alliances Between Civil Society and the State," currently being implemented in Chile.

This is an important change in the discourse and policies of the international and national political class. As we enter the 21st century, it appears as if every Tom, Dick and Harry is taking up the banner of "participation." To what do we owe this change? What does it imply? Is it a real transformation that opens up new possibilities or is it merely a new strategy for social control?

The Great Achievement of Chile's Military and Civilian Political Class

In an attempt to answer these questions, I will begin by sharing the astute observation by historian Gabriel Salazar that "one of the most distinctive characteristics of the neoliberal model imposed by the military political class since 1973 and legitimized by the civilian political class since 1990 has been the ability to transform the structural conflict of Chilean society (typical of the 1938-1973 period) into a subjectivized one; into a private malaise."[3] Based on this observation and on a critical analysis of the discourse on social participation throughout the past decade both at an international level as well as in Chile, I have come to the conclusion that the "politics of participation" has facilitated this achievement. In short, I argue that the "politics of participation" implemented by each of the three *Concertación* governments over the past ten years has not strengthened democracy in our society but the hegemony of the dominant classes. This assertion – which may appear contradictory at first glance – requires a much more profound and detailed analysis.

To develop my argument that the "politics of participation" has contributed to the strengthening of the hegemony of the dominant classes in Chile, rather than true democracy in our society, my research examined three elements. I first analyzed the different international experiences that have influenced the formulation of the international development agencies' discourse on participation.[4] Next, I undertook a detailed examination of how "participation" has been conceptualized and re-conceptualized by each of the *Concertación* governments over the past decade. And finally, I examined the role that the "politics of participation" plays in Chile, exploring some of the main contradictions evidenced so far by "participation" policy discourse.

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2 Ministerio Secretaría General de Gobierno, "Plan para el Fortalecimiento de las Organizaciones Sociales de la Sociedad Civil," Mimeograph, Santiago, Chile, May 2, 2001, p.1. Emphasis added.

3 Gabriel Salazar, "Proyecto y Exclusión: Dialéctica Histórica de la Desconfianza en Chile," in *Confianza Social en Chile: Desafíos y Proyecciones* (Santiago, Chile: Unidad de Investigaciones y Desarrollo, División de Organizaciones Sociales, Ministerio Secretaria General de Gobierno, 2001) p. 21.

4 The international origins of this shift in the dominant discourse can be found in: 1) the rationale of the counterinsurgency efforts launched by AID in El Salvador in the mid-1980s (for example, the Municipalities in Action program that provided the foundation for decentralization towards and strengthening of the municipalities implemented under Pinochet's dictatorship); 2) the technocratic rationale of the international development agencies interested in increasing the productivity of their project portfolio; and 3) the "Third Way" of renovated social democracy in Europe.

My argument will examine two elements: how "participation" has been conceptualized and re-conceptualized by each of the *Concertación* governments over the past decade; and the role that the "politics of participation" plays in Chile, and some of the main contradictions in the "participation" policy discourse.

The Evolution of the Discourse on "Participation" in the Decade of the *Concertación*

To study the evolution of this discourse in Chile during the 1990s, I focused my research on documents from the *Ministerio Secretaría General de Gobierno* (SEGEGOB) and, particularly, its *División de Organizaciones Sociales (DOS)* or Social Organizations Department, for two main reasons. First, within Chile's state apparatus, the SEGEGOB is responsible for designing, implementing and evaluating government relations with social organizations, civil society and the citizenry at large. Secondly, influential *Concertación* intellectuals such as Eugenio Tironi, Enrique Correa and José Joaquín Brünner have occupied key posts in the SEGEGOB over the last ten years.

We discover that the concept of "participation" has varied throughout the decade, being re-conceptualized in response to the challenges confronted by Chile during each of the *Concertación* governments. Aylwin's government faced the challenge of "governability," and thus the definition of participation was based on this objective. Under Frei, the challenge was "sacralizing the market." Under Lagos, the problem has been legitimizing the State and its institutions in the context of the population's increasing disenchantment with the political system.

"Participation" and the Challenge of "Governability" Under Aylwin (1990-1993)

According to leading *Concertación* intellectuals, the problem of transition was how to prevent the return to democracy from becoming an explosion of an autonomous civil society that would threaten the agreements established with the military and the local economic conglomerates.

The solution offered by the *Concertación* to this dilemma was the *"democracia de los acuerdos,"* or deal-based democracy, in which the political actors promised to maintain the economic model, guarantee amnesty for the military, and fulfill a series of other concessions designed to preserve untouched the power structure generated by the dictatorship. This required the completion of a process initiated by the years of repression, a process of undermining the autonomy of social organizations, so that they could not effectively and freely represent popular interests. The mechanisms for achieving this objective were *"Concertación social"* (social consensus) expressed in a series of *"Acuerdos Marcos"* (Fundamental Agreements) and an innovative social policy that co-opted the survival strategies of the organized urban poor.[5] In this first stage, the issue of participation was used effectively to meet the challenge of ensuring governability by preventing significant levels of grassroots autonomy.

"Participation" and the Challenge of "Sacralizing the Market" Under Frei (1994-1999)

The newly-elected government of Eduardo Frei, Jr., proclaimed "New Times" for Chile. The *Concertación* felt that the problems of transition and human rights had been overcome and that the issues of "governability" had been resolved successfully. It was time to look towards Chile's future, towards the country's capacity to compete internationally.

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5 See James Petras and Fernando Leiva, *Democracy and Poverty in Chile: The Limits to Electoral Politics* (Boulder, Colorado: Westview Press, 1994).

Early in 1994, SEGEGOB's *División de Organizaciones Sociales* undertook an in-house review on how "participation" was being conceived within the government. This study detected three different currents of thought with a common emphasis: *collective action* and the role of the *State as the central interlocutor.* The DOS put forward the need to advance towards another conception of participation in agreement with the "new times," one that emphasized *individual responsibility* and the *role of the market.*[6] Thus, the re-crafting of the "politics of participation" under the Frei government led to the ascendancy of a new policy discourse on participation described as the "sacralization of the market."[7] This glorification of the market and economic model would be a two-step affair.

Initially, the power of the market was celebrated as the solution to poverty. In this effort, social policies were designed to "incorporate the poor into the market," hence the programs for small business management training, the transformation of social organizations into commercial enterprises and the re-education of those who took part in *"ollas comunes"* (soup kitchens) and other grassroots groups in new values and attitudes which would allow them to operate in the market. This meant wiping out the "archaic" values, such as solidarity, horizontal cooperation and democracy and instilling new values that would allow the poor to be "successful" in the new context: individualism, an interest in profit and respect for hierarchy.

The So-Called "Cultural Revolution" and the Market

By 1996 or 1997, key *Concertación* intellectuals like Eugenio Tironi and José Joaquín Brünner – at that time SEGEGOB Minister – posited that this process of "sacralizing the market" was also bringing about a veritable "cultural revolution" in Chilean society. They viewed the market not only as a mechanism for uplifting the poor, but for bringing about a "cultural change." This cultural change meant the death of organized, collective participation. Tironi and Brünner celebrated the "new" forms of participation that emerged in Chile thanks to globalization: consumption and watching CNN.[8] According to Brünner, those criticizing *Concertación* policies were unable perceive these new forms of participation sweeping Chilean society.

You all know how this marvelous vision of what was happening in Chilean society came crashing down after the Asian crisis. The idea that a cultural revolution, a profound social change, was underway rapidly lost credibility with increasing unemployment and organized protests by the Mapuches, students and the unemployed.

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6 See Ministerio Secretaría General de Gobierno, División de Organizaciones Sociales, Departamento de Información, "Participación Social y Estado: Elementos Conceptuales y Programáticos Relativos al Rol de la División de Organizaciones Sociales," *Documento Interno de Trabajo* Nº 1 (Santiago, Chile: Ministerio Secretaría General de Gobierno, August 1994). See also Enrique Correa, "Participación Ciudadana y Gobernabilidad," Paper presented at FLACSO's *Primer Seminario Conceptual Sobre Participación Ciudadana y Evaluación de Políticas Públicas*, Santiago, Chile, June 30, 1997 (http://www.flacso.cl/confere2.htm#part4).

7 The term "sacralization of the market" is used by Marcelo Martínez in "Modernización, Modernidad y Participación en Chile: Límites y Perspectivas para una Situación Epocal," *Documento de Trabajo* No. 3 (Santiago, Chile: Ministerio Secretaría General de Gobierno, División de Organizaciones Sociales, 1999).

8 See J.J. Brunner, "Participación y Democracia: Viejos y Nuevos Dilemas," Mimeograph (Santiago, Chile: Ministerio Secretaría General de Gobierno, División de Organizaciones Sociales, 1996). See also Eugenio Tironi, *La Irrupción de las Masas y el Malestar de las Elites* (Santiago, Chile: Grijalbo, 1999).

"Participation" and the Challenge of Producing Legitimacy for the State under Lagos (2000-2006)

With the third *Concertación* government came a third understanding of participation. In this vision, participation is focused primarily on legitimizing the political institutions. A high-ranking official of the DOS argues that – given the current conditions – "the only means available for saving the legitimacy of the State would be an alliance with a strong civil society."[9] Why? Because in a globalized society such as Chile's, the traditional mechanisms of constructing legitimacy, such as the Welfare State, have been eliminated. Therefore, in the face of young people's disenchantment with the political system and widespread criticism of its institutions, the only political resource available is for the State to build an alliance with civil society, conceived as the articulation of actors capable of building horizontal and relatively stable networks of trust and cooperation. This is the crux of the *"Nuevo Trato"* (New Contract) policies.

There is a much more elaborate conceptualization behind all this, but what's most important is that this policy is based on the UNDP's classification of over 83,000 Chilean social organizations. And the DOS uses the analysis of these organizations to implement this new vision of participation. The existing social organizations are classified into two categories: *"materialist" organizations* and *"post-materialist" organizations.*[10]

The materialist organizations are those that make demands on the State, such as cooperatives, health organizations, mother's centers, neighborhood committees and unions: the grassroots organizations formed by our people in the struggle for democracy. There are also other, new materialist organizations, such as housing committees on overcrowding, committees demanding paved streets, etc., etc. According to the DOS, 80% of the more than 83,000 social organizations are of the materialist sort. The health groups are included in this category.

The crucial point of this classification is that the New Contract, the policy of alliance with civil society developed by the third *Concertación* government, does not target the materialist organizations. The New Contract is focused exclusively on "post-materialist organizations," which make no demands on the State, unquestioningly accept the existing model of development, and develop policies that do not challenge the *status quo.*

According to the DOS, post-materialist organizations include the Scouts, associations of indigenous peoples, cultural centers and professional associations. Senior citizens' clubs are an example of newer post-materialist organizations. These organizations fit the new conception of citizen participation and therefore are considered part of the "New Contract."

Up to now, I have tried to demonstrate the evolution of the "politics of participation" over the past decade, explaining the way in which the conceptions of participation have changed over this period. These transformations have generated different challenges for grassroots organizations such as the health groups and for NGOs like EPES.

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9 Marcelo Martínez, "La Sociedad Civil en Chile: Precisiones Conceptuales y Rol de las Elites," in *El Utopista Pragmático* (http://www.primeralinea.cl).

10 See Viviana Cáceres and Tamara Jeri, "Participación y Estado: Viejos y Nuevos Discursos para el 'Nuevo Trato,'" *Documento de Discusión* Nº 1. (Santiago, Chile: Ministerio Secretaría General de Gobierno, División de Organizaciones Sociales, 2000).

The Role of the "Politics of Participation": Supporting the New Model of Domination

What role do these "politics of participation" play in the Chilean context?

I believe that these "politics of participation" have helped generate the active consent of the subordinate classes. In other words, they contribute to the hegemony of the rich and powerful over the rest of society.

This new policy discourse contributes to the hegemonic project by enabling the achievement of the following objectives:

- Demobilizing and de-politicizing social organizations, facilitating the operation analyzed by Gabriel Salazar: transforming the conflict of Chile into a "private malaise," unrelated to the economic model and the 1980 Constitution;

- Subsidizing capital by subordinating the social sphere to the new logic of export-oriented accumulation: through public policies encouraging the self-provisioning of services and small businesses, the social energy of the poor is coupled to the cost-cutting strategies of capitalists firms, both domestic and export-oriented;[11]

- Producing legitimacy of the existing socio-economic power structures where traditional forms of producing such legitimacy (political parties, Welfare State, etc.) are no longer useful or available;

- Building a more effective hegemonic discourse by involving representatives of all those sectors with which one intends to build consensus, outlining the acceptable issues to be considered: under the State's conception of "participation," issues such as revoking privatizations, calling for a Constituent Assembly to rewrite the Constitution or subordinating the interests of the capitalists to the interests of the masses are all excluded.

Three Contradictions in the Discourse on "Social Participation"

Despite its apparent sophistication, the current discourse on participation already evidences serious internal contradictions which threatens its success. Nothing ensures that these policy discourses emphasizing participation will be able to permanently domesticate Chile's social organizations. The serious limitations of the current "politics of participation" already are clearly evident.

[11] See Fernando Leiva, *Los límites de la lucha contra la pobreza y el dilema de las ONG* (Santiago: Ediciones PAS, 1995).

Contradiction #1:
"Strengthening Civil Society" vs. Resolving the Profits Crisis of the Economic Model

The first contradiction lies in the fact that the "politics of participation" rhetorically emphasizes the principles of democracy, transparency and accountability; however, it does not promote their exercise in key sites of the capitalist economy such as the point of production, property relations or the sphere of reproduction. This inconsistency opens up gaps that can prove useful. In practice, "transparency" and "participation" are restricted to the limited realm of public policy "users" or "clients." The current discourse is unable to defend participation, transparency and democracy in businesses and the workplace because such an ample policy of participation is in conflict with the need to maintain the profit rates of the current economic model. "Transparency" and "participation" pose a threat to the very foundation of the export-oriented economic model based on the export of natural resources with low levels of processing produced by cheap and unprotected labor. So there is clearly a short circuit between the official discourse and the reality of Chilean men and women in their homes and in their places of work.

Contradiction #2:
Individualistic "User" Participation vs. the Collective Rights of Citizenship/Popular Sovereignty

The "politics of participation" emphasizes the importance of "civil society" and "citizenship." But upon closer examination, the "politics of participation" does so in a manner that eliminates the characteristics of traditional liberal democracy. Participation is promoted only in the limited realm of selected public policies and government programs. Chileans are recast as consumers and/or the individualistic "users," delinking "participation" from broader, foundational, collective concepts of "popular sovereignty" and "citizenship." Thus, as Gabriel Salazar posits, "participation" is transformed: it is subjectified, individualized. However, there can be no true participation nor exercise of internationally-recognized collective rights while we are governed by the 1980 Constitution and all its anti-democratic trappings.

Contradiction #3: The Destruction of the Social Fabric Through the "Politics of Participation"

Finally, the most salient inconsistency is that in their evolving formulations during the decade, the *Concertación*'s "politics of social participation" has contributed to *destroy, not strengthen, the social fabric of Chilean society.* Training programs encouraging the formation of small businesses destroyed the community-based organizations in Chile. The new version of social policies in the form of the governmental Competitive Funds (*Fondos Concursables*) has done away with a great number of NGOs, forcing competition between different social groups and robbing long-time social leaders of their legitimacy while endowing others with greater power. These new leaders are those linked to the DOS and the new Government-NGO complex, those able to meet the requirements for developing and winning the projects presented to the Competitive Funds.

Does the policy of the *Nuevo Trato* contribute to the destruction of the social fabric by prioritizing "post-materialist organizations"? Will the legitimacy of the system of domination in Chile be consolidated by using the "post-materialist" organizations to construct social ramparts that will hold the demands of Chile's "materialist" organizations at bay?

The Challenge that Remains: Building a Truly Democratic Society

If up until now EPES and the health promoters have fulfilled the role of "being dreamers of utopias and new dreams," what challenges are presented by this shift in the dominant discourse and political actions of the State, the international financial institutions and most NGOs?

In terms of the defense of health, it means having to confront and challenge the processes of "reform" that have been turning health into a commodity. But most importantly, it means that this defense will also have to deal with the "politics of participation." In other words, we must also confront the policies of participation that seek to legitimize the power structure, the institutions and the current government and that prioritize the market to the detriment of collective action.

We must continue to promote the concept of health that EPES has elaborated over these many years. Neither health nor the right to health can be subordinated to the logic of the market and international competition. In order to ensure a dignified life, health cannot be considered a commodity. Health, and social services in general, cannot be organized under the logic of capitalist competition nor under the limited models of participation that globalized capital seeks to impose upon all of society. This implies not only fighting for the right to health and a dignified life for all; it also means redoubling our efforts to build a *new culture* and a *new conception of democracy*. The fundamental elements of a real political alternative, of a policy that promotes true social participation, will be guided by the principles of solidarity, autonomy and the fight for justice. These will continue to be fundamental elements in the effort to defend the right to health for all in the new century. With the same intelligence, vision and courage that EPES and the health groups have maintained over the past 20 years, we trust that they will continue to show us how to dream and to build the future.

Our Light Will Not Go Out: Lessons and Proposals from Social Participation in Health

Valeria García*

"We have always existed, like drops of water,
Essential and necessary, but forgotten.
But we believe that if we think, if we talk, if we write,
Our words will be
Like the blows of a fist against concrete walls
That absorb the noise
Only to become a hushed and deafened explosion that turns into a shout,
No longer a cry of anguish or complaint but a loud battle cry
Of protest and desire to be seen and heard."

(From the poem *"Distintas"* by Rosa Quintanilla)

If we look back 17 years, when EPES first came to our neighborhood, we recognize that our situation today is clearly quite different, even though many of the same economic problems continue unchanged.

Most of us lived in shacks that leaked in the winter. We were unemployed. We didn't have anything to put on the table. We lived day by day, hungry, without the means to meet even the most basic needs of health and education. Many of us didn't have electricity or running water, and those of us who did often had our services cut off. We endured open garbage dumps, alcoholic husbands and, above all, overwhelming feelings of hopelessness and the inability to plan a future. Our lives were focused on cleaning and trying to be the best housewife, which would set us apart from the rest... but today I realize that I never got a medal for having the shiniest floor or the whitest sheets in the neighborhood, and for so long I though that this was the most important thing in the world.

This was the reality of many of the women who joined the health groups. If you were to ask us now, "Why did you join a health group? What were your motivations?" some of the answers might be:

1. To meet our basic, subsistence needs;
2. To learn how to give injections (since this would set us apart from our neighbors and perhaps unconsciously give us greater power within the community);
3. To help others;
4. To care for our families' health;
5. To get out of the house.

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* The author is a psychologist and member of the Llareta Community Health Group. The group takes its name from a resilient medicinal plant native to Chile.

These are some of the many reasons that motivated us to join the group. But once we were there, we confronted a myriad of contradictions. We began to question our lives, our families, the environment in which we lived and the system that provided no relief from despair. Many of us believed that we were not doing enough to escape from this legacy of misery because we had been brainwashed by misquoted Scripture, such as "the poor shall inherit the kingdom of heaven," or maybe because we just didn't understand the "power of positive thinking."

This is when the process of transformation begins: when you start to learn new concepts, such as politics or the idea of rights, then you begin to understand that health isn't just the absence of illness, being all chubby and rosy-cheeked. How innocent we were before! And how happy! Because learning, gaining understanding and awareness, well that really hurts! You get angry, frustrated, rebellious and even more eager to know and understand how everything works. You want to know how international agreements might affect us, what the free trade treaties could mean. You become aware of the need to know what all this has to do with our people and our culture.

Through this individual and collective process, we constructed a more humane concept of health, and we realized that EPES understood health in this way from the very beginning, before coming to train us as health promoters. The workshops' contents and methodologies and the commitment of those who worked with the organization were key to our development. They allowed us to discover and create many of the concepts that we currently use but using our own words and experiences.

This process also has been painful for the women who have taken part because of our different levels of training and education, power struggles, or domestic squabbles that reveal the worst of human nature. It has also been difficult for us to discover and deconstruct our own training as women, training that never prepared us to be colleagues and collaborators.

If we were asked, "What have you learned in these 20 years?" we could say that:

1. We have realized that we have to prepare ourselves as leaders, and we have slowly discovered our capacity for leadership.
2. We have recognized that it is possible to transform our reality.
3. We have understood that we can share knowledge based on our own experiences and that official knowledge is not the only kind that exists. We have realized that together we can develop collective processes in which theory and practice become knowledge which in turn becomes power, power to serve and to fight, but not to dominate.
4. We have discovered that we have knowledge and that we only needed help to recognize it.
5. We have learned that the economic model which transforms our daily lives encourages individualism and results in the loss of our sense of community, our ability to show solidarity. The neoliberal model would rather we spend our time in malls.

After these 20 years, I am more convinced than ever that working in health is still important and that this implies political work as well. Our understanding of working in health means being aware, really seeing people, understanding what globalization implies. It obliges us to take an interest in the public policies implemented in Chile in recent years.

We have learned that not only do the health groups provide an opportunity for our personal emotional development, they also train us politically to become social actors able to generate ideas and make decisions about the type of society in which we want to live.

We have discovered that we are no longer the same women we once were: we are brave, and we able to achieve goals and develop ourselves fully.

Today, we understand why those who are in power look at us from afar and seem fearful and threatened when we speak out or when we take to the streets, why in these past 11 years, the government has taken such an ambiguous position regarding how it wants social organizations to take part in this process. On one hand, we see that they are only interested in the participation of a certain type of social and community organizations – such as those which provide services for the municipalities and education in preventive care since the public sector is unable to provide these services. On the other hand, while the official discourse applauds social organizations' initiatives, in practice the experiences of "participation" are limited to voting in elections. As a result, many of the actions of social organizations are ignored or dismissed.

Because of these attitudes, the struggles against the hardships of everyday life, the struggles for housing, for health and a dignified life, are not recognized as political issues but merely the usual survival-related agitation of the poor and therefore reduced to "domestic" issues.

Our Strategies

If you were to ask me, "What should we do about this?" I would suggest that we resuscitate the dream and go back to believing in utopias. That's why we have to continue to develop methodologies that take into account our experiences, our knowledge and the creative approaches so characteristic of our efforts over these many years. We also have to keep working in networks because we are stronger when we collaborate with others. At the same time, we must continue to train ourselves and further develop our concept of participation in which our actions are understood as a continuous process of evaluation, planning and analysis of our activities.

Above all, we must always be alert. We must constantly review our common objectives. And in this effort, I invite you all to tear down the veils, to break the silence and to discover against what and whom we are truly fighting: the enemy is not here among us.

What should we do now, when our enemy is no longer clearly visible? Today, we are not fighting against a government, but against an inhumane model that pits us against one another, a reality in which we are valued for what we have and not for what we do, a model based on the fantasy that everything is just fine and that we'll be even better if each of us would just do their individual best to achieve their goals and personal success. We have seen how this model robs us of our ability to dream and to maintain our pride and dignity.

We must fight for our rights. We must create a life that is not ruled by the laws of the market. To do so, we have to preserve the history that we have forged over these many years. We must remember that when we first began this tremendous undertaking, we started from nothing. We must rescue our dreams; we must believe in our colleagues and collaborators. We must take care of ourselves and respect ourselves. We must believe in, love and dream about these utopias that the naysayers tell us no longer exist. We must create a different society.

20 Years is Just the Beginning: EPES Looks Towards the Future Filled with Hope

María Eugenia Calvin Pérez*

In commemoration of our 20th anniversary, we are here not only to celebrate this long history but to redouble our efforts as part of a larger social process.

From its beginnings, EPES has developed a successful strategy of health education inspired by proposals from the 1970s for a system of primary health care which included the training of community health workers and a commitment to the goal of "health for all in 2000." EPES was also strengthened in its early years by the direct actions of the grassroots social movements of the 1970s to improve the health of the poor and other basic needs, especially in regards to housing.

EPES' development was also inspired by the fervor of the 1980s: the Chilean people's efforts to organize and confront the scars of the 1973 military coup as well as the structural changes imposed by the neoliberal model. In this context, EPES offered the women and men of poor neighborhoods in Santiago and Concepción an opportunity to receive training and to organize themselves around their needs and the struggle for the right to health.

EPES applied the principles of grassroots education because we understand that information alone does not generate change in the community and in people's lives. Processes of change based on people's needs require their participation through forms of organization and mobilization that enable them to claim and exercise their rights and to strengthen their communities, which are their source of support and solidarity.

Grassroots education also has provided us with methodological elements for addressing health needs, an area traditionally restricted to medical professionals. By providing grassroots organizations with information, supporting the development of specific health care skills and, above all, encouraging the recognition of the knowledge these caregivers already have in the daily practice of health care, we have provided the health groups and promoters with tools for empowerment in their homes, their communities and in the public sphere.

The perspective of comprehensive health is also an integral part of our educational efforts and has allowed us to include a wide range of issues in the training we provide for the health groups. We not only address specific illnesses, but also sexuality, human rights, violence, the environment, leadership and other topics, providing the participants with tools that will allow them to meet their neighborhoods' needs.

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* The author is a social worker and member of the EPES team.

By working in networks, joining forces in the effort to make an impact on real problems – such as environmental contamination in Hualpencillo, domestic and sexual violence, or HIV/AIDS – EPES has been challenged to broaden our scope. These new efforts include documenting our proposals and the methodologies developed by the communities themselves through the systematization of our experiences and research which can then be shared at the local level as well as nationally and internationally.

The community strategy that EPES has supported these many years has helped build strong ties with other organizations in the sectors in which we work and with individuals and institutions in a wide range of areas. Forged in the debates on globalization and reflections on gender and the struggles of sexual minorities, these links have helped us comprehend the complex social reality in which we work and have also encouraged us to incorporate other methodological tools.

The new century presents tremendous challenges. "Health for all" is perhaps farther away than ever. The advancement of neoliberal ideology and the processes of globalization have widened the gap between the rich and the poor. The deterioration of the environment and our quality of life affects our physical and mental health. And in addition to the new problems associated with environmental contamination and stressful living conditions, some of old public health foes are back: illnesses such as tuberculosis and meningitis, which affect the poor in a far greater proportion.

The privatization of social services, including health, education and social security, have generated tremendous profits and shameful gaps in access to even the most basic services. In Chile, the weakened role of the state has resulted not only in a deterioration in health care but also a decrease in health prevention and promotion. While in the 1990s our country's public health budget increased from 0.8 to 1.6% of the Gross National Product, this figure is still far from the 2.5% spent on health before the military coup (as cited in the working paper "La reforma solidaria del sector salud que Chile necesita," prepared by CONGRESS in 2001).

Today, EPES' proposals for participation in health and our emphasis on prevention and health promotion encounter paradoxical responses. International agencies that collaborated with the destruction of Chile's social security and health care systems are now leading initiatives for citizens' participation in the development of public policies. Health promotion also is more significant in the discourses of these agencies than it was some five or ten years ago. Nonetheless, while this change of heart may seem like a step forward, we must remain alert: participation and promotion are not always understood as strategies for increasing people's power and control over the decisions that directly affect their lives.

At the same time, once-solid social movements are fragmented; the organizations have lost the strength of numbers and organizing capacity that they once had. Today, a multiplicity of non-governmental organizations advocate the participation of civil society, but few have preserved their autonomy from the state and are truly involved in the grassroots communities.

As a result, we face the tremendous challenge of recovering our faith in social change and our ability to recognize the need for justice and equal opportunity. In this important undertaking, one of our strategies is to promote forms of organization that can contribute consistently to the generation of identities and the strengthening of individual and collective abilities.

In this effort, EPES relies on its collective memory, harking back to the health rights we once had, rights that we knew and exercised. As the result of years of repression in which the word "rights" sounded subversive, our society gradually lost the concept of citizens as individuals with civil rights. As a result, the recovery of the notion of citizenship on an individual level as well as the concept of collective rights is a challenge for all of us. Now, as the right to health of health care systems' users is about to become law in our country, EPES and its partner organizations want to raise consciousness that the right to health is a basic human right that cannot be restricted solely to the users of one system or another. We also insist that the right to comprehensive health is not restricted to medical actions alone, but intrinsically linked to all of our basic human rights, including the right to housing, education and justice.

The inequalities that affect us as women and that reproduce cycles of violence that oppress us both in the public and the private spheres and limit our personal development are another source of motivation and action for EPES. Our proposals emphasize strategies to empower women, to encourage women to speak out, to develop leadership with a gender perspective, to educate and to promote specific rights – such as sexual and reproductive rights – while also recognizing that in addition to gender-based discrimination, most Chileans endure conditions of poverty, injustice and lack of opportunities.

There are still many reasons for us to continue our work. As the primary providers of health care, women must take action to ensure access to health and social security regardless of their status in the labor market. The women's health movement has accepted this challenge, and EPES and the health groups are part of this struggle for the social and economic recognition of women's silent but constant labor caring for their families' and children's health and well-being in their own homes.

EPES itself has been strengthened by the many achievements in its history, as evidenced by the processes of personal transformation in the community of which we form a part. Our participatory strategies create opportunities for personal development and collective empowerment. As one health monitor commented in 1995, "We are no longer the same: now we have stepped into the spotlight." We are part of the social processes that are forging a path of hope towards a meaningful world, a more humane existence with opportunities for our children. That is why we are here today, looking towards the future and saying that 20 years is just the beginning. We are standing on a road that we have all helped to build, by making history out of our daily experiences, out of our fragile and transcendent lives.