Who Are We To Care?
Exploring the Relationship Between Participation, Knowledge and Power in Health Systems

Barbara Kaim

OPEN SOCIETY FOUNDATIONS

Foreword

The field of International Development is a rapidly growing and challenging field. While the idea of poverty alleviation and economic growth has for remained a central concern for economists, concerns like income inequality, social inclusion, participation, transparency and accountability have become increasingly common ideas in many development for a including the World Bank. As these ideas are embraced and become integrated in practical development interventions, it is also necessary to review and understand how these ideas emerged or were first articulated. While some ideas came from academics and universities, many ideas and concepts became accepted as a result of the persistent struggles of practitioners in the field. COPASAH (Community of Practitioners on Accountability and Social Action in Health) is a collective of practitioners who have been developing these ideas and applying these principles in the field of health governance in different places around the world. In these Issue Papers COPASAH members have deliberated over some of their key concerns to draw lessons for future practice.

Health care is a contested area of governance and public policy action. It is also an area of immediate concern being featured prominently in the erstwhile MDGs and in the contemporary SDGs. In this series of Issue Papers, COPASAH members share their insights in critical issues especially related to the inclusion and participation of the poor and marginalised communities and how these may be negotiated or kept centre stage within contemporary development practice. The Issue Papers draw upon the years of practice of COPASAH members and are practical and insightful at the same time. We are sure these will provide important pointers for practice for any development practitioner in the field of heath governance. On behalf of COPASAH we look forward to your feedback and suggestions to continue the discussions and sharpen our practice.

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This issue paper is part of a series of papers commissioned by the Community of Practitioners on Accountability and Social Action in Health (COPASAH).

Acknowledgements

EXECUTIVE SUMMARY

This paper is dedicated to those many people who live in countries where health systems are failing to meet the needs of the majority, and where people with less power – whether health care providers, individuals, families or communities - have few structured opportunities to express their concerns openly and critically. It is aimed at those who work as health facilitators and activists at community level, civil society organizations, government personnel and anyone else interested in the rights of ordinary citizens to participate in decisions and have access to the resources that determine the way their country's health system functions.

The paper is divided into three sections:

The first section focuses on how the interaction between people's participation, knowledge and power effects the functioning of health systems. Section two pays particular attention to approaches we can use to build a more just and equitable health system. The final section concludes by asking a series of questions to provoke and deepen our thinking on ways we can overcome obstacles to achieving this goal, at both community level and as we move from the local to the global as a strategy for change.

Each section blends discussion on concepts and issues with descriptions of experiences and case studies from around the globe, especially from countries in Latin America, Asia and East and Southern Africa, where a wealth of material describes the impact of neo-liberalism and globalization on health systems, and attempts to build alternatives.

People, participation, knowledge and power

Despite the World Health Organization (WHO) definition of a health system as incorporating "all those actions whose primary purpose is to promote, restore or maintain health", people have systematically objectified in a sector that is supposed to be about and for people. This has been happening for many decades, culminating in the rise of 'neo-liberalism' in the 1980s, which saw the pursuit of market policies that undermined the role of state services, including health. The status of communities changed drastically over this time. Health systems became more about profit than about people. There were, and still are exceptions. In the 1970s, especially in some of the poorest rural communities in the world, people's participation in health led to improvements in health outcomes. This helped to inspire a movement that eventually led to the WHO Alma Ata Declaration of 1978 that gave powerful global recognition to primary health care (PHC).

One of the premises underlying PHC is that people's knowledge must be respected as a valid source of information when developing policies and programmes that affect their health. Just because the knowledge is local, however, does not mean that it serves the interests of the

poor. In a world where there are oppressors and oppressed and where knowledge, as much as any other resource, can be used to liberate or subjugate, we need to look at how alternative forms of participatory knowledge can be used as a means to social transformation and the betterment of people's lives.

Ultimately, this boils down to the issue of power. Power can be used to maintain the status quo, or as a form of resistance. One way of looking at this is through a lens that views power in four ways: as 'power over', 'power to', 'power with' and 'power within' where the last three forms of power are resisting the domination of 'power over'. Each concept of power carries with it different assumptions of how to bring about change and its own level of participation and relationship to knowledge.

Building knowledge and practice toward people-centered health systems

A people-centred health system gives voice and agency to the poor and most vulnerable in communities, situated in a larger context where national and global economic and political forces are harnessed to support community efforts and where resources – including public provision of adequate food, water, sanitation and housing - are equitably shared in the interest of all. In well-functioning, people-centered health systems, community actions are undertaken, in partnership with

health authorities, building a sense of trust and solidarity and opening up new spaces in which dialogue and development can flourish.

The reality is that most of our health systems are not people-centered. However, multiple approaches have been used to address people's concern with persistent inequalities. One such approach goes under an overarching term called participatory action research (PAR).

Literature on PAR identifies two distinct traditions. One focuses on systems improvement as its main goal in which it is assumed that problems can be solved through putting pressure on either state or non-state institutions to function better in the interests of the wider community. This approach opens up spaces for discussion and gives people the 'power to' act based on their growing understanding of the injustices they face.

The second tradition puts forward a more emancipatory approach to change. It challenges the political domination of elites who have 'power over' others. It seeks to change the unequal distribution of power and resources through the development of a collective consciousness, mobilization and action, moving people to look critically at themselves ('power within') and to act together ('power with'), both important components to social change and transformation.

Looking ahead: Who are we to care?

Many examples in this paper and in the literature as a whole show where 'health through people's empowerment' has led to positive outcomes in people's health. However, there is much to be done and many questions remain unanswered:

- What do we mean by 'we'? Who are the 'we' that is challenging the status quo, redefining our knowledge base and working toward more democratic and inclusive forms of participation?

- How can we be sure that participatory forms of knowledge creation are really giving voice to the excluded?

- How can we connect the range of different voices to develop a more 'collective consciousness' that will link up with wider social and knowledge processes and allow change to take place?

- If people do get a sense of the 'power within' and 'collective consciousness', how can it be sustained, especially since these so often get co-opted or are out maneuvered?

- How do people-oriented forms of power relate to other forms of power, such as the state and technical information power?

A number of questions surface as we think about the importance of moving from the local to the global as a strategy for change:

- How do we in the health movement build alliances with other movements?

- How do we make sure that the knowledge and voices of health advocates in many global decision-making arenas are accountable to local actors? Who speaks for whom, with whose knowledge and with what accountability?

- How do we move from articulating a critique of the present status quo to mobilizing for action at local, national and global levels in ways that involve integrating local knowledge with critical reflection and learning?
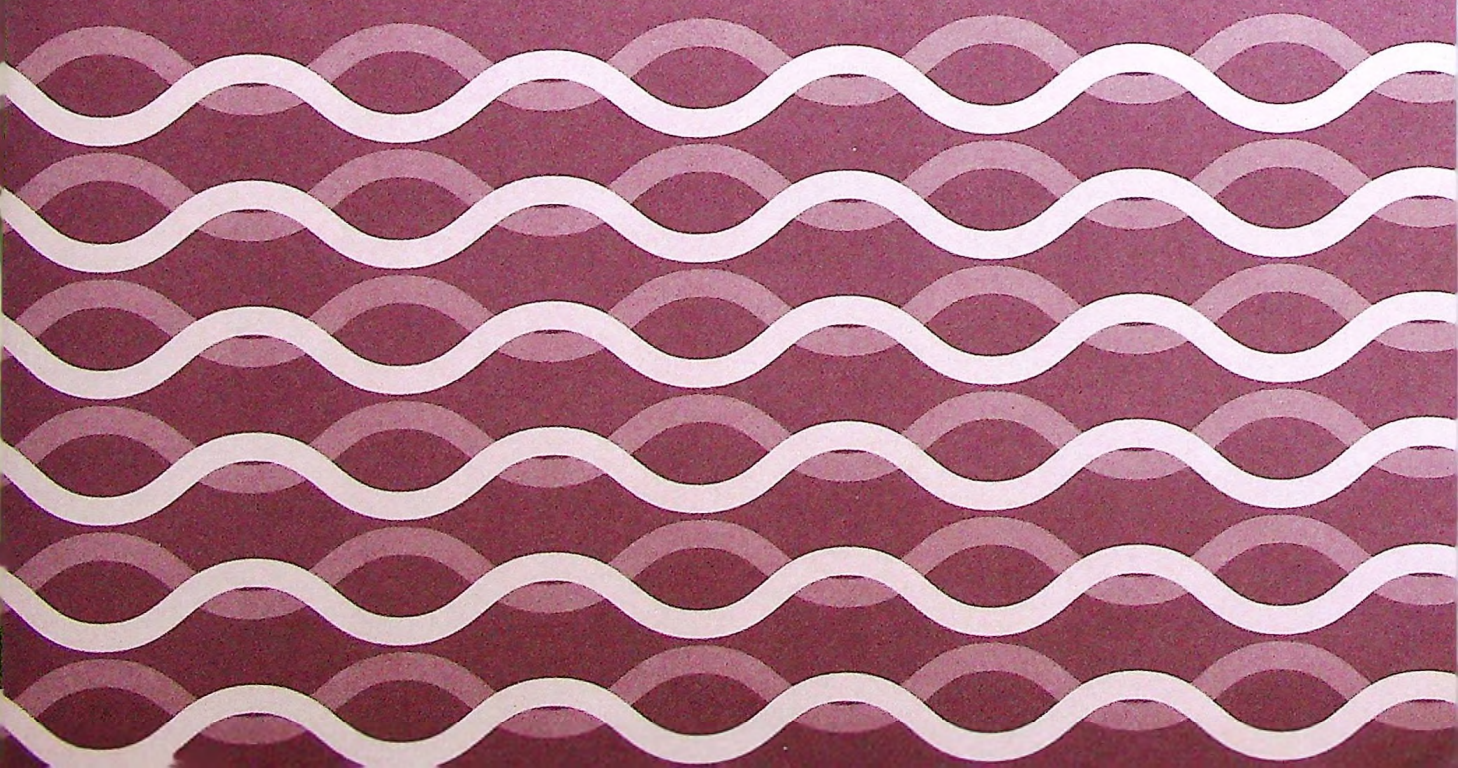
These pressing questions need to be addressed. It is up to every one of us to take up the challenge. We all need to care.

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INTRODUCTION

This paper is dedicated to those many people who live in countries where health systems are failing to meet the needs of the majority, and where people with less power – whether individuals, families, communities, or health care seekers, have few structured opportunities to express their concerns openly and critically. Those with power have control over what knowledge is shared, how resources are used, with what outcomes and to whose benefit. Those with unexpressed or dormant power have little influence over policies, structures and social norms that affect their lives and are left to claim or create spaces where their voices can be heard.

This unequal power dynamic – at local, national and global levels – is pivotal to understanding the constant struggles that unfold in different places and in different times between people and between nations. Central to these struggles is the way people, or more usually groups of people, use their knowledge and influence to assert their values and ideologies. This, in turn, impacts the dynamic nature of society, and affects how people's lives are constructed and how they understand and use the systems of which they are a part.

While this reality is relevant within almost any socio- economic or political struggle, for example,

in the women's, environment or civil rights movements - this paper is specifically looking at the impact it has on the health sector. The paper is divided into three sections:

- The first focuses on how interaction between participation, knowledge and power effects the functioning of our health system/s.

- The second section pays particular attention to approaches we can use to build a more just, equitable and people-centred health system, specifically approaches in systems improvement and the emancipation tradition.

- The final section concludes by postulating a series of questions to provoke and deepen our thinking on ways we can overcome obstacles to achieving this goal, at community level and as we move from the local to the global as a strategy for change.

The paper draws on published sources, case studies, informal discussions and community informants. It is aimed at those who work as health facilitators and activists at community level, civil society organizations, government personnel and anyone else interested in the rights of ordinary citizens to participate in decisions and have access to resources that determine the way their country's health system functions.

2

PEOPLE, PARTICIPATION, KNOWLEDGE AND POWER
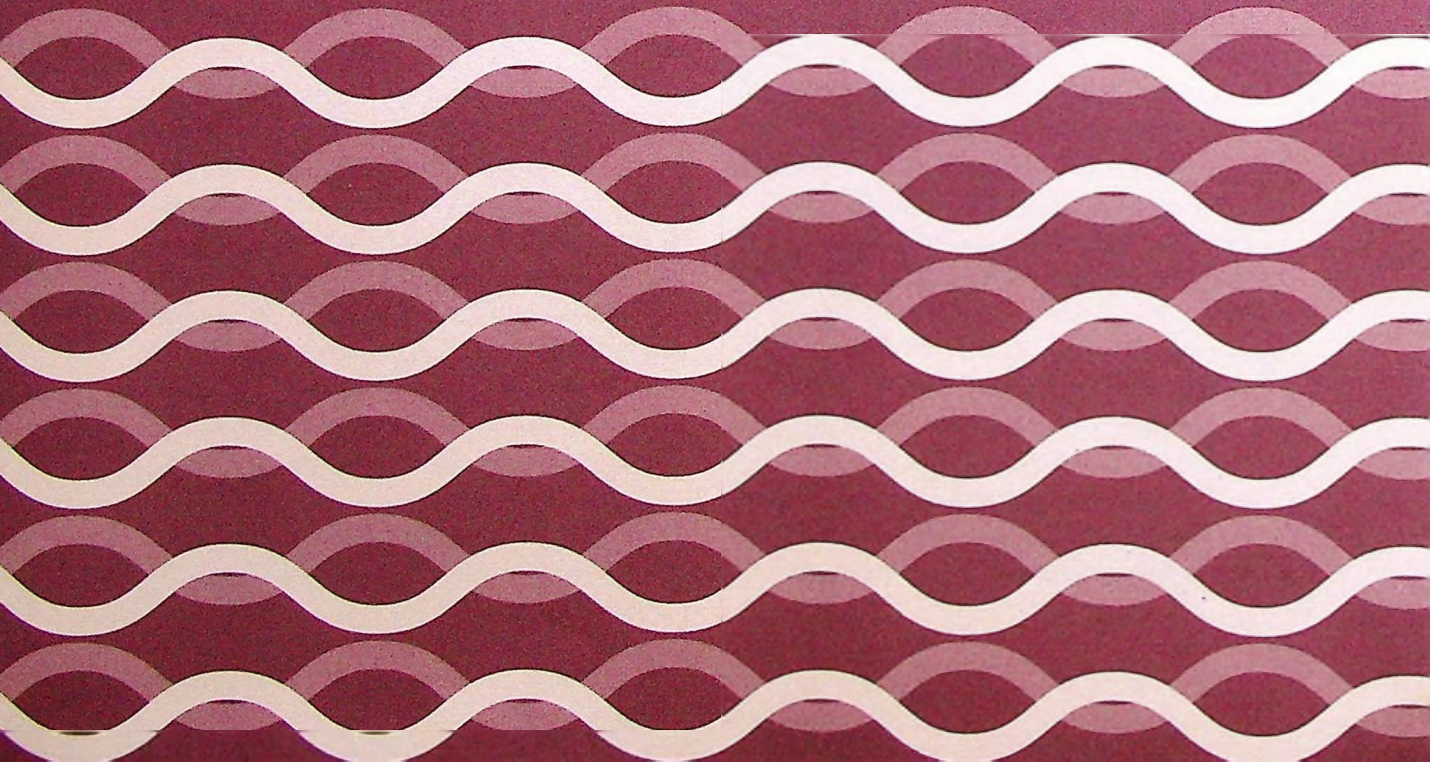
For the last 20 years, the Chikukwa community in the Eastern Highlands of Zimbabwe has been working on a range of activities from permaculture development to strengthening marginalized groups such as women and youth, providing support groups for people living with HIV and AIDS and offering preschool education for vulnerable children. The community members' work is united by a common understanding that despite their many differences (for no community is homogeneous) and the economic, political and ecological challenges they have faced over the years, the fate of their community lies in their hands. It is up to them to ensure continued respect for their environment, for their local culture, belief systems and traditions and to continue to teach sustainability and responsibility.

To this end, the Chikukweans have developed a framework for dealing with conflict and to improve internal communication. The framework is called the Three Circles of Knowledge, consisting of the circle of indigenous knowledge (that is collectively affirming the best of what traditional society has to offer), the circle of spiritual knowledge (which explores their own deep knowledge and innate wisdom) and the circle of analytical or transformational knowledge (CELUCT, 2008). These three circles of knowledge are interdependent and assume participation of all community members in defining and acting upon this collective knowledge. The model recognizes that conflicts related to national resource allocation, gender and the family, HIV and AIDS and governance are often rooted in power differences in hierarchy, gender, age or ability. The Chikukweans, based on their own experiences and insights, have come to understand the link between participation, knowledge and power.

2.1 Health Systems are about People

The Chikukwean experience is important because it provides a positive example of how people can cultivate respect for the views and experiences of every member of their community. We live in a social system where people (should) matter. This cannot be taken for granted, especially in this century where we have created so many 'systems' – the education system, information system, economic system, legal system – and where systems are often seen as quite alienating, connoting something distant and impersonal, not really about people but about structures that have their own internal rules and logic.

The 'health system' is a case in point. According to the WHO, a health system "incorporates all those actions whose primary purpose is to promote, restore or maintain health" (WHO, 2007). Such a definition sees health improvement as moving beyond the provision of health services and the development of technical, biomedical interventions to include, for example, a mother caring for a sick child at home, a farmer growing food for local consumption, other social determinants of health such as access to water, housing and education, as well as efforts that protect people against the financial consequences of ill health. It also identifies equity, social justice and the participation of communities – especially the poorest, least organised groups who bear a disproportionate burden of health problems – as important factors in improving health outcomes (CSDH, 2005).

Health systems, therefore, include actions taken by women and men, old and young, in rural and urban areas, by health providers, in schools and in any other institution that works for the social and economic development of a population. People have important roles to play in all health processes as, for example, in planning, allocating resources, delivering services, promoting health, and monitoring health systems. And, yet, despite these potential roles, numerous examples abound where vertical disease-focused interventions have taken precedence over people's active roles in defining and taking action on their priority health needs.

For over five decades, from the mid-1950s, some dimensions of international public health have

been characterized by the proliferation of 'vertical' programs. These programs saw implementation of narrowly focused, technologically driven campaigns targeting specific diseases such as malaria and smallpox. Despite a few notable successes, especially in the eradication of smallpox, this approach ignores the social context in which people live and tends to undermine the population health orientation of a health system (CSDH, 2007). Global health initiatives (GHIs), such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), bring enormous amounts of money into health systems within low income countries (USD$ 8.9 billion in 2006 for HIV and AIDS alone. Hanefeld, 2007), but these international agencies "rarely give explicit attention to the need to take equity seriously in their activities; these activities may actually work to exacerbate health inequity" (CSDH, 2007) and undermine people's action at the local level.

This situation has been re-enacted time and again over the last 50 years. In the 1980s industrial countries, through the powerful agency of the International Monetary Fund and World Bank, and fuelled by corporate capital and their motive for profit, colluded with the elite in numerous countries in the south to cut back on public financing. Social services, such as health, were badly affected. As the quality and outreach of public health services were undermined by underfunding, a weakened public infrastructure and competition with the private sector, health care came to be seen as a commodity to be bought and sold on the market, rather than as a basic right to be realized by all citizens (Loewenson, 2008).

Why and how did this happen? How is it that people have been so systematically objectified in a sector that is supposed to be about and for people? As already intimated, economics and politics play a large part. The 1980s saw the rise to dominance of the economic and political model known as 'neo-liberalism', which saw the pursuit of market policies and the opening of countries to transnational corporations (TNCs). These

policies reflected an ideological commitment to unbridled market principles at a global level that, through privatization and commercialization of state-owned enterprises, undermined the role of state services. The status of communities changed drastically over this time – as put succinctly by Loewenson (2008) - "from citizens with public rights and responsibilities to consumers with market power, or lack of it". Health systems became more about profit than about people.

However, there were exceptions. During the 1970s, some of the poorest rural populations in the world, in countries like Guatemala, Indonesia and Tanzania, were improving people's health. While these program were often small-scale projects run by charismatic leaders and "an expression of a quietly functioning and informed community", all of them recognized that people were the most important resource in improving a community's health (Newell, 1975).

Let's look, for example, at Jorge's story, as described in 1975 by Carroll Behrhorst in the book Health by the People (Newell, 1975). Dr. Behrhorst was a clinical doctor working with the Cakchiquel Indians of Guatemala. In 1962, Jorge was a five-year old boy who lived in a village near Dr. Behrhorst's clinic. He came to the clinic suffering from malnutrition, a common condition (amongst others) in that village. The underlying causes of Jorge's malnutrition lay in the political and economic environment in which he lived, where villagers had no access to agricultural land due to the dominance of large plantations operating for the benefit of absentee landlords. It did not take Dr. Behrhorst long to realize that his efforts to keep Jorge and his community healthy through treating their symptoms were fruitless – drastic changes were needed in the village itself. Thus began a whole program that started with the clinic providing short-term loans to villagers to raise chickens and produce eggs. Over time, villagers' banded together and bought some land from one big absentee owner, using a small fund borrowed from the clinic that they paid back conscientiously as crops began to bring in some income.

Thirteen years later, the village is a "reasonably healthy, economically viable community" (Newell, 1975). By 1975, Jorge was a robust teenager and malnutrition had all but disappeared in his village. In addition, villagers had set up community health committees responsible for identifying and monitoring the work community health promoters, trained by the clinic to undertake basic health services. Promoters were also trained as community catalysts, working in areas such as literacy, family planning and agricultural extension work.

Many lessons emerged from this program, including the importance of tackling basic social and economic problems to improve people's health. Related to this was the realization that "public health work should begin with a dialogue with the people, encouraging them to consider themselves and their situation and to state their needs. People everywhere have their own ideas about what should be done with their lives, health and homes" (Newell, 1975:49).

While this story is inspiring in its own right, it did not influence the Guatemalan health system, mainly because of political developments within the country. In 1976, the 35-year civil war in Guatemala intensified, leading to massive repression and assassination of prominent activists including the Cakchiquel Indian leaders who were involved in the health program close to Dr. Behrhorst's clinic (personal discussions with Walter Flores, CEGSS Guatemala, November 2012).

We have to look further – to China - for an example of a national-level program aimed to address the health needs of the poor. In 1968, the People's Republic of China introduced the 'barefoot doctors' program to provide basic health services at low cost to the rural population. Barefoot doctors lived in the community they served, usually in agricultural communes and collective brigades, providing basic preventative and curative health services through a combination of western and traditional medicines. They also provided other services such as immunization and improved sanitation (Hakley

2005). Despite the repressive environment in China at that time[1] and problems associated with devolving primary care provision without adequate backup, this approach saw impressive gains in the health of the people. In 1973, an American doctor visited China and wrote glowingly about the health care system there, noting that, since 1949, "there has been a pronounced decline in infant mortality. Major epidemic diseases have been controlled.... [and] nutritional status has been improved" (WHO, 2008).

These experiences from different parts of the world reinforced the notion that people's participation was central to the functioning of a successful health system. They inspired a movement within the WHO that, together with earlier struggles around social and economic rights, eventually led to the Alma Ata International Conference on Primary Care in 1975 and the resulting Alma Ata Declaration (WHO, 1978). In it, almost all 134-member states of the WHO agreed to a radically new approach to health, in which they rejected vertical, disease-focused approaches in favor of accessible, integrated health care. Known as primary health care (PHC), this approach shifted the focus from large urban hospitals to local health providers as the first point of contact. Importantly, the strategy also embraced the role of communities and citizens, including local government and civil society organizations. The Alma Ata Declaration gave powerful global recognition to primary health care and was lauded as one of the most important moments in the history of people's health.

2.2 Valuing People's Knowledge

Throughout history, popular systems of knowledge transmission and knowledge production have been ignored by the dominant system more set

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1   The barefoot doctor program was implemented during the Cultural Revolution in China when millions of people were persecuted and displaced. It is, therefore, questionable to what extent these barefoot doctors empowered communities beyond basic health provision.

on maintaining the status quo. Nevertheless, local knowledge, passed on from one generation to the next through imitation, oral storytelling, art, music and other forms, has been embedded in community relations, practices and decision-making for centuries. It suffuses not only people's way of thinking, but also the way they feel and experience their environment.

Paulo Freire (1921-1997), arguably one of the most influential educationalists of the twentieth century, understood the importance of drawing on community wisdom. He was born in Brazil and worked with the marginalized poor in slum areas for many years, until the military coup in 1964 when he was forced into exile. After that, he spent some time in Chile and the United States, and later in Switzerland, until he was able to return to Brazil in the early 1990s. Throughout his life, Freire argued against a 'banking system' of education, in which people are treated as empty vessels into which knowledge can be deposited (like deposits in a bank). Rather, he claimed, the purpose of education is human liberation where people are the subjects of their own learning and where their culture, values, experiences and relationships are central to how they interpret and create their own world (Freire, 1970).

This view of participatory knowledge, as liberating rather than as domesticating, has had an important influence in the way institutions around the globe promoting primary health care have been working to create more equitable, people-oriented health systems. Over the last 10 years, in 20 sites spanning 9 countries in east and southern Africa (DR Congo, Kenya, Malawi, Namibia, South Africa, Tanzania, Uganda, Zambia and Zimbabwe), health organizations have been strengthening community/health system interactions through a process called participatory action and reflection (PAR, also called participatory action research, see www.equinetafrica.org for all reports). These groups of health practitioners have engaged with the Regional Network on Equity and Health in Southern Africa (EQUINET) – a network consisting of professionals, civil society members,

policy makers, state officials and others within the region who aims to promote and realize shared values of equity and social justice in health. They have implemented work in various areas of health, including mental health, maternal health services, HIV and AIDS care, environmental health, and more broadly on strengthening mechanisms for community involvement in health planning (Mbwili- Muleya et al., 2008; University of Namibia, 2008; HEPS Uganda, 2008). Their work has shown the wider EQUINET family how participatory approaches can strengthen communication between health personnel and communities, enhance mutual respect and joint analysis, leading to a greater understanding of the barriers to health and strategies for overcoming them. In turn, other work within EQUINET, for example in the use of sentinel surveillances on monitoring health equity and the debates around human resources for health, has helped PRA practitioners understand the value of using multiple sources of knowledge to deepen community actions in health.

Access to communities' or people's knowledge is not a simple panacea to the challenges we face in making our health systems more equitable and people centered. Local knowledge is not spread evenly throughout a community or among communities. People may have different objectives and interests, and they certainly have different access to information and resources. Differences in social status or gender or age also affect what individuals within a community know. Therefore, in defining local knowledge, we need to be clear who it is that is expressing that knowledge. It is of little use only talking to a group of male leaders, for example, about where to place a water pump, when it is always the women who collect water.

Furthermore, we also need to be careful that, just because the knowledge is local, it serves the interests of the poor. It has been argued (Gaventa and Cornwall, 2008; Cooke and Kuthari, 2001) that the relatively powerless may actually mirror the views of a dominant, more powerful group. As Noam Chomsky (American philosopher and

political activist) ironically says: "In a well-run society, you don't say things you know. You say things that are required for service to power" (Chomsky, 2007). Control over knowledge production, as well as how it is disseminated and used, is one of the main ways in which powerful societal interests are reinforced. Chomsky tells this intriguing story about a pirate who was brought before Alexander the Great (356-323 BC) who asked him "How dare you molest the seas with your piracy?" The pirate answered: "How dare you molest the world? I have a small ship so they call me pirate. You have a great navy, so they call you an emperor. But you are molesting the whole world. I'm doing almost nothing by comparison" (Chomsky, 2007:2).

This is how it was, and how it continues to this day. In the contemporary context, knowledge control is undertaken to fulfill powerful corporate (for example, the tobacco or pharmaceutical industries) and state interests, using the mass media as one of the key ways in which society 'manufactures consent' (Herman and Chomsky, 1988). Through the domination of the elite, knowledge has become private property; and some people's knowledge has become easier to access than others have.

This is not to say that the birth of the Internet and mass communication has not offered significant new ways for people to access information, assert their own interests and connect with each other. ItaiRusike (personal discussions, September 2012), from the Community Working Group on Health in Zimbabwe, tells a story about an old man in a remote rural district who approached Itai to ask him whether he'd met the Minister of Health before the minister went to the World Health Assembly meeting. "No", Itai responded. "But why?" the old man asked. "Last time you were here we told you what we wanted him to say!" The old man knew about the meeting because his village had access to the Internet. In addition, note that he says 'we', not 'I', reinforcing the notion that knowledge is – should be – collectively owned and used.

Nevertheless, even though mass communication, such as the Internet or radio, can potentially break the monopoly of powerful societal interests, we also need to be careful not to assume that greater access to information means greater control over the content of that information. In a world where there are oppressors and oppressed and where knowledge, as much as any resource, can be used to liberate or subjugate, we need to look at how alternative forms of participatory knowledge can be used as a means to social transformation and the betterment of people's lives. Ultimately, this boils down to the issue of 'power'.

2.3 Power Lies at the Centre of Social Relationships

Power is a complex term with multiple interpretations. Supporters of a neoliberal doctrine see the use of power, often referred to as influence, as the product of an open system of equal competing agendas (Harvey, 2005). If certain people don't participate in the freedoms given to them, it is either because they choose not to or because of "their own apathy or inefficacy, not as a process of exclusion from the political process" (Gaventa and Cornwall, 2008). But, as many others - including well- known thinkers such as Stephan Lukes, Michel Foucault and John Gaventa (Minkler and Wallerstein, 2008; Foucault, 1977; Gaventa, 1980; Gaventa and Cornwall, 2008) - have pointed out, power affects people's lives in much deeper ways. Having or exercising power means some people control and have access to information and resources, while others do not. Any relationship - whether between individuals, groups or societies - is affected by a particular power dynamic that impacts the development of that relationship.

To explain this, Gaventa (2006), drawing on work done earlier by Lukes (1974), developed what he called 'the power cube'. This cube gives a three-dimensional view of power. One set of gradients recognizes that power can take place at different levels – household, local, national, and global. Another refers to where the power is acted out –

some spaces are closed to select elite who may in certain situations invite others to participate but within set boundaries. Then there are situations where less powerful actors choose to claim a space for themselves where they can set their own agenda. Finally, there are different forms of power – visible, hidden – where agendas are set behind the scenes, or invisible, relating more to the norms, beliefs or ideology of a group (see www.powercube.net).
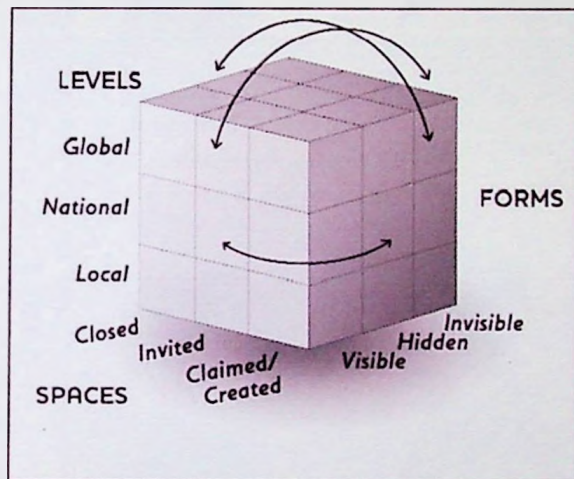
One of the strengths of the power cube is that it does not assume that power is always in the hands of those who have a hold on the traditional forms of power. Instead, it echoes work done by Foucault (1977) in recognizing that power can also be seen as a form of resistance – where visible, hidden or invisible power may be mobilized, whether consciously or unconsciously, as strategies to challenge or transform existing power relations.

This recognition of forms of 'resistance' fits in well with four other ways to describe power:

- *Power over* – refers to the power of the strong over the weak, including the power to exclude others.
- *Power to* – where individuals or groups of people exercise agency and begin to realize theirrights and their capacity to act.
- *Power with* – which is a more collective form of power through organization, solidarity and jointaction to counter injustices; and finally.

- *Power within* – where people have gained a sense of self-identity, confidence and awareness often linked to culture, religion or other aspects of identity and which influences their thoughts and actions.

The last three definitions of power – 'power to, with or within' – are all forms of power resisting the domination of 'power over'. They are not separate entities. People, individually and collectively, can be expressing more than one form of power at the same time and in different situations. The external environment – the laws, rules, norms, customs, social identities and standards that either constrain or enable people to act (Hayward, 2000), affects these situations.

Linked to this is an understanding that not all uses of power are destructive. Certainly, the abuse of power can undermine and halt the process of change; but Foucault (1977), in particular, argues that the manifestation of power is not always negative and oppressive, but can be positive and productive – a necessary, creative source of change.

2.4 Making the Link between Participation, Knowledge and Power

Take a look at the pictures (Loewenson *et al*, 2006). It shows four windows of two people, a nurse and a young man, facing each other with eyes open or blindfolded to represent the degree to mutual understanding established. Let's call the young man Jim and let's say that he is an unemployed youth from a remote rural area. The nurse, on the other hand, is from the capital city, is formally educated and has a salary income. Especially in windows 2 and 3, there is a strange dynamic being played out between Jim and the nurse. In window 2, the nurse thinks he holds all the knowledge; Jim is perceived to be ignorant or blind. And Jim, in turn, is not willing to see what the nurse has to offer. And, since the nurse perceives that his greater status over Jim (by virtue of his age,
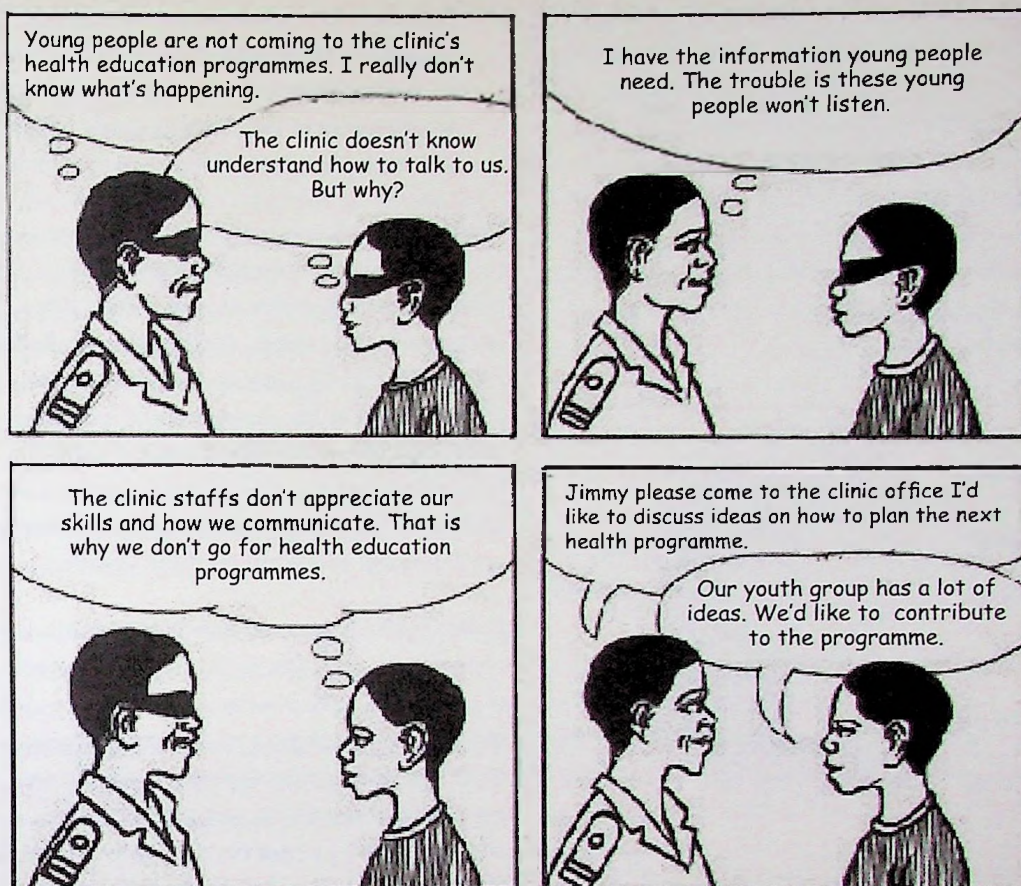
Source: Loewenson et al (2006)

education and position) gives him greater authority, he is also as good as blind (as reflected in window 3), unwilling to listen to Jim to find out what he can offer, to understand his values, his passions, his dreams.

The two are stuck. Neither will be able to break down the barriers that separate them, until they are both able and willing to remove their blindfolds and talk with each other, with respect and understanding. Only when they begin to share their respective knowledge (window 4), participate equally in a shared vision and, most important, acknowledge and attempt to change the unequal power dynamic that exists between them, including their unequal access to resources, will they slowly relearn how to interact with each other, each from a position of strength.

Take this example and broaden it outwards, placing this dynamic in a political and economic context in which those with 'power over' others use that greater power to dominate, control and exclude. Communication is impeded because those with greater authority determine what is important or possible, for and by whom. Other forms of power ('power to', 'power with' or 'power within') then come into play, as groups of people begin to flex their muscle and push the boundaries of what is possible, demanding greater access to knowledge and greater participation in its production, use and dissemination.

The question, though, is how does this interplay between power, participation and knowledge play itself out in relation to the development of our health systems?

These links are summarized in Table 1, **Interface between Power, Knowledge and Health Systems**

The Table 1, (Interface between power, knowledge and health systems) points to a number of issues.

First, the empowering processes are not linear and if marginalized groups organize themselves, they can influence power relations and pressure the state into action (de Vos et al., 2009). However, it is clear that each concept of power carries with it different assumptions of how to bring about change. In some cases, it is about finding ways to work within the system, to gain access to information usually not available to them and then to use that knowledge to make the system more accountable. In other instances, it's about rebuilding the health system itself or even a wider process of seeing health rights as part of a larger struggle for justice.

In the latter case, we are not merely talking about building knowledge but about transforming the way people and systems interact, literally to counter the monopoly of expert knowledge producers who exercise 'power over' others. When

Table 1: Interface between power, knowledge and health systems

	Level of participation	Relationship to Knowledge	General Implications of Health Systems
Power over...	Dominated by those in control. Decision-making and knowledge creation shifts away from communities.	Creates a 'normative' world – in media, education, shaping of political beliefs – where knowledge of some groups more valid than others.	Public health planning and health systems analysis mostly top-down. Quality and outreach of state services weakened by neoliberal policies and competition with the private sector.
Power to...	People recognize injustices created by dominant ideology and begin to organize; want 'a seat at the table', to be part of the discussions. Usually facilitated by civil society.	Opens up spaces for discussion and debate and expands who participates in knowledge production. Often not about creating new knowledge but about demanding access to information.	Introduces concept of state accountability to meet their obligations to people's right to health, for example, budget tracking.
Power with...	Restores people's agency as active participants for change. Involves community mobilization and action.	Knowledge deepened through a participatory process of people acting together to understand and change their reality. Shared knowledge builds a sense of solidarity and collective understanding of what the world should look like.	Creates the possibility for demands at local, national and international level for the development of a more people-centered health system based on social justice and equity.
Power within...	Involves capacity to imagine, have hope and the ability to Act and change the world (agency). Not about wanting greater access to what already exists, but about wanting something different. Creates own power base.	Produce own knowledge that changes awareness or world view of those involved. People understand there is an alternative and become strategic.	Community participation in health systems is not enough. Needs to be dynamically linked to power in decision-making, access to resources and consciousness of actions. Health rights seen as part of a larger struggle for economic and social justice.

people begin to gain power it usually involves greater activism and organizing. The power to act ('power to') and to act in concert with others ('power with') is fundamental to social change. At a deeper level, when people begin to acquire 'power within' they are developing a stronger individual or group consciousness and a sense of identity about who they are and what change they want. This is when change becomes more transformative. It is not about wanting greater access to what already exists, but about wanting something different.

This is never quite as simple as it looks. For example, while it is generally acknowledged that community participation is one of the determinants of positive health outcomes, i.e. for health to improve, people need to be informed and motivated to make choices and take action that promote health, it is also clear that the use of participation as a discreet 'magic bullet' weakens understanding of its complex nature (Rifkin, 1986). Participation by definition is not necessarily

transformative. It can just as easily be used to target groups to participate as beneficiaries of programs with the objective of improving delivery of health services. This is quite different from a more empowering concept of participation that encourages people to use their own knowledge and the knowledge of others to celebrate their individual and collective strengths and agency as active participants for change.

Ultimately, knowledge creation needs to be linked to action, either directly or indirectly. "Knowledge without action is meaningless, just as action without reflection and understanding is blind" (adapted from Reason and Bradbury, 2008:4). Although development of an equitable health system rests solidly on our understanding of the complexities of participation, knowledge and power relations, none can exist without its practical application. This directly links into the focus of the next section.

3

BUILDING KNOWLEDGE AND PRACTICE TOWARD PEOPLE-CENTERED HEALTH SYSTEMS
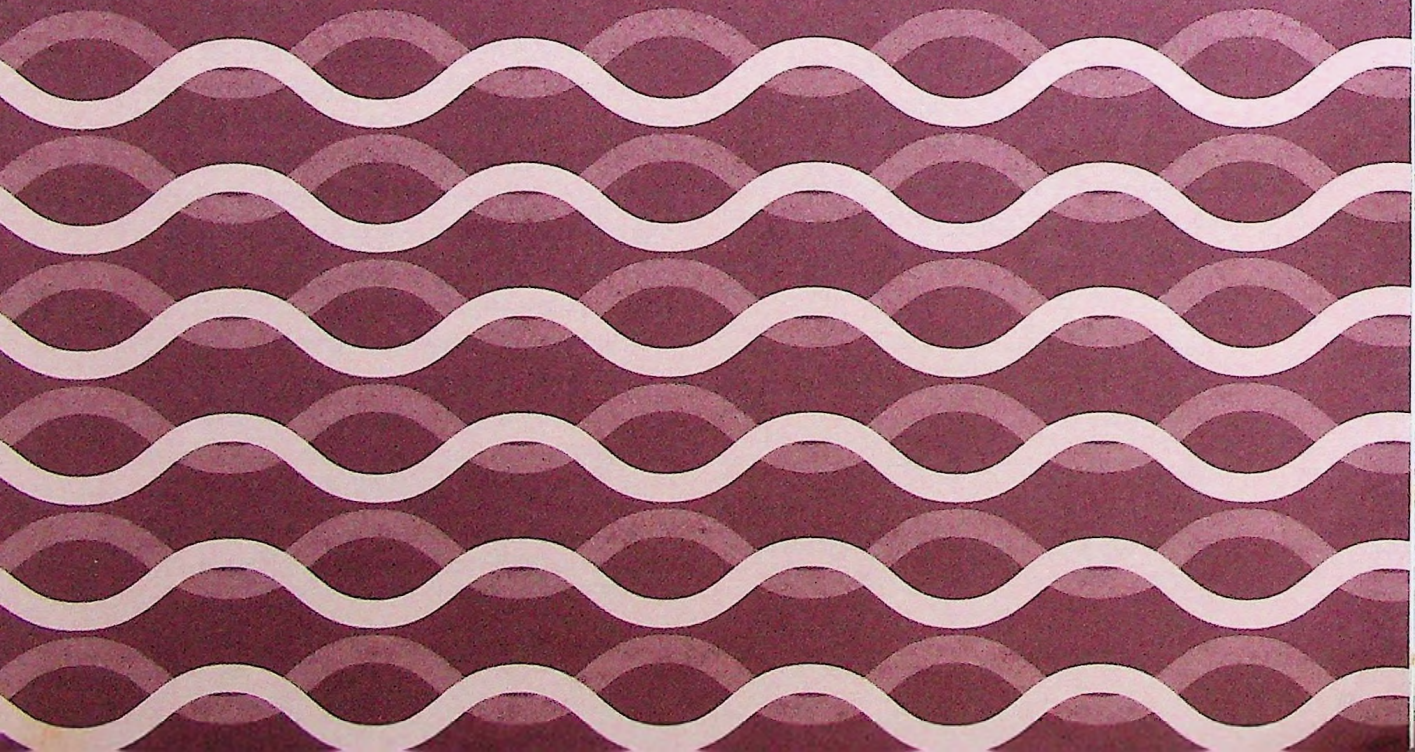
So, how can we change the power relationships to make them people centered, just and pro- poor? How can we get to a point where participation is not a form of tokenism, but connects with and builds the consciousness of communities, reinforces their identity and knowledge processes, and leads to action?

As a starting point, let's begin by exploring what we mean by the term 'people centered'.

3.1 What Do We Mean by a People-centered Health System?

At its core, a people-centered health system values people's knowledge and acknowledges the important role people play in improving their health. As Loewenson et al (2006) has pointed out, people are important in many aspects of health systems:

- People stay healthy by their understanding and awareness of health – parents are responsible for the health of their children, partners for each other's health, and communities should care for the elderly and poor in their communities.
- People share information with health services on the conditions in their community and on preventing and treating disease.
- People have local health knowledge to contribute to health systems, including information on healthy foods and local health risks.
- People play a role in implementing health actions, including outreach of health programs, caring for ill people and supporting health services.
- People set priorities and make decisions on how health problems should be addressed and how resources should be allocated.
- Communities also monitor and make sure that their services are functioning in the way they expect. They give feedback to health authorities and discuss issues with health

workers. (Loewenson et al, 2006:54)

As we see, people-centered health systems enable people to take action to improve their health and the health of their community. People participate in defining their own problems and in designing, implementing and monitoring their actions in an empowering process. In well-functioning people-centered health systems, community actions is undertaken in partnership with health authorities, building a sense of trust and solidarity and opening up new spaces in which dialogue and development can flourish. The focus is on strengthening comprehensive primary health care.

The role of the state in supporting these processes is crucial, especially in providing resources to the primary level and in supporting community efforts. People-centered health systems are more sustainable when supported by adequate health financing and progressive means of resource mobilization. In these situations, the state can become an instrument of transformation, as has been shown in countries such as Brazil where there is a political commitment to the provision of a publicly funded, rights-based health system where citizens are involved in discussions over health policy and in mechanisms for accountability and decision-making (Cornwall and Shankland, 2008).[2]

Community participation in health systems can also take place in isolated pockets. During the civil war against the military dictatorship in El Salvador in the 1980s, one community in Guarjila came together to improve its own basic conditions of life, constructing a potable water system, houses and latrines, developing their own food production system, and generally assuming responsibility for their collective health. Despite adverse conditions characterized by militarization and institutionalized repression, health and living conditions improved dramatically, thanks to the efforts of everyone in the community and under

2 Ironically, we have also seen authoritarian states, such as in Vietnam, China and Cuba, transforming their health systems to be more 'people centered', done in a top-down manner with little focus on participatory or democratic processes.

the leadership of a highly organized health team (Abrego et al, undated). Spring forward 20 years and the present El Salvadoran Ministry of Health is using the successes in Guarjila as a model for the current health reform processes. "We have come to learn of this population which has strived so much to build its own health", MI Rodriguez, Minister of Health, said. "We wish to support them with health that is superior and of better quality." (Quoted in Abrego *et al*, undated).

3.2 Approaches to Building Knowledge and Practice toward People-centered Health Systems

The reality is that most of our health systems are not people centered. However, this should not deter us. Our challenge is, first, to be clear about what changes we are striving to achieve, and then to find the means of getting there, step by step. As I have argued in this paper, our ideal is the creation of a health system that gives voice and agency to the poor and most vulnerable in communities, situated in a larger context where national and global economic and political forces are harnessed to support community efforts, and where resources – including public provision of adequate food, water, sanitation and housing - are equitably shared in the interest of all. It is about developing a caring environment where health rights are seen as part of a larger struggle for social justice. This is not an ideal that can be put into practice immediately – many problems and constraints are involved. The real challenge is to look for entry points to help differing perspectives emerge and, in doing so, to help move the social change agenda forward.

Fortunately, multiple approaches have been used to address people's concern with persistent inequalities in the distribution of power and resources, and the linking of processes of knowing to learning and action (de Koning and Martin, 1996). These all go under an overarching term called participatory action research (PAR), but are

also known as participatory reflection and action (PRA), mutual inquiry, critical action, feminist participatory research, and others. While these different approaches may have varying goals or perspectives (feminist research, for example, has a much more nuanced approach to looking at the different experiences of men and women), they all share a common set of core principles that:

- View people as the subjects rather than the objects of knowledge generation.
- Include a commitment to engaging community members and outsiders in a joint process of learning and reflection.
- Involve an empowering and power-sharing process that attends to social inequities.
- Emphasize collective ownership of knowledge and promote skills sharing and capacity building.

As Robert Chambers, a strong proponent of PRA has said: "These sources and traditions have, like flows in a braided stream, intermingled more and more" (Chambers, 1992 and quoted in Minkler and Wallerstein, 2008).

Methodologically, PAR is known for its emphasis on the acquisition of qualitative information – involving visual and tangible expressions of analysis – for example, mapping, modeling, diagramming and scoring through to methods arising from oral traditions of communication and dissemination of knowledge, such as songs, drama and music. PAR also uses more traditional, quantitative methods such as questionnaires, group discussion formats and different ways of ranking and scoring. The issue is not whether the methods are qualitative or quantitative, but rather how the information is used to validate the firsthand, practical experience of the group as an important source of knowledge. Integral to this is an understanding that PAR allows for different ways of producing knowledge that is systematic and verifiable and leads to the production of knowledge that can be used both by the scientific community and for society (Loewenson et al, 1994). Other forms of health

systems research can be done using PAR methods, such as sentinel surveillances or policy analysis, thus advancing new ways of accessing knowledge drawing on these approaches. It is not a situation of either-or.

A key component of PAR is the commitment to a process of reflection and action, an ongoing cycle of learning that allows for a deepening analysis of the problems people face and an increasing capacity to initiate action to bring about change. A healthy tension arises between knowledge and action, between knowing and doing, where knowledge production itself may become a form of mobilization (Gaventa and Cornwall, 2008). Thus, PAR moves:

focusing more on substantive structural change. While it is all too easy to see this as a 'one or the other' dichotomy, Chomsky argues that tinkering is, actually, preliminary to large-scale change. As he says: "There can't be large-scale structural change unless a very substantial part of the population is deeply committed to it. It's going to have to come from the organized efforts of a dedicated population. That won't happen, and shouldn't happen, unless people perceive that the reform efforts, the tinkering, are running into barriers that cannot be overcome without institutional change" (Chomsky, 2007:121).

With that in mind, let's take a closer look at how these two traditions are used in the struggle for health equity and social justice.

From	To
Objectivity	Knowledge for its own sake as less relevant than knowledge for change
Individual interpretation	Group analysis and validation of evidence and experience
Expressing needs for others to address	Addressing own needs and analyzing underlying causes to take actions
Separation between subject and object	The experience of those affected is the primary source of information
Statistical analysis provides the only scientific basis for Verification	Verification arises from collective agreement and from evaluating action based on information generated
Acceptance	Critical thinking
Isolation	Creative action with and through others
People being treated as a commodity	A sense of humanity
Defensiveness, fear and exploitation	Appreciation and hope

Source: Adapted from Tandon (1988); Loewenson et al (1994).

Much of the literature on participatory action research (Minkler and Wallerstein, 2008; de Vos, 2009; Tandon, 1988) identifies two distinct traditions in this approach. One focuses on systems improvement as its main goal, and the other puts forward a more emancipator approach to change that challenges the political domination of elites and the structural inequities in which we live. To use the words of Noam Chomsky, one 'tinkers' and is engaged in undertaking cosmetic improvements, while the other 'overhauls',

Approaches for Systems Improvement

The assumption underlying this approach is that problems are solved by putting pressure on either state or non-state institutions to function better in the interests of the wider community. It does this through the pragmatic use of community-based knowledge, through strengthening frontline health worker/community dialogue and other forms of acquiring information (such as budget monitoring or social audits). This approach opens up spaces

for discussion and gives people the 'power to' act based on their growing understanding of the injustices they face.

A good example of this approach can be seen in the community-based monitoring of health services in India (see www.copasah. net/practitioners-convening-at-johannesburg. html). In 2005, the new government in India introduced a national rural health mission (www. nrhmcommunityaction.org) with a mandate to improve the health system and overall health of the Indian population. The government developed clear delivery standards and guidelines under the Indian Public Health Standards (IPHS) that spelt out the range of services that should be available at different levels of care. These guidelines were used as the basis for community monitoring of the public health system.

Maharashtra was identified as one of nine pilot states for this community-based monitoring (CBM) program. Working with and through a number of civil society organizations, and coordinated at state level by the Support for Advocacy and Training to Health Initiatives (SATHI), village health committees were trained in community monitoring and undertook to work with community members in gathering information on the functioning of health services. The program used a number of methods, many of which were accessible to the illiterate, including report cards at village, primary health care and rural hospital levels, public hearings, media coverage and state level conventions.

Over nearly six years, SATHI has developed community monitoring in collaboration with partner organizations in over 600 villages in 13 districts around the state (SATHI 2012). And, in the process, SATHI documented some impressive improvements in rural health services, including a reduction in prescription of medicines to be privately purchased, putting an end to illegal charging by some medical officers, an improvement in health service delivery such as immunization and an increase in extension

services by village health workers and midwives.

Clearly, this program gave a strong message to the government that it had to respond to the needs of rural people. However, this in itself was not enough. In addition to the monitoring that was going on, communities were also part of a strong civil society movement linked to a national campaign platform for health rights in the form of the people's health movement. This meant that key systemic issues were picked up by the health rights campaigners and used to strengthen wider social support and political commitment to CBM that were not adequately addressed through the CBM program. As noted in the Practitioners Convening Report (OSF-AMHI, 2011): on the one hand, civic organizers "plan to continue to occupy and expand the spaces for community monitoring and, on the other, develop health rights struggles and policy-related campaigns for structural change. The belief is that when people's knowledge and people's organization are combined then change will start to happen." Even though there has been no major impact in policy changes in the health sector to date, mainly because of the unwillingness of the state government to make such required changes, these campaigns have been important in generating wider social mobilization and ongoing pressure for pro-people health system change (correspondence with AbhayShukhla, SATHI, March 2013).

The Emancipation Tradition

The emancipation tradition came into being around the 1970s. It arose out of the struggles against the structural crisis of underdevelopment in Latin America, Asia and Africa and the impact of globalization (Minkler and Wallerstein, 2008). Influenced by such thinkers as Paulo Freire (1970) and Walter Rodney (1973) and later by people such as John Gaventa (2006) and Fals -Borda (2001/2006), this tradition challenges the hegemonic dominance of certain groups who have 'power over' others. It seeks to change the unequal distribution of power and resources through development of a collective

consciousness, mobilization and action. It moves people to look critically at themselves ('power within') and to act together ('power with'), both seen as important components to social change.

At this stage, it is useful to explore Brazilian educator Paulo Freire's views on emancipation. As mentioned earlier in this paper, Freire opposed what he named the 'banking concept' of education that prevents the oppressed from 'restless, impatient, continuing and hopeful inquiry" (Freire, 1970). He argues that the banking system teaches fatalism: the world is a given and "one can but submit to it". The system of dominant social relations, says Freire, creates a culture of silence that instills a negative, silenced and suppressed self-image into the oppressed. To overcome this, the oppressed need to regain their sense of humanity and develop a 'critical consciousness' - that is, an ability to look at a problem, not as individually created, but as rooted in the socio-economic contradictions and structural problems of society.

Source: MashetNdhlovu in Loewenson, et al (2006)

Here, it is logical to ask the question: "So, what can be done to let people speak for themselves so they can liberate themselves and others from domination?" According to Freire, change can only come about through 'praxis', by which he means the integration of reflection and action, practice and theory, thinking and doing. To facilitate this praxis, he proposes an alternative method of education called 'problem posing' which concentrates on showing people that they have the right to ask questions and to find out about causes and influences in their lives. The focus is on creating a dialogue around a specific 'generative theme' that poses a problem (not a solution,which is the more usual way of transferring knowledge) resonating with the reality of people's lives. Through dialoguing around this theme, people develop a critical awareness of the problem that, in turn, will motivate them to act.

It is not difficult to see how Freire's work has influenced the approaches used in participatory action research, and particularly in participatory reflection and action (PRA). Freire's generative themes have been used in multiple ways over the decades – through, for example, drama ('theatre of the oppressed') and the use of picture codes, as shown in the diagram above (Loewenson et al 2006), and in a range of sectors from health literacy, AIDS program, health and safety, sanitation and the environment (see present and back issues of PLA Notes www.planotes.org).

The challenge is to move from the local to the global. Newman and Beardon (2011) use a beautiful image to describe the challenges related to this process: of a pebble that has been thrown into the water which has an immediate visible impact – the splash – and then ripples outwards, getting weaker and less defined as it loses momentum. They continue: "In the same way, a good quality participatory grassroots process can have a strong local impact... but the influence and impact naturally dissipates the further away from the original context you get." The challenge is how to bring the knowledge and information generated at community level to bear on international processes, especially with regard to decision-making and action. Progressive international non-government organizations who support the value of local knowledge and capacity, and who understand the unequal power dynamic

at play, have a complex role in this. On the one hand, participatory processes are time consuming and require a long-term commitment to building principles of equity, respect and collective action. On the other hand, policy advocacy involves timely inputs into complex advocacy initiatives, using dense, technical language (Newman and Beardon, 2011). It is not easy to marry these two processes, especially when issues of downward accountability and attempts to turn the 'subjects' of development into equal partners are necessary ingredients to international solidarity.

Social movements that have a south-to-south perspective probably have more space in which to do this. The People's Health Movement (PHM) is one such organization. Formed in 2000 in Bangladesh at a People's Health Assembly attended by nearly 1500 people from 92 countries, the PHM is a global network of health activists, civil society organizations and academic institutions from around the world who are seeking to revive the core messages of Alma Ata. The movement has a strong critique of neo-liberalism and the negative forces of globalization that prevent equitable distribution of resources necessary for people's health, particularly to the poor. The People's Charter for Health, endorsed by participants at thefirst People's Health Assembly, calls for action at grassroots, national

and international levels. It maintains its grassroots, community focus by consciously supporting the creation of structures – called country circles - and planned activities in about 70 mostly low- and middle-income countries. Its focus is on opposing the weakening of public health systems, making health systems accountable and effective, countering commercialization of health care, and in ensuring access to health care for all within a broader 'right to health' framework (www. phmovement.org, GHW 2, 2008).

There certainly are obstacles, not only within the larger political and economic world order, but also in relation to struggles to combine local activism with horizontal global networking and advocacy (Danielsen and Scheel, 2012). The PHM has managed to relate directly to global bodies, such as the World Health Organization (WHO), and has successfully initiated a People's Health University where hundreds of young people from many parts of the south have participated in short courses on 'The Struggle for Health'. Nevertheless, there are still challenges to keeping the country circles active and integrated into the larger movement. The motivators behind PHM continue to explore creative ways of ensuring the diversity of people involved in PHM remain the drivers of the change they so clearly demand.

4

LOOKING AHEAD:
WHO ARE WE TO CARE?

It is 34 years since the signing of the Alma Ata Declaration. While there has been progress in global health since that time, especially in life expectancy, we have also seen a massive widening of inequalities between and within countries. Despite the initial commitment to primary health care, the conservative climate of the 1980s and subsequent economic crises led to a global reluctance to tackle inequalities and the underlying causes of ill health. While Alma Ata pointed to the importance of community-oriented comprehensive primary health care for all, some argued that the basic concepts of this approach were unattainable because of the costs and numbers of trained personnel required. This argument also suited the dominant neoliberal economic and political consensus of the time that focused on privatization, deregulation and a shrinking role of the state. Instead, a selective, disease-oriented approach gained dominance and, with it, a whittling down of the earlier commitments to equitable social and economic development, inter-sectoral collaboration and community participation (GHW3, 2011).

Nevertheless, despite this sustained hegemony of the rich and powerful, this paper has shown that it is possible to build alternatives. The villagers in Chikukwa District, Zimbabwe, continue to share and respect each other's knowledge and to build a more collective understanding of their right to health; Thailand and numerous other countries have made significant progress in implementing program to make health coverage available to all; Maharashtra State in India is still making strides in publicizing health service abuses of health rights at community level through a state-level community monitoring program; and the People's Health Movement continues to mobilize health activists from around the globe in critiquing and taking action against neoliberal policies that undermine the right to health for all. These are just a few examples: the literature draws on other case studies – for example, from Brazil, Cuba and until recently, the United

Kingdom (Cornwall and Shankland, 2008; de Vos, 2009; GHW3, 2011) where "health through people's empowerment" (do Vos, 2009) has led to positive outcomes in people's health.

These examples show how a range of strategies has led to increased spaces for dialogue between different actors in the health system and an increased level of organizing at all levels. Groups of people have confronted exclusion through networking and the building of social movements for change. Many are also demanding state action and accountability. While some of these actions are taken with the support of public health structures, civil society organizations (CSOs) have played a pivotal role, especially those that have connections with local communities (Loewenson, unpublished) or have managed to act as pressure groups at national or global level.

However, even though progress has been made, much is still to be done and many sticky questions to be addressed.

A key question is: what do we mean by 'we'? Who are the 'we' that is challenging the status quo, redefining our knowledge base and working toward more democratic and inclusive forms of participation? The problem to date is that our 'we' is still fragmented ideologically, strategically and geographically. This results in a subsequent loss of collective identity. Take, for example, the Occupy Movement in which the main message of rampaging economic inequality got lost in "a flurry of other equally important but somewhat distracting issues" (Labonte plenary presentation at PHA, July 2012) . This ultimately undermined their ability to organize and mobilize. In his opening address at the third People's Health Assembly in South Africa this year, Ronald Labonte, an authority on Globalization and Health Equity,addressed this issue, lamenting that our neoliberal 'compatriots' have learnt the lesson of using short, sharp and simple messages that tap into people's moral outrage. Their message – 'we blame the government for

usurping the rights of the individual' – has won support amongst a large number of people from a broad range of social classes, even if the message is incorrect. What about 'us', those of us in search of an alternative? What is our collective message? He proposes, as a start, the following:

"Life that is secure,
Opportunities that are fair,
a planet that is livable and
governments that are just."

It is a slogan that most people would support.

This still does not answer the questions as to how we can achieve these goals; questions that relate to processes we need to engage in for us to get to this alternative world, a world where every one of us is a 'rich human being' (Lebowitz 2004) in terms of our mental, spiritual and physical well-being. In relation to the issues addressed in this paper on participation, knowledge and power, I attempt to put down some of the burning questions - to provoke us into deeper thinking and action:

One of the arguments that has surfaced in this paper is that participatory forms of knowledge creation and use can give previously marginalized people greater access to their own power (their 'power within') to change and create a greater sense of solidarity and potential for collective action ('power with'). As pointed out by Gaventa and Cornwall (2008), there is a growing legitimacy globally of different forms of knowledge and a lessening of a dependence on the voice of the 'expert'; they also state quite clearly, however, that "simply creating new spaces for participation, or new arenas for diverse knowledge to be shared, does not in itself change social inequities and relations of power" (Gaventa and Cornwall, 2008:184). The voiceless can still be co-opted or manipulated, they are limited by the dominance of the 'old ways' of interacting in these spaces including the language used, and often are silenced by their own internalized sense of powerlessness. While there are a number of

examples in the struggle for more equitable, people- centered health systems of citizens coming to the decision-making table, participating in public hearings or stakeholder consultations, engaging in community monitoring of government expenditure or implementing PRA processes, we need to ask:

■ How can we be sure that these processes are really giving voice to the excluded?

■ How can we connect the range of different voices to develop a more 'collective consciousness' that will link up with wider social and knowledge processes and allow for more fundamental change to take place?

■ If people do get a sense of that 'power within' and 'collective consciousness', how can it be sustained, especially since these so often get co-opted or out maneuvered?

■ How do these people-oriented forms of power relate to other forms of power, especially state and technical power?

■ Finally, to quote Hall (1981), "What happens after people have spoken up, have made alliances, and had a taste of countering the dominant forces? Is there a 'memory' of power which will resurface at a later time?"

A number of questions surface as we think about the importance of moving from the local to the global as a strategy for change. Clearly, solidarity is essential if we want to create meaningful change. Compared to just a few decades ago, many more movements – environmental, labor, trade, women – are questioning the logic of capitalism and speaking out with a loud voice. This suggests that 'manufacturing consent' as a strategy of the powerful is being slowly undermined. Nevertheless, as we move toward a more global civil society:

■ How do we in the health movement build alliances with all these other movements?

■ How do we make sure that the knowledge and voices of advocates in many global decision-making arenas are accountable to local actors (Gaventa and Cornwall, 2008)?

Who speaks for whom, with whose knowledge and with what accountability?

- How do we move from articulating a critique of the present status quo to mobilizing for action at local, national and global levels in ways that involve integrating local knowledge with critical reflection and learning?

These pressing questions need to be addressed. It is up to every one of us to take up the challenge. We all need to care.

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ABBREVIATIONS & ACRONYMS

CBM	Community-based Monitoring
CEGSS	Centro de Estudiospara la Equidad y Gobernanza en los Sistemas de Salud, Guatemala
CHSJ	Centre for Health and Social Justice, India
CWGH	Community Working Group on Health, Zimbabwe
COPASAH	Community of Practitioners on Accountability and Social Action in Health
CSO	Civil Society Organisation
CSDH	Commission on the Social Determinants of Health
EQUINET	Regional Network on Equity and Health in Southern and East Africa
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
IPHS	Indian Public Health Standards
NRHM	National Rural Health Mission, India
PAR	Participatory Action Research
PHC	Primary Health Care
PHM	People's Health Movement
PRA	Participatory Reflection and Action
SAHAJ	Society for Health Alternatives, India
SATHI	Support for Advocacy and Training to Health Initiatives, India
TARSC	Training and Research Support Centre, Zimbabwe
TNC	Trans National Corporation
UNHCO	Uganda National Health Consumers Organisation
WHO	World Health Organisation

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