Consciousness
(Ideology, Praxis, Solidarity)

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15 Mar 2023

Usage

The focus of this chapter is on a network of ideas centred around the idea of 'consciousness': how we see ourselves in the world. Consciousness is not a leading pre-occupation of neoliberal economics but for political activists working in the Marxist tradition, seeking to both understand *and* change the world (see Marx's Thesis Eleven), it is an essential concept.

This commitment to *changing the world* leads to some practical questions.

1. *Why do many oppressed and exploited people accept their oppression and sometimes even reject the truths that they are offered by revolutionary explainers?*
2. *How do oppressed and exploited people find their own truths about their oppression?*
3. *How to build solidarity across difference?*

These three questions have far-reaching implications for political strategy and have generated lots of scholarly reflection and commentary, much of which involves ideas about consciousness. We shall explore this commentary around each of the above questions, focusing on 'ideology', 'praxis', and 'solidarity' respectively.

Finally, we will return to the Struggle for Health and explore three case studies in which these ideas are reflected.

Ideology

Why do many oppressed and exploited people accept their oppression and sometimes even reject the truths that they are offered by revolutionary explainers?

The concept of 'ideology' deals with the relationship between consciousness (how we see ourself in the world) and reality (how we really are in the world).

For people who see themselves 'as they really are', the term ideology is generally used as an explanation as to why others may have a different understanding of the world. Their understanding of the world is presumed to be distorted by their ideology (patriarchal, neoliberal, fascist, communist, religious, etc).

Whether it is possible to see things 'as they really are' is controversial; this is the debate between realists and relativists. The realists generally recognise that their vision is clouded by lack of knowledge but believe that the disciplines of science are progressively revealing the truth of a knowable reality. The relativists are less confident. Their reservations, about the knowability of reality, draw from four separate fields: linguistics, recursion, informatics, and quantum mechanics. These are discussed further in Box 1 below (but feel free to skip the box).

The linguistic case for relativism originates with the work of de Saussure (Saussure 2013[1916]) and Wittgenstein (Wittgenstein 1958) who demonstrate that words are coined to capture difference rather than corresponding directly to reality. The realist assumes that the language, in which their knowledge of reality is cast, bears a one to one relationship to the reality that it seeks to know. But Wittgenstein and de Saussure argue that new words are coined when existing terms are overloaded; the new term is coined to capture a newly recognised variant or distinction which is understood within that linguistic community as needing to

be recognised. There are three propositions here: first, the new term corresponds to difference rather than identity; second, that the distinction matters to people; and third, that the importance of this distinction is recognised within the relevant linguistic community. Understanding language as specifying difference, rather than corresponding on a one to one basis with reality, casts some doubt on knowability of the real world (whatever that is) in language.

The recursive case for relativism rests on the simple fact that we (humans) are inside, are part of, the world we are seeking to understand. The paradox of the map maker trying to make a map which includes representation of the map maker making the map captures the challenge that recursion presents to a correspondence theory of truth. The painter who is inside the room they are painting needs to wait for the paint to dry and move to a new position before finalising the painting. Science explores many different perspectives but each one is necessarily partial because of this recursion. Theory-making involves building a singular narrative which integrates the insights of the partial stories gained from each perspective.

The informatics case for relativism starts with Laplace's demon. According to the Information Philosopher "Laplace postulates a super-intelligence that could know the positions, velocities, and forces on all the particles in the universe at one time, and thus know the universe for all times. The concept has been criticized for the vast amount of information that would be required, impractical if not impossible to collect instantaneously. And where would the information be kept? If in some part of the universe, there would be an infinite regress of information storage".

The quantum case for relativism arises from the demonstration that, at a fundamental level, reality is uncertain until it is observed. The role of the observer in fixing the real underlines the significance of our presence in the field of knowledge.

Box 1. The case for relativism

The concept of ideology bears on a further set of questions about how our understanding of ourselves in the world is shaped.

Eagleton (1994) describes how the term 'ideology' was coined (by Destut de Tracy) in a prison cell during the French Revolution. "Ideology, then, belongs to Modernity – to the brave new epoch of secular, scientific rationality which aims to liberate men and women from their mystifications and irrationalisms, their false reverence for God, aristocrat and absolute monarch, and restore them instead to their dignity as fully rational, self-determining beings" (Eagleton). Napoleon was critical of de Tracy and his colleagues for their irrational hyper-rationalism and their disregard for "custom, piety, intuition and concrete experience" (Eagleton).

Eagleton describes the political conflict around the Enlightenment faith in reason. "In late eighteenth-century England, the names for this running battle were Paine and Burke: Thomas Paine, with his revolutionary fervour and serene confidence in reason; Edmund Burke, for whom the whole notion that the social order can be submitted to rational critique is a kind of blasphemy."

Marx and Engels, in The German Ideology (Marx and Engels 1932[1846]), argued that consciousness (how we understand ourselves in the world) is shaped by the institutions, practices, power relations and discourses of the society in which we live. They were critical of Hegel and his followers who (they said) treated ideas as somehow disconnected from the material world. To the contrary, the consciousness of workers living under capitalism is shaped by their lived experience of a class society.

In the Marxist tradition, ideology (understood as the sum of the pressures which naturalise the ruling narratives of capitalism) is a material force which contributes to reproducing the power relations, institutions, and practices of capitalism. A range of different approaches to ideology contend within the Marxist tradition ranging from the truth-knowing realists of historical materialism (and their diagnosis of 'false consciousness'), through to the relativists who see the truths of our world as always mediated through curtains shaped by our experience and our aspirations (individual and collective). This more relaxed view of ideology does not negate the

influence of the prevailing pressures of hegemonic forces but neither does it assign a determining role to such narratives.

Returning now to the question with which we started, "*Why do many oppressed and exploited people accept their oppression and sometimes even reject the truths that they are offered by revolutionary explainers?*

There could be many answers to this question including the naturalising of the status quo by the dominant ideology and the structures and dynamics which promote that ideology. However, there may be other answers also including lack of knowledge, isolation, and simply the daily struggle of survival.

Why they '*sometimes even reject the truths that they are offered*' may also have several possible answers; perhaps those truths are not as self-evident as they may seem to the explainers; perhaps the explanations and strategies being offered do not map across different world views. Perhaps the ideologies of the revolutionary explainers are also shaped by the legacies, institutions, and power relations of the revolution.

Nevertheless, the concept of ideology, as a material force mediating between consciousness and prevailing institutions, practices and power relations, is useful. Ideology can be a conservative force, protecting the status quo, but it can also serve as a platform for liberation.

Praxis

How do oppressed and exploited people find their own truths about their oppression?

Paolo Freire's concept of 'praxis' is a useful place from which to start in addressing this question (Freire 1971; Freire 1972).

Freire recognises the fog of ideology but also affirms the agency of the oppressed. Praxis starts with action by the individual, in community, engaging with the structures which shape their experience. Praxis involves a conscious reflection on the experience and outcomes of that engagement, and in in that reflection we explore new ways of understanding the world we inhabit (a reshaped world view, a new consciousness). Praxis assumes a struggle to improve that drives engagement with the structures of oppression. Praxis - the action, the reflection, and the striving - is collective.

Freire was an educator and seized with the importance of reflecting on the words and the networks of meaning which we bring to the struggle; seized with the role of dialogue in reflecting on the action and the outcomes; and focused on the dynamics of dialogue in renovating the words and adjusting the networks of meaning in the context of reflection.

Freire's praxis provides a powerful way of addressing our second question. Oppressed people may find new ways of making sense of their world through trying (collectively) to change it, and reflecting (collectively) on that experience. There is of course no guarantee; the forces of oppression may overwhelm, but the logic of praxis has been found liberating in many different struggles.

The methodologies of consciousness-raising groups during second wave feminism parallel Freire's praxis closely. Small groups of women, sharing their experience of patriarchy, exploring different ways of understanding their worlds in dialogue, trying new strategies, and then returning to collective reflection.

Freire was a teacher and much of his writing is about the pedagogy of liberation. His writings have shaped many different strands of adult education, including educational initiatives of social movements such as feminism. However, while in formal adult education the methodology starts with the teacher, in feminist consciousness raising the methodology is owned by the movement.

Solidarity

How to build solidarity across difference?

The Communist Manifesto urges, "Workers of the world, unite. You have nothing to lose but your chains". A similar sentiment is expressed in 'Solidarity Forever – for the union makes us strong'. However, the notion that solidarity of the working class (nationally and internationally) might be sufficient to demolish capitalism has proved disappointing; indeed, the project of building global solidarity around this proletarian identity has also proved difficult.

The anti-colonial wars of liberation built solidarity around various mixtures of ethnic, religious and national identity as well as the shared burden of colonialism. The rise of identity politics from the 1960s challenged Marxist assumptions that allegedly privileged working class solidarity over ethnicity, gender, ability, or colonised status. These issues are explored in more detail under Class and Intersectionality. It is sufficient here to summarise the conclusions reached in those chapters (see Box 2 from Intersectionality)

> Confronting capitalism (and imperialism and colonialism) as the central challenge does not mean that the pain mediated by sexism, racism and ableism is somehow less important than the pain mediated directly by the power of capital. The reason that the pain mediated by sexism, racism and ableism matters is not primarily because it fragments the forces against capitalism. Human pain matters because it is humans in pain. Confronting racism and sexism, as sources of division among the forces confronting transnational capitalism cannot be addressed without honouring the grievances, recognising the suffering mediated by the power relations of sexism, racism and ableism. A global people's movement against transnational neoliberal capitalism must address these as a core part of its program.

Box 2. Convergence and solidarity

Discourse theory and the concept of intersubjectivity provide useful resources for addressing this question, '*How to build solidarity across difference?*' However, the reader might prefer to skip the Box 3 and go straight to the bottom line below.

> The term 'discourse' is used in many different ways, from a self-conscious conversation to counting words. The discourse theory we use here deals with the world view which is reflected in how we speak or write, and the institutions, practices and power relations which set the context for our writing and speaking.
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> This branch of discourse theory owes much to Wittgenstein, de Saussure, and Foucault (Foucault 1976), all of whom highlight the role of language in mediating experience and consciousness. Discourse theory sees a reciprocity between subjectivity (the understanding I have about myself) and world view (my understanding of the world I inhabit), both of which are shaped by the language we use to articulate them. Discourse theory, like ideology, recognises how the language (and the meanings) we use (to speak and think about ourselves and our worlds) is shaped by the institutions, practices, and power relations of those worlds. Discourse theory agrees with Freire in recognising how our subjectivity and our world views are also shaped by our agentic engagement with the world we inhabit. However, where Freire focuses on reflection in dialogue, discourse theory focuses on the stories we tell, about ourselves and our world, and the networks of meaning which we assume and express in telling such stories.
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> This is well illustrated in the field of narrative therapy which understands the process of telling, reflecting upon, and then retelling our stories, as the reshaping of our subjectivity. However, insofar as there is a reciprocal relationship between the stories we tell about ourselves and our world, and the relation of those stories to power, changing our story about ourselves may be resisted by our world, and, conversely, may change the world.
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> Discourse theory provides a linguistic interpretation of 'intersubjectivity'. At its most basic level this refers to a sharing of the meaning of the words, and the networks of meaning, which constitute our discourse. It refers also to the shared stories about ourselves and our worlds, including shared stories about the world we need to see.

This leads to the question about how shared stories arise and how shared stories can be deepened. Drawing on Wittgenstein, de Saussure and Freire, we can imagine the following scenario. A disparate group of activists confront a project with a certain level of trust, a certain level of shared meaning. Our protagonists share in general terms an agreed purpose, analysis and strategy. They engage with the structures; they observe and reflect on the experience and the outcomes; if the outcomes are recognised as confirming the tentative assumptions on which they were based, then the tentative assumptions of solidarity, which were carried by trust in the first instance, are solidified, trust is deepened, and the domain of shared meaning is widened.

Box 3. Discourse theory and intersubjectivity

The bottom line is that collaborative action based on tentative agreement about purpose, analysis and strategy, where the outcomes confirm the initial assumptions, builds intersubjectivity, shared consciousness, deeper trust, and stronger solidarity.

Applications in health activism

Ideology, praxis and solidarity, all of which draw on the idea of consciousness (or world view) are critical tools for social movement activism, including movement building around Health for All.

Comprehensive Primary Health Care imagines PHC practitioners working with the communities they serve to address the local and immediate circumstances which constrain community health and access to health care, and doing so in ways which also contribute to redressing the larger scale, longer term forces which reproduce those circumstances (Legge et al. 2007). This work may involve challenging hegemonic ideologies (perhaps involving praxis informed dialogue), and building solidarity across difference.

My colleagues and I have undertaken two large multi country case study collections in recent years which offer detailed accounts of comprehensive primary health care in action. The first, Revitalising Health for All (International Development Research Centre 2017), collected case studies from a wide range of primary health care projects in 13 countries. The second collection, Civil Society Engagement towards Health for All (CSE4HFA - Bodini et al. 2018; Bodini et al. 2020), focused on streams of health activism from six countries where community involvement or community leadership were prominent; many of these were also based in primary health care settings.

These case studies offer many vignettes of activist engagement where hegemonic ideologies, associated with institutional power, were operating as barriers to health development, and where challenges to such ideologies (and power structures) were described. They offer vignettes of capacity building where the Freirian principle of praxis was consciously deployed; where communities were struggling to improve their life circumstances, and actively reflecting on their experience, and on that basis reframing their engagement. The case studies also include vignettes of building solidarity across difference through collaboration in struggle, reflection on outcomes, and the deepening of trust and widening of engagement where the outcomes vindicate the original trust.

In the following pages I review three case studies which illustrate ideology, praxis and solidarity respectively. However, these episodes were not unidimensional and a broadly based account of each is necessary to convey the context as well as highlighting the centrality of ideology, praxis, and solidarity.

Victorian Aboriginal Health Service: resisting the assimilationist ideology

The story of the Victorian Aboriginal Health Service, as documented by Fredericks and colleagues (Fredericks, Luke, and Brown 2011) and further analysed by Fredericks and Legge (2011), provides a useful case study for exploring the role of ideology in the struggle for Health for All.

This case study was developed in the context of the Revitalizing Health for All project (International Development Research Centre 2017), in association with the Cooperative Research Centre for Aboriginal Health and Lowitja Institute.

The Fredericks and Legge commentary summarises the background of Aboriginal and Torres Strait Islander health in Australia, from invasion, colonisation and dispossession to the development of a vibrant network of Aboriginal community controlled health services (ACCHOs) from 1971.

The Victorian Aboriginal Health Service (VAHS), established in Melbourne in 1973, was one of the earliest to be established. It provides a comprehensive range of health services as well as campaigning around housing, employment, land rights, and against racism. It has also assisted in setting up ACCHOs elsewhere in Victoria and setting up state and national representative organisations. VAHS is a safe place for Aboriginal and Torres Strait Islanders in Melbourne.

ACCHOs in Australia have struggled with state and national governments since 1971 over Indigenous policies which affect health as well as the funding of health services. These struggles have gone through different phases but the tensions between governments and ACCHOs have been ongoing. Even now, ACCHOs are constrained by a myriad of narrow funding streams all with separate purposes and accountabilities.

The feature of VAHS history we focus on here involves the ongoing contestations about Aboriginal identity which are discussed in the Fredericks and Legge commentary. Assimilationism was for many years the underlying principle of official policy regarding Aboriginal people, including the practice of forcibly removing children of mixed heritage from Aboriginal communities. Assimilationism remains a powerful theme in mainstream policy discourse, particularly where continuing expropriation of land or degradation of cultural values is in play.

In South-eastern Australia where the colonial presence and assimilationist policies (including forced removals) have been long standing, many people who identify as Aboriginal have a lighter skin colour than in the remote centre and experience a further twist in relation to assimilationist ideology through discourses regarding who is a 'real' and 'not real' Aboriginal or Torres Strait Islander person.

Assimilationism as a policy framework is closely related to racism; it draws support from and contributes to the different expressions of racism. This conjunction is reinforced by the discourse of the 'real' versus the 'not real'. For the many Aboriginal families who have generational memories of forced removals, the equation of light skin and 'not real' is particularly hurtful.

The establishment of community controlled health services nationally has played a leading part in affirming the continued cultural and political integrity of Aboriginal communities, against the pressures of colonisation and assimilationism. Because of this affirmation and resistance ACCHOs like VAHS have been able to contribute to health development in Aboriginal communities in ways that mainstream health programs are not able to.

Assimilationism naturalises the continuing processes of colonial dispossession including the discounting of Indigenous rights. It is an ideology which is reproduced through the voices of conservative politicians and the coverage of the conservative media. Mining and large pastoral interests that are at the forefront of continuing colonial dispossession are major donors to mainstream political parties; those industries are large export earners, and they figure in the investment portfolios of pension funds, banks and insurance companies.

In the Aboriginal and Torres Strait Islander context the struggle for health is not separate from the struggle against the racist ideology of assimilationism. The struggle for health is also a political struggle against the continuing encroachments of colonisation and confronting the ideology of assimilationism and the power structures which reproduce it are part of that.

These reflections on the experience of the Victorian Aboriginal Health Service illustrate the relevance of ideology as an analytic tool in the Indigenous struggle for health in the white settler

colonial context, in particular the relationship between power structures and consciousness. However, the tool is also helpful in interrogating the ideologies of patriarchy, imperialism, religious bigotry and capitalism (which is where we started).

The South African Community Health Worker project: the power of praxis

The story of the community health worker (CHW) project of the South African circle of the People's Health Movement (PHM) provides a useful context for exploring the implications of Freirian praxis for health activism.

Between 2014 and 2018 PHM globally undertook a large multi-centre study supported by the Canadian International Development Research Council (IDRC) exploring civil society engagement in the struggle for 'Health for All' (CSE4HFA). Over four years, 130 activist-researchers in 10 countries produced 50 research reports. Five themes framed the project: movement building, campaigning, capacity building, knowledge generation, and engagement with global governance (Bodini et al. 2018).

Our focus here is on several projects undertaken by PHM South Africa involving community health workers (CHWs). The following account is based on five reports prepared by PHM South Africa as part of the CSE4HFA project (Trafford 2016; PHM South Africa 2016b, 2016a, 2016c; Paremoer and Sanders 2018).

The democratic transition in 1994 has led to some progress towards Health for All but much remains to be done. The continuing challenge is reflected in poverty levels and economic inequality. In 1995, a year after democratic transition, about 53% of the SA population lived below a poverty line of R322 per month. This proportion had declined by five percentage points, to 48%, by 2008. However, in absolute terms the number of individuals living below the poverty line in SA went from 21.5 million in 1995 to 23.4 million in 2008. During this period South Africa's Gini co-efficient remained constant at about 0.67. Across the post-1994 period, South Africa has experienced virtually no redistribution of income from its wealthiest citizens to its most impoverished.

Access to basic services such as electricity and water is limited by the ability of consumers to pay for them. By 2009 government efforts resulted in only 4% of households being without access to basic water infrastructure, 23% without access to sanitation (as compared to 50% in 1994), and 27% without access to electricity (down from 51%). Nevertheless, low-income households frequently experience service disruptions or become increasingly indebted to the state or service providers because of their inability to pay for more than a very basic free allocation of water and electricity.

The expansion of the CHW workforce has been a major change in the profile of health care in South Africa since the transition, driven in the first instance by the AIDS/HIV crisis. By 1996, AIDS/HIV prevalence had increased dramatically in South Africa. For many years the denialist Mbeki government hampered access to highly active antiretroviral treatment (HAART) for people living with HIV/AIDS (PLWAs). From the early 2000s onwards, NGOs stepped into the vacuum created by the government's refusal to provide HAART. Many local NGOs secured funding from foreign governments, international organisations or philanthropic foundations to provide services to PLWAs. These NGOs often hired community health workers (CHWs) to support their efforts to expand treatment access. CHWs were mainly responsible for doing HIV/AIDS prevention and education activities, and for promoting treatment adherence amongst PLWAs who had started HAART.

Today an estimated 72,000 CHWs are active in South Africa. They comprise a large and heterogeneous group incorporating a wide range of auxiliary health care providers including home-based carers, lay counsellors, and community care workers, among others. They may be based either within the community or at a clinic or operate as a go-between. CHWs are generally either volunteers or employed through NGOs, either from government disbursements or independent funding.

The CHW case study was initiated as part of PHM South Africa's participation in the global IDRC funded CSE4HFA project. The project started with assessment of the strengths and weaknesses of PHM South Africa in its campaigning for Health for All, including action on the social determination of health as well as health system reform to provide universal access to decent health care.

Following the government's policy announcement in 2010 of its intention to establish a national health insurance (NHI) scheme, PHM, in conjunction with Section 27 and the Treatment Action Campaign (TAC), undertook a campaign around health insurance directed to ensuring the equitable distribution of financial, human and institutional resources and ensuring universal access to health care.

The assessment of the NHI campaign, that was undertaken as part of Stage 1 of South African involvement in the CSE4HFA project, recognised that the campaign had not been as effective as hoped. Two putative reasons for this were, the 'demobilisation of civil society following majority rule', and the decline in voluntarist activism associated with the 'NGO-isation of civil society'.

During the 1980s, a powerful anti-apartheid movement had operated in the health care sector. Progressive health professionals started recruiting and training lay health workers who also acted as anti-apartheid activists. During this period much health activism focused on de-racialising health care services, training more black health care workers, developing a national network of community based primary health care clinics, and exposing and preventing the involvement of health workers in human rights abuses (particularly during the 1980s and early 1990s).

However, with the transition to majority rule many of the leaders of the anti-apartheid movement, including in the health sector, moved into bureaucratic positions within established institutions and in government, leading to what was, in effect, a demobilisation of civil society, impacting particularly on its leadership.

With majority rule and heightened expectations of government there was also a waning of voluntarist activism in South African civil society, associated with an expectation amongst potential health activists that they can and should be paid for their participation in health campaigns. This has been referred to as the NGO-isation of South African civil society.

Building on these reflections it was decided to hold a National (People's) Health Assembly (NHA) and in 2016 PHM again joined forces with TAC and Section 27 to plan and co-host the NHA. The assembly took place in Cape Town in June 2016. It was organised around six themes, each pointing to the different crises facing the South African (SA) health system. These were:

1. Lack of meaningful community participation in primary health care, and more specifically, the marginalisation of health committees – the primary formal mechanism for community participation in decision-making at the health facility level – that has taken place in recent years.
2. Human resources for health, and more specifically, the poorly defined role and exploitative working conditions of community health workers, who are required to serve as the "foot soldiers" of the government's primary health care strategy.
3. A lack of responsive, equitable and effective leadership and management within the health sector, particularly at the level of health facilities.
4. Unreliable access to HIV/AIDS and TB treatment for public sector patients, particularly due to stock-outs of essential medicines and difficulties accessing treatment facilities in rural areas.
5. The disproportionate resources and influence of the private health sector in the SA health system. The possibility that efforts to implement a National Health Insurance (NHI) scheme would further entrench this influence because of the increased role of private sector providers in the national health system, as well as the amount of public funding they receive through reimbursements claimed from the NHI fund for services performed.

6. The need for sustained civil society mobilisation to address the social determinants of ill-health.

The NHA was preceded by three types of activities, which were all designed at generating empirical information, providing political education and stoking debate about the key themes of the Assembly in the months leading up to it. Each co-host (PHM, TAC, S27) took responsibility for organising activities in specific provinces. These activities included provincial health assemblies, which were aimed at documenting the main health problems and other provincial level activities; and a South African People's Health University (SAPHU), which is an activist school hosted by PHM-SA.

Two initiatives directed specifically at community health workers were, first, a research and consultation project directed to exploring the working conditions and health activist involvement of CHWs; and second, the 2016 SAPHU, a five day training course which was specifically aimed at training community health workers and was held immediately preceding the NHA.

The initial research and consultation project aimed to explore how CHWs were responding to the needs being faced in their communities and to identify and better understand the scope for, and barriers to, activist engagement by CHWs. Qualitative research was done in five provinces including interviews, focus groups and workshops. The workshops focused closely on the nature of community health work, the circumstances of CHWs, and explored CHWs' thinking about the provision of government health services.

There was also a strong emphasis throughout the project on support for CHWs and the critical role they are and could be playing in uplifting the country's health and wellbeing, including their work with individuals and as well as in advocating on behalf of their communities. Reflecting on the six crises listed above, the potential contribution of community mobilisation to health development is clear. Such activism figures prominently in many interpretations of the Alma-Ata Declaration on Primary Health Care.

The response to the workshops and the CHW-focused SAPHU was very positive. Having known very little about the policy changes proposed for the NHI, CHWs generally appreciated any information and if anything, wanted more. They enjoyed the chance to get together with other CHWs and to share their anger and frustration – often specifically at the government and the formal health system.

Two important discourses emerged and engaged during the workshops and the SAPHU which might be referred to as 'health activism' and 'labour rights'. While not necessarily contending these are not perfectly aligned.

Over the last few years, various groups have begun to champion and advocate for CHW labour rights, advocating for "decent work" for CHWs and their inclusion in the formal health system. Much of the contemporary advocacy in this area was urging for CHWs to be absorbed into the state-employed workforce to obtain employment security, decent working conditions, and a living wage.

The sequence of CHW workshops, followed by the 2016 SAPHU, provided an opportunity for the CHWs to explore in dialogue their lived experience as CHWs. Out of this emerged a heightened determination to achieve labour rights, including formal employment, proper training and further career prospects.

PHM South Africa and other partners in the South African arm of the CSE4HFA project have been fully supportive of the drive for labour rights and have actively assisted by providing the organisational spaces for sharing, reflecting, and exploring new approaches.

However, the organisers of the workshops and the SAPHU had other objectives also in reaching out to CHWs, aiming to strengthen their roles in community mobilisation around the social determinants of health and access to health care, in accordance with the principles of comprehensive primary health care. These objectives have inspired some in the CHW workforce but for many, the

immediacy and urgency of the labour rights agenda displaced the activist agenda. (This is not so surprising in view of the apolitical stance adopted by many more highly trained health practitioners. Even during the anti-apartheid years, the activists were in a minority.)

However, gross health inequities remain, and the public health system appears incapable of addressing them. Continuing activism and advocacy for health, at all levels, is still urgently needed.

The program of SAPHUs continues, although no longer labelled a 'university', and has been successful in raising awareness among many CHWs, of the social determinants of health, the political barriers to universal health care, and the urgency of community mobilisation.

The question we posed at the beginning of this chapter, to capture the concept of praxis was, "*How do oppressed and exploited people find their own truths about their oppression?"*

The idea of praxis highlights the importance of finding the words, and the wider networks of meanings, which satisfactorily express the experience of oppression and exploitation. It highlights the significance of reflection, action and further reflection; talking together about the shared experience; exploring different ways of responding; reflecting together on outcomes.

These processes were clearly operating during the CHW project, although not exactly as the organisers had hoped.

The El Salvador International People's Health University: a case study in solidarity building

A unique sequence of IPHU courses in El Salvador, also documented as part of the CSE4HFA project, provides the backdrop for exploring the processes of solidarity building (Zuniga 2017).

The International People's Health University (IPHU) is the umbrella term for the program of capacity building run by the People's Health Movement. The first IPHU was a 10 day training course held in 2005 in the lead up to the second People's Health Assembly (PHA2) in Cuenca Ecuador. Since then there have been more than 40 of these short courses, ranging from one to two days to a week or more.

In 2009, the candidate of the Salvadoran Left (the Farabundo Martí National Liberation Front - FMLN) won the presidential elections with an electoral platform that included health policy themes that had been widely discussed within PHM and at various IPHU courses. Their electoral slogan was "Hope is born, change will come,"

In the months leading up to taking office, the social movements, academics and unions that had supported the FMLN organized a 'Social Dialogue' and developed proposals for the new government's policy platform, including for public health. In May 2009, Dr. María Isabel Rodríguez, former rector of the University of El Salvador who became the health minister in that first FMLN government, presented the president-elect a proposed policy platform called "Construyendo la Esperanza" (Building Hope), which incorporated many themes from PHM's Charter and proposals which had emerged in the Social Dialogue. It was adopted as the government's National Health Policy for the first five-year program, which began the following month.

El Salvador's "Building Hope" National Health Policy identified human resources in health as the cornerstone of the health reforms, prioritizing community health and primary health care. The need was recognised to build greater understanding of PHC and to conduct awareness-raising courses among health personnel and communities.

In late 2011 the first of a series of IPHU courses was held, co-sponsored by the Ministry of Health (MINSAL), PHM Latin America, the community-based National Health Forum (NHF), and the Salvadoran chapter of ALAMES (the Latin American Association of Social Medicine). Personnel from

all of these organisations had participated in previous IPHU courses and were familiar with the general structure and style of the courses.

There were two unique aspects of this program of courses. First, the recruitment deliberately included both health practitioners from the Ministry and community-based health activists from the National Health Forum. Second, the course design was based explicitly on the concept of the social determination of health.

The distinction between 'social determinants' and 'social determination' had been under discussion within ALAMES for several years. While the social determinants approach tends to focus on 'factors' in the social environment which are associated with poorer or better health, the concept of social determination seeks to focus on the social, political and historical processes through which population health is improved or is held back; through which health equity improves or regresses. Accordingly, the IPHU courses in El Salvador were oriented around identifying, and learning how to engage with, the social and political processes through which population health improves and universal access to decent health care is achieved. The inclusion of both health professionals and community-based health activists was both consistent with, and necessary for, this social change perspective.

The processes and outcomes of the first six courses were evaluated in 2016 as part of the CSE4HFA project, using the 'most significant change' methodology and extracts from the evaluation report (Zuniga 2017) follow.

"The IPHU produces an intense shock that shakes one. The contents are profound, very strong, and unveil 'real reality.' There's a break between before and after the IPHU. We're changed; nobody's the same as before."

Some health professionals saw the IPHUs as helping to link knowledge from university vocational training with activist commitment. The course was a link between these two ways of thinking, acting and living. Practitioners valued the IPHU experience from a theoretical and academic point of view. There had been no other space for discussing the topics developed in IPHU, such as the differences between social medicine/ collective health and conventional biomedical practice and statist *public* health.

Health personnel have had access to knowledges that had not been seen before in El Salvador's traditional medical education. They learned to look at health from a human point of view, which allows them to make better decisions. "IPHU is an opportunity to meet other people, hear other ideas, learn to listen to the population. It's a motivation to share and reach a personal commitment as an agent of change."

The significance of social participation in health policy and service delivery, which was highlighted during the IPHUs, was an unknown for most health personnel entering the courses. That bridging of the professional-activist gap has been mutual, thanks to the IPHUs.

Many saw the field visits as an opportunity unavailable in the daily health services work at the primary care level, much less in the hospitals. With these visits, they learn for the first time about the health problems of open-pit mining, the use and misuse of agrochemicals and chronic kidney disease, and violence.

For their part, NHF activists valued that people such as themselves who are not health professionals could participate. "Participating in IPHU broadened our vision that health can and should be promoted from different disciplines." The IPHU strengthened ties of companionship and communication among NHF people with the same desire for change. Networking among activists has increased and many projects have become easier or faster to complete.

NHF participants experienced some differences with MINSAL personnel during the course. The IPHU provided a space to generate new relationships and attitudes. After participating in IPHU, the

attitude of some health workers changed with respect to their previous image: “Now I see the course participants in a different way, not by academic level but as IPHU comrades.” Initially, some of the medical professionals tended to look down on the NHF leadership because they were not highly educated. Many of them came to appreciate that the NHF includes community leaders who may not have much formal education but do have leadership skills and community support.

“In the course, NHF leaders have come to understand that some doctors working in the communities may be arrogant because they have been formed by the hegemonic system, so we hope to change the training of professionals. In the course, we learned a lot from the health personnel, but they learned about the other side of the problem and what the communities are thinking.”

The NHF leadership found that the courses fuel self-esteem. Participating in such a university, studying with medical professionals and with national and international teachers, was very satisfying. While the NHF leaders feel some differences, they realize their own value and different skills and abilities. The NHF’s participation in the IPHUs has strengthened its organization, motivation, militancy and commitment to health reform.

NHF activists reported the course had helped a lot, particularly enhancing community participation. There is more rapprochement with communities. Fear is reduced and value is gained. Now they go to other municipalities to strengthen community organization, making people aware of organized struggles. There is an opportunity to work on new approaches that help to rethink the traditional approach to health.

Examples of projects initiated within the IPHU and involving collaboration between NHF leaders and health personnel who have participated in IPHUs, include the health committees formed in the municipalities of Santiago de María and Jiquilisco in Usulután. This initiative was developed as a community organizing approach to the problem of chronic kidney disease produced by agrochemicals. Sometimes these initiatives come from the NHF and sometimes from the MINSAL personnel, but both sides have come to respect and value one another and work together.

Another IPHU project was the formation of a social audit committee of the National Hospital of Chalchuapa, which allowed the development of a health committee in the same municipality and later the formation of a departmental NHF committee in Santa Ana (‘department’ here refers to the administrative region). “Even the specialists in hospitals want to know the results of the social audit exercises. It has caused a boom in the hospital.”

Other projects designed in IPHU that have been implemented are the production of educational material such as a brochure and plan summarizing the pillars of the health reform (2011), an initiative on climate change (2012), NHF newsletters and educational bulletins (2013) and a brochure summarizing the pillars of the updated health reform (2016).

There have also been advocacy projects directed to MINSAL’s health services, including improving the quality of care in the Ciudad Barrios National Hospital (2015), and a new approach to the problem of pockets of Salvadoran populations on the Honduran side of the El Salvador-Honduras border (2012). Other projects include an atlas of health inequities in El Salvador (2013), the drafting of clinical guidelines and approach to pharmacovigilance (2012), and the design of an approach to social violence by health services in the municipalities of Mejicanos and Cuscatancingo (2013).

Some intellectuals and academics who have participated as teachers/tutors in IPHU courses have shared their reflections for this study.

> “The strategic alliance generated between the PHM-IPHU and MINSAL of El Salvador is of vital importance. On the one hand, the PHM-IPHU makes available to the ministry a teaching methodology and a group of facilitators trained in a pedagogy for liberation, while MINSAL assumes as a priority the formation of political and technical cadres as a central element to advance the health reform. Today, it can be said that the leaders in charge of the Salvadoran

health system are the IPHU graduates who consider the struggle for the right to health their fundamental objective."

"There is no health reform that will survive in time if not defended by its professionals, its workers and the organized population. That is precisely what the issues discussed in El Salvador's IPHU are affecting."

"In the reforms of health systems, in addition to the political will of the government to prioritize social policies and specifically health policies and citizen's right to health, the socioeconomic context and the attitude of the population and the leadership in support and defense of the reforms are important. The ideological position of the professionals working in the central health structures, health centers and hospitals is key."

"The role of health professionals and workers is fundamental in the defense of a democratic public health system, with efficient and effective citizen participation and control of scientific and technical quality in accord with the objectives of the health plan."

The El Salvador case study of IPHU courses illustrates the processes involved in building solidarity across difference; in this case between health professionals and community activists.

In our initial discussion of these processes, we imagined a scenario which starts with protagonists from different backgrounds, embarking on a collaboration supported by a certain level of trust, a certain level of shared meaning and shared purpose. Our protagonists join the action and then they observe and reflect on the experience and the outcomes of their collaboration. If the outcomes are recognised as confirming the initial propositions, then the tentative assumptions of solidarity, which were carried by trust in the first instance, are solidified; trust is deepened, and the domain of shared meaning is widened. The next round of collaboration can now go further.

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