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HEALTH THROUGH PEOPLE'S EMPOWERMENT: A RIGHTS-BASED APPROACH TO PARTICIPATION

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ABSTRACT

Analysis of the academic discourse on participation, empowerment, and the right to health since the 1978 Alma-Ata International Conference on Primary Health Care and the subsequent Alma-Ata Declaration shows that each phase of the evolution of these concepts added important new aspects to the discussion. This article focuses on three crucial issues that relate to these additions: the importance of social class when analyzing the essentials of community participation, the pivotal role of power highlighted in the discussion on empowerment, and the role of the state, which refers to the concepts of claim holders and duty bearers included in a rights-based approach to health. The authors compare these literature findings with their own experiences over the past 20 years in the Philippines, Palestine, and Cuba, and they offer some lessons learned. The concept of "health through people's empowerment" is proposed to identify and describe the core aspects of participation and empowerment from a human rights perspective and to put forward common strategies. If marginalized groups and classes organize, they can influence power relations and pressure the state into action. Such popular pressure through organized communities and people's organizations can play an essential role in ensuring adequate government policies to address health inequities and in asserting the right to health.

INTRODUCTION AND METHODOLOGY

The 1978 Alma-Ata International Conference on Primary Care and the resulting Alma-Ata Declaration promoted the principle that people should play a role in developing policies and programs that affect their health — a clear call for participation.[1] However, the concrete implications of this principle have become the subject of intense debate.[2] Thirty-one years after Alma-Ata, a review of global policies noted that, of all the Declaration's key principles, the principle that has most notably failed to take root is that of community participation.[3]

This paper traces the chronological progression of academic discussions on participation, empowerment, and human rights as separate yet coordinated approaches to health. Beginning with the Declaration of Alma-Ata and its emphasis on participation, we follow the development of empowerment from this body of thought and the integration of these two related but discrete approaches into the human rights framework popularized by Paul Hunt, the first UN Special Rapporteur on the right to the highest attainable standard of health. In order to limit this paper to a concise discussion, the literature review focuses primarily on the work of Susan Rifkin, identifying three key issues: social class, power, and the

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state. Importantly, each approach — while distinct — interacts with, complements, and informs the others.

Consequently, we draw lessons from each of the issues of social class, power, and the state from our experiences working with nongovernmental organizations (NGOs), government agencies, and grassroots organizations in three countries: the Philippines, Palestine, and Cuba. By synthesizing these experiences as "health through people's empowerment," we propose common strategies based on best practices of community participation from a human rights perspective.

PARTICIPATION APPROACHES: AFTER ALMA-ATA

A multitude of approaches to community involvement and people's participation emerged in response to Alma-Ata's call for primary health care.[4] By the mid-1980s, Susan Rifkin was able to review no fewer than 200 case studies involving community participation implemented since the start of the decade. She described three different approaches toward community involvement: first, the medical approach, in which health professionals foster community participation in order to reduce individual morbidity and to improve sanitation; second, the health service approach, in which community participation aims to mobilize people to participate in the delivery of health services; and third, the community development approach, in which community participation aims to involve community members in decisions that are related to the improvement of the social, economic and political conditions that affect their health.[5]

Despite initial enthusiasm — or perhaps because of it — the concept of community participation gradually lost much of its force as it came to be perceived as a convenient means to compensate for the failure of states to make significant improvements related to primary health care. Not long after the Alma-Ata conference, the Rockefeller Foundation began to promote "selective primary health care" as a more cost-effective alternative for allegedly "costly and unrealistic" comprehensive primary health care.[6] This competing perspective detracted from Alma-Ata's vision of primary health care through community engagement and broader social change.[7] In an environment of an increasing dependence of resource-poor countries on foreign loans and a rising burden of international debt, selective primary health care began to be viewed as a more realistic solution.[8]

The concept of community participation was purposely limited to cost-sharing and the co-production of services.[9] Rather than seeking to involve people in defining their own development, community participation came to be largely focused on engaging "intended beneficiaries" in development projects in the 1980s.[10] In addition to the "cost-cutting" potential of this model of participation, international agencies were also drawn to its potential to neutralize popular resistance to imposed reforms.[11]

FROM PARTICIPATION TO EMPOWERMENT

In the context of the movement of community participation into the mainstream, Rifkin further developed her analysis, presenting two distinct participation frameworks. The target-oriented framework described "present day health improvements as mainly the result of discoveries of science and technology."[12] Contrasting with this, the empowerment framework applied Paulo Freire's theories on popular education to participatory processes in health.[13] Rifkin viewed the empowerment approach to community participation as "the result of community people, essentially the poor, gaining information, access to resources and eventually control over their own lives rather being dominated by the authorities by whom they have been exploited."[14]

While the target-oriented framework is top-down and aims to get target groups to participate as beneficiaries of programs with the objective of improving health services delivery, the empowerment framework mobilizes community members to participate in decision making, planning, implementation, and evaluation of programs with the main objective of empowering the community members. This framework considers the participation process important, but the outcomes — the redistribution of resources and power in the political process and the increased ability of marginalized communities to control key processes that influence their lives — are considered more fundamental.

Rifkin suggested that the two frameworks are neither mutually exclusive nor opposed to one another. She proposed to replace the "either-or" paradigm with a more flexible "both-and" paradigm in which the two frameworks could coexist and even merge. When open-minded practitioners respect local knowledge and capacities, she argued, this flexible approach offers more possibilities to act in a constructive way. Glenn Laverack and Ronald Labonte also echoed this position.[15] In her later work, Rifkin acknowledged the limitations of participation, as it does not address concerns about more long-term and sustainable change related to health improvement. She therefore observed the need to pursue empowerment to address issues concerning deep-rooted, inequitable, and structural obstacles.[16]

During the 1990s, other scholars also began emphasizing empowerment as either an extension of or a substitution for participation approaches. Nina Wallerstein expressed ideas similar to Rifkin's when she described community empowerment as "a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life."[17]

As the decade progressed, the concept of empowerment gradually replaced community participation in the discourse of NGOs and health planners.[18] Rifkin explained that "empowerment can be defined as creating opportunities and inspiration to enable those without power and/or influence to gain skills, knowledge and confidence to direct their own lives."[19]

Drawing on Rifkin's work on participatory approaches, Laverack developed a framework for empowerment approaches.[20] He believed that the essential difference between participation and empowerment approaches was the explicit orientation of empowerment toward social and political change.

Simultaneously during this time period, many international financial institutions dramatically altered their missions, intensifying interventions in national economic policies.[21] In the health field, the World Bank gradually replaced the World Health Organization as the most important international institution and — with the prescription to "invest in health" through privatization and liberalization — began imposing neoliberal policies on poor countries.[22] In the midst of the increasing social and economic inequities resulting from these neoliberal globalization processes, the concept of empowerment became controversial.[23]

Interestingly, the World Bank adopted an empowerment discourse, defining empowerment as "the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes."[24] It is not surprising that this interpretation of empowerment hardly addressed essential issues of power, such as control over resources, or the ability to make decisions on the direction of one's life.[25] References to power relations and social change are conspicuously absent in this definition.

HUMAN RIGHTS PERSPECTIVES

In the early years of the 21st century, human rights perspectives on health became increasingly promi-

nent and influenced discourse on participation and empowerment.[26] Like other scholars, Rifkin was inspired by Amartya Sen's work on equity. In *Development as Freedom*, Sen argued that individuals act in their best interest whenever they have the choice, that is, when they possess adequate knowledge, competencies, and resources.[27] Concepts of freedoms, rights, individual entitlements, and people's capabilities are central to Sen's empowerment concept.

In the context of the right to health, participation requires an accessible, fair, transparent, and continuous process in order to ensure adequate accountability. The means of participation should be accessible to different groups; fairness dictates that all groups should have an equal opportunity to participate. Through a continuous monitoring process, transparency allows participants to make the most informed decisions.[28] Moreover, the human rights framework that has been popularized by Paul Hunt stresses the crucial role of the state in respecting, protecting, and fulfilling the right to health. This human rights framework therefore requires independent accountability mechanisms through which governments explain and justify, to rights-holders and others, how they have fulfilled or failed to fulfill obligations regarding participation.[29]

Similarly, a rights perspective informs empowerment approaches by expanding the scope of the capabilities people strive to secure. Empowerment frameworks often focus on enhancing people's and communities' capacities; a rights-based approach empowers people not only to claim their rights but also to demand accountability from the primary duty-bearer: the state.[30]

Recently the People's Health Movement, a global network of health activists and organizations seeking to revive the core messages of Alma-Ata, launched the Right to Health and Health Care Campaign, which also gives particular attention to issues of participation and empowerment.[31] In a paper about the Right to Health and Health Care Campaign, Laura Turiano and Lanny Smith, two of its initiators, acknowledged that

> [w]ithout an explicit link between human rights, participation, and empowerment for social change — and without the concepts of claim holders and duty bearers as a key for analysis — the potential benefits of human rights approaches are minimal. An empowering participation is the most difficult requirement of the human rights-based approach to implement meaningfully, but its emotional and political appeal makes it very vulnerable for use in "rights-washing" projects or organizations.[32]

This statement by Turiano and Smith confirms that rights-based approaches are building on concepts of participation and empowerment, adding the concepts of claim holders and duty bearers. Moreover, participation and empowerment are critical — and potentially controversial — requirements that are particularly prone to misuse as misleading slogans when their meanings are vague. It is therefore useful to identify and describe the core aspects of participation and empowerment from a human rights perspective.

SOCIAL CLASS, POWER, AND THE STATE

Participation, empowerment, and rights-based approaches to health have much in common. Today's rights-based approaches to health have evolved from empowerment concepts that, in turn, were built on the concept of participation enshrined in the Alma-Ata Declaration. However, in practical efforts to achieve primary health care for marginalized groups and communities, each approach adds a unique — and necessary — element:

- a *participation* approach draws attention to issues of *social class*, particularly the existence of conflicting interests among social groups, and the need to involve the poor and other marginalized groups as decision makers in the policies that affect their communities;
- an *empowerment* approach highlights the role that *power* plays within communities and on a larger global scale; and
- a *human rights* approach introduces the essential concept of accountability of *the state* through its articulation of rights bearers and duty holders.

Over the past twenty years, while these conceptual academic discussions were taking place, the first three authors of this paper have been working with health organizations in four countries: the Philippines, Cuba, Palestine, and the Democratic Republic of Congo (DRC). Their involvement has included curative care,

prevention, advocacy, health planning, and lobbying. Lessons were drawn from these diverse experiences through a series of workshops, held from 2004 to 2007, with representatives of partner organizations from these four countries. Commonalities were described as "health through people's empowerment" and touched on each of the three key issues listed above. Although each country presented a different context in which these issues were encountered, we came to similar conclusions. Below we offer some lessons learned, in light of the previous discussion of three critical issues in the discourse on participation, empowerment, and the right to health. We explore each issue through experiences in three specific countries; the DRC is excluded here for the sake of brevity.

SOCIAL CLASS AND THE PHILIPPINES

Alma-Ata's focus on the need for participation has highlighted the lack of homogeneity within communities and the frequent inability of all social classes to participate equally in decision making. In most communities, not all members have the same values, needs, or interests. The definition of "community" as a group of persons who share common interests and needs, or whose needs can be summarized by a common factor, may be highly controversial. Moreover, the composition of a community can change over time as the interests and needs of its members evolve.

When we acknowledge the heterogeneity within communities, the question of representation arises. People with expertise in health can be hard to find, or they can belong to the elite and will therefore not necessarily represent the interests of poor and/or marginalized community members.[33] Similarly, people with certain influence or power may use their privilege or position to enrich themselves at the expense of the community.[34] For these reasons, the improvement of a community's health situation requires the participation of all social classes.

If people — especially the poor — set their own priorities, make their own decisions, and take a lead role in implementing these priorities and decisions, these empowering processes will likely provoke resistance. In our experience, a class perspective is helpful in understanding these power-related conflicts. Different social groups should be distinguished, each with its own interests and needs. Obviously, making a distinction between landless peasants and landowners is very relevant when discussing issues of poverty and ill health. Paul Hunt warned that

> [s]ome people have a naïve view of participation. In reality, effective participation (like access to information) is power. Some traditional elites are likely to resist the active and informed participation of disadvantaged individuals, communities and health-related sectors.[35]

Our work in the Philippines confirms the importance of social class when attempting to ensure participation. In the Philippines, we have been working with the community-based health programs (CBHPs) that took shape in the anti-dictatorship struggle of the 1970s, which united to form a national consortium, the Council for Health and Development, in the late 1980s.

In the early 1970s, the CBHPs in the Philippines initially worked with rural communities without significant examination of social class. Only after several years of experience in community work did they begin to use a tool for social investigation that allowed them "to achieve a more systematic and deeper analysis of the economic, political and cultural structures shaping the national and local health situation."[36] It became clear that issues such as land reform, which is critical for the social and economic emancipation of the majority of landless peasants, could not be addressed adequately at the community level. The CBHPs therefore forged alliances with provincial and national peasant organizations in order to challenge existing legislation on agrarian reform.

As health is tied to subsistence and livelihood, which directly relate to issues of land and income, communities that are able to take control of their own land are able to take control of their lives. The rise in family income that occurred when formerly landless peasants came to own the land they farmed resulted in better nutrition and improved access to health care. Moreover, the fact that peasants were able to plant a mix of crops for their own consumption apart from cash crops for market sale in itself increased variety in family diets.[37] Our experience illustrates the importance of addressing class structure in order to ensure sustainable health outcomes.

The CBHP experience likewise showed that community organizing is a pivotal strategy to maximize the

participation of community members. The CBHPs understood that "health care from the point of view of CBHPs is making the people self-aware. It is a process of helping the people understand their situation, analyzing what causes their miseries and bringing about changes in their lives, in their community, in society."[38] Wherever CBHPs were able to put these principles into practice, they ceased being only an alternative health care delivery system that substituted for the government's defunct system and became instead an avenue for social change.

Community organizing is also important for another reason related to social class. In the Philippines, health professionals are generally recruited from the wealthier classes and are paid accordingly. As Lynn Morgan has argued, the biomedical training of such persons often fosters hierarchical attitudes.[39] These findings suggest that it is dangerous to allow health professionals from the wealthier classes to be leaders in community health work as, more often than not, their interests will not represent those of the majority of the community members.

In 1993, the CBHP general assembly approved "Implementing Guidelines" for community organizing, which drew a distinction between organized and unorganized communities and formulated appropriate strategies:

> In unorganized communities, the direction of organizing work should be to assist in the formation of genuine people's organizations, to whom the management of the health program can eventually be turned over. In organized communities, health programs should assist in further strengthening the people's organization by building the capacity of their health committees to plan, administer and evaluate their community-based health care system. [40]

This dual strategy was based on previous experiences in which community organization had been neglected, resulting in health programs that were unsustainable or ineffective. As a result, programs were either abandoned as soon as outside assistance was withdrawn or were hijacked by the privileged classes within communities. Therefore, in unorganized communities, the CBHPs made organizing a priority, initiating the capacity-building component of their programs only when adequate structures were in place and with appropriate representation of the most disadvantaged. This strategy of emphasizing community organizing with an intentional focus on classes composed of marginalized persons proved to be successful in remedying the flaws of previous approaches.

POWER AND PALESTINE

Participatory processes to health often encounter obstacles or resistance when they begin to alter the status quo. Consequently, health becomes a highly social and even political and conflictive issue. Empowerment approaches aid in navigating these conflicts by drawing attention to the issue of power. Empowerment requires that power, which is often monopolized by a small group, be shared by the entire community.[41] Sharing power between more people obviously implies that certain persons or groups will lose some power. While applying an empowerment framework, one must accept that conflict is not necessarily negative; it may be essential to moving toward sustainable participatory and empowering practices. Rather than avoiding conflict, an empowerment framework should manage it well.[42]

Our experience suggests that people's organizations are central to any process of genuine empowerment. Such organizations should therefore be seen as the cornerstone of comprehensive, participatory, and empowering health work and should be part of any empowerment process from its inception. Genuine people's organizations are those in which the most disadvantaged classes, often underrepresented in society, are duly represented in leadership. People's organizations are the means through which individual community members foster enough collective strength to influence power relations. People's organizations are therefore an important tool to effect democratic social change.

Working since the late 1980s with the Union of Health Work Committees (UHWC), our partner organization in the Occupied Palestinian Territories (OPT), we have witnessed how the 1993 Oslo Accords and the ensuing "peace process" have dampened the empowerment processes by diverting people's attention from the root causes of the

conflict. The UHWC, like other health groups and NGOs, emerged from the many popular committees formed since the late 1970s to organize basic health services for local populations. During this period, popular and professional Palestinian committees were developing services, using their own vision and means, that Israeli military rule failed to develop in the territories under its occupation.[43] It is estimated that in 1993 some 50% of secondary and tertiary care in the OPT was provided by NGOs, while primary health care was largely the work of several independent Palestinian organizations, most of which were considered illegal.[44]

With the advent of the Palestinian National Authority (PNA), a consequence of the Oslo Accords, massive amounts of aid arrived to build the infrastructure of the OPT. During our work in Palestine, it appeared that large international NGOs and the World Bank gained influence over local Palestinian organizations through the financial dependence of the local organizations. Even more influential was the appeal of "civil society" discourse, which provided a role for professional NGOs as a necessary complement to Palestinian state building. Palestinian NGOs found themselves caught in a difficult negotiation process between international funding agencies on the one hand and their own constituencies on the other. Benoît Challand described the evolution of local organizations from the popular committees of the 1980s, which represented and served local interests, to the professional NGOs of the post-Oslo era, which were well-connected with international donors but which lost ground among their constituencies.[45] For these post-Oslo NGOs, the OPT was a "post"-conflict area, not an area in active conflict where the interests of the occupying power were antagonistic to those of the people living under occupation. International agencies took on the role of so-called neutral mediators, ignoring the root causes of the conflict and its colonial nature.[46] Local NGOs influenced in this way lost their legitimacy with the local population, with the result that many people turned instead to radical Islamist groups.

Palestinian volunteers who were working in the health sector established the UHWC in 1985. The organization continued to exist through the evolution described above. Upon the establishment of the PNA, the UHWC closed down a number of its clinics and established working relations with the Palestinian Ministry of Health and international organizations. Although it benefited from foreign aid in the building of its health infrastructure beginning in 1993, the UHWC never forgot the root causes of the conflict. In recent years, the organization reformulated its strategic goals while reaffirming this orientation, and it devised a new foundational principle stating that "[h]ealth work cannot be effective unless it is part of a larger social change."

One of the organization's pioneers and its former general director, Dr. Ahmad Maslamani, reminded the attendees of the 2007 International Conference on the Right to Health that

> [t]he right to health implies the need to challenge the interests of the major forces, opposition of globalization, and the need to have a drastic change of political and economic priorities, first of which is for us Palestinians to have our unbending basic rights fully achieved, most important of which is the right of return in accordance with UN resolution 194.[47]

An example of the translation of these words into practice occurred in the difficult months following the 2006 Palestinian elections, which were won by Hamas. The European Union refused to continue providing financial support to the government because of Hamas's electoral victory. Even in those dire circumstances, the UHWC led other NGOs in taking a principled stance. The NGOs refused the aid that the European Union wanted to channel through them. Instead, they urged the European Union to respect the democratic choice of the Palestinian people and to resume sending aid to the PNA, enabling it to fulfill its obligations to secure the health and human rights of the Palestinian people. These NGOs likewise held the Israeli government — as an occupying power — legally responsible and held the international community morally responsible.[48]

THE STATE AND CUBA

A human rights perspective adds the role of the state as a duty-bearer. Glenn Laverack and Ronald Labonte have described an empowering approach to health

as a process that goes beyond the local community. They see community empowerment as a continuum consisting of five stages: empowerment, the development of small mutual aid groups, the development or strengthening of community organizations, the development or strengthening of inter-organizational networks, and political action.[49] Ultimately, this process ends with a challenge to state power.

Ruby Greene took the argument even further, putting forth that, although community action is essential in defining health needs and needs in other areas related to health promotion, only government action can provide the framework within which substantive improvements can be made.[50] This comment was made in relation to Cuba's experience with community health participation. We agree that Cuba is indeed an example of the potential synergy between people's empowerment and the state in realizing the right to health.

The sharp social and economic contradictions that characterized Cuban society in the 1950s (along with most of Latin America for that matter) stirred an armed revolution against the Batista dictatorship. After the 1959 revolution, Cuba's economy and class composition were dramatically restructured. Socioeconomic changes were complemented by a massive literacy campaign, the development of an accessible, high-quality education system, and programs in culture, science, and sports.[51] Although improvement of health care services played a significant role in reducing the consequences of disease and in tackling health problems of a more technical nature — such as maternal mortality — the importance of deliberate action on the social determinants of health should not be underestimated.[52]

The importance the Cuban government gives to the right to health is likewise reflected in the Constitution of the Republic of Cuba. Article 50 ensures that

> [e]veryone has the right to health protection and care. The state guarantees this right: by providing free medical and hospital care by means of the installations of the rural medical service network, polyclinics, hospitals, preventative and specialized treatment centers; by providing free dental care; by promoting the health publicity campaigns, health education, regular medical examinations, general vaccinations and other measures to prevent the outbreak of disease.[53]

Various people's organizations (such as neighborhood committees, women's organizations, labor unions, and youth organizations) contributed significantly to the active participation of the people in the country's revolutionary transformation.[54] By creating and supporting formal and informal channels for participation at all levels and in all fields of society, the Cuban state plays an important role in all types of empowering processes.[55]
The Cuban Constitution underlines the importance of this structured people's participation. Article 7 of the Constitution confirms that

> [t]he Cuban socialist state recognizes and stimulates the social and mass organizations which arose from the historic process of struggles of our people. These organizations gather in their midst the various sectors of the population, represent interests of the same, and incorporate them to the tasks of the edification, consolidation and defense of the socialist society.[56]

Article 104 develops the tasks of the lowest government level, the People's Councils, made up of locally elected delegates. They

> are constituted in cities, towns, neighborhoods and rural areas. . . . They work actively for efficiency in the development of production and service activities and for meeting the needs for health care, economic, educational, cultural and social activities of the population, promoting the broadest participation of the population and the local initiatives to resolve their problems.[57]

What does this mean in practice? In the harsh economic crisis of the 1990s, a consequence of the Soviet Union's collapse, unions of workers and farmers, youth and student movements, and artist and neighborhood organizations intervened directly in decision making.[58] The best example of this is the "workers' parliaments," in which all of Cuban society participated to reflect

openly and deeply about the general and concrete problems with the economy during the worst moments of the crisis (in 1993).[59] This participatory approach was essential to the implementation of practical solutions. During the most difficult years, community organizations, trade unions, and state enterprises helped, for example, to ensure that prioritized groups (pregnant women, children, and the elderly) had access to basic food and milk.[60]

Working with Cuban health institutions throughout this period, we witnessed how the right to health was maintained as a state priority.[61] The health system continued to offer free qualitative services at all levels of care, while ratifying principles of state responsibility, equity, and universal coverage.[62] The right to health was ensured through further development of primary health care, strengthening family and preventive medicine, and further developing decentralization, intersectoral action, and community participation.[63]

At present, many links exist between local public health services and neighborhood people's organizations. Neighborhood and health committees work closely with local authorities and health care providers and participate in health-needs analyses of their communities, in activity planning, and in preventive actions.[64] These committees also function as a space in which people can voice their complaints about the health care system. Health committees can call doctors and other health workers to account and — if necessary — request that they be replaced.

Efforts such as these improve participatory planning and evaluation at the local level. Neighborhood committees and trade unions actively participate in disaster preparedness training for emergencies, whether this means a hurricane, heavy rainfall, or a dengue epidemic.[65] In the most successful processes, active Popular Councils avoid the continuous risks of paternalism and bureaucratization by developing thorough participatory leadership styles.[66] In our present work, we have noted that more and more intervention projects and research initiatives are being developed to support these participatory processes, local organizations, and structured empowerment, all of which exist in a complex and continuously changing reality.[67]

CONCLUSION

Evolution in the academic discourse on participation, empowerment, and the right to health has brought three crucial issues to the fore: the importance of social class, the pivotal role of power, and the role of the state. In this paper, we have compared these findings with our own experiences, described as "health through people's empowerment," and we conclude that our experiences confirm the importance of these three issues, as summarized below.

Analysis of social class: Considering that communities and society are not homogeneous entities, we believe in the importance of devoting attention to issues of social class. We cannot neglect the fact that power relations — within communities and broader society — are intimately related to people's economic interests. We therefore believe in the value of participatory processes, which bring issues of social class to the fore. Likewise, the inclusion of class analysis is essential in ensuring meaningful participation of disadvantaged social classes. In the Philippines, the CBHPs took social class differences into account through social investigation, and they developed a central strategy to ensure due representation of marginalized groups in decision making.

Empowerment is about power: Although much of the literature on empowerment recognizes that power and power relations have their significance, we believe that issues of power, power relations, and power conflicts should be seen as the cornerstone of the empowerment framework. Without due analysis of power relations and interests, it is impossible to work on empowerment. In Palestine, for example, the UHWC refuses to be swayed into "neutrality" by international aid agencies and continues to place the struggle for health into the framework of the struggle against the occupation.

The role of the state: Frequently in discussions of participation or empowerment and their relation to health, focus is placed on individuals and their relations within the community. State and international relations are all too often kept out of the picture. As many root causes of health problems are to be found at levels beyond what is usually described as a community, broadening the horizon of the empowerment discourse and its context to include wider society is mandatory. The human rights framework effectively provides this broader perspective, giving the state a clear role and responsibility for the people's right to health. Cuba's recent history illustrates the role that the state can play in ensuring its citizens' right to health, while respecting

participatory and empowering processes, if the necessary political will is present.

Empowering processes are not linear. If marginalized groups and classes organize, they can influence power relations and pressure the state into action. Such popular pressure through organized communities and people's organizations can play an essential role in ensuring the implementation of adequate government policies to address health inequities. This is what is required to assert the right to health.

Finally, we acknowledge that our experience is too anecdotal and fragmented to draw broad, general conclusions. The concepts and strategies identified in our work can be further enriched by more empirical research, as concrete experiences are necessary to grasp the intricacies and dynamics of social relations. Therefore, we believe that more systematic documentation of grassroots experiences and further research on these issues would be beneficial.

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