HEALTH, CULTURE and SOCIETY

Editorial Introduction

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Editorial Introduction

I. Perspectives

The first issue of Health, Culture and Society has been entitled "perspectives", in the hope of communicating that the paradigm of health is indeed (to use a term from the German philosopher Nietzsche) "perspectival", in that many experiences and vantage points, from many cultures and societies (and many voices in fact) constitute the true composite value of this lived reality. We often take for granted what we insinuate by using the noun "health". It is an ever so commonly used word in contexts of the economic and personal, and likewise used politically, with casualness even. But what exactly does this habitual term signify? And is it independent of the socio-economic and socio-cultural contexts defining our society?

It is arguably today, through leading institutions such as the Oswaldo Cruz Foundation (Rio de Janeiro), the Institute of Public Health (Bangalore), the Collège de France (Paris), the Institute of Tropical Medicine (Antwerp) and the Wellcome Trust Foundation (London) amongst others, that the enterprise of research meets the demands of our modernity, where practice and policy can strike a more synchronous tone in concomitance with social reality, and that man (*homo natura*), both in the private and public sphere, is understood not only in terms of the pathophysiological evidence to his existence, but equally in terms of the historical, cultural and social dimensions to his being. With the realities which progressively shape the picture of health, we must at the same time ask whether the socio-historico experiences constituting such a paradigm measure with policy. Does our research, strike true with policy? Does legislation tally with the daily demands of health and society? And, what is the relation, old and new, now and later, between the ideas and theories we nurture?

Thus visibility of research and the articulation of mutual understanding mark a modern responsibility. Similarly the recognition of social needs and the necessity for scientific delivery edify the mindset of a researcher in a world which awaits 2015, the year where all governments will look back to see if the Millennium Development Goals (MDGs) have been met, with 1990 as a comparative measure to all subsequent efforts. At the same time we see that the equation of the classical world, in that it did not separate human being from the historical, environmental and cultural contexts definig it, remains strong for us today, as it did for High Antiquity. The insight and teachings of Hippocrates of Cos, and the Roman, Marcus Vitruvius Pollio still stand, even though they are often distant to the mind of modern Man.

How we today understand, and engage change in the context of health means that we have to look beyond the boundries of modern medicine, and engage the social, historical, cultural, political and moral aspects of human experience. The challenge, is as to how these experiences can be addressed by policy and how cultural values can be retained in the design and language of legislation.

II. Society, History and Change: a look back at Brazil

Socio-historical change and economic determinants affect the scientific and epistemological paradigm. With this intrinsic fact to common knowledge in mind, and without seeking to overly "intellectualize" the very important, constructivist moments in the organizational structure of science and society, we would do well to remember the mid to late 1970s Brazil, wherein was witnessed the social blueprint for the future medical, social and cultural

strategy of the country.[1] It is important to note that the idea of "health reform" and likewise that of what we historically term "psychiatric reform" was, in Brazil, edified by popular and community politics. Health, in fact, under the auspices of re-democratization, is a social and historical phenomenon, and, more broadly speaking, what we call the specific case of "health," its "reform" and "revision", is, in the case of Brazil, a tapestry weaved by numerous voices and vigorous social movements which sought to affirm community autonomy, national identity and social liberty. Professor Paulo Amarante, who is now the director of the Laboratory for Psychosocial Assistance at the Oswaldo Cruz Foundation´s School of Public Health (ENSP) at once paints the complexity and compelling nature of Brazilian reform:

> At the time of its inception [the late 70s], there was a definition of a movement of *professionals* or *specialists of* mental health or *in* mental health […] In terms of the transformation into a social movement the debate was articulated through the *anti*(anti-asylum) or *without* (asylums) or *pro* (psychiatric reform). The very expression *reform* is itself a subject of lengthy discussions as well as mental health. We know that such an expression was borne from preventative psychiatry as a utopia free of suffering, disease or pain, the hygiene idea.[2]

Let us take as a guiding example the years from 1975-1980: these carry evidence of a national expansion and geographical penetration by numerous social movements which act as a growing response to economic shortcomings and the mortal realities of a weakened system. It is at this time that the "encontro popular" (popular meetings) of organizations representing the many aspects of Brazilian society strive to maintain and develop community and neighborhood continuities. Groups such as FAFERJ (Federação das Associações de Moradores de Favelas do Estado do Rio de Janeiro**)**, FAMERJ (Federação das Associações de Moradores do Estado do Rio de Janeiro**)**, ABI (Associação Brasileira de Imprensa), and MAB (Movimento de Amigos de Nova Iguaçu) present important, non-institutional voices which accelerate the process of democratic change. It is a time, according to Amarante, that marks the beginning of a "deepening and permanent critique through popular social movements and a move towards a more complex notion of human and community rights in the debates of health, society and madness (locura).[3]" Another important example of the decade is the presence of the Italian radical psychiatrist Franco Basaglia between 1978 and 1979 in Rio de Janeiro[4]. Basaglia, for Amarante, marked the possibility for a "totally

[1] That Brazil is a country which had, and still continues, to experience the greatest of all the psychiatric and public health shifts, means that the historically manifesting consciousness of public health has to be considered within the wider reconstruction of its social and cultural system. A country in socio-economic transition in a world of geo-political shifts, Brazil's present initiatives in mental and public health are rooted on the re-structuring of its system known as the "desconstrução do aparto manicomial" which was headed by the likes of Professor Paulo Amarante. This not only marked a profound moment in the re-democratization of the country, but also in the epistemology of mental illness as well as the direction of public health research and policy. These particularities urged eminent European scholars such as Emeritus Professor Jacques Schotte of Louvain to eventually ask, in 2007, "if there is in fact a Brazilian psychiatry?" Indeed, the arbitration and closure of the Anchieta Clinic in 1989, the adaptation of the Italian Law 180 ("Basaglia's Law") to Brazil, Paul Delgado's proposal of quasi silenced Bill 3.657, and the gradual setting up of "therapeutic residences" across the country marked a new age in Brazil's history and public health design as well as the emerging reality of popular participation.

[2] Paulo Amarante, Loucura, cultura e subjetividade. Conceitos e estratégias, percursos e atores da reforma psiquiátrica brasileira, in, Sonia Fleury (org.) Saúde e Democracia: A luta do CEBES, p.182, Lemos, Brazil 1997

[3] Unpublished interview, October 2010, Rio de Janeiro, Paulo Amarante and David Reggio. This interview is currently in preparation and being edited for publication.

[4] It is precisely in 1979, that Basaglia's ideas and practices edifying the movement of Italian Democratic Psychiatry are met with an enthusiasm and recognition in an intensely political phase of Brazilian history articulating the necessity and direction justice in

new reflection [indicating] a way which, for the first time […] was not merely one of modernization […][5]", but an alternative *in* and *to* psychiatric (and indeed medical) perception and practice. It is interesting to note that the political and legislative transformation of public health in Brazil was political and social practice even before becoming legislation: social groups and a collective critique opened new avenues for health actions: *madness*, in the words of Amarante, *invents the city*[6]. This is why in situating the question of health and society, we have to be mindful of historical episodes unique to each continent, as well as the innovative social organizations which not only anticipated many of the political developments later instituted (in Brazil) but also the possibilities for a more socio-cultural contextualization of what we commonly call health research.[7]

When the military coup of 1964 took place on April 1, President Jango Goulart found refuge in Uruguay. This event was a traumatic upset to democratic processes, and carried profoundly damaging effects on the systems of medicine and psychiatry, for as Messais Padrão remembered:

> From the 1960s onwards, Brazil experienced the most brutal of interruptions in its struggles for democracy for the next twenty years […] the highest levels of recession […] the highest level of unemployment […] one of the largest asylums in the world […] on one hand there was the suspension of civil liberties, on the other the privatisation of Health Politics […] expanding asylum beds threefold […] increasing the number of private psychiatric hospitals four-fold.[8]

We recall that Brazilians had experienced a domino-rally of harsh rule by Castelo Branco (1964-1967), Costa e Silva (1967-1969), Médici (1969-1974), the industrially geared Geisel (1974-1979), and Figueiredo (1979-1985) all favoring the optimization of the medico-industrial complex and the progressive privatization of social institutions. In the mid-1970s postgraduate students of the medical field began to react publicly to the suppression of civil liberties and voiced a, "political, ideological and legislative fight for the authentic representation of the Brazilian population, carrying the greater concerns of Health reform […] its principle theme being the overturning of legislation affecting everyone who suffered psychically.[9]" The voice of Padrão, was accompanied by those of Anna Maria Pitta, Paulo Amarante, Robert Machado, David Capistrano de Costa Filho and Joel Birman among others, who, in the mid 1970s emerged from preventative medicine, psychiatry, psychoanalysis, and philosophy,

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all areas of social life. His visit to the asylum of Barbacena in Minas Gerais,one of the cruelest examples of Brazilian psychiatric history comparable to those examples of the alienated in medievil Europe, urged Basaglia to describe such violent conditions as being similar to the "concentration camps of the Nazis"

[5] Paulo Amarante, in, Franco Basaglia, Psychiatrie et Democracie: conferences Bresiliennes, p.205, collection eres, Ramonville 2007

[6] Paulo Amarante, Loucura, cultura e subjetividade. Conceitos e estratégias, percursos e atores da reforma psiquiátrica brasileira, in, Sonia Fleury (org.) Saúde e Democracia: A luta do CEBES, p.182, Lemos, Brazil 1997

[7] Paulo Delgado Law was eventually rejected, with a substitute bill be passed which improved many aspects of psychiatric care model in Brazil. Currently the country has almost a thousand mental health services open, regionalized, with multidisciplinary teams, involving various social sectors and not just the health sector.

[8] The State of Mental Illness, in, Saúde em Dabate, pp.11-12. N.37 - dez. 1992 - Os Caminhos da Reforma Psiquiatrica brasileira

[9] Padrão, Op., Cit.

representing a broader impulse for democratic change and civil liberty: political Decrees were outdated and bore the resemblance of a criminal rather than civil code, institutions were over-crowded leading to poor and at times deplorable living conditions, and medical institutions were controlled by what some young writers described as the "prejudices[10]" of industry.

And let us consider the other tolls the populous was experiencing. Industrial production had increased four-fold since 1949, the minimum salary had slumped to an all time low of 65 Real (as opposed to 90 R$ in 1950) and relative to this significant drop in earnings was infant mortality, which had peaked by 1970. It was also reported that migration to larger cities of industrial output meant that São Paulo, in one year, received 400,000 citizens from other Brazilian territories who were permitted to live on its "elastic" periphery as workers. Only 20% of these "migrated" citizens had access to treated water and transport, and to every 1000 births there were 180 deaths.[11] A student,Emerson Merhey wrote in 1977, "this, a phenomenon affecting all large Brazilian cities, and given that São Paulo is the richest of all, imagine the surreal conditions of the impoverished working population.[12]"

In October 1977, on the back of worsening ratios within a climate of pervasively mercurial clientelism, political favoritism and low levels of social activism, David Capistrano da Costa Filho, then, like Mehey, a postgraduate student in preventative medicine, presented at the Ist Paulist Congress of Public Health. Charged with the impassioned voice which became his signature, Capistrano contested that although since the 1960s, the era of the "Brazilian [economic] miracle" had furnished "the growth of Brazil's Internal Brut Product," at the same time "mortality rates across every generation" had increased as well as "record highs of work accidents" leaving an already struggling population of workers maimed if not disabled. For Capistrano, the traditional idea of the vicious circle between poverty and illness was not an epidemiological tendency of the poor but sooner a pathological consequence of "capitalist development" and the economic "miracle" itself. In his words, the poverty = illness equation was in fact a more complex matter of industrial production (Capitalist development) = poverty = illness, or rather, as he put it: "the cumulative circle of productive growth and the worsening of the nation's health.[13]" Imbalance was an all too familiar everyday reality for students and practitioners of medicine: how on the one hand could you possibly have increased economic growth and at the same time increased deaths through an under-financed health system, underdeveloped sanitation, and workers who had to increase their performance for lessening pay ?[14]

The statistics and bitter ratios reflected the broader humanitarian necessity to "transform social relations" and forge grass-roots solidarity between workers, doctors, patients, and families. Only by doing this, by increasing active associationism and social participation in Brazilian cities, could a critical, social process begin to counterbalance the disproportion and dissymmetry between (industrial) development and social welfare. As

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[10] Saúde em Dabate, p.3, N.3 - June 1977 - A Desnutrição e o Planejamento Econômica-Social

[11] Data taken from Saúde em Dabate, p.8, N.4 - Sept 1977 - A Saúde Pública em Questão

[12] Emerson Merhey, then a post-graduate of preventative medicine at the University of São Paulo, writing in, Saúde em Dabate, p.10, N.4 - Sept 1977 - A Saúde Pública em Questão

[13] David Capistrano da Filho, The Vicious Circle of Poverty and Illness, in, Saúde em Dabate, pp.65-66, N.6 - mar. 1978 - Mensagem aos Tropicalista Brasileiros

[14] It is interesting to note, and there have been no statistical studies performed, that those who worked during this era either as children or adolescents are at times without fingers or evidence some other work related affliction to the human limb. It would be important to not only collect demographic statistics, but oral historical testimony of those who had lost limbs or suffered visible affectation through working conditions during the 1960s and 1970s.

Capistrano expressed, it was only by transforming social relations through the "consciousness" of "syndicates, community movements, and political groups" that "democratization" could be achieved – and this, a "struggle" which the clinician would "be an integral part of.[15]" Capistrano's call for a surge towards a civil activism was symptomatic of mid 1970s Brazil – a time, "not only marked by the reestablishment of political competition, but also by a marked increase in the propensity to create voluntary and independent forms of association.[16]"

These brief yet often overlooked examples, which I have taken the liberty to present in urging the patience of the readership, show us, whether we are clinicians, patients, or scholars, that health is articulated within a historical, cultural and social framework: the historical, pathological and psychological "aspects" which compose "us," collectively and individually as living beings, means that the common noun "health" is very much positioned at a complex juncture, or more precisely, at the point where these factors intersect. Many years ago, in 1946 in fact, the celebrated psychiatrist Henry Ey expressed that health is a "bio-psycho-social" reality. Our perception of health then, our practices, our research and work, our experiences in the field where we act and at our desks where we reflect, thus urge us to perceive such a paradigm in much the same way as we would look at certain crystals, observing the "pleochroistic" effects they carry, whereby different degrees of brightness, tone and/or color appear when viewed from different directions.

III. The contributions

Our first issue of HCS is honorably opened by, Professor Jean-Pierre Unger, Pierre De Paepe, Patrick Van Dessel, and Alicia Stolkiner, from the Institute of Tropical Medicine (Antwerp), in their address of a n urgent and important theme: namely, the condition and viability of public research and education within the context of encroaching private interests. What, for example, is the future and very nature of theory and epistemology within our contemporary contexts of financially driven outcomes? What are the strategies of professionalization and learning? Such a questioning is complimented by Dr. Meg Stalcup (Fred Hutchinson Cancer Research Center) and Dr. Stéphane Verguet (Department of Global Health, University of Washington) who position the question of global health within the context of the demands which shape contemporary health and the composition of what we could call the "commonality" of knowledge which circulates.

Arima Mishra, a senior member of the Institute of Public Health in Bangalore, India, provides us with a unique research of the Print Media´s role in the national consciousness of health by analyzing certain linguistic and psychological strategies employed. Presented is an extremely precise exposition of how a globalizing and mediatized health discourse, in much the same way as private interest groups, weighs upon our social and clinical vocabularies.

Craig Boyd Garner (attorney, health care consultant and Pepperdine University Law Faculty), Judith M. Berry (Medicare and Medicaid specialist) and David A. McCabe (a speechwriter specializing in health) provide a detailed and learned exposition of Medicare. The authors shed critical light upon the possibilities and inconsistencies of such a strategy, by positioning the question of future national health care policy within historical bi-focal reading of American health care policy.

[15] Capistrano. Op. Cit.,

[16] Leonardo Avritzer, Participatory institutions in democratic Brazil, p.26. Woodrow Wilson Center Press. USA 2009

Dr. Roberto. J. Ibarra, follows, by examining the geo-political activities of interest groups and the attempts to extend Medicare into Mexico through the population of U.S retirees to the country. The equation of retirement migration and health is revealed to have a deeper program of the privatization of Mexican health sectors.

Mirella Veras, (Center for Global Health, Institute of Population Health, University of Ottawa) and Dr. David Zakus (Director, Global Health Division of Community Engagement) investigate the imbalances within Canadian immunization strategies with a view to highlighting the need for research, policy and programs which can engage with all communities composing the Canadian populous, overcoming the disparities of ineffective delivery, access and outreach.

Through her extensive work and experience in the field of NGOs, Dr. Laine Berman (Monash Asia Institute) examines Community Based Rehabilitation (CBR) in two rural, isolated regions of Eastern Indonesia, analyzing the methods adapted by local NGOs to integrate children with disabilities into the community. This is followed by Dr. Riawati Jahja (DUKE-NUS Graduate Medical School, National University of Singapore) exploring statistical data of perinatal mortality in Idonesia, highlighting the disproportionate readings which render the construction of a "national picture" problematic for public health policy and childcare.

Dr. Ngambouk Vitalis Pemunta (Central European University, Hungary) presents findings from detailed research into the socio-economic and psychological factors of sex work, present in South-West Cameroon. Likewise, Dr. Aderemi Suleiman Ajala (Department of Archaeology and Anthropology, University of Ibadan. Nigeria) investigates the historically troubled and polluted city of Ibadan, seeking to bring to light the relation of factors between public hygiene, spatial management and community awareness.

In our "Rear Matter" section of the journal, Dr. Bernard Jouanjean (Collège de France) provides us with a review of his published work which from a series of integrated perspectives (anthropological, physiological, sociological, historical, neurological) analyzes the construction, and indeed the possibilities, of establishing a new health system rationale based on an in-depth and learned reading of Chinese and Indian culture, which couple with his extensive experience of preventive medicine.

Dr. Dominik Wujastyk (University of Vienna, Áustria) presents both a highly informed argument and profound attempt to relativize allopathic medicine, in the context of the ayurvedic medical system of India, by positioning the concept, and reality, of Daniel Moerman's "meaning response" (elsewhere termed the placebo effect).

Our first issue concludes with a contribution from Satlaj Dighe, a freelance writer and journalist based in India, experienced in health care programs. Reviewed, is the work of Dr. Rani Bang entitled *Kanosa*. Ms. Dighe examines the rich material collated by Dr. Bang over the years which forms the basis of her study on rural women, measuring the sense of Community Health in India within questions of cultural cosmologies as well as the possibility of articulating a "cultural nosography" and programs more attuned with cultural systems.

It is with a very great appreciation of the scholarly efforts, energies and excellence of all contributors, that HCS is facilitated, along with that "pleochroistic" understanding, and appreciation, of the health paradigm.

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