

EDITORIAL

Towards a new model of development, the state, and society

Eduardo Espinoza, MD

I never had the good fortune of meeting Juan César García personally*, although I came to know him through his writings. These were introduced to me (along with many other things) by María Isabel Rodríguez. Subsequently, I had the honor (and good fortune) of meeting Edmundo Granda, Asa Cristina Laurell, Jaime Breilh, and Saul Franco, cherished colleagues whom I count among my friends. They have now handed me the responsibility of giving this lecture, named by ALAMES in honor of our great teacher.

I did not feel that I was the most appropriate person to take on the sensitive task of delivering the keynote address at an ALAMES Conference. In fact, I did everything in my power to have someone else stand here on this podium before all of you tonight. But this was not to be. Thus, I would like to thank the Latin American Association of Social Medicine for this great – and undeserved – honor.

I don't want to repeat what has already been said by my colleagues in the ample and thorough discussions that have preceded this talk. They are certainly more qualified to do this than I am. Instead, I would like to see this Congress develop a set of recommendations – action plans – for those of us who are preparing ALAMES' next generation.

These are particularly difficult and strategic times. Every day we see overwhelming evidence that time is running out both for our planet and for the human race. It is a propitious moment to reflect on health conditions within a broader context by examining several particularly alarming situations that call into question both the present and the future in terms of health, wellbeing, and development.

People tend to easily forget that today's issues are not new. Similar problems have plagued

humanity since the development of social systems that have concentrated riches among the few, created inequalities, and stimulated the outsized appetites of those who always want to hoard even more. These systems have crushed any attempt to better distribute social wealth. Mahatma Gandhi summed this up well when he said: "The world has enough for everyone's need, but not enough for everyone's greed."

With this in mind, I would like to start with an excerpt from the Juan César García lecture delivered by Jaime Breilh in Montevideo in 2012:

Amid this grim reality, we cannot, for example, slip back into empty, arbitrary rhetoric repeating phrases such as "social determinants of health" which lack any emancipatory vision and just put a new face on the obsolete, functionalist paradigm of positivism. We must return to the original Latin American construct of "social determination of health," which sounds similar, but which has a diametrically opposite meaning and practical implications. In its search for the keys to a social order that promotes life, it seeks to expose, together with our people, the insatiable machinery that is destroying the natural rights of humanity and nature. This order, created by a miniscule corporate elite, is taking ownership of the planet and is leading the world and the human race to the brink of disaster.

The world in general – and health rights activists in particular – face a three-pronged challenge: a new neoliberal and neocolonial offensive; the need to create a new model of development, of the State, and of society; and the urgency to do all this before it is too late. Therefore, I will be addressing five main ideas throughout my talk:

1. The evidence of plunder, devastation, neglect, poor health, and underdevelopment.

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* This talk was given as the Juan César García Lecture, San Salvador 2014, XIII ALAMES Conference. It has been translated from the original Spanish.

2. How pain, death and global panic are turned to profit through increased sales of equipment, medications, and vaccines.
3. The need for strong public healthcare systems.
4. Constraining or diversionary health actions that perpetuate the current model.
5. Truly effective actions that activists can take to support the right to health.

Ebola

In recent months, the appearance of Ebola virus in three West African countries led the World Health Organization (WHO) to declare a “Public Health Emergency of International Concern” and to characterize the outbreak as a “threat to world peace and security.”¹ As a result, the United Nations Security Council was convened for the sole purpose of addressing a health issue; this is only the third time in UN history that this has occurred. In its Resolution 2177 the Council stated, “unless contained, [the outbreak] may lead to further instances of civil unrest, social tensions and a deterioration of the political and security climate...”²

Much about this epidemic remains unclear and this has led to debates on questions such as:

1. Ebola has been present in Africa for over 40 years when it was first recognized in simultaneous outbreaks in Sudan and the Democratic Republic of the Congo. Why is it only now that the Security Council has shown such concern?
2. Why did it have to take 24 outbreaks (seven with over 100 cases each), to trigger a global alarm?
3. Out of 187 countries monitored by the United Nations Development Program, Liberia stands at number 175, Guinea number 179 and Sierra Leona 183. Why did the epidemic occur in three countries that are among the bottom dozen on the Human Development Index?

These are three of the world’s poorest countries even though, paradoxically, they are vastly wealthy in terms of natural resources. This paradox has resulted from the plunder of all three countries, from wars organized by contending foreign economic

powers, from neocolonial incursions by numerous transnational corporations who have expropriated the land for enormous palm plantations, and from the importation of racist mercenaries who grow wealthy on the iron and diamonds extracted from the earth. In fact, Hollywood coined the term “Blood Diamonds” to describe precisely these conflicts. The resultant exploitation and poverty drove the population into the forests and thus exposed them to the deadly virus.

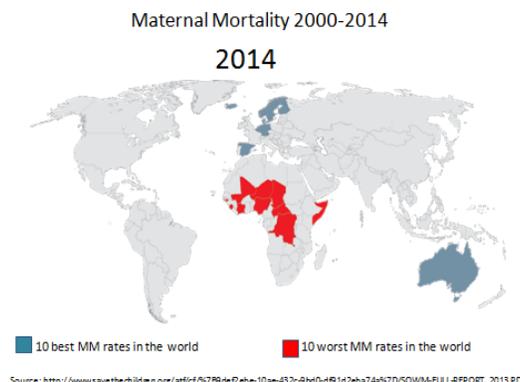
The Peoples’ Health Movement recently noted that during the first four months of the epidemic 848 people contracted Ebola in Sierra Leone; of these, 365 died.³ There were other deaths in Sierra Leone during this period that did not attract any attention: 650 people died of meningitis; 670 of tuberculosis, 790 from HIV, 845 from diarrheal diseases, and 3,000 from malaria.

Deaths from these diseases have been going on for decades. Why did they not lead to the same mobilization of resources or at least to some degree of alarm?

The neocolonial offensive doesn’t just disproportionately exploit and disturb ecosystems; it also conspires against local development. It is not an accident that the health systems in these African countries are virtually nonexistent. More Liberian and Sierra Leonean doctors live in developed countries than in their own homelands. (One of them recently died of Ebola in the United States where he held dual citizenship.) For decades now – far longer than other developed countries – these countries have been ravaged by violence, poverty, corruption, war, plunder, ruthless exploitation, and brain drain. Aggressive structural adjustment policies delivered the final, decisive blow to health systems that were already teetering on the edge.

All of this has added up, conspiring to make the African continent a victim and not just of Ebola. Africa is home to the 10 countries with the world’s worst maternal mortality rates. These rankings have been consistent since 2001.⁴

As might have been expected, the medical industrial-financial complex has taken advantage of the Ebola outbreak to fuel global panic and increase its already obscene profits. For example, the outbreak led to a global shortage of the



Biosafety Level 3 suits that are necessary to protect people who are caring for Ebola patients. There are additional shortages in both prefabricated field hospitals and the kits used for cleanup and burial.

Despite forty years of Ebola outbreaks, the medical-industrial-financial complex saw no reason to develop an Ebola vaccine. Ebola was just one more so-called “neglected disease” that did not offer a market or a population group from which Big Pharma could make an attractive profit. Yet, as soon as Ebola arrived on the doorsteps of the United States and Europe – carried by European nationals and repatriated U.S. citizens – a media offensive set to work (suspiciously in sync with the medical-industrial-financial complex) to spark the required global panic and an active search (Now is the time!) for vaccines and antivirals. There was an impressive mobilization of resources promised “to help” the affected countries. Billions of dollars were pledged; but, as usual, the reality is always far less impressive than the promises.

It is quite instructive to consider how the first US Ebola patient was treated. There are lessons to be drawn here for those who see the technological and curative paradigm (the faithful partner of private insurance) as the right model for healthcare design. It just so happens that in the country with the world’s most technologically advanced healthcare and its highest health expenditure, the care received by U.S. and Liberian citizen Thomas Duncan was not the best.

At the time, CNN published its analysis of the causes contributing to this patient’s death: 1) Duncan was not immediately hospitalized. 2) He did not receive medication immediately. 3) He was given the wrong medication. 4) The hospital was not prepared. 5) There was a breathtaking confusion regarding his medical history, travel history, and other relevant issues.⁵ The family has said that his disjointed treatment was a consequence of his not having insurance; this led to the decision that he not be hospitalized initially.⁶

Reverend Jesse Jackson, acting as the family’s spokesman, stated: "I would tend to think that those who do not have insurance, those who do not have Medicaid, do not have the same priorities as those who do." Well, this happens always (or almost always) in the world of private insurance. Each individual has as much health as they are able to pay for, and the system works as a whole, not to produce health, but rather to earn profits and reproduce capital.

Manufacturing Diseases

Instead of investing in unprofitable diseases such as Ebola, instead of strengthening the health systems in underdeveloped countries, it is more profitable for the pharmaceutical industry to invent new diseases. The creation of female erectile dysfunction authorizes my colleagues to prescribe sildenafil to women. Dubious syndromes such as “child hyperactivity” encourage the use of psychoactive drugs in children. *Ad hoc* committees constantly lower disease thresholds. This leads to exponential increases not just in the army of drug takers, but also in the profit margins of the pharmaceutical industry.

Lower Thresholds = Higher Profits

Test	Thresholds		Take Drugs!
	Previous	Current	
Blood Glucose (mg/dL)	140	126	Antidiabetics
Blood Pressure (mmHg)	160/100	140/90	Anti-hypertensives
Cholesterol (mg/dL)	240	200	Statins

The greed of the transnational corporate elite seems insatiable. Scandals proliferate, laying bare a world of corruption, bribery, collusion, rigged clinical trials, hidden or distorted data, made-to-order research, and many more tricks that entangle and manipulate students, researchers, health professionals, patient associations, and the public at large.

In recent years, the media has reported on some of these scandals. We have learned about the millions in fines imposed on transnational pharmaceutical companies by developed countries, including the United States, France, Italy, and others. As astronomical as these fines are, sometimes in the billions of dollars, a comparison of the fines with the annual sales of these companies suggests that these fines must be just one more part of their annual budget. The additional expense is passed on to the consumer so as not to affect the bottom line.

2013 Sales vs. 2014 Fines
(the scales *in millions of dollars* are different)



Furthermore, the transnational pharmaceutical industry has stopped its research into synthetic chemical products. Instead, it is concentrating on developing biological and biotech drugs, which are harder for the traditional generic industry to copy. This niche includes vaccines, monoclonal antibodies, stem cells, nanotechnology, and other products. The costs of these new technologies are tailored to each patient. Costs that once outraged us (e.g. costs for third generation antiretrovirals) pale by comparison. One small example: treatment of one person for hepatitis C with monoclonal antibodies can easily cost as much as \$300,000.

The human papillomavirus (HPV) vaccine is also worth mentioning. In the last two years, amid great controversy, this vaccine has been released on the market and has been included in national programs in some 25 countries, among them several in Latin America, among which are Argentina, Colombia, Mexico, Panama, and Peru. Other countries, such as ours, are skeptical of the vaccine. However, we are under heavy pressure to jump on the bandwagon with those who are enthusiastically using the vaccine.

Clearly, global cervical cancer mortality underscores the inequities of our times in terms of wealth, gender, and access to health services. Today, cervical cancer is the second most common cancer in women in the developed world and is the leading cause of cancer deaths in women in most developing countries. According to Cervical Cancer Action, each year, 500,000 women develop cervical cancer and about 275,000 die from the disease.⁷ Women around the world are exposed to HPV, but it is women in underdeveloped countries that have, for decades, had little or no access to early detection and treatment and who die as a result of infection with this virus. Moreover, by 2030, cervical cancer is

expected to kill over 474,000 women per year, over 95% in low- and middle-income countries.

We know that the human papillomavirus (HPV) is a necessary, but not sufficient, cause of cervical cancer.⁸ Multiple factors must converge for the disease to develop, among them, early sexual debut, multiple sexual partners (or a sexual partner with multiple partners), certain sexual behaviors, prostitution, and multiparity.⁸ It is important here to reiterate the need for strong, universal public healthcare systems to guarantee low-cost screening (including Pap smears and related tests) that also guard against 100% of potentially cancer-causing strains.

Two HPV vaccines are currently available. Despite controversy, they have been marketed and taken up by almost two dozen national immunizations programs at public expense.

The Government of India, through the Indian Council of Medical Research, ordered an immediate halt to the proposed HPV vaccination program after verifying violations of ethical protocols during clinical trials for the vaccine. There had been six deaths and 120 cases of adverse reactions associated with the vaccine.⁹ Austria rejected mass vaccination because it estimated that in the best case scenario, with 95% vaccination coverage in girls aged <12 years, it would take 52 years to reduce cervical cancer prevalence by 10%. HPV vaccination has been controversial even in the United States. In the state of Texas, Governor Perry made it compulsory by executive decree. The state legislature overturned his decree amid a scandal regarding unethical practices that included donations to the governor's electoral campaign from the transnational pharmaceutical companies making the vaccine.¹⁰

In El Salvador we conducted a thorough analysis and arrived at the following conclusions:

1. No study has demonstrated the effectiveness of the vaccine. Such a study would have to last from 20 to 30 years because of the natural history of the disease. Available studies have utilized secondary or surrogate outcomes, such as an increase in antibodies against the two virus strains covered. However, this is not yet proof that the vaccine would be capable of reducing the incidence of precancerous lesions and cervical intraepithelial neoplasias (CIN).
2. Existing studies have lasted at most three years and have measured antibody titers of genotypes 6, 11, 16, and 18. A decrease in these titers over

time has been observed with the tetravalent vaccine. This suggests that if the vaccine is adopted it will be necessary to give booster immunizations (since there are no studies on the appropriate antibody titer for effective protection) with a corresponding increase in cost.

3. Given this, it is neither appropriate nor advisable for an underdeveloped and poor country such as El Salvador to adopt a long-term program, such as HPV vaccination, with questionable efficacy and with considerable associated adverse reactions that included deaths. In the best of cases, cervical cancer incidence will drop in the cohort of vaccinated adolescents within 30 years. It will not solve the problem that is affecting hundreds of Salvadoran women today.
4. In addition, there are other measures with a demonstrated cost-effectiveness ratio exceeding that of the vaccine, and which *alone* provide a proven 70% decrease in morbidity and mortality; these include early detection by Pap smear and early treatment of *in situ* cancerous lesions. Paradoxically, the vaccine could actually make things worse. By providing a false sense of security it could encourage women to forego regular Pap smears.
5. In a country with limited health resources, implementation of such a vaccine will surely take resources away from secondary prevention programs (Pap smears and colposcopy). Worse, we do not even know which HPV strains are present in our country.
6. A decision to include the HPV vaccine on our immunization schedule should not be based on the donation of the initial, partial, or even total funding for the program. It should be based on criteria of efficacy, safety, and cost-benefit. Our evaluation of the vaccine would not change if were provided at low cost or even free for a limited amount of time. The real problem is that once demand for the vaccine is generated, it is very difficult to reverse course and remove it from the immunization schedule, even if there are valid concerns regarding cost, safety, or effectiveness.

A Catalonian researcher has exposed the greed of the transnational pharmaceutical companies by reporting on a rigged trial of the vaccine. I would recommend you listen to the talk given by Dr.

Teresa Focades I. Vila and available on YouTube.¹¹ Dr. Focades I Vila notes: "Testing is always double-blind. One group is vaccinated and the other is given a placebo. Initially, they saw that the side effects were the same in the two groups; there was no problem. But it has just been discovered that the control group was not injected with water, but rather with aluminum.¹² That is, it was a pseudo-placebo. And, I would add, deliberately used to cloud the comparison with those subjects receiving the actual vaccine."

My talk so far has focused on the longstanding conflict as to whether health is a basic human right or a commodity. This is the background to the renewed debate between those who support private insurance systems, in which the individual's ability to pay determines the benefits, quality, coverage, and access to health, and those who favor universal systems that are public, sustainable, and funded by general revenues.

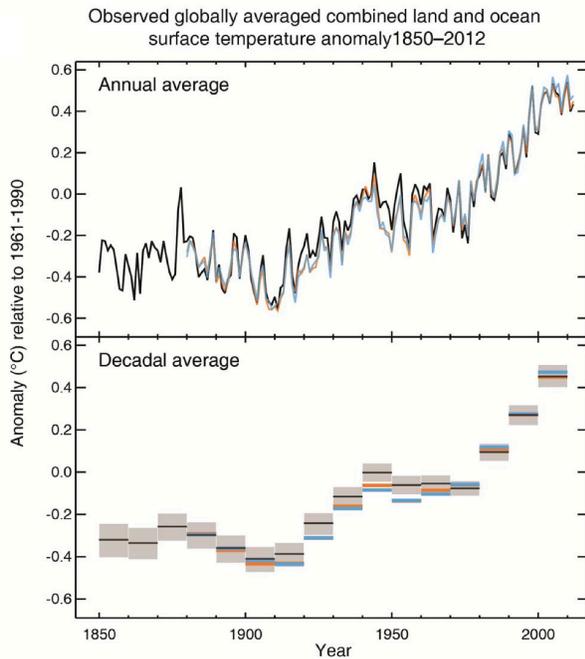
El Salvador has chosen the latter system for its health reform. However, a health system involves something more than just traditional healthcare facilities and their incorporation into service networks. A health system must also constantly identify and fight inequity among population groups, promote harmony with ecosystems, and strive to create healthy environments for the population.

Climate Change

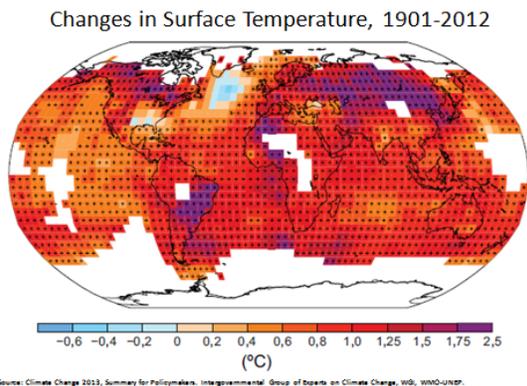
These considerations lead me to another indicator of the current development model. If I raise this issue at a meeting such as this conference – concerned as it is with finding a new development model – I reconfirm its importance as measure of the current system's predatory essence. This characteristic is inherent to our current system and lays bare the terrible consequences awaiting us in the future if we maintain our current course. More than anything else it shows us that the current model is unsustainable. For the current model is not just unhealthy for individuals and communities as we have seen in the preceding paragraphs. It also threatens the health and existence of all life forms on this planet, indeed of the planet itself.

The indicator I am referring to is climate change. Climate change, more than any other measure (and there are many) sums up the non-sustainability of the current model. In this slide, taken from the fifth intergovernmental meeting of experts on climate change convened by UNEP, you can see both by

year and by decade the unusual and sustained increase in combined land and water surface temperatures since 1850. Pay particular attention to the rise over the past 30 years.



The next slide is even more illustrative. It shows that this rise in temperatures is not uniform. The most overheated areas precisely match those areas where there has been extensive deforestation in order to open land for intensive monoculture, such as soybeans in South America and coconut palm in Africa, etc.



The Amazon, Orinoco and La Plata river basins and the Guaraní aquifer, all in South America, are strategic water resources for the world's peoples. Taken together, the continent holds over one-third of the world's fresh water, a resource that is

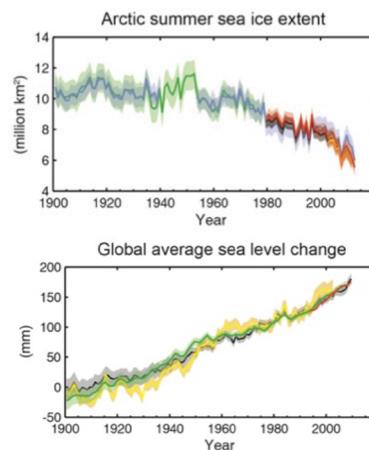
endangered and that has begun to deteriorate in quality.¹³

Once again, it is the development model that emerges as the global villain operating on several fronts: deforesting the Amazon to make way for cattle ranching (creating huge, increasingly dry regions); polluting and drying up rivers for intensive monoculture, such as soybean plantations, (linked to more deforestation); erosion and massive use of Monsanto pesticides; and progressively and irreversibly melting the primary source of fresh water—the Andean glaciers—as a consequence of global warming.

The Aral Sea, at one time the world's fourth largest lake covering 68,000 km², has almost completely disappeared, leaving behind a toxic desert and poisoning the communities that used to make a living off the lake. In the 1960s, “economic growth” encouraged the diversion of the large rivers that fed the Aral (the Amur Daria and Syr Daria) so that their water could be used for irrigation. The lake shrunk by 20 cm per year in the 1960s, by 60 cm per year in the 1970s, and by almost 90 cm per year in the 1980s. This progressive decline in the lake's level has left it on the brink of disappearing forever.

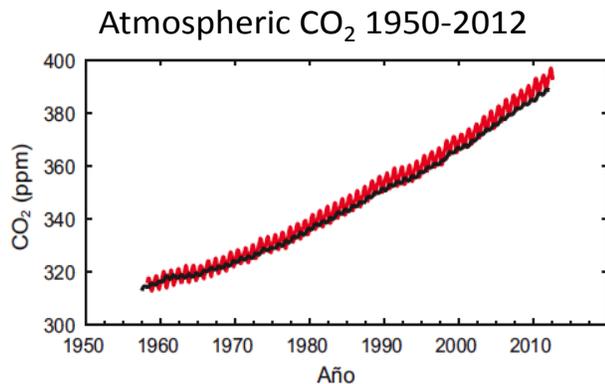
This has been a genuinely manmade disaster, which reinforces climate change and provides a warning of what could happen to the South American aquifer.

Global warming is not only melting Andean glaciers. The Arctic Ocean is also melting at a rate of 2.7% per decade. These figures show the close correlations between ocean warming and the disappearance of Arctic sea ice. The Arctic ice cap is expected to totally disappear before the end of the century, coinciding with a progressive rise in sea level.



Over the past 50 years, human activity, in particular the burning of fossil fuels such as coal, oil, and natural gas (66%), together with deforestation (33%), have released increasing amounts of CO₂, methane, nitrous oxide, and other greenhouse gases, causing the planet to warm.

Measurements of CO₂ and methane release surpass the amounts calculated for the previous 650,000 years of our planet's life. From 1970 to 2004 alone, human activity increased greenhouse gases by 70% over the preindustrial era.



Source: Climate Change 2013, Summary for Policymakers. Intergovernmental Group of Experts on Climate Change, WGI, WMO-UNEP.

No place on Earth has escaped the impact of these far-reaching climactic changes: flooding; increasingly early, longer, and more violent hurricane seasons; heat waves; heavy snowstorms; extreme drought; and the increasing frequency and severity of forest fires are all now more common. The poorest members of society are, as they always have been, those who pay the highest price in deaths and injuries.

Climate change is also responsible for increasing mortality among those with chronic respiratory and heart diseases secondary either to heat waves or sudden drops in temperature. As sea levels continue to rise, the world's population, most of whom live along a narrow strip 60 km wide along coastlands, will increasingly migrate, with all the resulting marginal settlements, disputes over an ever-dwindling supply of water (already affecting 40% of people), overcrowded cities, urban sprawl, worsening mental health conditions, and social and domestic violence.

Scarcity of safe drinking water will inevitably worsen hygienic conditions and lead to an increase in water-borne diseases, such as diarrheal diseases and bacterial conjunctivitis (which can cause blindness). Neoliberal greed noted the scarcity of water some time ago and is increasingly profiting

while shamelessly exacerbating the problem with its bottled water business and the sale of water to communities. A slum dweller here in El Salvador, for example, pays *one dollar for a barrel of water*. A middle or upper class resident who gets his or her water from ANDA, our public water company, pays only *16 cents*.

Across the continent, it has become increasingly more difficult to stop the spread of the *Aedes aegypti* mosquito, which happily follows the unstoppable migration of people from the countryside to the city in search of a better life. Urban environments characterized by a scarcity of water and its irregular or onerous delivery force people to store water at home, creating ideal conditions for the reproduction of the mosquitos who transmit Dengue and Chikungunya. This situation is accompanied by its vicious counterpart: the rise in temperature produced by climate change reduces the length of the mosquito's lifecycle and of the virus' lifecycle inside the mosquito. The deadly result is greater numbers of more aggressive mosquitoes reproducing in less time.

Traditional crops experience increasingly unstable cycles and declining productivity. This will exacerbate malnutrition, especially in tropical regions, where food security and sovereignty are already serious problems.

In the past 50 years, global temperatures have risen about twice as much as they did in the preceding 100 years. As it appears that the burning of fossil fuels will continue to increase, we can anticipate increases of atmospheric CO₂ levels by 40% to 110% over the next 20 years. This will continue to warm the planet. For us in Central American this will mean an increase of 2 to 3.7 degrees Celsius.

In summary: We can no longer deny that we are in the midst of a growing and increasingly dangerous emergency that poses a mortal threat to the human race and to our ecosystems. Scientists and other experts are accumulating an increasing body of evidence that this disaster is the unquestionable consequence of *a predatory, extractivist developmental model based on individualism, competition, selfishness, and conspicuous consumption. It is a model obsessed with profit. It is unsustainable and runs counter to life and equity.*

Al Gore was very clear in this regard. During his U.S. Presidential campaign, he referred to George Bush's hostility toward the Kyoto Protocol and said:

“Bush said once that there is a trade-off between the economy and the environment. This is a false dichotomy; if we do not have a planet, we will not have an economy.”

On the road ahead, health rights activists must deal with at least two substantive issues:

First, we need to identify and denounce diversionary actions. This is increasingly important and necessary because these diversions deflect attention away from the fundamental problem: the search for a new development model.

Diversionary actions are those that either circumscribe potential solutions, limiting them to the narrow scope of health services or use a “health determinants” lens which breaks reality down into separate parts, thus losing sight of the forest for the trees. These approaches end up applying patches to the dominant development model, doing it a service by perpetuating it. Such approaches include:

- Climate change “adaptation” strategies demanded of underdeveloped countries: Underdeveloped countries produce only 27% of greenhouse gasses, compared to the 73% produced by developed countries. Yet, developed countries have refused to implement strategies to reverse climate change. They have not only rejected, but also undermined the Kyoto Protocol (as in the most recent Canadian case).
- Interventions confined to the health services network: For example, proposals to address chronic kidney failure have not gone beyond the creation of dialysis centers and kidney transplantation. To address this problem we need to regulate the agrochemical industry; this means banning pesticides and other agrottoxins.
- Using extractive industries to fund social programs and reduce poverty: This is a dangerous alternative that has been adopted by some governments that claim to be progressive. I would like to quote here from Gudynas, Director of the Latin American Center for Social Ecology (CLAES). He said: *“In the past 15 years, a time during which Latin America has had democratic presidents with a leftist bent, extractive industries have doubled in the region’s countries, to such an extent that Ecuador and Uruguay, which have never focused their attention on mining, are now doing so.”*

Our second task is to propose substantive actions to address climate change. Here is a list of such actions that health rights activists must undertake or support, in line with social determination of health and the watchword of this conference: “a new model of development, the state, and society.”



- Develop multiple venues for intersectoral work to ensure an integrated approach to any health problem.
- Foster genuine social participation and build a broad, militant community organization to ensure this participation and engage collectively.
- Design and continually strengthen unified health planning and information systems that effectively monitor health, ensure universality and quality of data, are transparent, and facilitate development of solutions and decision-making using critical epidemiology.
- Work for the creation of unified, public, universal systems, funded by general revenues.
- Public higher education in particular should confront commercialization, the pharmaceutical industry, technology, and obsolete, reactionary biologically based models.

The True Threat:

The current development model

Are we brave enough? Will we have the courage to face the challenges and change the model before it's too late?

- Play an active role in discussions and advocacy for universal coverage and universal access to health in your respective countries.
- Prepare to do battle in legislative work around health in 2015. Advocate in the ministries of health for collective interests to be prioritized over individual interests. Disseminate and debate particular legislative frameworks, particularly within academia.
- Continue to fight for implementation of climate change “reversal” strategies (not just “adaptation” by underdeveloped countries); this is primarily the environmental responsibility of first-world countries.
- Health rights activists should widen their areas of action in the health sector to fight for a new development model.
- Actively participate in the demands and protests around COP20 (Conference of the Parties), to be held on 1-10 December in Lima, which will discuss the current climate crisis, and COP21 in Paris in 2015.
- Urgently work to preserve the basic principles of indigenous lifestyles with exist in harmony with ecosystems and try to apply them to our reality.

My dear compañeros in ALAMES and dear colleagues who are visiting us from every corner of our country and the continent: You have come here representing many others who could not be here. They are anxiously awaiting your return, hoping that each of you will come back enriched by the themes of this conference, and ready to ignite their passion and to give new life to their hopes and their work for a better world with greater equity and solidarity.

I would like to close by sharing an anecdote; this is something that I found very moving the first time I heard it. It is a story from the Cuban revolution. On Thursday, January 8, 1959, Fidel Castro, at the head of a massive, spontaneous, and impressive march that had left Santiago de Cuba one week earlier, arrived in Havana. From the Columbia military base, he addressed a colossal and historic rally that cheered him on jubilantly. During his speech, he would pause every once in a while and would ask the Master of the Vanguard: “How am I doing, Camilo?” And, Camilo Cienfuegos, smiling, would invariably answer, “You’re doing fine, Fidel!”

My dear comrades in ALAMES, we also have our own Camilo, our own Master of the Vanguard. My greatest wish today is that once we are back home at work, when we are striving to put into practice everything we have discussed and agreed upon in these five days, we can turn to that Master and say, “How am I doing, Juan César?” And that at the end of each day, our work will have been so consequential, of such quality, and of such a scale, that all of us in ALAMES all across Latin America will invariably hear Juan César Garcia resoundingly answer from the bottom of our hearts, telling us: “You’re doing fine!” I thank you.

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