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POLITICAL ECONOMY OF HEALTH AND DISEASE IN AFRICA AND LATIN AMERICA
Proposal for an International Conference

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INTRODUCTION

Studies of health and disease in Africa and Latin America have increasingly recognized the limitations of research and policy analyses which focus narrowly on the biological determinants of disease or on specific health care interventions, especially curative care for individuals. Such approaches approaches ignore the multiplicity of geographic, climatic, economic, and political factors that affect health and disease patterns in these areas. Moreover, health interventions which attack disease on an individual case basis are increasingly viewed as so limited in scope that they are unable to significantly improve health in areas where environmental factors threaten human health and well-being (Gish, 1979; World Bank, 1980; World Health Organization, 1978). Recognition of the broader range of factors which influence patterns of health and disease has generated an expanding body of cross-disciplinary scholarship both by medical professionals drawing on anthropology and sociology and by social scientists applying their skills to health problems. This literature is beginning to chart new theoretical approaches to the problems of health and disease and to produce important empirical studies of health and disease in Africa and Latin America. Despite significant advances in research on these topics, however, much current scholarship is bound by the perspectives of a single discipline or methodology. One result is that the field itself is polarized between studies which focus exclusively on macro level national and international transformations and those which examine only community and individual level dynamics. Macro level research projects have grappled with national and international processes of development and explored such themes as the investment of nations in health care (Abel-Smith, 1978; Navarro, 1976;

World Bank, 1980), the role of western medical technology in the design of Third World health systems, and national trends in food production and supply (May and McLellan, 1972). Studies at the local level on the other hand, focus attention on the subsistence production of domestic units, household decision-making, and time allocations (Messer, 1981), local attitudes toward the use of birth control devices, breast feeding, nutrition, latrines, and local health services (Gwatkin, 1980).

We propose to develop a new conceptual framework which draws on the theoretical perspectives and empirical contributions of these two scholarly traditions. One goal is to provide an interdisciplinary forum where scholars can explore the complex, dynamic relationship between the broad processes of development and social change and the social roots, patterns, and consequences of health and disease in specific areas of Africa and Latin America. Specifically, we will examine from various perspectives the shaping influence which political and economic forces have had upon contemporary problems of health and disease. A principal objective of the conference therefore is to define and develop a political economy approach to the study of health and disease in Third World regions.

Second, the conference will provide an opportunity for scholars to compare problems of health and disease in Africa and Latin America. These continents obviously share many similar dilemmas of dependent development, including strong colonial heritages, accumulated national debt, and difficult conditions of trade in the world market. Yet the different patterns and levels of industrialization, economic dependence, and market commoditization,

as well as different state and family structures, also suggest promising areas for comparison (Markovitz, 1979; Cardoso and Falleto, 1979). Comparisons of particular regions in each continent may be particularly instructive, for example, where economic factors such as land tenure, crop production, or income levels may be similar, while factors such as family structure, state penetration, and market development may be quite different. Collaboration between social scientists in Africa and Latin America should also be helpful in integrating macro and micro levels of analysis, since the relevant research in Latin America has given more attention to macro level issues, while that in Africa has focused more frequently on local communities. Thus, each should be able to provide the other with new directions and theoretical insights with which to explore the relationship of households and communities in varied cultural settings to the larger processes which affect them, and the quality of life within them.

A third objective of the conference will be to make the results of these studies accessible to health and nutrition officials in the field. To accomplish this, we intend to invite to the conference several researchers who have experience both as academics and health officials. In addition, we will produce summaries of conference presentations and discussions, as well as other case materials, which will be specifically targeted for training programs and schools of public health and medicine in Latin America and Africa (for example, see Lindenberg and Crosby, 1981).

Four topics have been selected as specific areas for discussion at the conference: 1) Workplace, health and disease; 2) Nutrition and commoditization

of food systems; 3) Women, household and health; and 4) The state, class, and the allocation of health care. We have chosen to focus on these topics both because they reflect central issues of concern within the political economy perspective, and because they are topics on which some research in both Latin America and Africa has already been completed.

Given the comparative nature of the project and our desire to make the conference small enough to encourage the free exchange of ideas among all of the participants, we have decided to commission two discussion papers for each topic -- a Latin America specialist will produce one such paper; an Africanist another. These papers are intended to be thought pieces which allow the authors to draw on a wide range of case material in an attempt to identify major substantive and methodological problems and approaches related to their topics. We will also encourage authors to explore the broader theoretical implications inherent in their respective areas of research concern, and to identify areas for possible future research. Two additional specialists from each area will be asked to prepare responses to the discussion papers on each topic on the basis of their research experience and wider knowledge of the field. The four day conference will allow a full day for discussion of each topic, with a morning session focused on one geographical area and an afternoon session on the other. The four topics are elaborated below.

1. Workplace, Health and Disease

In the past thirty years, both Latin America and Africa have experienced rapid industrial growth, intensification of agricultural production, and

the expansion of mineral and manufacturing industries. This growth, aimed at achieving higher national levels of economic self-sufficiency, has brought mixed blessings, however. Industrialization has generated, both directly and indirectly, health problems related to the work process itself (Hunter and Hughes, 1970).

One direct consequence of industrialization on both continents is indicated by the rising incidence of occupational diseases associated with the workplace. Other indirect health costs are a product of environmental changes and transformations in the use and organization of land and labor generated by the development of agriculture, mineral, and manufacturing industries.

Studies of industrial health in Africa and Latin America reveal an alarming increase in the incidence of chronic diseases and injuries resulting from inadequate regulation of hazardous materials and processes. A recent report on occupational health in South Africa, for example, reveals that over 150,000 workers annually are exposed to the dangers of lead poisoning and over 77,000 to mercury poisoning (Green and Miller, 1979). Similarly, studies of mortality rates in Mexico show increases as high as 80% in accident and disability rates during a recent period of rapid industrialization (Laurell, 1979). Studies have also shown that disabled workers seldom receive adequate care or maintenance (Katz, 1979).

The intensification of agricultural development in the Third World has also had similar, though often more immediate, consequences for the health of agricultural workers. A number of studies have noted marked increases

in the incidence of schistosomiasis among agricultural workers employed on irrigation projects (Lanoix, 1958; Sturrock, 1965; Weisbrod, 1973). Of equal importance, though less studied, is the impact of pesticide and fertilizer use on workers' health (Chediack, 1981; Franco, 1981).

In both Africa and Latin America, industrial development has created social conditions which threaten, in new ways, the physical and mental well-being of people. Inadequate housing and sanitation facilities at work sites, policies which discourage wives and families from accompanying their husbands to new labor centers, stress related to workers' adjustment to new forms of discipline, social life, and job insecurity have all impinged upon the health and well-being of industrial workers (Corin, 1979; Fendell, 1959; Gambel, 1962; Phimister, 1978; Ribeiro, 1981). Moreover, industrial development has resulted in major changes in the organization of labor supplies, the proletarianization or semi-proletarianization of laborers, and widespread labor migrancy. These changes are, in turn, linked to the spread of infectious diseases. Studies show, for example, that tuberculosis and syphillis, contracted first by mine workers, have been conveyed to rural populations by returning migrants (Collins, 1981; Dawson, 1979; Delmoras, 1960; Kuper, 1947; Prins, 1979; Schapera, 1947). And increases in the geographical distribution of parasitic disease such as malaria, schistosomiasis, and trypanosomiasis similarly have been linked to the growth of labor migration (Prothero, 1965; Ruyssenars, J. et al., 1973; Vail, 1977).

Industrialization also has produced important side effects on health patterns. For example, involvement in wage employment may reduce the amount

of labor available to rural households for the cultivation of subsistence crops. This increased dependence on external markets for food has not only increased the general vulnerability of rural households to fluctuating prices of food commoditities, but has also induced nutritional and health problems in those seasons or years when the wage earning power (and purchasing power) of rural households diminishes.

Finally, the social roots and consequences of health and disease patterns are often fundamentally related to ecological change wrought by rapid industrialization and agrarian development in parts of Africa and Latin America. The creation of irrigation schemes, for example, may produce new environments for the breeding of vectors for malaria and schistosomiasis (Lanoix, 1958; Sturrock, 1965). Increased pesticide usage has been associated with a resurgence of malaria in areas in which it had previously been under control (Bruce-Chwatt, 1956; Chapin and Wasserstrom, 1981). The reduction of land under cultivation, and the concomitant advance of bush areas in some parts of Africa, has led to an increase in both man-tsetse contact and the incidence of human trypanosomiasis (Ford, 1971; Vail 1977).

The literature on development and disease cited above clearly identifies important associations between industrialization and changing patterns of health and disease in Africa and Latin America. Yet, in general, the literature has suffered from a degree of medical myopia, with most studies narrowly focused on etiological problems concerned with identifying the direct causes of ill health. As a result, the wider political and economic forces which have generated these direct causes tend to fade from view. For example,

while much research describes the working conditions which breed ill health, little attention has been given to the linkages which may exist between these conditions or to the interests of multinational corporations and the economic constraints and needs of developing countries. We need to explore the extent to which adverse working conditions in Africa and Latin America result from the exportation of hazardous industrial processes and materials from industrialized countries in Europe and North America. It is well known that developing countries in need of capital and desirous of attracting industry present an inviting prospect for investment, since health regulations are less rigorously enforced. But we need to know far more about the eventual effects of this investment climate on health levels in these countries. To what extent is inadequate care of disabled industrial workers the product of agreements made at the national level between representatives of foreign capital and government leaders afraid of discouraging international investment? What precisely are the linkages between rural malnutrition, wage and employment practices of industrial employers, and the development needs and constraints of national governments in Africa and Latin America? In short, to what degree are the developmental priorities of national governments antagonistic to their health policies?

By identifying these wider linkages between macro and micro level processes of development, and highlighting the structural causes of ill health, a political economy perspective would greatly assist the study of the relationship between development and disease. In addition, the joining of African and Latin American experiences should provide useful comparative material

and ultimately provide a basis for constructing a wider theoretical framework for understanding the complex interrelationship between the macro and micro levels of development. This comparative framework should be particularly useful to Africanists, since their understanding of the potential health consequences of industrialization can benefit from studies in Latin America, where industrial development has a much longer history and greater attention has been given to issues of political economy and industrial health.

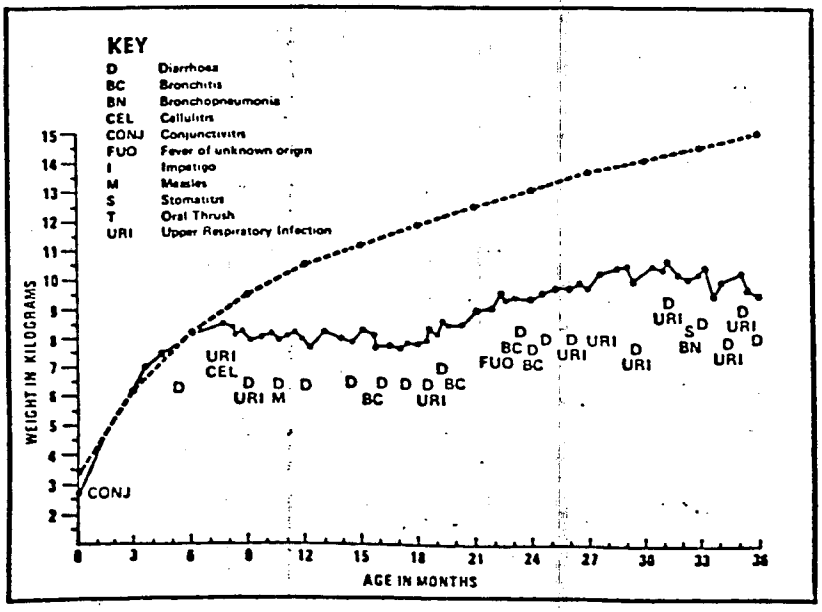
2. Nutrition and the Commoditization of Food Systems

The persistence of widespread malnutrition in developing countries is cause for much recent concern by social scientists and medical authorities. In the past, epidemiological research has tended to base analysis on the aggregation of individual pathologies, without exploring the processes that work at the level of the society as a whole. The resulting programmatic or normative statements therefore tend to appeal to individual behavior. The well-known "growth chart" based on this approach, which is widely used both in Africa (Jelliffe, 1966; King, 1965; King et al., 1972) and in Latin America (Grant, 1982), is a useful descriptive tool. But it offers no more useful causal analysis than the simple assertion of the synergism of nutrition and infection (see Figure 1).

Figure 1

The chart below plots the growth of an actual child in a poor Central American community and tells a story typical of the childhood of millions in the developing world. For the first six months of life, breastfeeding keeps the child growing normally. Thereafter, as weaning begins, malnutrition increases the risk of infection and infection exacerbates the malnutrition. Together, they attack the child's rate of growth so vigorously that there is no weight gain at all between the age of six months and eighteen months. Often, the flattening of the child's weight curve is a slow and invisible process — especially if it is also happening to a majority of the children in the community. But regular monthly weighing and the use of a simple growth chart — kept at home by the mother — is an early warning system which makes malnutrition visible and can be a vital aid to the mother in maintaining her child's growth and health.

The chart shown here is based on studies by L.J. Mata, J.J. Urrutia, and A. Lechtig for the Institute of Nutrition of Central America and Panama (INCAP)



Source: Grant, 1982, p.5

Similarly, the frequent association between the onset of growth failure at weaning and a repeated series of infant infections has often been interpreted by "health educators" as a matter of individual responsibility. Women, in particular, are exhorted by these health personnel to change their child care, dietary, and sanitary behavior.

Such individually based interpretations exemplify the weakness of the behavioral approach in its failure either to take account of wider social and economic processes that explain malnutrition and disease, or to suggest the necessity for broad-based social and economic solutions (Clark, 1980; Trudy, 1980). In practice, the improvements in child nutrition made in the 1970s are due largely to mass vaccination campaigns and direct food supplements or food price subsidization/control. They owe much less to modifications in individual behaviors. The results of India's "fair price shops," Sri Lanka's direct food supplementation program, Tanzania's efforts at staple food price control, and Mexico's (now defunct) S.A.M. program are all obvious examples of the importance of national efforts in improving nutritional levels. These examples emphasize the importance of taking a broader political economic approach in the study of malnutrition and disease.

We propose here to focus analysis specifically on the effects on nutrition of two crucial and interrelated processes: commoditization and proletarianization. In both Africa and Latin America, the transformation of basic foods, goods, and services into commodities has accelerated rapidly in the past three decades (Bernstein, 1977; Blanc, 1975; Bryceson, 1980; Buch-Hansen and Marcussen, 1982; Deere, 1979; de Janvry and Garramon, 1977; Spitz, 1980).

At the same time, the allocation of these commoditized goods and services has shifted from the domain of families and small communities to the marketplace where large scale distributive processes are controlled by the state, business elites, or overseas corporations and donors (Burbach and Flynn, 1980; Dinham and Hines, 1982; Lipton, 1977; Sampaio, 1980; Sobrinho, 1981). This uneven process of commoditization has deeply affected patterns of food consumption and opened new markets for sugar, cigarettes, alcohol, baby foods, super-refined cereals, and soft drinks. The growing dependence on food commodities has had profound affects on levels of health, which raises questions that recent research has only begun to explore (Chetley, 1979; Morgan, 1979). For example, what have been the health effects on small family farmers who have reoriented subsistence production towards production for sale, often for an international market and often requiring purchased inputs and more labor (de Leal and Deere, 1981; Dumont, Reboul, and Mazoyer, 1981)? Where the commoditized crop is also a valued local food crop, as is the case with manioc in Brazil, rice in the Sahel, or maize in Kenya, are the health consequences more severe (Bueno, 1981; Franke and Chasin, 1981; McCarthy and Mwangi, 1982)? When states or international corporations introduce large-scale food production into an area (e.g., state farms in Mozambique, Zambia, Nigeria, Sudan; joint venture plantation/contract sugar complexes in Kenya; or agribusiness in Central America), what are the consequent changes and perturbations in local food and health systems (Burbach and Flynn, 1980; Conti, 1979; Dewey, 1981; Dinham and Hines, 1982; Wisner, 1982)? The food system effects of such large-scale development projects are likely to interrelate

synergistically with the health effects of industrialization discussed earlier.

While the processes of commoditization and proletarianization are similar in both Africa and Latin America, important social and historical differences between the two continents need to be recognized. For example, both landlessness and market development are more advanced in Latin America than in Africa. Two consequences of this are Latin America's earlier and more thorough urbanization, and the longer established and more widespread organization among rural and urban poor in demanding social and political relief from malnutrition. Comparative analysis that takes these differences into account will deepen our understanding of both the processes of social transformation and their health consequences for the two areas of study.

3. Women, Household, and Health

The role of women in household health is a promising focus for exploring the effects of macro level socioeconomic changes, such as proletarianization and commoditization, on the health and disease levels of individuals. Households both respond to such changes and, through their collective coping strategies, affect the shape of future transformation. For example, the ways in which household members manage their scarce resources of land, labor, time, and cash in their attempts to satisfy such basic needs as food, water, fuel, shelter, clothing, education, and health care, clearly affect their levels of health.

Because of their responsibilities for child care and domestic tasks, women occupy a pivotal role within the household in matters concerning health.

In addition to their role in allocating scarce resources, women affect a number of health activities directly. They produce, process, and purchase food; they determine infant feeding practices; and they affect household hygiene. Because women often serve as terminal points of exchange in the complex process of food commoditization in Africa and Latin America, their decisions about household consumption are important for understanding the health effects of increasing commoditization. Women are also central to the processes of diagnosing illness, managing therapy, and selecting among alternative health care services. A crucial phenomenon for household health that affects not only the nutritional level and survival of infants, but women's fertility patterns as well, is breastfeeding. Recent studies reveal an overall decline in breastfeeding levels in developing countries -- a decline which is most severe in the most industrialized and urbanized areas of these countries (Jellife and Jelliffe, 1978; Latham, 1977; Rutzen, 1972; Shattock and Stephens, 1975; Vis and Hennart, 1978; WHO, 1979). Women's decisions about breastfeeding -- in particular, decisions to use packaged infant formulas -- are related to intensified rural to urban migration, increased stress, and loss of family support systems (Raphael, 1976). Researchers have also found that increasing pressures on women's household time, economic incentives to wage labor, and consumer advertising of infant formulas are correlated with a decline in breastfeeding (Butz, 1979; Greiner, Esterick, and Latham, 1981; Greiner and Latham, 1981). The research results suggest ways in which the effects of wider social changes on women's domestic activities affect the health of household members.

Other health related activities of women may be expected to reveal similar linkages to broader processes of change which involve increasing pressures on their time and labor. Increasing wage labor employment of women has led to the pressures and burdens of the infamous "double day." These pressures undoubtedly force women to reduce or modify their household health roles, but the processes and outcomes have not been studied. Critical issues for research include the effects of increased labor force participation of rural women on household food consumption patterns and nutrition levels, on the diagnosis and management of household illness and therapy, and on levels and patterns of household hygiene. These changing health patterns need to be examined in relation to the availability of family health benefits at the workplace, and changes in the availabililty and location of health facilities.

Research bearing on these issues is contained in two bodies of literature -- one on women and development and the other on women and health. The growing literature on women and development analyzes the effects of the growth of industrial capitalism on the sexual division of labor and the position of women (Boserup, 1970; Hafkin and Bay, 1976; Nash and Safa, 1980; Sauliners and Rakowski, 1977; Wellesley Editorial Committee, 1977; Youseff, 1974). Research on women in rural areas of both Africa and Latin America reveals a general decrease in women's participation in agricultural work (ILO, 1980), with patterns varying considerably according to the level of capitalist penetration, region, and social class (Deere and de Leal, 1981; Wilson, 1982; Young, 1978). In some areas, women have diversified their economic

activities into petty commodity production and service sector employment (Bourque and Warren, 1981; Long and Roberts, 1978). In other cases, either female labor in subsistence agriculture has intensified, or women have shifted to agricultural wage labor (Arizpe and Aranda, 1981; Stolcke, N.D.). Seasonal, temporary, or permanent migration often accompanies the shift from subsistence agricultural labor to wage work. These diverse patterns of agrarian change may have important consequences for the health of household members. As yet, however, little is known about the effects of women's intensified subsistence production on the allocation of their time and labor in matters concerning household health. Nor do we understand the nutritional consequences of increased dependence on imported food products. The effects of migratory patterns on health also needs to be explored.

In urban areas, the absolute growth of women entering the urban wage labor force often masks strong variations according to sector, class, and the age and marital status of workers. In Latin America, for example, there has been a general decline in the proportionate participation of women in both industry and manufacturing, while a greater percentage of women has found employment in white collar jobs (Kelly, 1981; Safa, 1977) or in service sector jobs, especially domestic service (Jelin, 1977; Rubbo, 1975). On the other hand, working class women in the paid labor force are increasingly young, unmarried women (Arizpe, 1977; Kelly, 1982; Safa, 1981).

Research is needed which examines the health consequences of these patterns, viewed in the context of the increasing disparity in health benefits available to different sectors of the wage labor force. Because

this literature has focused primarily on women's role in the paid labor force (Beneria, 1982), it is only beginning to explore the effects of these changes on women's unpaid domestic labor (see Tilly and Scott, 1978). Moreover, the broad range of women's activities in household health has received virtually no attention.

A second body of relevant literature focuses on topics directly related to women and health. This research has generated much useful and important data concerning women's attitudes and participation in fertility control, birth practices, and breastfeeding (Browner, 1980; Newman, 1981; Schlesinger, 1982; Schwartz, 1981). The approaches employed in these studies are limited, however, in their analytical capacity to examine the impact of wider social transformations on women's health related behavior, and, more generally, on the levels of health and health care among distinct sectors of the population.

The proposed conference aims to bring together these two perspectives and create a new, synergistic focus on the dynamic interrelationships among women, domestic economy, and health. In so doing, we hope to enrich these separate fields and to identify new areas for research which focus on women as mediators of political and economic changes which directly affect the health of household members. This new approach is intended to deepen our understanding of women's consciousness about the health consequences of social change, and of their own roles in this change, both as its agents and its victims. Taking as a point of departure women's actions and consciousness of their role in the physical and mental well-being of household members, it is hoped that this approach will help to redress the present lack of attention

given to gender issues by governmental planning agencies (Beneria and Sen, 1981; Boserup, 1970; Rogers, 1980). Thus it should be of potential concern to both development planners and health officials.

In reconceptualizing the relationship between women and household health, the conference will explore how changing patterns of household production relate to women's reproductive behavior and the consequences for household health levels. It may also throw new light on ways in which national and international efforts to influence women's reproductive behavior mesh with women's interests and their influence in shaping household survival strategies.

4. The State, Class and the Allocation of Health Care

Studies of health care and delivery systems in Latin America and Africa have documented: (1) massive inequality in the availability of services with rural populations persistently disadvantaged (Sharpson, 1972; USAID, 1977; World Bank, 1980); (2) low levels of health care expenditure, with some nations spending less than one dollar per capita (World Bank, 1980; Zschock, 1979); (3) an emphasis on high-cost, limited-access, urban-based curative care when many health problems could be better addressed by broad-based, preventive services, combined with housing, food production, and other social and economic programs (Gish, 1979; WHO, 1978). While comparisons between Africa and Latin America reveal fewer health care resources and greater inequalities in their distribution in Africa (Caldwell and Dunlop, 1979), general characteristics of health care systems on the two continents are remarkably simliar.

Research has appropriately focused on the role of states and/or regimes in allocating resources for health and in designing and implementing health care systems. States in Africa and Latin America are responsible for most health care services, both curative medical institutions and public health sanitation and immunization services. In addition, states usually regulate, or attempt to regulate, the services of private physicians and traditional healers, occupational health and safety, and pharmaceuticals (Dunlop, 1975; Geraffi, forthcoming; Katz, 1979). Studies of the role of states in health care have been largely descriptive and have tended to follow one of two contrasting perspectives. One group of authors suggests that state programs designed to improve health planning and managerial capability, or to initiate village-based primary care health policies, will lead to more equitable and appropriate health care systems (Abel-Smith, 1978; Bossert, 1978). In contrast to this flexible view of the capacity of the state to alter health systems, another group of authors views the state as a reflection of the broader economic and social systems, with the implication that changes in health systems can only follow from radical changes in economic and social structures toward progressive, socialistic, and egalitarian principles of organization (Gish, 1975, 1979; Roemer, 1977; Sidel and Sidel, 1977).

More recent studies utilizing a political economy perspective have suggested a much more complex approach to the relationship between the health system, the state, and the socioeconomic system (Doyal, 1979; Elling, 1980; Navarro, 1976; Renaud, 1975). They emphasize the relative autonomy of the state from elite classes and its ability to legitimize its rule through

cooptation and control of lower classes (Evans, 1974; Hamilton, 1982; Markovitz, 1977; Marks and Trapido, 1977; O'Connor, 1973; Poulantzas, 1973; Saul, 1979). Rejecting the notion of a mechanistic state response to class demands, these studies have emphasized that state responses may be influenced by the specific historical development of states, and in Africa especially, by widely different colonial experiences. State responses may also be affected by the ideology of the regime's elite, the effectiveness of physician interest groups and health worker unions, the economic or electoral importance of the rural poor, and by the availability of international funding (Bossert, forthcoming; Danielson, 1979; Ferguson, 1981; Ugalde, 1979). Latin American scholars, in particular, have begun to emphasize the importance of these issues for analyzing health care systems (Belmartino and Bloch, 1982; Garcia, 1982; Morales, 1981; Testa, 1982; Vasco Uribe, 1978). This is an area in which comparisons drawn between more highly developed but perhaps less autonomous states in Latin America and the less structured but more autonomous African states may provide powerful insights into the effects of state autonomy and decision-making processes on health care allocations.

Research is needed on: (1) the complex distribution of class access to public and private health care; (2) the class forces that shape the structure and ideology of the state and its relative autonomy; (3) the role of international influences on the ideology, design, and funding of health care systems; (4) the historical decision-making processes which have determined the role of states as providers and regulators of health care; and (5) practical policy recommendations for advocates of equity-oriented health

care services.

Since the state plays such an important role in determining resource allocation in health care, advocates for changes in health policy usually focus their attention on influencing state policy. Policy relevant proposals which emerge from other sections of this conference may be useful in considering how best to promote state activities to address these problems. Experiences of progressive regimes such as Tanzania, Cuba, Zimbabwe, Nicaragua, and Chile under Allende, will be particularly relevant here (Danielson, 1979; Gish, 1975; Hakim and Solimano, 1979; Bossert, forthcoming).

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POLITICAL ECONOMY OF HEALTH AND DISEASE IN
AFRICA AND LATIN AMERICA

An International Conference
Fall 1984

Preliminary Outline of Sessions and Possible Participants

I. WORKPLACE, HEALTH, AND DISEASE

Discussion Papers:

Africa	Meredeth Turshen, Rutgers University
Latin America	Asa Cristina Laurell, Universidad Autonoma Metropolitana, Mexico

Respondents:

Africa	Wilson Abok, Ohio University
	A.D. Kiwara, IDS, Dar es Salaam
Latin America	Miriam Ribeiro, University of Sao Paulo
	Mario Epelman, Ministro de Trabajo, Nicaragua

Alternate Respondents:

Africa	Maureen MacIntosh, University Eduardo Mondlane
Latin America	Roberto Chediack, CSUCA, Costa Rica

II. NUTRITION AND THE COMMODITIZATION OF FOOD SYSTEMS

Discussion Papers:

Africa	Deborah Fahy Bryceson, St. Antony's College, Oxford
Latin America	Kathryn Dewey, University of California, Davis

Respondents:

Africa	T.N. Maletnlema, Tanzania Food and Nutrition Center
	J. Kreysler, WHO advisor for francophone West Africa
Latin America	Carlos Amat y Leon, Universidad del Pacifico, Peru
	José Carlos Escudero, Universidad Autonoma Metropolitana, Mexico

Alternate Resondents:

Africa	Dr. Ebraihim, Institute of Child Health, Hospital for Sick Children, London
Latin America	Flavio Valente, M.D., Federal University of Bahia, Brazil

III. HOUSEHOLD, WOMEN, AND HEALTH

Discussion Papers:

Africa	Jette Bukh, Denmark
Latin America	Carole Browner, Wayne State University

Respondents:

Africa	Miriam Were, University of Nairobi
	Harriet Ngubane, Swaziland
Latin America	Dora Cordassi, Universidad Autonoma Metropolitana, Mexico
	Luz Helena Sanches, Colombia
	Diana Medrano, Bogota

IV. THE STATE AND THE ALLOCATION OF HEALTH BY CLASS

Discussion Papers:

Africa	Shula Marks, SOAS, University of London
Latin America	Eduardo Morales, FLACSO, Chile

Respondents:

Africa	F. Mburu, University of Nairobi
	David Saunders, University of Zimbabwe
Latin America	Mario Testa, CENDES, Venezuela
	Carlos Bloch, Centro de Estudios Sanitarios y Sociales
	Susana Beltramino, Centro de Estudios Sanitarios y Sociales

Alternate Respondents:

Africa	John Caldwell, The Australian National University
Latin America	