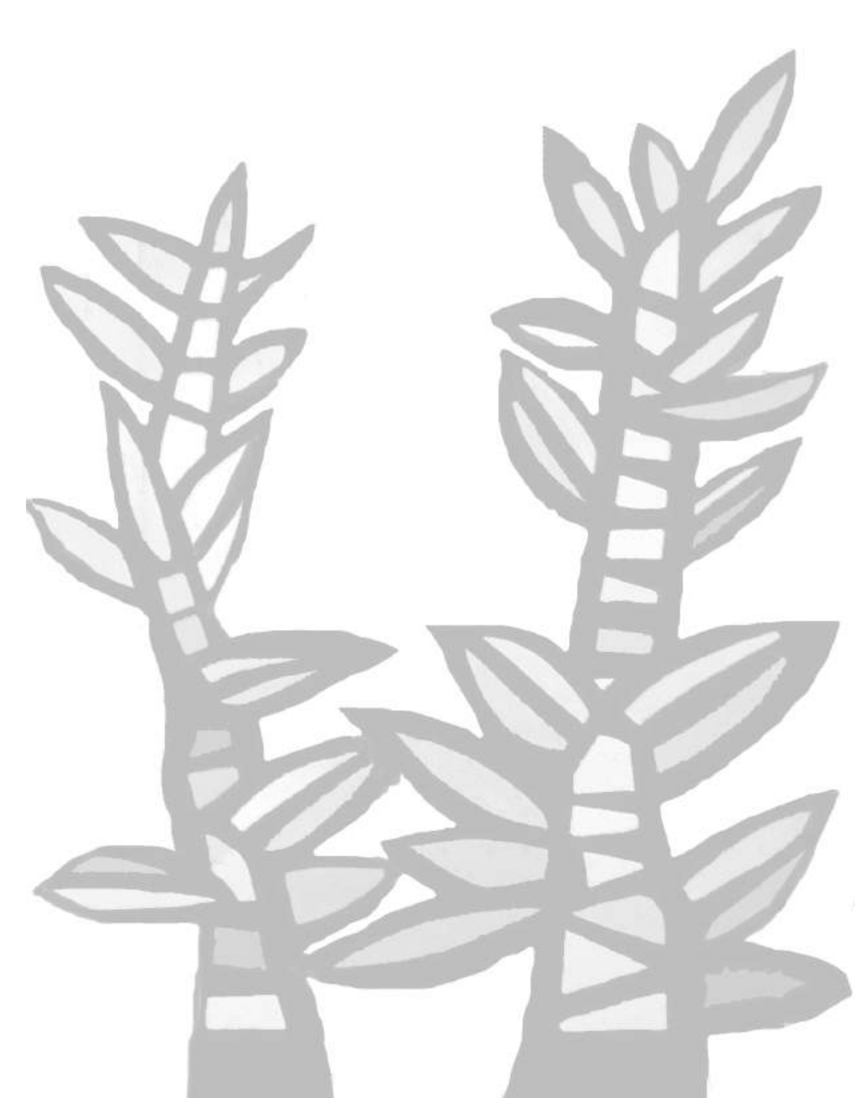
PEOPLE'S STRUGGLE FOR HEALTH AND LIBERATION IN LATIN AMERICA

A HISTORICAL PERSPECTIVE

DAVID WERNER



People's struggle for health and liberation in Latin America: a historical perspective

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PEOPLE'S STRUGGLE FOR HEALTH AND LIBERATION IN LATIN AMERICA: A HISTORICAL PERSPECTIVE

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David Werner

PRESENTACIÓN

"Hay hombres que
luchan un día y
son buenos. Hay
otros que luchan
un año y son
mejores. Hay
quienes luchan
muchos años, y
son muy buenos.
Pero hay los que
luchan toda la
vida, esos son los
imprescindibles".

Bertolt Brecht
1898-1956.
(Dramaturgo y poeta alemán)

Un espacio para hablar de la lucha y los luchadores por la salud, es un tiempo propicio para mencionar el mayúsculo rol que ha jugado David Werner. Su obra, más allá de las fundamentales producciones "Donde no hay Doctor", "El Niño Campesino Deshabilitado" o "Aprendiendo a Promover Salud" y muchas otras más, ha sido y es un verdadero camino de vida. Un camino, en cuyo luminoso trajinar han ido generando lecciones y herramientas de enorme significado para la defensa y la construcción colectiva de un quehacer de salud desde la perspectiva de los más excluidos, plena de dignidad y valientemente contrahegemónica.

Sus reflexiones y metodologías alentaron a lo largo de no menos las cuatro últimas décadas un accionar de salud comunitaria marcada por la presencia fraterna y solidaria de las y los promotores de salud, mujeres y hombres nombrados por sus comunidades para capacitarse y actuar con total legitimidad enfrentado por igual al dolor de la enfermedad como al calor y color de la organización comunitaria.

Y es que este movimiento sanitarista popular se ha constituido en quizás la respuesta más sólida que desde la una orilla comunitaria tuvo la invocación de Alma Ata (1978): poner en marcha una apuesta que debía llegar a proveer Salud para Todos. Hoy, 35 años después de ese llamado, seguimos esperando que "la otra orilla", El Estado, concrete aquello a lo que se comprometió.

En este tiempo en que la "oficialidad" habla de la necesidad de impulsar una APS "renovada", y en el que nosotros reconocemos que la APS integral no ha perdido vigencia, se hace más necesaria aún esa luz que David "Camino" Werner es capaz de encender para iluminar el sendero por el que deberemos transitar este diario construir colectivo aprendizajes y, desde luego, en el diario combate por una vida digna, por una salud para todas y todos.

Leer "La Lucha del Pueblo para la Salud y la Liberación en América Latina: Una Perspectiva Histórica" escrito a propósito de la I Asamblea del Movimiento para la Salud de los Pueblos – Latinoamérica, es sin lugar a dudas una motivación especial, un llamado a no claudicar, a vencer el miedo que muchos de los gobiernos llamados progresistas han impulsado como estrategia para controlarnos, una invocación a mantenernos en la trinchera, un sacudón para que recordemos con que al final del túnel, siempre está la luz.

Gracias David, por ser testimonio vivo de esta lucha; por recordarnos, que la roja bandera de la salud y la dignidad, sigue y seguirá flameando por lo alto, por ser ejemplo, por ser camino.

Jorge Parra
MASTER EN SALUD FAMILIAR Y COMUNITARIA
PROFESOR PRINCIPAL DE LA FACULTAD DE CIENCIAS MÉDICAS
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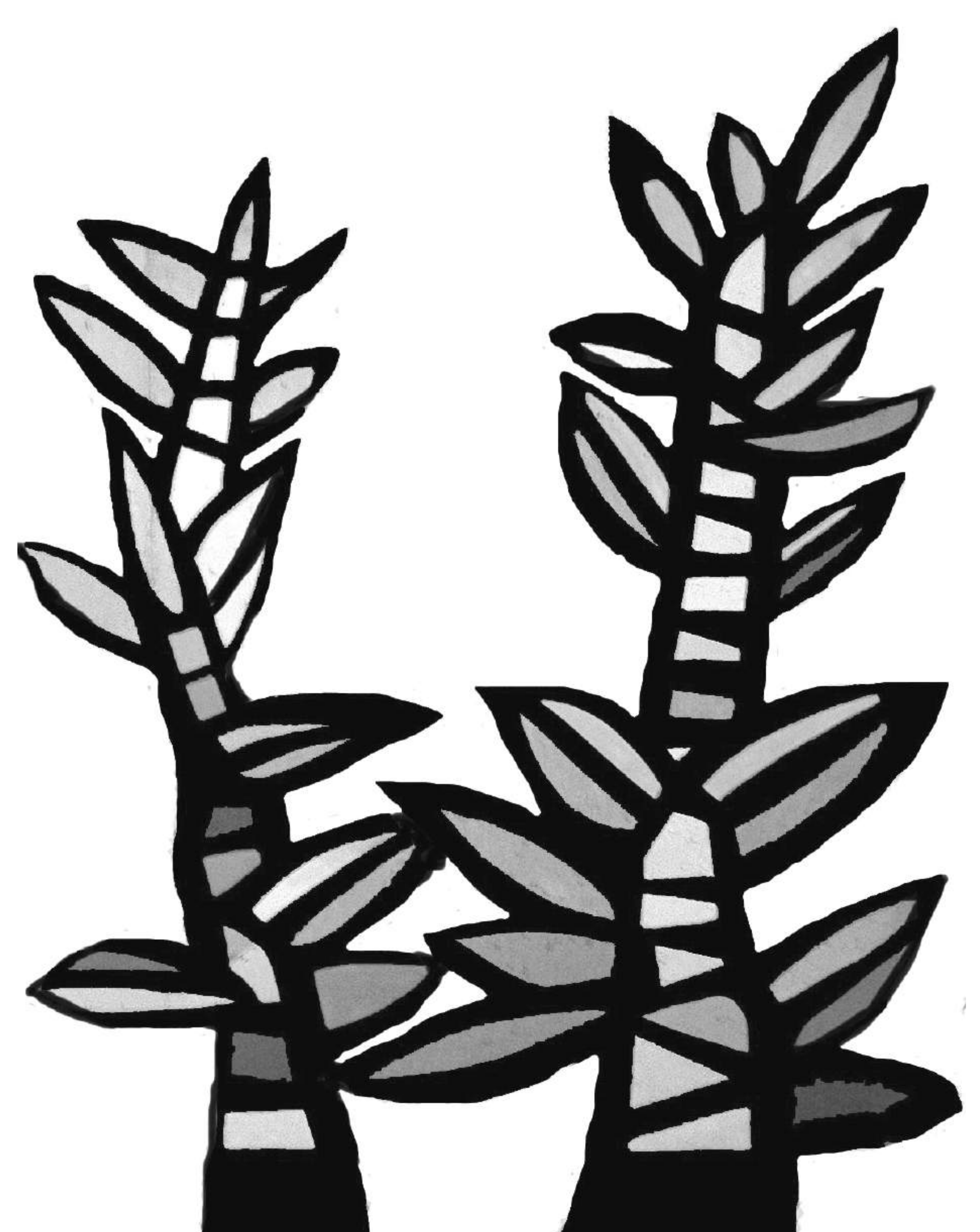
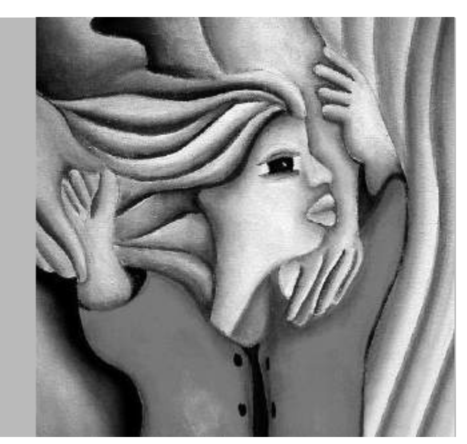


I. INTRODUCTION



THE STRUGGLE FOR HEALTH IS A STRUGGLE FOR SOCIAL JUSTICE

In our ongoing struggle for the Health and Rights of All, now in the 21st Century, what can we learn from the hey-day of the Community Based Primary Health Care in Latin America during the last half of the 20th Century?

I would suggest we can learn a lot ... including things that can help ground us in our current strategies of organized action for change. As an aging activist from those challenging times, I would like to share with you some stories and lessons about the role that village health promoters and their grassroots networks played in the pursuit of health and social justice in those days.

The period from the 1960s into the 1990s was an exciting if difficult time, one of valiant popular action for equal rights and the common good. These grassroots actions in many countries were countered by the ruling classes with brutal repression including torture, disappearances, and other violations of human rights and international law. But for all the suffering and setbacks, this was a time when some very positive, deep-seated changes took place. A number of heavy-handed dictatorships were ousted, in spite of -- and in part because of -- their overt or covert support from the United States. In many ways, the struggles from the '60s into the '90s laid the foundation for the more recent, dramatic shifts toward representative government and "Power by the People" that have been emerging in the 21st Century. Indeed this new millennium has promise of becoming the "post-neocolonial era" where marginalized peoples collectively stand up to both national and foreign potentates, and cry out, "Ya basta!" (Enough is enough!)

What we all need to remember and learn from is the key role that Community Based Health Care played -- and can still play -- in this liberating, bottom-up Struggle for Health for All. The People's Health Movement in Latin America, as an outgrowth of this popular struggle of the previous century, can indeed be informed and inspired by its early history.

THE POLITICIZATION OF PRIMARY HEALTH CARE IN LATIN AMERICA

Beginning in the late 1950s, in various parts of Latin America, small non-government health programs began to crop up in the poorest, most underserved rural areas and urban slums. It was a time when a large percentage of the population lived in extreme poverty, with little or no public support. The political system was largely "neocolonial," in so far as the foreign powers that had colonized and dominated the indigenous peoples of the Americas had been replaced by internal power structures that were equally oppressive, though still beholden to their northern masters. Some of these countries were clearly dictatorships. Others had the trappings of democracy, but the huge gap in privilege and power between the "haves" (los de arriba) and "have-nots" (los de abajo) left the poor largely voiceless and powerless. This downtrodden majority lived in abject poverty. Hunger was common and the classic diseases of under-nutrition and poor sanitation took a huge tool. Child and maternal mortality was distressingly high. Formal health services were out of reach of the poor because of distance and cost. And ironically, professional medical care -- for those folks who could get it -- was another big cause of sickness and death. Its high price increased hunger and lowered resistance to disease. Even today, in many countries, the outrageously high cost of doctors and medicine is still a leading cause that drives low-income, working families into absolute destitution and total dependence.

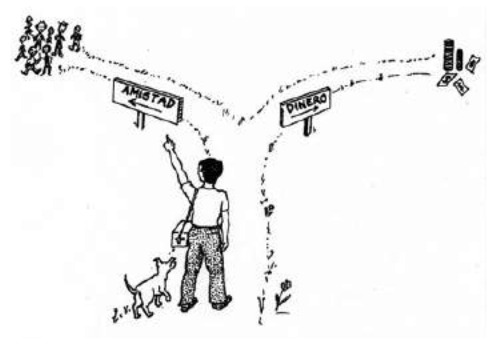
This combination of social injustice, poverty-related ills, and minimal public services at this time led to the "spontaneous generation" of numerous small, non-government community health programs, which sprung up in the remotest villages and most destitute barrios throughout the region. Many of these projects were started by concerned outsiders -- priests, nuns, doctors, nurses, social workers -- committed to serving the poor.

Of those who started these small grassroots projects, many were socially idealistic but politically naive -- at least initially. They had little understanding of the cruel-pecking order and systemic injustice that kept the poor campesinos voiceless, disempowered, and economically enslaved. On the contrary, these well-meaning outsiders (and I was one of them) tended to see the devastating health problems in biomedical terms, to be corrected primarily with biomedical treatment. But through working closely with the people, we gradually became aware of the underlying social determinants of health.

In these marginalized and underserved and largely indigenous communities, the backlog of needs was vast. The small makeshift clinics were soon swamped as people poured in from farther and farther away. Short of staff, the programs began to train local people -- including traditional healers and birth attendants -- as frontline health workers or "promotores de salud." Because these promotores were selected by and served their own communities, most were very dedicated. They tended to work for the people, not the money.

As the community-based, primary care programs evolved and became more participatory, the promotores and villagers began to discuss and analyze the underlying causes of the health-related problems. Then they began to organize to overcome their common problems, at least at the local level. Out of these collective efforts grew informal organizations: of mothers, landless farmers, day laborers, share-croppers, even street children and youth, all seeking a louder voice in the decisions that affected their health and their lives. In this way, many informal community-based programs evolved from a focus on curative care, to preventive measures, and finally to socio-political action.

As such community initiatives began to mobilize people to address the root causes of ill health, often they were seen as threats by the local power structure: landlords, public authorities, loan sharks, medical professionals, and others whose routine exploitation of the poor contributed to hunger and poor health. As a result, many of the non-government programs that were first welcomed as inoffensive charities were eventually blacklisted by the local authorities and in time by national governments -- especially those that were most oppressive and distant from the poor. The last thing they wanted to see was peasant communities organizing to defend their health and their rights. Increasingly harsh rules and obstacles were imposed for such grassroots initiatives, and in some countries health workers or participating midwives were arrested -- or worse.



Work first for the people, not the money.
(People are worth more...)

As a result, in countries where organized opposition was on the rise, many persecuted health workers went underground and joined resistance movements. With their valuable health and organization skills, some become leaders in the growing liberation struggles against tyrannical rule.

In this way, grassroots Community Based Health Care in Latin America came to play a key role in the mobilization of marginalized people in the struggles that contributed to the emerging process of genuine democratization in Latin America ... and beyond.

Let me give you a few examples with which I am more familiar.

II.
LOCAL AND NATIONAL ORIGINS

A.
GUATEMALA

In Guatemala, one of the earliest and most influential Community Based Health Care programs was started in the highlands of Chimaltenango by a visionary doctor, Carroll Behrhorst, to serve marginalized and cruelly exploited indigenous communities. This was one of the first programs to train local promotores de salud. As the promotores began to help the villagers to analyze the underlying determinants of health and take collective action to improve their situation, the military government began to view the community program and its workers as subversive. Some promotores were murdered or disappeared. And in the years of the "scorched earth" pacification program, entire villages were burned to the ground.

Farther north, in the highlands of Huehuetenango, a Community Based Program started by Maryknoll Sisters also trained local promotores, mainly women, who mobilized villages around health-related concerns. As in Chimaltenango, the program soon fell out of grace with the power structure. Promotores had to keep a low profile. They certainly didn't want to get caught by the authorities with a copy of my book, Donde No Hay Doctor (Where There Is No Doctor).

This village healthcare handbook -- which the program gave to all its promotores -- was considered subversive, because it encouraged community organization around needs. When the Sisters gave the book to their promotores, they also gave them a small knife. That way, when the promotores travelled from vi-

The village of San Martín was burned down soon after david werner took this photo, which appears on the cover of "helping health workers learn.

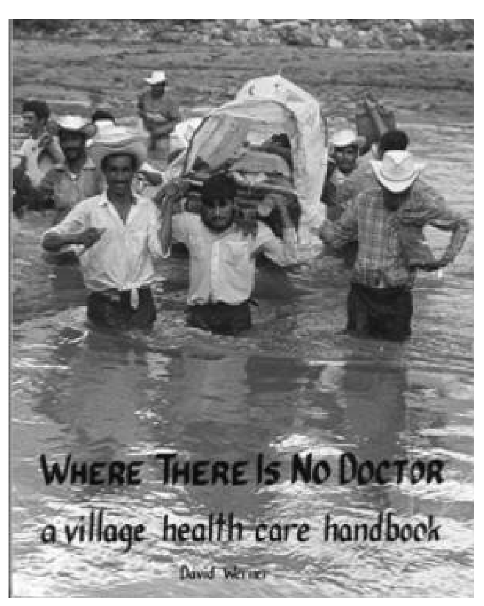
llage to village in their health work, if soldiers stopped the bus to search passengers, a promotora would quickly cut open the upholstery of her seat, and stuff the book under it, to hide it. This preventive measure could be life saving. At times health workers or midwives had been killed simply for being caught with my book.

During the "scorched earth" policy of General Rios Mott, entire villagers were laid waste by death squads for the crime of organizing around urgent needs. An example is the village of San Martín, where I took the cover-photo for Helping Health Workers Learn, which shows a promotora teaching a group of mothers. A year later San Martín as burned to the ground by the military. However, for the government such brutal measure tended to be counterproductive. Surviving villagers and promotores would often flee to liberated areas and join the guerillas in their struggle for a fairer, healthier system.

B. CHILE

In Chile -- after the democratically-elected president of Salvador Allende was overthrown by the US-supported military coup in 1973 -- the autocratic Pinochet junta implemented the neoliberal "free market" policies imposed by the "Chicago Boys." It privatized government industries and public services, including health. The resultant "Chilean Miracle" made the rich richer while further impoverishing the struggling underclass. During the dictatorship of Pinochet, Donde No Hay Doctor was banned by the military. However, the publisher of the Chilean edition, Editorial Cuatro Vientos, took the government to court. Amazingly the court sided with the publisher and lifted the ban.

During this time of violent repression and vast unmet needs, a radical community health program called EPES (Educación



Popular en Salud) was born in the impoverished sectors of Santiago and Concepcion. As part of its health education, EPES promoted the "concientización" (awareness-raising) and mobilization of people around the root causes of poor health. This "empoderamiento popular" (community empowerment) played a critical role in the groundswell of resistance that eventually led to the ouster of the repressive dictator in 1988.

3 phases in the evolution of PIAXTLA

1. Curative Care

2. Preventive measures

3. Socio-Political Action

EL SALVADOR

Similarly in El Salvador in the 1970s and '80s, in impoverished areas a number of community based health programs had arisen out of the enormous unmet needs. Widespread unrest was on the rise. As measures of social control became more oppressive, complete with death squads, community health programs and workers increasingly aligned themselves with the Frente Farabundo Marti para la Liberación Nacional (FMLN). As elsewhere, the promotores played a key role in mobilizing the groundswell of resistance to the Gringo-supported military dictatorship.

MÉXICO

PROJIMO, the community based rehabilitation program I just mentioned, grew out of Project Piaxtla, a villager-run health program in Mexico's Sierra Madre Occidental. It is from experience with Piaxtla -- which I helped start back in 1965 -- that the books Donde No Hay Doctor and Aprendiendo a Promover la Salud were born -- and years later, Cuestionando la Solución: las políticas de atención primaria en salud y la sobrevivencia infantil – Questioning the Solution: The Politics of Primary Health Care and Child Survival. These three books

Like many grassroots health programs in Latin America, Piaxtla evolved through 3 stages, from an initial focus on curative care, then to preventive measures, and finally to socio-political action. These three books that were born from the Piaxtla experience in large part correspond to these 3 stages of the program.

In rural Mexico, the key political action that the promotores and the villagers addressed was the misdistribution of farmland. In violation of the Mexican Constitution -- which grew out of Revolution of 1910 -- half a century later the best farmland was still illegally held by latifundistas (wealthy landholders). These land-lords sharecropped small parcels to landless farmers at such exploitive rates that

hardship and hunger were inevitable. A survey we took in the mid-1960s showed that one third of the children died before 5 years, mostly from diseases related to under-nutrition.

In the Sierra Madre of México:

1 of every 3 children were dying before age five, principally from povertry and under nutrition

As the program evolved, the promotores brought their fellow villagers together to analyze the root causes of poor health, and explore solutions. People began to organize and demand their constitutional land rights. It was long battle, with both formal demands and direct confrontations. Several health workers were killed in the process. But in the end, the campesinos succeeded in invading and reclaiming over 50% of the illegally large parcels, which they divided up among the landless farmers.

The health results were impressive. In a little more than a decade, child mortality dropped to under 20% what it had been. Maternal mortality fell to less than half. And the population as a whole appeared happier, healthier and more self-determined. If an outsider were to ask a village mother, "Is it true fewer children die now than a few years ago?" she would proudly answer, "Yes!" and would give credit to the community health program -- if not primarily to its medical services. Along with the others in her village, she would have a basic understanding of the chain of causes: With the curative care, fewer children died. With the preventive measures, still fewer children died -- but even so, many remained too thin, and got sick and died. But when the people took united political action -- and together struggled to gain their constitutional land rights -- that's when the child death rate really dropped. The reason is obvious: When the people have their own land, they have more to eat.

E. NICARAGUA

1. NICARAGUA UNDER SOMOZA

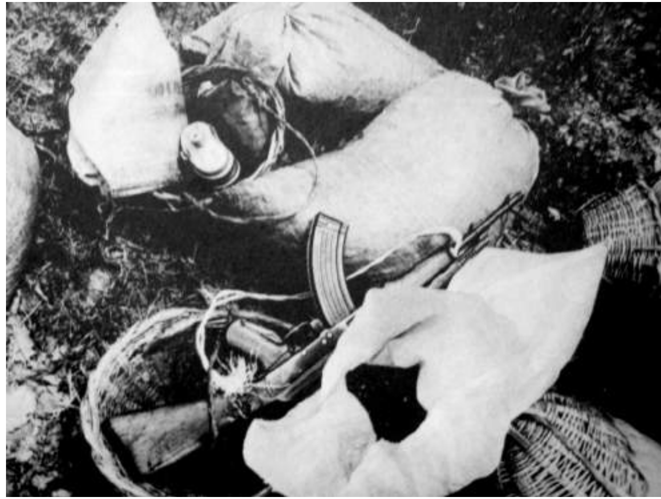
An outstanding example of the role grassroots community health initiatives have played in the struggle for liberation from tyrannical oppression is Nicaragua. During the Somoza family dynasty -- a brutal regime supported by US government-corporate complex from 1936 to 1979 -- the poor majority lived in deplorable conditions. Public services, including health and education, were minimal. Violations of human rights were rampant. Unionization was suppressed and wages kept insupportably low. Community organizing was branded as subversive, unless initiated and managed by the state. Health care was mostly curative, doctor-hospital based, privatized, and like other services

was designed to primarily benefit the tiny privileged class. In the 1970s, 90% of the nation's health resources were consumed by just 10% of the population. One in ten infants died before age one. And more than half of Nicaragua's children were undernourished.

In Nicaragua under Somoza — as in many countries where human rights were systematically violated — community health initiatives began to spring up. Many such initiatives were assisted by foreign non-government organizations or by charitable religious groups that initially had no political motives, other than to serve the needy. But the pervasive "diseases of poverty" they encountered were so clearly the result of a cruelly unjust social order that program leaders inevitably became more politically aware. Community health workers began to facilitate organized action at the local level, in an effort to ameliorate some of the underlying man-made causes of poor health. Thus the "promotores de salud" gradually became agents of change — and were soon branded as subversives.

Due to the profound needs of los de abajo (those on the bottom), by the mid-1970s an extensive scattering of nongovernmental community health programs extended throughout Nicaragua, from rural areas to poverty-stricken urban barrios. When I visited the country in 1977, these grassroots health initiatives had begun to play a role in mobilizing people in defense of their well-being and rights. And they were encountering increasing repression.

In an attempt to co-opt these popular initiatives or make them redundant, Somo-



za's Health Ministry — with the help of the United States Agency for International Development (USAID) — launched an ambitious project to train government-managed village health workers. But despite millions of US dollars, the top-down government program received limited community support.

Meanwhile the informal network of community based programs continued to expand. In response, Somoza's brutal National Guard, as well as paramilitary troops, increasingly targeted grassroots health workers -- along with union leaders and community organizers -- for harassment, detention and disappearances.

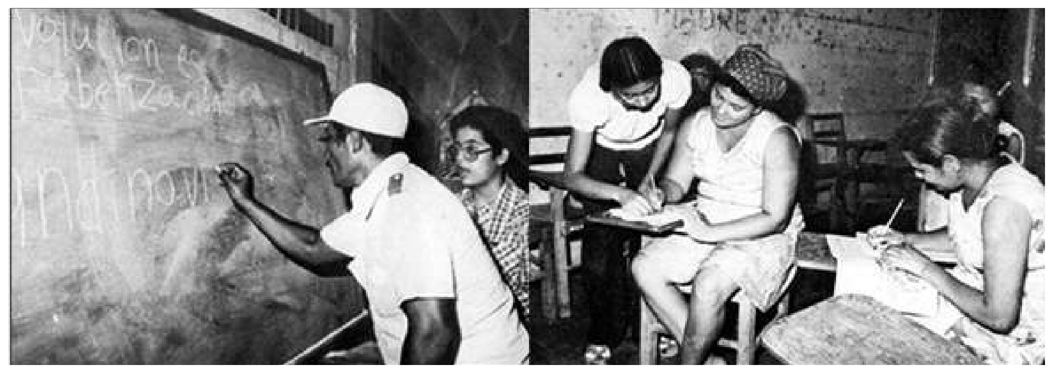
This grassroots network of community-run health initiatives played a vital role in the broad-based awakening and mobilization that eventually led to the overthrow of the oppressive Somoza dynasty. In the later years of the popular uprising, the persecution of community health workers — as well as socially concerned doctors, nurses, and medical students — led many to go underground and join the growing Sandinista resistance. As collective punishment, the government cut off water, food, and other basic supplies and services. In response, the comunidades de base (base communities) that supported the Sandinistas set up Civil Defense Committees that acted as ad hoc local governments. In these "liberated" communities an effort was made not only to distribute food, water, and other essential supplies, but also basic health services. Local health volunteers, known as brigadistas de salud (health brigadiers) were recruited and trained. These were joined by numerous pre-existing promotores de salud who had been harassed or threatened by the National Guard, and hence gone underground.

In sum, it was the National Guard's collective punishment of liberated areas that provoked the Sandinistas to launch a new community-based health system led by local activists. Historically, this approach provided the foundation for strong popular participation in the remarkably effective "Jornadas de Salud" (national health campaigns) after Somoza was overthrown and the Sandinistas took over in July, 1979.

2. NICARAGUA FOLLOWING LIBERATION

In the period of transition following liberation, the new Sandinista government (FSLN) set about building a new, more people-centered Health Ministry. In working towards the goal of "Health for All", on a very limited budget, it recognized the importance the grassroots community based health movement had played in the revolutionary process. It started training more brigadistas, using the multiplier approach the FSLN had employed in the base communities. All brigadistas, after their training, were asked to share what they had learned with several new recruits. Those who proved capable teachers were graduated to the role of multiplicadores, or hands-on trainers. Also, People's Health Councils organized their local communities in Jornadas Populares de Salud (People's Health Days). These Jornadas were massive, country-wide mobilizations against major health problems, for which the entire population was called upon to participate. In 1980

an estimated 30,000 volunteers carried out a series of Jornadas to combat polio and measles (through mass immunization), dengue (by eliminating mosquito-breeding sites near homes), and various infectious diseases (through sanitation projects and garbage disposal). The Jornadas included public education campaigns, and home visits to immunize children whose families had not taken them to the neighborhood centers during the Health Days.



III. THE GROWTH OF SOLIDARITY

SOLIDARITY BUILDING BETWEEN PROGRAMS

A process of networking and solidarity-building, within countries and between countries, has been one of the most important, strategic outcomes of what became known as the Community Based Health Care Movement -- of which the Movimiento para la salud de los pueblos (People's Health Movement) has been its more recent and far-reaching accomplishment.

The network grew stage by stage in an organic, bottom-up way. In the early 1960s no serious networking existed. In Latin America there was only a handful of small isolated nongovernment community health programs. Each had arisen independently in response to overwhelming local needs. Most kept a low profile in order to survive under oppressive regimes. And most were unaware of each other's existence -- even when in neighboring areas. Contact between programs was minimal. But then, little by little, some of the programs began to discover one another, and communicate.

As an example, in the first years of Project Piaxtla in western Mexico, the villager-run health program I helped to start in the '60s, we were totally ignorant that any similar programs existed. We were in an isolated mountain area without electricity, and with only mule-trails connecting the villages. When I first wrote Donde No Hay Doctor in the early '70s, we never imagined it would ever be used beyond the wilds of the Sierra Madre. The first edition I wrote in the regional dialect of Spanish with a mix of local indigenous words. But somehow news of the handbook began to spread to other grassroots health programs I'd never heard of, in Mexico and beyond. Little by little, different programs began to communicate, share ideas, and eventually exchange visits.

SOLIDARITY ACROSS NATIONAL LINES

One of the more inspiring aspects of these grassroots struggles for health and liberation in Latin America has been the people-to-people solidarity that grew out of it -- across national borders.

For example, in sympathy with the guerrilla uprising for social justice and self-determination, a spectrum of idealistic volunteers from different countries went to El Salvador, where they risked their lives in support of the popular uprising. Among the best known on the medical front was the North American doctor, Charlie Clements. Formerly a US soldier in the Vietnam War, Charlie had seen the evil of his country's role in that war, and refused to participate further. Later, after becoming a doctor, he grew upset with the US support of the brutal dictatorship in El Salvador, and went there as medic and health educator with the guerilla forces. His experience is recorded in his book, Witness to War.

There are many such examples of cross-country solidarity at a personal or grassroots level. For instance, Project PROJIMO -- a Community Based Rehabilitation in Mexico that grew out of Project Piaxtla -- empathized with the marginalized villagers struggling for liberation in Guatemala. During the late '80s and early '90s the PROJIMO team arranged secretly to bring severely disabled guerillas from Guatemala to their backwoods center in Sinaloa, Mexico. There they provided free rehabilitation services and assistive devices. When rehabilitated, their disabled compañeros returned to Guatemala and the struggle.

In like manner, a young Mexican doctor, Carlos Miyazaki, spent three years in Salvador during the '80s, volunteering in the embattled and liberated villages. There he trained over 300 health promoters -- and provided each with a copy of Donde No Hay Doctor (Where There Is No Doctor). Currently Dr. Miyazaki runs La Clinical para los Pobres in Sinaloa, Mexico, and is enthusiastically cooperating with the PROJIMO children's wheelchair program, with which I am currently active. (The books, Disabled Village Children, and Nothing About Us Without Us grew out of the PROJIMO program.)

GRASSROOTS SHARING BETWEEN NICARAGUA AND MEXICO

During the long struggle for liberation in Nicaragua, brigadistas had used the two handbooks that grew out of Project Piaxtla in Mexico: Donde No Hay Doctor and Aprendiendo a Promover la Salud (Helping Health Workers Learn). The new Sandinista Health Ministry, MINSA -- wanting to apply the participatory methodologies presented in these handbooks -- sent a representative from the Ministry to visit the villager-run health program in the mountains of Mexico. Next, MINSA

invited a small group of the village health workers from Mexico to visit Nicaragua, to facilitate a workshop on their learning-by-doing methodology.

I had the good fortune to accompany these promotores from Mexico on this groundbreaking international exchange, held in Ciudad Sandino. It was an eventful workshop, attended by brigadistas and multiplicadores, where we all shared experiences and learned from each other. To facilitate community involvement in health, analyze underlying determinants, and explore practical alternatives for action, we used story-telling, role plays, "But why?" games, and a participatory "chain of causes," all of which will be described in more detail later.

A STUDY TRIP TO LEARN ABOUT OTHER PROGRAMS

Largely through the informal distribution of Donde No Hay Doctor, in the 1970s Project Piaxtla in Mexico made contact with an assortment of community health programs in Latin America. In 1974 a group of us from Piaxtla began to plan a study trip through Mexico, Central America, and the northern part of South America, to visit and exchange ideas with the various programs. The trip took place the following year. Financed on a shoestring, this informal study trip -- and the publications that grew out of it -- became a catalyst for the early networking process.

In a paper I wrote, The Village Health Worker – Lackey or Liberator? I describe some of our findings. I quote from this paper:

On the study trip a group of my co-workers and I visited nearly 40 rural health projects, both government and non-government, in nine Latin American countries (Mexico, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica, Venezuela, Colombia and Ecuador). Our objective was to encourage dialogue among the various groups, as well as to try to draw together many respective approaches, methods, insights and problems into a sort of field guide for health planners and educators, so we could all learn from each other's experience. We specifically chose to visit projects or programs which were making significant use of local, modestly trained health workers or which were reportedly trying to involve people more effectively in their own healthcare.

We were inspired by some of the things we saw, and profoundly disturbed by others. While in some of the projects we visited, people were in fact regarded as a resource to control disease, in others we had the sickening impression that disease was being used as a resource to control people. We began to look at different programs, and functions, in terms of where they lay along a continuum between two poles: community supportive and community oppressive.

- Community supportive programs or functions are those which favorably influence the long-range welfare of the community, that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision making

and self-reliance at the community level, that build upon human dignity.

- Community oppressive programs or functions are those which, while invariably giving lip service to the above aspects of community input, are fundamentally authoritarian, paternalistic or are structured and carried out in such a way that they effectively encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions; those which in the long run are crippling to the dynamics of the community.

It is disturbing to note that, with certain exceptions, the programs that we found to be more community supportive were small non-government efforts, usually operating on a shoestring and with a more or less sub-rosa status.

As for the large regional or national programs -- for all their international funding, top-ranking foreign consultants and glossy bilingual brochures portraying community participation -- we found that when it came down to the nitty-gritty of what was going on in the field, there was usually a minimum of effective community involvement and a maximum of dependency-creating handouts, paternalism and superimposed, initiative destroying norms.

The "Lackey or Liberator" paper also looks at the role of the community health worker in the different programs we visited. Key questions we asked were:

- What skills can the village health worker perform?
- How well does he or she perform them?
- What are the limiting factors that determine what he or she can do?

Again I quote:

We found that the skills that village health workers actually performed varied enormously from program to program. In some, local health workers with minimal formal education were able to perform with remarkable competence a wide variety of skills embracing both curative and preventive medicine as well as agricultural extension, village cooperatives and other aspects of community education and mobilization.

A good health promotor shares his knowledge with others

In other programs--often those sponsored by Health Departments--village workers were permitted to do discouragingly little. Safeguarding the medical profession's monopoly on curative medicine by using the standard argument that prevention is more important than cure (which it may be to us but clearly is not to a

mother when her child is sick) instructors often taught these health workers fewer medical skills than many villagers had already mastered for themselves. This sometimes so reduced the people's respect for their health worker that he (or usually she) became less effective, even in preventive measures.

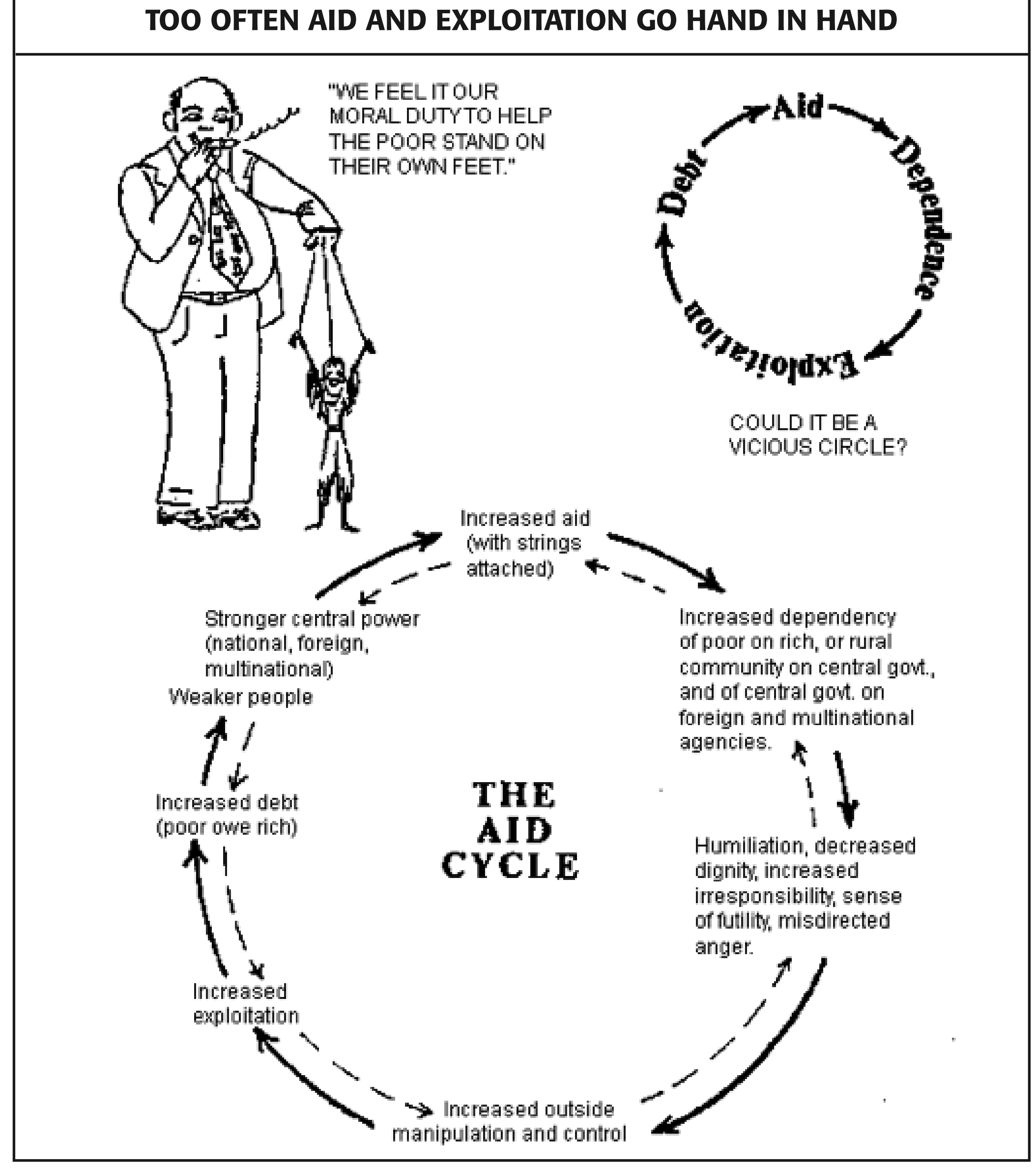
In the majority of cases, we found that external factors, far more than intrinsic factors, proved to be the determinants of what the primary health worker could do. [insert Outline 1 around here] We concluded that the great variation in range and type of skills performed by village health workers in different programs has less to do with the personal potentials, local conditions or available funding than it as to do with the preconceived attitudes and biases of heath program planners, consultants and instructors. In spite of the often-repeated eulogies about "primary decision making by the communities themselves," seldom do the villagers have much, if any, say in what their health worker is taught and told to do.

The limitations and potentials of the village health worker--what he is permitted to do and, conversely, what he could do if permitted--can best be understood if we look at his role in its social and political context. In Latin America, as in many other parts of the world, poor nu-

FACTORS THAT INFLUENCE WHAT A PRIMARY HEALTH WORKER CAN DO	
Intrinsic factors	**Extrinsic factors**
Factors influencing personal potential of VHW • cultural background • level of literacy influencing • personal factors: - compassion - integrity - judgment - initiative - perceptiveness - special talents - learning capacity Local conditions: • acceptance of VHW and program by community • health priorities within the community • available funding (from within the community)	Outside decisions and control. • attitudes, open or preconceived, as to what the VHW should be taught and permitted to do • length, content, quality and appropriateness of training • limitations of 'norms' imposed on health worker by outside authorities (e.g. Health Dept.) • ability or inability of instructors and supervisors to build upon the existing knowledge, skills and cultural perspectives of the VHW. • available funding (from outside the community)

trition, poor hygiene, low literacy and high fertility help account for the high morbidity and mortality of the impoverished masses. But as we all know, the underlying cause -- or more exactly, the primary disease -- is inequity: inequity of wealth, of land, of educational opportunity, of political representation and of basic human rights. Such inequities undermine the capacity of the peasantry for self care. As a result, the political/economic powers-that-be assume an increasingly paternalistic stand, under which the rural poor become the politically voiceless recipients of both aid and exploitation.

TOO OFTEN AID AND EXPLOITATION GO HAND IN HAND



In spite of national, foreign and international gestures at aid and development, in Latin America the rich continue to grow richer and the poor poorer. As anyone who has broken bread with villagers or slum dwellers knows only too well: health of the people is far more influenced by politics and power groups, by distribution of land and wealth, than it is by treatment or prevention of disease.

The paper concludes that, "Political factors unquestionably comprise one of the major obstacles to a community supportive program," In this context, we looked at the implications in the training and function of a primary health worker:

If the village health worker is taught a respectable range of skills, if he is encouraged to think, to take initiative and to keep learning on his own, if his judgment is respected, if his limits are determined by what he knows and can do, if his supervision is supportive and educational, chances are he will work with energy and dedication, will make a major contribution to his community and will win his people's confidence and love. His example will serve as a role model to his neighbors, that they too can learn new skills and assume new responsibilities, that self-improvement is possible. Thus the village health worker becomes an internal agent-of-change, not only for health care, but for the awakening of his people to their human potential. . . and ultimately to their human rights.

However, in countries where social and land reforms are sorely needed, where oppression of the poor and gross disparity of wealth is taken for granted, and where the medical and political establishments jealously covet their power, it is possible that the health worker I have just described knows and does and thinks too much. Such men are dangerous: They are the germ of social change.

So we find, in certain programs, a different breed of village health worker is being molded . . . one who is taught a pathetically limited range of skills, who is trained not to think, but to follow a list of very specific instructions or 'norms', who has a neat uniform, a handsome diploma and who works in a standardized cement block health post, whose supervision is restrictive and whose limitations are rigidly predefined. Such a health worker has a limited impact on the health and even less on the growth of the community. He--or more usually she--spends much of her time filling out forms.

NETWORKING: FROM NATIONAL TO REGIONAL

Through these study visits and the exchanges that began to develop, members of the grassroots, non-government "community supportive" programs recognized they had a lot in common, could learn much from each other, and be supportive of one another in difficult times. Associations and networks began to form.

The early associations were within a single country. In Mexico it was PRODUS-

SEP. In Guatemala, ASECSA. In Nicaragua, CISAS and PROSALUD. Soon national associations began to arrange international encuentros (encounters), out of which evolved a new sense of solidarity. It was clear that the social determinants of health were similar throughout Latin America. Some countries were nominally democracies and others were indisputably dictatorships. But in virtually every one a rich, powerful ruling class ran the government and wielded debilitating control over the impoverished majority. What was more, the oppressive heads of state often were put into power and propped up by the US government, and were in league with the powerful transnational corporations that had controlling interests in Latin American politics and business. In country after country, when the poor majority dared choose a leader who put the health and rights of the people above profiteering of transnational corporations, the US government-corporate complex overtly or covertly intervened. The CIA, through mercenary troops or military coups, assured the disposal of the progressive leader, replacing him with a business-friendly puppet-tyrant. With this agenda, the United Fruit Company helped engineer the overthrow of President Jacobo Arbenz in Guatemala, and the US Anaconda Copper industry engineered the assassination of elected president Salvador Allende in Chile and his replacement with the ruthless dictator Pinochet. The story is similar in country after country.

In the international encuentros of community health programs, as participants analyzed the root causes of poor health in their respective countries, it became painfully clear that an overriding determinant of health -- even in the smallest, most isolated village -- is the top-heavy global economic system, controlled by a very small but incredibly powerful ruling class. People in a remote village -- or even a small country -- can work collectively to improve local conditions affecting their health. But as our interconnected global crises -- political, economic, and environmental -- become more all-consuming, the need for a united worldwide popular front is even greater.

It was the common concern about social injustice as the mega-determinant of health that spurred the national associations in Mesoamerica to join forces. In 1975 a groundbreaking Encuentro was organized in Emaus, Guatemala. This gave birth to El Comité Regional de Promoción de Salud Comunitaria – or CRPSC (Regional Committee for Community Health Promotion) covering Mexico, Central America, and the Caribbean. The agenda of this new coalition was radical, in the sense that radical means getting to the roots. Everyone recognized that Health for All would only be possible though a collective people-centered effort -- both local and international -- to transform the dominant neoliberal socioeconomic system. The prevailing paradigm, designed to benefit the privileged few at huge human and environmental costs, has to yield to a harmonious approach that benefits all: a system that is truly democratic, egalitarian, and humane -- founded on universal human rights.

Was this a utopian dream that grew out of the rebellious '60s? Perhaps. But in the long haul, we all realized that the future of humanity -- indeed, the very sur-

vival of our species -- depends on transforming our current super-macho social order that caters to greed, to a gentler, more feminine order that answers to common needs. It depends on our achieving an all-inclusive egalitarian system in which we all live collectively and compassionately, for the common good.

REACHING OUT TO OTHER PARTS OF THE WORLD

Over time, the Regional Committee for Community Health Promotion (CRPSC) gradually expanded to include more countries of the Caribbean and representatives from programs in South America. Also they began to have exchanges with like-minded programs and networks in other parts of the world.

For example in 1980, Martín Reyes, one of the lead village health workers of Piaxtla, in Mexico, had a chance to visit India for an international health conference titled, "Let the Village Hear." As it turned out, Martín was one of only a few villagers present at the conference. Yet his impact was transformative: Martín stressed the need for more villagers to have a chance to speak up rather than to just be talked about -- the concept of "nothing about us without us." The conference closed with an official decision to change its theme from "Let the Village Hear" to "Let the Village Be Heard."

The following year, in August 1981, a unique interchange was arranged between village health workers from Central America and the Philippines. A group of health workers from programs in Guatemala, Honduras, and Mexico traveled to the Philippines, where they exchanged ideas with health workers in the country-wide network of Community Based Health Care programs there.

This interchange was a great stimulus for all of us, from both sides of the Pacific. We realized how much the countries of Latin America and the Philippines had in common, both historically and in the present: first the conquest and colonization by Spain, then neo-colonization by the United States. There were strong parallels between the rape of the land and the peasantry by United Fruit in the Americas,

and by Del Monte in the Philippines. In both cases the US military-corporate complex propped up dictators who bowed to its neoliberal agenda.

All in all, in the exchanges between health workers from distant lands -- and the "situational analyses" that they presented of their respective homelands -- engendered a new sense of international and intercontinental solidarity. By sharing stories of their similar sufferings and struggles, everyone could see that the major determinants of poor health, in all our countries, are rooted in the increasingly globalized, cruelly inequitable economic system. Clearly, the so-called "free market," despite its lip service to democratic process, is designed to favor the rich and powerful. Despite all the rich countries' token gestures of "international aid" and the non-binding mandates of the UN, the gulf between rich and poor has continued to widen between countries and within them. And despite the "Universal Declarations of Human Rights," the most basic rights are routinely violated with impunity -- especially the rights to adequate food and universal health care.

INTERNATIONAL NETWORKS AND GLOBAL CHALLENGES

As the social determinants of health became more central and overbearing, the network in Mesoamerica sought to extend communications and solidarity with parallel groups in other parts of the world. Over the years more far-reaching coalitions were formed, with much of the groundwork spearheaded by the Regional Committee and its associated organizations.

In the '70s and '80s, when the World Bank was forcing its neoliberal trade policies and Structural Adjustment down the throats of heavily indebted nations, the plight of the underclass and the harsh disciplinary measures by national rulers added fuel to the fire of popular resistance. In Latin America, the marginalized were mobilizing a struggle for liberation from their heavy-handed ruling classes.

In these popular struggles for liberation, the networks of grassroots community-based programs played a significant role. In some cases these struggles were successful -- at least temporarily. In a few countries the old plutocracies gave way to more democratic, more people-supportive governments. In others, the struggle for liberation appeared to be gaining ground.

In the Philippines, which has a lot in common with Latin America, there had long been smoldering resistance to the despotic US-supported Marcos government. At last Ferdinand Marcos was overthrown in the massive, largely non-violent, popular uprising called the "Revolution of Flowers." Thousands of people marched on the soldiers and put flowers in their guns. And the astounded soldiers listened to their hearts and sided with the people. ... But this didn't just happen out of nowhere. The Community Based Health Care Movement, whose health workers reached nearly every town and village,

had played a strong underground role in mobilizing and preparing the people. Numerous socially minded doctors, nurses and nuns, as well as community health workers, had been jailed or killed. But this had only strengthened the people's resolve. And at last the puppet dictator was ousted.

Of course the people's victory was only partial. The global power system corporate imperialism remains intact -- and soon a new group of puppet heads of states took control, It is a similar story in many parts of Earth. But at least the people are awakening, and the powers-that-be are increasingly on the defensive. A luta continua.

PARTIAL SETBACKS IN STRUGGLES FOR SOCIAL CHANGE

As already indicated, the country in Central America where the Liberation Struggle appeared most successful -- at least for a while -- was Nicaragua, where in 1979 the Sandinistas overthrew the Somoza dynasty. This was the shining success story of "poder popular" -- or power by the people. Through avid promotion of universal health care and countrywide campaigns to promote literacy and eradicate endemic diseases such as polio, malaria, and dengue, by the mid-'80s Nicaragua had achieved astounding improvements in the basic indicators of health (child survival, maternal mortality, greater life expectancy).

To celebrate and learn from these remarkable achievements -- and to examine the key role played by community mobilization in the struggle for change -- some of us in the Regional Committee, together with community health pioneers in other parts of the world, began to plan an international symposium. The event, called "Health Care in Societies in Transition," was planned for 1998 in Managua. We felt that those countries around the world engaged struggles for health and social justice had much to learn from Nicaragua. To this end we invited health activists from various countries where grassroots struggles for change were underway -- notably South Africa, India, Bangladesh, the Philippines, Palestine, and several Latin American countries.

The date originally set for the symposium -- 1988 -- was repeatedly postponed, until 1990. In those two disturbing years the global situation changed, in some ways for the worse. The Nicaraguan victory had threatened to demonstrate that an alternative model to the one advocated by the global elite could work well and provide far superior health, welfare and educational opportunities to the people. Although Nicaragua is only a small country, such a demonstration could have far reaching consequence. This could not be tolerated by the global elite, and it had to be undermined at all costs. So the United States, under Ronald Reagan, initiated economic embargos and a program of counter-revolutionary terrorism carried out by the Contras. These actions were clearly in violation of a variety of international laws:

- The Nuremberg Principles.
- The United Nations Charter.
- The Inter-American Treaty of Reciprocal Assistance (Rio Pact).
- Rome Statute of the International Criminal Court.

It is a strange world, indeed, when simply asking that the United States comply with international law must be seen as radical. Beyond this it is worth noting that the Contra's were largely financed by the laundering of weapons sales through the Middle East that came to be known as the Iran-Contra scandal.

It is important to see this attack on Nicaragua and other central and south American countries in the larger context of the world economic system. The current economic system that is centered in the United States and dominated by multinational banks and corporations has placed the collective health and survival of humanity in graver danger than ever before. It would be absurd to expect that an economic system that is motivated by greed, organized for domination, and inadequately regulated should paradoxically provide for the health and wellbeing of the planet and its people. To the contrary, this system now threatens the wellbeing and the very existence of our species because of the Pandora's box of problems that it has created:

- the growing gap between rich and poor
- the eroding of what little there was of democratic process
- the growing toll on health through the withdrawal of public systems of health and welfare
- the endless conventional war and the threat of nuclear war
- economic meltdowns
- the use of the mass media to distract and misinform the people through the merging of news, propaganda and entertainment
- the damage to our food system though the unregulated and experimental creation of genetically engineered crops
- a growing shortage of clean water
- the turning of our environment into a carcinogenic pool by nuclear and chemical wastes we cannot dispose of peak oil
- the unbridled exploitation of non-renewable energy resources

and, last but not least -- as the result of all this ever-increasing exploitation of people and the environment, looms the biggest threat to humanity and to life on the planet: **GLOBAL WARMING**.

The enormity and interaction of these crises leads to pandemic despair and violence. It is a Pandora's box full of horrors. We are fast approaching a turning point where there may be no turning back. Yet the world's top politicians, bought off or intimidated by the multinational banks and corporations, have no interest in taking the radical steps that are needed.

The overall influence of the Catholic church also played its part in rolling back some of the gains we saw in Nicaragua and elsewhere, though the facts here are complex. The Church became divided between the traditionalists who stood up

for the top-heavy status quo, and the Theology of Liberation, which followed the teachings of Christ by siding with the oppressed. Many priests and nuns, motivated by the theology of liberation, stood up as powerful voices for a more just social order, and for their courageous stands some paid with their lives. Yet, it seems clear that the church hierarchy was at best lukewarm with regard to people's struggles for their rights.

In Nicaragua, the institutionalized terrorism perpetrated by the United States, the embargo and other more sophisticated strategies of social control took their toll. In 1990 --shortly before the symposium finally took place, the Sandinistas were voted out, and the conservative UNO coalition party, propped up by the CIA, took power. It was a familiar story of US imperialism. The US had made it clear that the devastating "counter-revolution" would continue until the Sandinistas fell. The Nicaraguan population, exhausted by the endless mercenary violence and duped by UNO's false promises, finally gave in and voted yes for defeat.

Once UNO was in power, many of the inequities of the old regime resurfaced. Public services were cut back, medical care was privatized, and health statistics deteriorated accordingly. This can be seen on the graph in the next page.

So the long-awaited Symposium on Health in Societies in Transition, initially planned to explore positive transitions toward more equitable, health-promoting governance, was instead revised toward analyzing the current negative transitions, and to strategize on how to preserve whatever gains had been made before the tides turned and things regressed in an unhealthy direction.

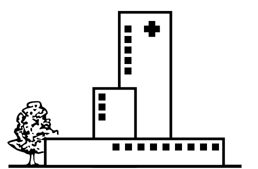
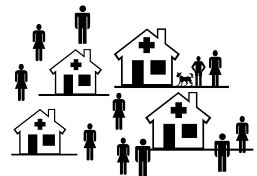
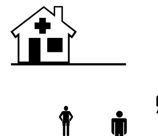
For all these troubling reversals, the Managua Symposium broke new ground. There was penetrating analysis, and solid proposals for local and international action. Through the open exchange among health activists from Asia, Africa, the Middle East, and the Americas -- the similarity of problems faced in different corners of the Earth was unmistakable. A strong sense of denationalized solidarity emerged. During the closure, the group agreed that the exchange that had begun needed to continue and expand. To this end they formed a new intercontinental coalition, called the "International People's Health Council" (IPHC).

During the 1990s the IPHC arranged periodic international gatherings, held in South Africa, Palestine, Europe, and Australia. Conjointly it facilitated short courses on topics such as Health Education for Change, Child-to-Child activities, grassroots organization, and other action-oriented topics.

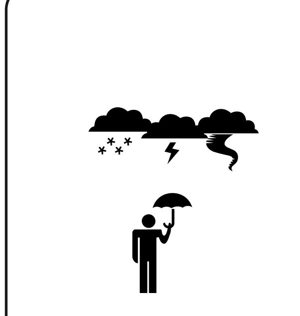
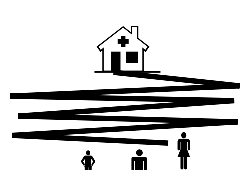
Towards the end of the 20th Century, key players in the IPHC and the Regional Committee, together with other national and international health networks, began to plan of a turn-of-the-century global conference, named the People's Health Assembly. This was held at Gonashasthaya Kendra in Bangladesh in December, 2000. The "PHA" was attended by over 1400 health workers and activists from more than 70 countries. Out of this groundbreaking Assembly emerged the ongoing Peoples Health Movement (PHM), which has held subsequent assemblies in South Africa and here in Ecuador.

SOMOZA	SANDINISTAS	CHAMORRO

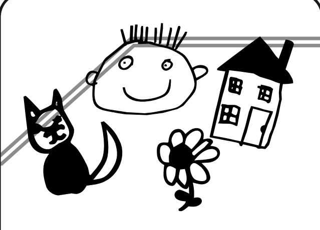
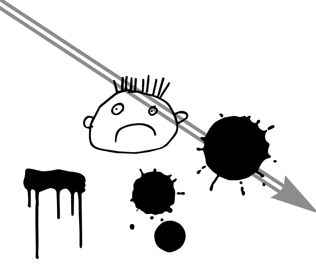
CURATIVE ASPECTS

CONSERVATIVE Doctors and hospitals for urban rich	**REVOLUTIONARY** People based rural and community health posts	**MARKET ORIENTED** Neoliberal, many health posts closed down
		
Too costly and inaccessible for the poor majority	Free services accesible to almost all	privatization and cost recovery put services out of reach

PREVENTIVE SERVICES

		Preventive work desired...
		
Did very little preventive work	Excellent preventive campaigns	...but unable to mobilize people

IMPACT ON HEALTH

		
Poor health and very high child mortality	Rapid health improvement and fall in child mortality	Stagnation and reversals in healt and child mortality

Currently -- with thousands of members, a diversity of national and regional programs, numerous watchdog groups, and a foot in the door of the World Health Assembly -- the PHM now adds a sobering "voice of the people" to the discussions of the world's top planners and decision-makers in health-related concerns. And -- as all of us here know -- a regional arm of the PHM is El Movimiento para la Salud del Pueblo-America Latina (MPS-LA), now engaged in its first international conference, in which we are gathered.

I.

NEED FOR EVOLUTION AS PART OF REVOLUTION

Unfortunately, the high expectations for healthier, more fully democratic rule following the overthrow of oppressive regimes in the late 20th century often turned to bitter disappointment. In Nicaragua after Somoza, in the Philippines after Marcos, and in South Africa after liberation from apartheid rule, people's hope for radical change was high. But within a few years reversals took place, back toward the top-down, cruelly polarized social order of before. Even for a revolutionary as visionary as Nelson Mandela, the overarching power of the globalized plutocracy was just too much.

What is more, with the victories over the old regimes in the late 1900s, and the global dream of Primary Health Care for All by the Year 2000, subscribed to by all members of the United Nations, many of the popular organizations and community health programs let down their guard. Many of the long-struggling grassroots health programs quietly disappeared, or were absorbed by new government extension services with such progressive-sounding names as, in Mexico, "Seguro Popular," and "Solidaridad."

What can we learn from the fact that so many "Struggles for Liberation," after overcoming oppressive regimes, gradually slip back to the old pecking order, with a new batch of tyrants rising to the top? The chief lesson, perhaps, is that revolution without evolution doesn't change much -- or at least not for long. If we are looking for radical change of governance, we have first to build a radical change in the way ordinary people see themselves in relation to other people and natural world. And much of this has to do with the way they are taught, from the time they are children. For this reason, if we as a people are to advance, through transformational evolutionary struggle, toward a healthier, kinder, more sustainable social order, we need to start with our children -- and specifically, with how they learn.

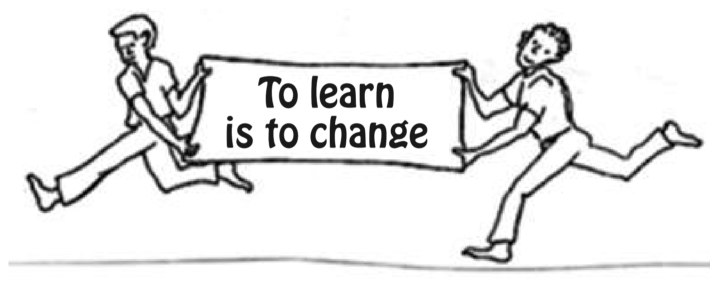
IV. HEALTH EDUCATION FOR CHANGE

This historical sketch of the Struggle for Health in Latin America would not be complete without underscoring the methodology of "Liberating Health Education" which evolved as part of the movement.

In today's polarized society, "education" is a two-edged sword. A better name might be "Indoctrination," or "Obedience Training." A major purpose of public schooling, as it exists today, is to condition young people to follow rules and obey laws, no matter how just or unjust. It is to mold students into subservient workers willing to do repetitive tasks for miserable wages under orders of a commanding patron. The need to prep children for such degrading jobs perhaps explains why schooling tends to be so boring and authoritarian. Rather than encouraging youth to think independently, or analyze their life situation, they are compelled to memorize heaps of dates and data, regardless of how true or useful. What passes for "Education" has become the science of turning young people into smoothly oiled wheels of a heartless machine that churns out more wealth and power for the rich and powerful. This kind of "education" is an instrument of social control. Of institutionalized oppression.

But education needn't be like this. It can be an instrument of liberation. Indeed, an empowering approach to learning is essential to any grassroots movement for a fairer, healthier social order.

Latin America has been a leader in developing an approach to education that is potentially liberating -- in the sense that it helps people figure out the underlying determinants of health and work together to improve their situation. Key to a liberating approach to learning -- or "Education for Change" -- is the rea-



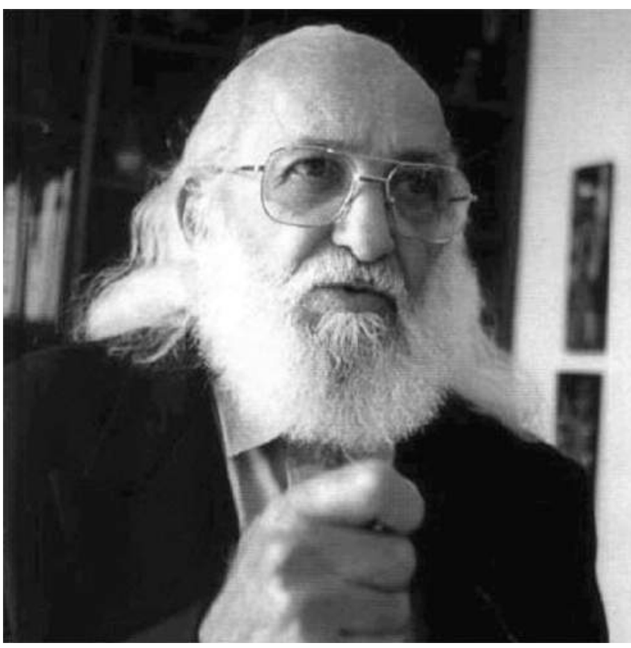
lization that everyone has valuable knowledge and experience, and that we can all learn from one another other, as equals.

The most well-known proponent of Education for Change in the last century was the Brazilian adult-literacy facilitator, Paulo Freire. Freire's classic book, Pedagogy of the Oppressed, revolutionized the methodology of information sharing and "concientización" (awareness raising) in community-action movements worldwide.

As many of you may already know, Freire describes two of kinds of education.

The first is the "banking" approach, where an all-knowing authority deposits ideas into his or her pupils' empty heads.

The second is the "liberating" approach, where the facilitator pulls ideas out of the heads of the learners, and helps them build on their own observations and experience.

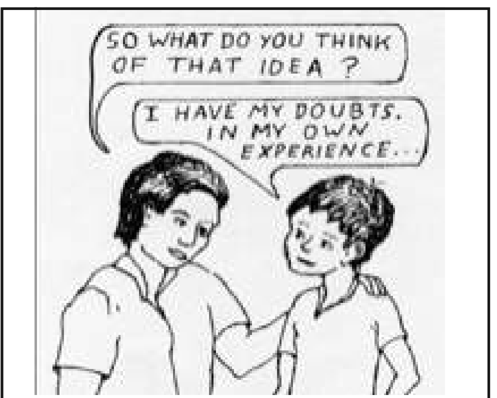


PAULO FREIRE

In the "learning for change" approach advocated by Freire, everyone's ideas and experience matter. Everyone learns from each other. People collectively analyze the situation in which they live, discuss their common problems, and examine the underlying causes. Then they plan a collective course of action, carefully weighing the potential risks and benefits. Freire insisted that through such an awareness-raising, action-oriented process, a self-empowered group of people can "change the world."

In Latin America, the Philippines, and elsewhere, health workers have adapted Paulo Freire's ideas to community health education. Through trial and error, they have come up with their own approaches to collectively analyzing health-related needs, figuring out solutions, and accommodating them to the local situation.

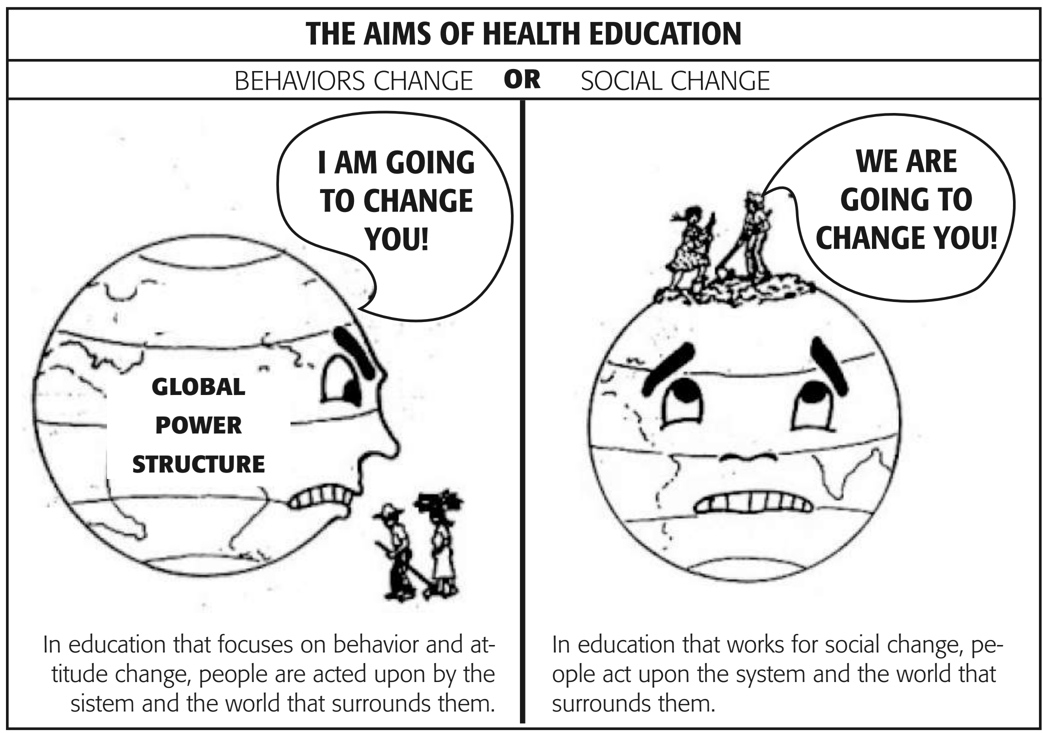
EDUCATION OF AUTHORITY
putting ideas in



EDUCATION FOR CHANGE
pulling ideas out

THE AIMS OF HEALTH EDUCATION

BEHAVIORS CHANGE **OR** SOCIAL CHANGE

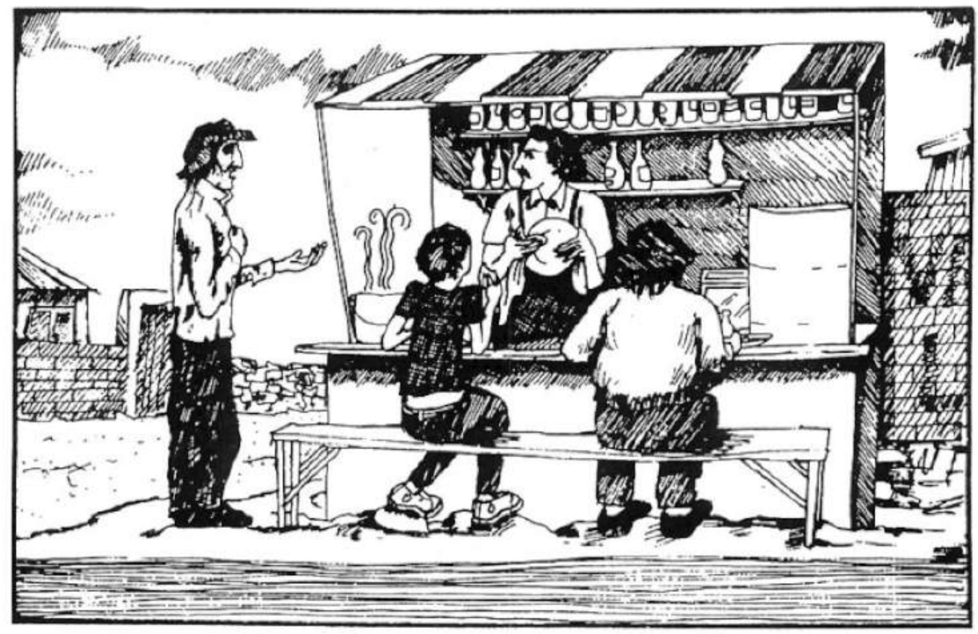


In education that focuses on behavior and attitude change, people are acted upon by the sistem and the world that surrounds them.

In education that works for social change, people act upon the system and the world that surrounds them.

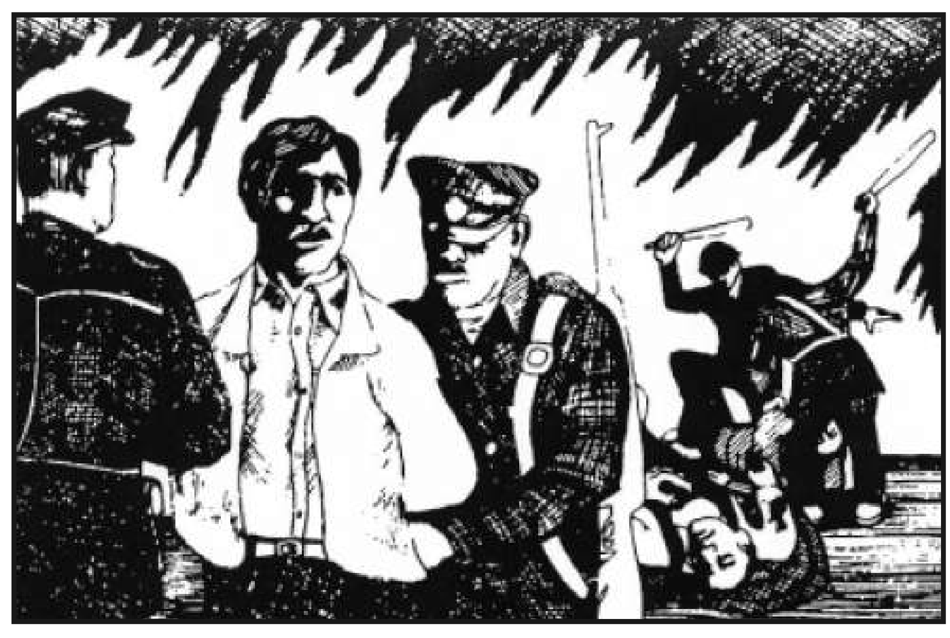
In Guatemala, Nicaragua, Chile, and Mexico, health educators experimented with "key pictures" as community "discussion starters" to get people talking about concerns that affect their well-being. For this purpose, Freire had advocated "key words." But health promoters found that a provocative picture could often stimulate group discussion or major concern more effectively. Here are examples of "pictorial discussion starters" used in the huge slum community of Netzahuacoyotl on the outskirts of Mexico City, where high cost of food, and heavy-handed abuse by authorities, are seen as major obstacles to well-being.

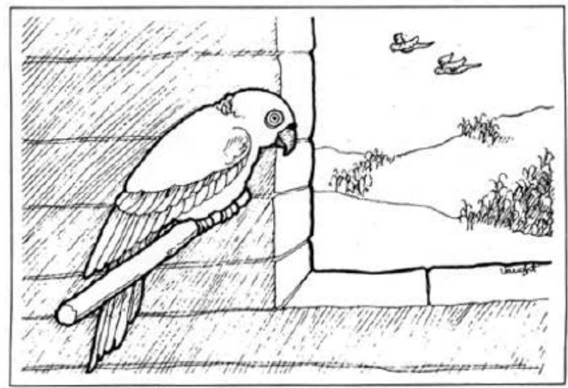
HUNGER



WHY IS THERE HUNGER? WHAT CAN WE DO TO END IT?

TELEVISION





A good example is the "parrot picture" -- a drawing I first saw used in the Behrhorst Hospitalito in Guatemala (used as a discussion-starter by our fellow health educator, María Zuniga)

The facilitator starts by asking something like, "What do you see in this picture?" and perhaps, "Why doesn't the parrot fly away?" Usually this triggers a lively discussion that leads to questions about the psycho-social disempowerment of los de abajo (the underclass) as a strategy of behavioral training and social control. At some point the facilitator may want to ask, "In what ways is this parrot like us?" but usually the question comes from the group. The facilitator must take care to let participants take the discussion where they choose: that is, to pull ideas out rather than push them in.

This parrot picture has proved to be one of the most provocative discussion starters, to get disadvantaged people talking about their hardships, underlying causes, and how to gain more of a voice in the factors that determine their health and their lives.

A.

THE MEASLES MONSTER

At the same time as this workshop, MINSA had organized a vast national immunization Jornada against measles. They asked us, in the workshop, to explore ways to get the people more involved and less suspicious. In those days a big obstacle to effective immunization was a disinformation campaign triggered by the United States Central Intelligence Agency. The CIA had funded various conservative evangelical groups and private US charities to spread rumors throughout Nicaragua that "vaccination causes sterilization and impotency." (To prove this, they pointed out the word "sterilized" on vials of distilled water used with the vaccines.) So lots of people were afraid to immunize their children.

To counter this malicious disinformation and educate people about the lifesaving importance of vaccination, workshop participants involved the local community in creating a street theater skit called "The Measles Monster."

The skit opens with a huge, fearsome monster chasing after and infecting unvaccinated children (photo 1).

PHOTO 1

One sick child nearly dies. But when his parents discover that the rumors about sterilization are lies, they insist that all children be vaccinated.(photo 2).

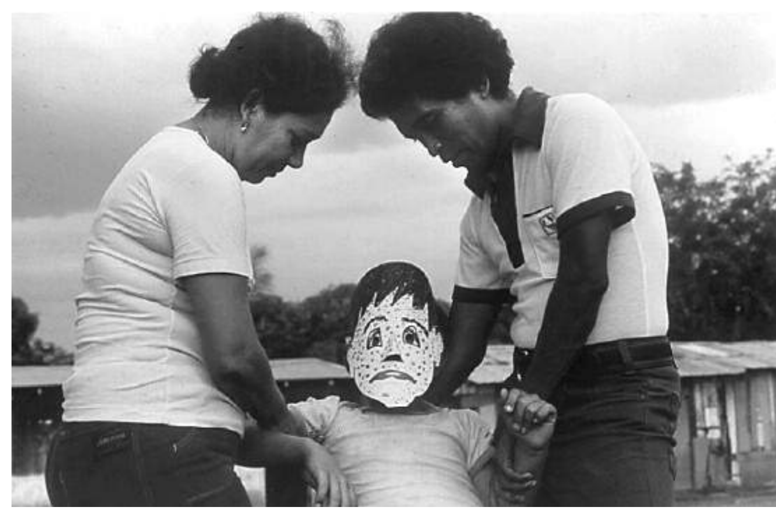


PHOTO 2

Then a large group of children -- now protected and strengthened by the vaccine -- attack and overcome the Measles Monster. At the close of the skit, the jubilant children cry out, "¡Los niños unidos jamás serán vencidos!" (The children united shall not be overcome!) (photo 3).

PHOTO 3

The skit of "The Measles Monster" -- which is included in the Spanish edition of Helping Health Workers Learn -- has been enacted or adapted to local themes and circumstances in many countries. The process of community empowerment is contagious.

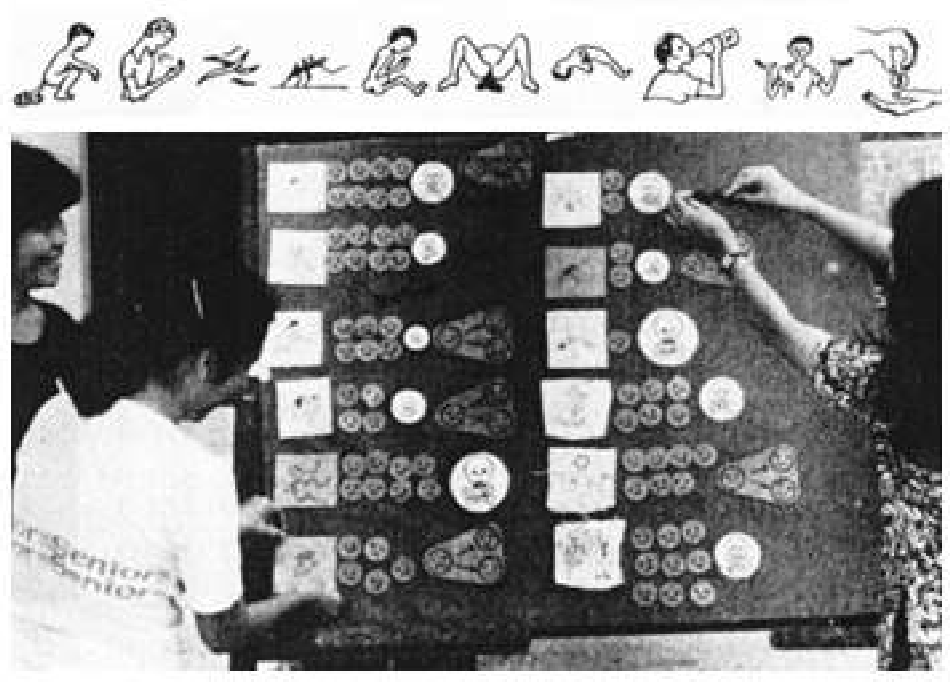
B.

COMMUNITY DIAGNOSIS

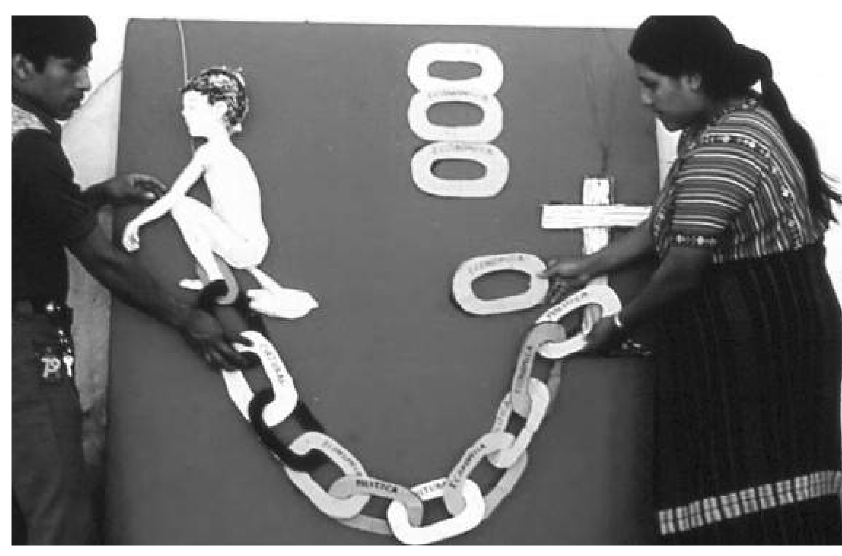
Different programs used different methods to help people analyze their health-related needs and explore solutions. To engage groups of farm workers, mothers, or schoolchildren in a "situational analysis," many promotores begin with a "Community Diagnosis."

The group identifies their common health-related problems, which they label according to Frequency, Severity, Contagion, and Duration. Next they look at which problems contribute to other problems, and how.

For all this they use pictures, because pictures speak louder than words, and because with pictures, people who can't read or write can participate equally. Participants make their own simple drawings to create a colorful display of their Community Diagnosis. Finally they discuss which problems they should try to attack first, and try to develop a plan of action. Because the activity is so visual and hands-on, nearly everybody gets involved. It is an eye-opening, action-oriented learning experience ... and lots of fun.



STORYTELLING, THE 'BUT WHY?' GAME AND THE 'CHAIN OF CAUSES'



One widely used method to help people learn about interrelated causes of different health problems uses storytelling, followed by a "But why?" game, and the creation of a "chain of causes." First, a true story is told, perhaps about the recent death of a child. Into the story is built a whole series of causes, one leading to the next. After the story is told, the learning group retells it backwards, and each time a cause is stated, everyone asks, "But why?"

The process is in four parts:

1. The story relates a series of events that lead to a tragic ending, such as the death of a child. (People's attention is captured better if it is based on a recent, local sequence of events everyone is familiar with.)
2. After the story, participants play a (very serious) 'But why?' game, in which they itemize and analyze the series of factors leading up to the child's death
3. Next, they collectively build a Chain of causes leading the sick child to the grave. To make this more lively and "hands on," the links of the chain, as well as a graphic of the child and the grave, can be cut out of cardboard.

The links, labeled with symbolic drawings, initially represented 5 types of causes:

- physical (things)
- biological (worms and germs)
- cultural (beliefs and attitudes)
- economic (having to do with money and who has it)
- political (having to do with power and who has it)

To these five categories of causes, we later added a 6th type ...

- environmental (having to do with ecological balance)

This extra link for environmental causes was added because disturbances in ecological balance have become such a major threat to health, locally and globally, in recent times.

4. Finally, the group explores which links of the causal chain they may be able to break in order to prevent similar loss of health and life in the future. They ask themselves:

   - Which links can be broken by the committed action of a single person?
   - Which links require action at the family or village level?
   - Which require action at a national level? At a global level?
   - What is the likelihood of successfully breaking different links?
   - What preparations and resources are needed? What are the risks?
   - With which links can we most effectively begin to take action?'

In our handbook, Helping Health Workers Learn, the 'Chain of Causes' is presented through the "Story of Luis," a child in a Mexican village who died of tetanus in the early years of Project Piaxtla, when immunization of children was just being introduced. The story points out how questions of land tenure, share-cropping, flooding due to deforestation, failures in the health system, institutionalized corruption, and the profiteering of drug companies all contribute to the causal chain leading to Luis' death.

Through such graphic dissection of the complex chain (or web) of causes leading to one child's tragic death, the community gains a broad view of the contributing factors. Then they can begin to formulate a realistic plan of which links they can first try to break, and what kind of preparation and action is required. And as we have all learned the hard way, weighing possible risks against benefits is essential

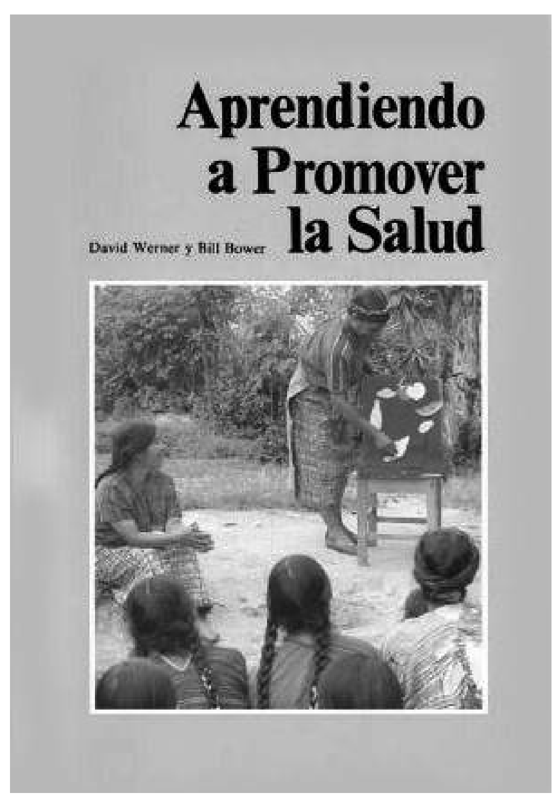
DISCOVERY BASED LEARNING

The "Chain of Causes" is one of the many methods we health educators call "Discovery Based Learning," an approach pioneered in the community based programs in Latin America, and elsewhere. Such methods are in tune with Freire's "Education of Liberation" because people critically analyze the interlinking determinates of health and then embark on a reasoned plan of action.

As mentioned, a selection of these "discovery based" methods is included in Helping Health Workers Learn, a follow-up handbook to Donde No Hay Doctor. The idea for this latter book came from the previously mentioned study trip a group of us from Project Piaxtla, in Mexico, took to visit community health programs in Latin America. In the different programs, we saw marvelous examples of health education tools addressing a wide range of health-related problems. Everyone, at least in the community supportive programs we visited, was interested in sharing ideas and learning more.

So we decided to pull together a collection of "Education for Change" learning methods and publish them for anyone to draw on. However, this turned out to be easier said than done. To facilitate the sharing of methods and ideas, at the center of our village health program (Piaxtla) in the village of Ajoya, we organized a series of Intercambios Educativos (Educational Exchanges). To these we invited health promoters from the various countries in Mesoamerica. Our challenge was not just to have participants demonstrate existing methods, but to encourage and develop creativity: to invent new methods and learning aids.

So first we asked folks from different countries to demonstrate one of their most unique and successful teaching methods or materials. Next everyone commented on the strengths and weaknesses of what they'd seen. And finally, we'd divide into small groups, each with participants from different countries. Each group would then try to improve one of the methods or aids they had seen, or use the method as a launching pad for a new and different approach.



The outcome was a wealth of exiting methods, games, devices, and ideas -- many of them highly participatory, analytical, and thought-provoking -- aimed at collective action to cope with or correct common health-related concerns. Helping Health Workers Learn contains a distillation of these methods, together with examples from health initiatives in different parts of the world. Throughout the book, there is strong emphasis on the social determinants of health. In fact, the introduction is titled "Why this book is so political," because it is so clear that "The struggle for health is the struggle for social justice."

E.

CHILD-TO-CHILD

Speaking of Education for Change, I would like draw your attention to what for me has one of the most exciting developments to emerge out of the people-centered struggle for health. I speak of the Child-to-Child initiative, in which Latin America has played a key and in some ways revolutionary role.

The Child-to-Child concept did not originate in the Americas. It grew out of an international gathering of health educators in 1979, convened by David Morley, a pediatrician with long experience in rural Africa, and a leading pioneer in Primary Health Care. I had the good fortune to attend this seminal meeting. The idea for Child-to-Child emerged from the fact that in very poor families often the persons who spend most time caring for babies and toddlers are not the parents, who often are gone from dawn to dark working to feed the family. Rather, the primary care providers tend to be the infants' somewhat older brothers and sisters. Often young children, especially girls, are kept out of school because they are

> "If in truth we are going to achieve peace in this world, we will have to begin with the children".
>
> Mahatma Gandhi

To transform the world we first need to transform the educational system.

needed to care for their younger siblings while their mother is working.

So the original goal of Child-to-Child was to help school-aged children -- whether or not they go to school -- to learn to play an active role in protecting the health and stimulating the development of their

younger brothers and sisters. A variety of Child-to-Child "activity sheets" were developed to help children learn preventive, and curative skills regarding the health of young children. In some cases these skills were life-saving Early activities addressed topics such as diarrhea, lowering fever, getting enough to eat, cleanliness, prevention of accidents, and so on.

Since its modest start, the concept of Child-to-Child -- now practiced in more than 70 countries -- has expanded in a number ways. In many programs, schoolchildren in older grades are now involved in teaching Child-to-Child skills to those in younger grades. And the range of activities has grown. Now children not only help meet the health needs of younger siblings, but play a role in community activities, ranging from home gardens, to tree planting, to recycling garbage as fertilizer, to care of the elderly.

From the first, the teaching methods advocated for Child-to-Child were "child centered": they relied on things the child could see and touch, they engaged the child's active participation, they encouraged thinking and exploration, and they were fun. But in practice -- particularly in schools -- too often the teaching style was still very didactic and top down: "Do

THESE CHILDREN ARE THE PRIMARY CARETAKERS OF THESE BABIES. **A:** This girl manages to take good care of her baby sister. **B:** This girl has not managed to take Good care of her baby brother.

this! Do That!" Children were simply asked to memorize things and told what to do, As ever, teachers pushed ideas into the children's heads, rather than encouraging them to build on their own experiences and observations.

This is where Latin America has made its big contribution to Child-to-Child, helping to transform it from an useful but fairly orthodox teaching tool to a liberating learning experience. The transformative potential of Child-to-Child should not be underestimated, either for children or for schools. Standard schooling, as the "Schoolboys of Barbiana" describe, is too often "a war against the children of the poor." It teaches the young to follow orders, to compete against each other, and to memorize and vomit back boring information -- or misinformation -- that has little to do with their day-to-day needs and lives. It challenges them to pass exams, rather than to think for themselves.

By contrast, Child-to-Child, in its more liberating form, encourages children make their own observations, draw their own conclusions, and take collective action to solve problems in their own homes and communities. Thus Child-to-Child, when practiced in the schools, can help make schooling more relevant to their lives.

Latin America, as the leader in this liberating, discovery-based approach to Child-to-Child, has begun to disseminate it to other parts of the world. Project Piaxtla, the village health program in Mexico, played a key role in developing the early Child-to-Child "Activity Sheets," which were then translated and distributed internationally. In the early '80s, a lead promotor in Piaxtla was Martín Reyes, who loved the concept of Child-to-Child because, as a boy, he'd begun volunteering in the program. So Martín facilitated the early trials of various activities. As a teacher of health workers, he was well versed in the facilitation of "discovery based learning," and he built this empowering methodology into the Child-to-Child activities he helped develop.

NIÑO A NIÑO EN LATINOAMÉRICA

Los niños como agentes de cambio.

Los niños aprenden a:

- **Pensar por sí mismos**.
- **Incluir a todos**; no excluir a nadie.
- **Defender a los** que son **más débiles o despreciados**.
- Hacer sus **propias observaciones** y llegar a sus **propias conclusiones.**
- Analizar sus **problemas comunes** y **trabajar juntos** para resolverlos.
- Más cooperación, menos competencia: **buscar soluciones juntos**.

The Regional Committee of Community Health Promotion, helped spread Child-to-Child methods to other countries and programs. A big boost came when Martín won an Ashoka Fellowship, to promote Child-to-Child through Latin America. Our compañera Maria Zuniga, coordinator of the Regional Committee, helped Martín set up a base at CISAS (Centro de Información y Servicios de Asesoría en Salud) in Nicaragua. For 5 years he led workshops for future Child-to-Child facilitators throughout the region. In these training workshops, Martín always insisted on having children participate. That way, the future facilitators would learn though hands-on practice, not just theory ... and would learn not just about children, but with them and from them.

To begin the Child-to-Child experience with a group, Martín likes to start by having the kids conduct their own interactive "Community Diagnosis," using colorful pictures they make themselves.

This helps the kids look at "the larger picture of sickness and health" in their village and to visualize how the various health problems are linked together. Often, based on their findings, the children choose which health problem about which they want learn first, and about which they wanted to explore possible solutions.

The children begin by doing their own community diagnosis

F.

EXAMPLE OF CHILD-TO-CHILD DISCOVERY BASED LEARNING: THE GOURD BABY

When village children discuss the most troublesome health problems in their own home, diarrhea often tops the list. And with good reason. Worldwide, diarrhea remains a top killer of young children, along with pneumonia, especially in impoverished families with insufficient food and sanitation. Notable, however, in some places where Child-to-Child is practiced, mortality from diarrhea has dropped amazingly.

So let's take a look at the Child-to-Child activity on diarrhea, and see how the discovery-based learning as practiced here in Latin America can make a real difference.

The first version of the Diarrhea activity sheet, developed in Africa, had some good features. It used clear graphics and simple language. To teach children about dehydration, it showed drawings of a bowl with a hole in the bottom. When the hole was plugged, the bowl stayed full of water. When the plug was pulled, the water ran out. The children were told that the bowl represents a baby. "When a baby loses too much water, it dries up and dies." The next thing the on the activity sheet was a list, with pictures, showing the Signs of Dehydration: sunken soft spot, no tears, dry mouth, scant urine, etc. The children were instructed to memorize these signs.

The problem with this activity sheet was the teaching method. For all its colorful images, it was still top-down and didactic. Information flowed one way: from teacher to student.

There is an old saying: If I hear it, I forget it; if I see it, I remember it; if I do it, i know it.

To this, health educators in Latin America have added:

If I hear it, I forget it.

If I see it, I remember it.

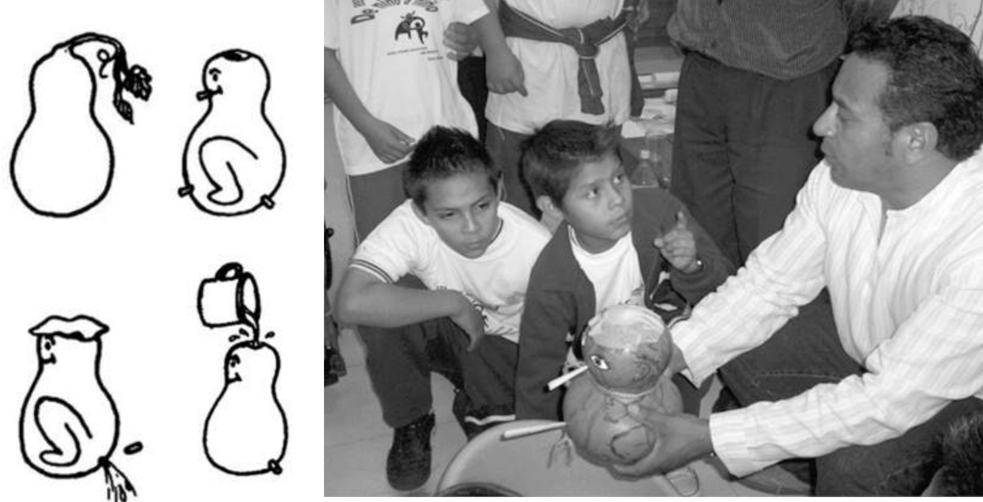
if I do it, i know it.

¡ If I discover it, I use it!

¡ If I discover it, I use it!

With this in mind, the health workers in Mexico came up with a teaching aid called the "Gourd Baby." They used a double-knobbed gourd: the kind farmers use to carry water. With the children's help, they painted the gourd like a baby ... and put all the holes in it that a real baby has. By filling the it with water, children can pull the plug in its backside to give it diarrhea ... and observe what happens.

This way they discover for themselves how the different signs of water loss -- or dehydration -- develop.



En el Estado de Michoacán, México, se introdujo el aprendizaje de la deshidratación con el "bebé calabaza" en el currículo de la educación primaria.

To learn if such water loss can be dangerous, they can pick some flowers in the schoolyard, put one flower in a bottle with water and the other in a bottle without water, and leave them in the hot sun for a couple of hours. They see that the flower in water stays healthy, while the one without water wilts and dies.

Good thinking!

To find out how much water a baby with diarrhea needs, again the children fill the gourd with water, and pull the plug. One child measures in cupfuls how much comes out. Another pours cupfuls of water into the top of the gourd. Half the class counts how many cupfuls come out. The other half counts how many are poured back in. In this way, the children conclude they have to put in at least as much liquid as comes out.

"So what do you suppose happens when a baby loses a lot of water through diarrhea?" the teacher asks?

"Maybe she wilts and dies, too," say the children.

"And how could you prevent that?" asks the teacher.

"By giving the baby lots of water!"

This direct observation is crucial -- because researchers have found that a big reason why oral rehydration sometimes fails is that caretakers often don't give enough of the solution. But when children learn these things through their own observations, they are more likely to put them to into practice. This can quite literally save lives: it empowers the children to think for themselves and take intelligent action.

The idea of the gourd baby has caught on around the world. CISAS, in Nicaragua, even uses the gourd baby as its logo.

Here is a photo of a local "gourd baby" in East Timor -- which health workers made by gluing two coconuts together!

Today in Timor, this "coconut baby" is being used not only to teach children and mothers about oral rehydration, but also to help health-workers and schoolteachers learn about the empowering potential of discovery-based learning.

In Bangladesh, too, the idea of the gourd baby has been widely used to teach schoolchildren about home management of diarrhea. The method was first introduced as part of the Child-to-Child experience by a groundbreaking community health program named Gonoshasthaya Kendra -- or "GK" -- in the township of Savar. Health workers there had learned about the liberating approach to Child-to-Child through exchange with programs in Latin America. In schools associated with GK, pupils in the upper grades of primary school teach the younger grades about management of diarrhea and dehydration, using a painted plastic bottle instead of gourd.

"Bebé calabaza" hecho con dos cocos pegados en Timor Este.

Bangla children teach each other about diarrea

They use a plastic bottle for the gourd baby

The children shared what they learned with their families. And in the evenings they taught neighboring children who were too poor to go to school. Through the spread of knowledge in this convivial way, and by the use of homemade rehydration drinks instead of commercial ones, in GK's area of coverage the death rate from diarrhea fell remarkably. Eventually the Ministry of Education, impressed by GK's carefully documented achievement, introduced the Child-to-Child diarrhea activity into the national school system. But because double-knobbed gourds are rare in Bangladesh (as in Timor) the Ministry mass-produced baby-shaped plastic sacks with all the necessary holes and plugs, so children could learn through the hands-on approach.

Over the following years in Bangladesh there was a dramatic reduction in child mortality from diarrhea. The diarrheal death rate in Under-5s fell to less 20% of what it had been 6 years before! This huge drop lowered overall child mortality so much that Bangladesh -- which used to have among the highest child mortality in the world -- is now showcased by WHO as an example of "Good Health at Low Cost."

Clearly other factors have contributed to this impressive fall in child deaths in Bangladesh. But there is little doubt that the introduction of this empowering methodology throughout the country's schools has contributed to popular understanding of home-based diarrhea management that has helped save hundreds of thousands of children's lives. Another reason for these remarkable gains, I suspect, is that Bangladesh has one of the most extensive networks of well trained, politically aware community health workers in the world.

There are countless examples of how children, through this discovery based learning process, have helped save babies lives, even when they have been left at home as sole caretakers. I used to say, with tongue in cheek, that, "If all the world's children could learn how to manage infant diarrhea from the gourd baby, then

the gourd baby -- with the children's help -- could save more babies lives than all the world's doctors put together.”

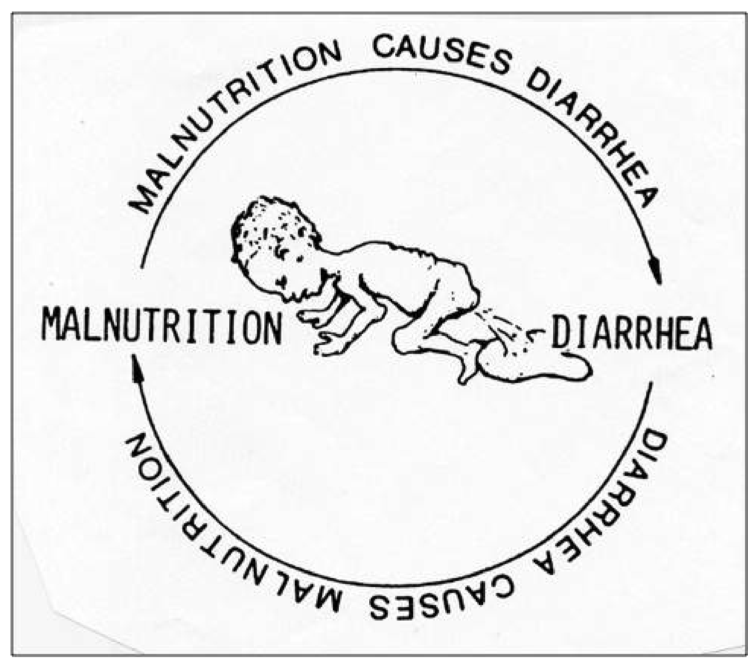
This is, of course, not altogether true -- mainly because dehydration is only the final link in the chain of causes leading to death from diarrhea. Other links include malnutrition, poverty, low wages, mal-distribution of farmland, top-heavy free trade agreements, corporate power, authoritarian school systems, and the corruption of democratic process -- not to mention the privatization of public services and the wickedly high costs of commercial medicine and doctors.

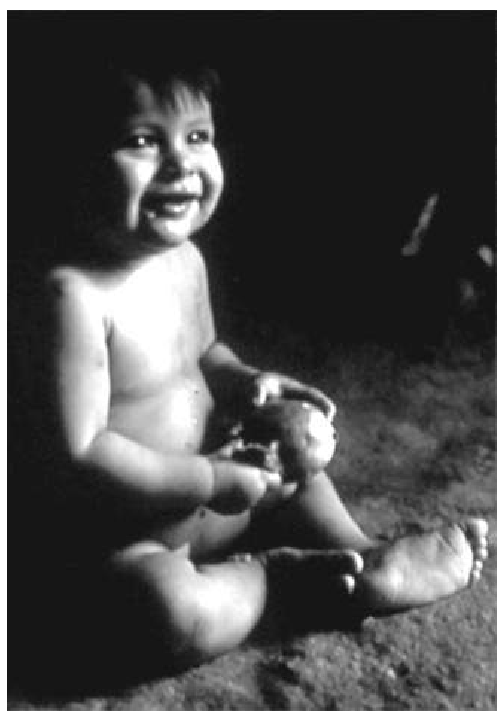
But it is precisely because these oppressive social determinants perpetuate the high rate of preventable illness and death in the world today, that a more liberating approach to education is sorely needed. Our children will be the leaders and the followers of tomorrow.

USING CHILDREN'S "PARTICIPATORY EPIDEMIOLOGY" TO COMBAT MALNUTRITION

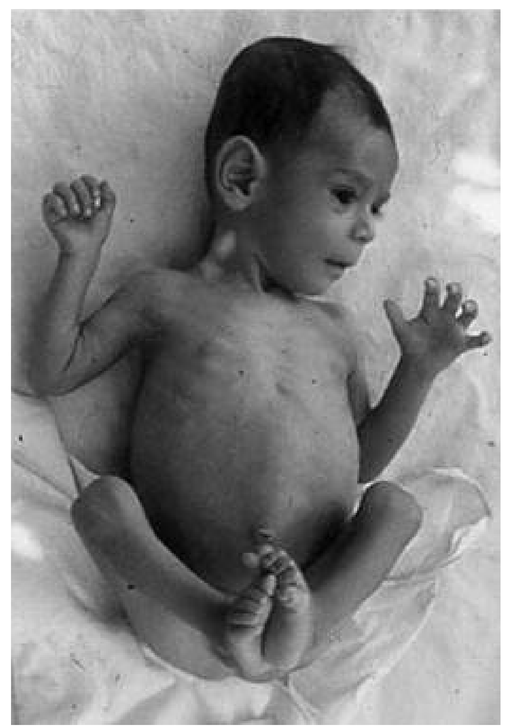
In the chain of causes leading to death from diarrhea in children living in poverty, malnutrition is often the most pernicious link. A well-nourished child who gets diarrhea usually recovers. An undernourished child is far more likely to get thinner still, to get sick more often, and to die.

To combat death from diarrhea, oral rehydration therapy (ORT) only attacks the last link in the causal chain: dehydration. To get closer to the root problem, we must combat malnutrition. So in a discovery based Child-to-Child approach, learning about "Management of diarrhea"





Well fed



Too Thin

and "Combating under-nutrition" logically go hand in hand.

In Latin America, the Child-to-Child activity titled "Helping children who are too thin" likewise takes a discovery-based, learning-by-doing approach. It even engages the children as researchers in "participatory epidemiology" or epidemiologia participativa Infantil.

To start the activity, the teacher or facilitator asks the group of children questions like:

- Do you know of any babies or little kids in the village who look too thin?
- Or who are all skin and bones?
- Do these little ones seem happy and healthy?
- Why not?
- Why do you think they're so thin?
- What other problems do they sometimes have?
- Are they in danger?

Then the children are encouraged to ask related questions, such as:

- What do you suppose these very thin children need?
- What can we can do to help?

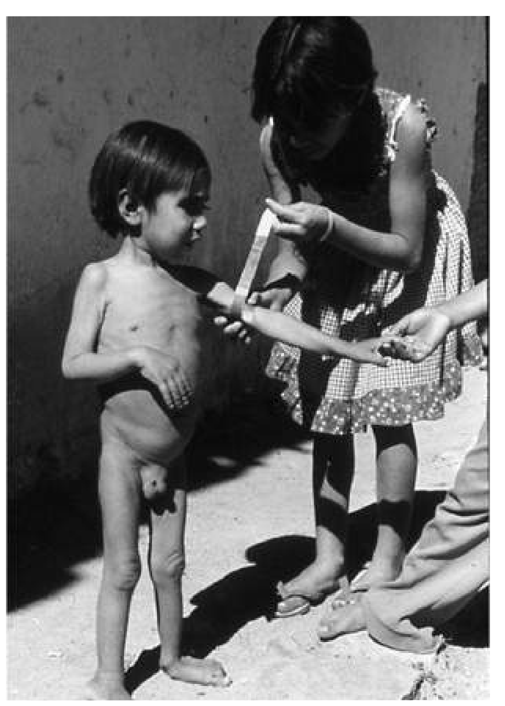
After discussing these and other questions, and arousing the children's empathy, the teacher helps the class decide on a plan of action.

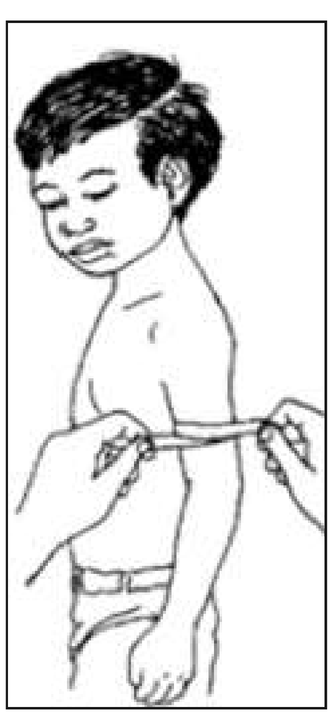
First, the children decide to conduct their own house-to-house survey. To discover

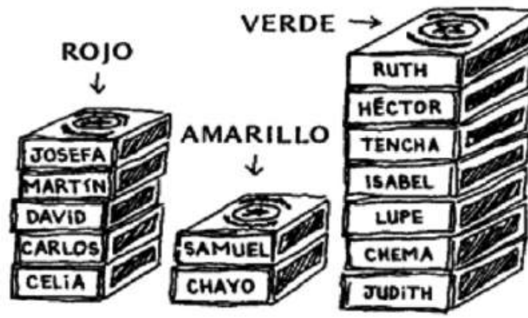
which and how many pre-school children in their village are "too thin," they start by making simple measuring tapes -- or Shakir stripes -- to determine the distance around the upper arms of the all the small children under five years old.

They color these paper tapes in 3 zones: red, yellow and green, to show which arms measure too thin, borderline, or OK.

After school the group of children spread out through the village, measuring the arms of all "under-5s." With so many children taking part, they complete in one afternoon a survey that would take a nurse or health worker weeks.







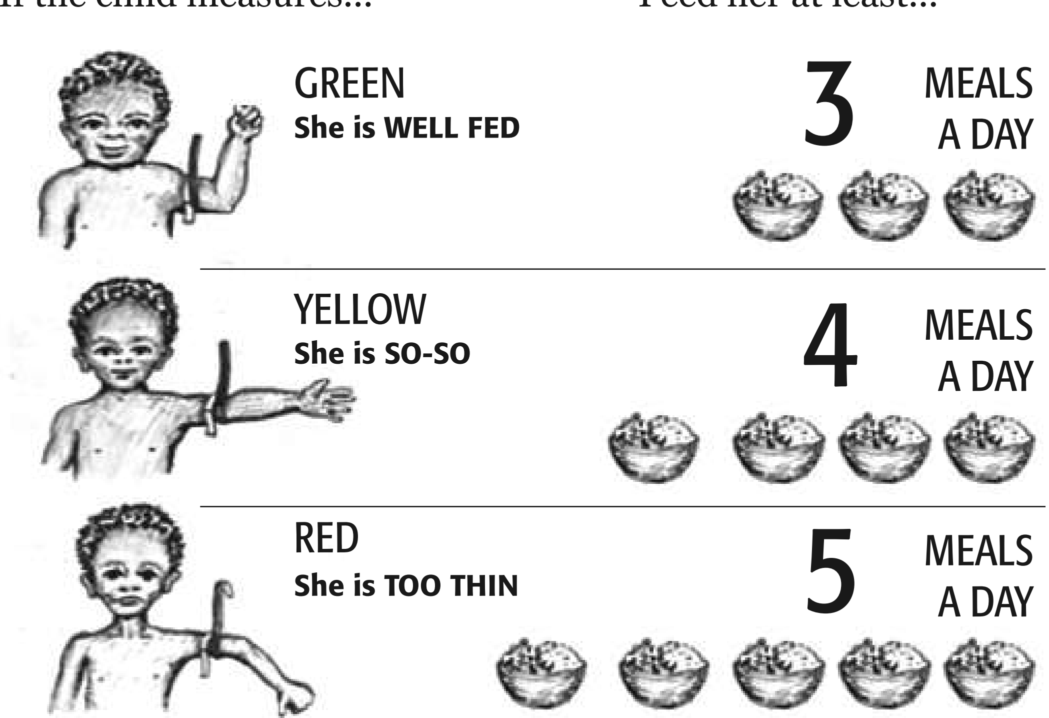
Next day back at school the young rese-archers pull together the results. They could do this with a graph on the black-board. But graphs can be hard for chil-dren to understand. So they use match-boxes, coloring them red, green and yellow to represent the Under-5 kids they measured. They stack the boxes in 3 co-lumns, to see how many fall into each group.

"But what can we do they about this?" the children ask. This leads to a study of how to help toddlers who are "too thin" gain weight. They learn about a number of simple, low cost measures that might help. Things like:

- Feed the thin child more often -- at least 5 times a day [drawing Child-to-Child show]
- Make weaning porridges thicker (with less water, more calories)
- Add concentrated energy -- like cooking oil or mashed peanuts -- to the child's standard foods.

With this simple knowledge, the classroom of primary school deci-des on a course of action. Each youngster who wants to (and most do) assume a responsibility for one or two of the toddlers who mea-sured "too thin." They visit their homes before and after school, and do whatever they can to get a bit more energy-rich food into the little bellies. Frequency of feeding can be especially important. If both parents are gone from dawn to dark, the toddler may be fed only twice a day. Even if her stomach is filled up each time, the toddler still doesn't get enough calories for adequate nutrition. So a schoolchild's friendly visits, offering a snack of energy-rich food before and after school, can sometimes make a measurable diffe-rence.

And to measure that difference, after a few months of their collective action, the schoolchildren can repeat their survey. When this Child-to-Child nutrition activity was first conducted in the village of Ajoya, Mexico, the schoolchildren discovered from their follow-up survey 4 months la-ter that the number of "too thin" children had dropped to half of what their original (base-line) survey showed.



No doubt the enthusiasm of these "junior health workers," and the involvement of the parents and grandparents of the undernourished children in focusing on their nutritional needs, had much to do with the favorable results. The process is empowering and unifying for the whole community.

THE IMPACT OF DISCOVERY BASED AND CHILD-TO-CHILD TECHNIQUES

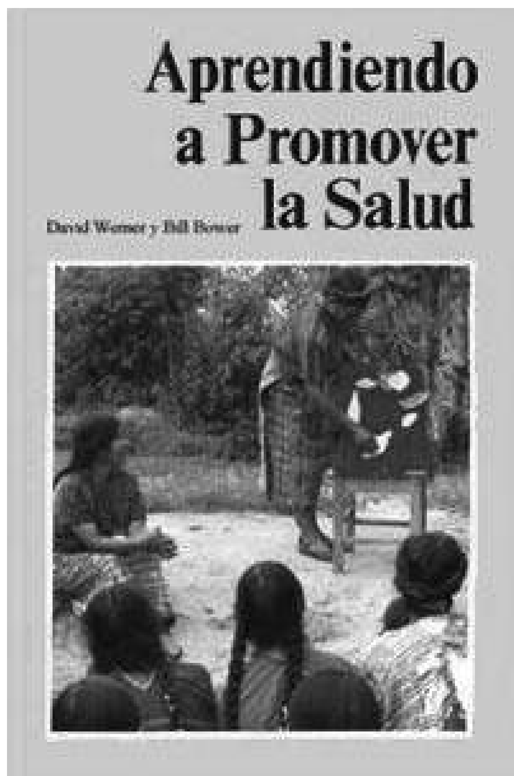
Clearly the health and nutrition needs of infants in impoverished, marginalized families will not be resolved by the willing assistance of a group of schoolchildren. To do away with hunger, the underlying "social determinants" of health (cultural, economic, and political) must also be collectively

addressed. But the long-term transformative potential of the Child-to-Child approach to education should not be underestimated. Its influence both on the children involved and on the school system can be far-reaching. Introducing empowering service-related activities like these into public education, beginning with primary school – can, little by little, help make schooling more relevant to the daily needs and lives of the children in their homes and villages. This can be a big step forward toward transforming "compulsory education" from an oppressive tool of social control into an open-ended adventure in learning that challenges children to think for themselves and work together for the common good.

Many schoolteachers are at first quite skeptical about Child-to-Child. The open-ended, bottom-up methodology strikes them as undisciplined, chaotic, and disrespectful to authority. Because it challenges children to decide things for themselves, it scares the teachers. But many of these same skeptical, fearful teachers, once they begin to take part in the Child-to-Child activities, become just as excited as the children. They discover that through a two-way learning process, where everyone's thoughts and ideas are valued, they can gain the pupils' respect, not as bosses but as friends. This new more amiable, more equal interaction somehow strikes a deep, convivial chord in their nature. And the educational process becomes more friendly and natural for everyone.

With Child-to-Child and discovery-based education, children will begin to question the injustices, inequities, and shortsightedness of our current social order. In this way education can become transformative for the children, their teachers, their schools and our societies.

The world we are handing down to our young is a time bomb with a short fuse! If our children are to have a chance at defusing this deadly bomb, they will need to look in a radically new and different way at how we human beings relate to one another and to our endangered planet. Starting now, concerned young people need to throw off the chains of the dominant world view ... to question what they're taught and told ... to resist the myopic dictates of the ruling class ... to expose the fallacy in what is miscalled "progress" and "development." They need to critique the failings of our current social order, and embark on a revolutionary, evidence-based quest for the health and well-being of all.



SE PUEDE HALLAR INFORMACIÓN Y EJEMPLOS DE NIÑO A NIÑO EN ESTOS TRES LIBROS DE DAVID WERNER:

- NADA SOBRE NOSOTROS SIN NOSOTROS
- APRENDIENDO A PROMOVER SALUD
- EL NIÑO CAMPESINO DESHABILITADO

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V.
CONCLUSION: WHERE DO WE GO FROM HERE?

A.
THE CHALLENGE

Today, in the 21st Century, we live in a different and more endangered world than in the past. In some areas we may have seen improvements, as with women's rights and gay rights (at least in some places). But in terms of wealth and power, humanity has become even more polarized. And environmentally -- with the looming tsunami of global warming -- we are on the brink of disaster. Yet the world's rulers appear to be blind to the horrendous dangers their megalomania is creating. North-American neo-imperialism knows no bounds -- even as the great dinosaur sinks into the quicksand of its own greed.

But some healthy things are happening, too. One encouraging advance of this new century, led by Latin America, is the growing number of populations who, after enduring centuries of colonial and then neocolonial oppression, have begun to rise up en masse and say, "Ya basta!" (Enough!) People who for generations have been brainwashed to obey their masters and suffer in silence have finally begun to shake off the shackles of institutionalized exploitation. What a huge step forward for Latin America! And soon, let us hope, for humanity!

But this momentum for change did not just happen in a vacuum. The groundwork was built over decades, through grassroots efforts of common people working together to resolve their basic needs, to improve their health, and finally to demand their basic right to self-determination. Beyond a doubt, the web of community-based health programs, and the movements that grew out of it, have played a seminal role that helped mobilizing the groundswell for change. Key to this was the concientización (awareness-raising) that helped trigger this empowering process: what Paulo Freire called "Pedagogy of Liberation," -- and we health activists call "Education for Change."

When we talk about improvements in the health of an entire nation, Cuba is exemplary. In solidarity with the poor peoples of the world through their creativity in finding solutions to feed its people, and its excellent universal health care – for its advances in medicine and biotechnology – Cuba inspires.

We are no longer so naive as when we began. We know that the economic elite will oppose anything that considers their profits less important than the wellbeing of all people. The world's giant, profit-hungry corporations have more wealth and decision-making power than most of the world's nations, or than the United Nations, so we face a daunting task. Obviously we cannot look to those in power to initiate the changes that are needed.

The push needs to come from below. It is time for the world's people -- like the people in a growing number of Latin American countries -- to stand up and cry, "Ya basta!" But for such a global groundswell of solidarity to come about, a groundswell of organized action is needed. The People's Health Movement, at regional and global level, is already playing a critical role in this process.

But many of us are getting older. We have struggled, sacrificed and learned. We have done some things well. We have also made mistakes. Now we must look to young people to learn from both our successes and our failures, and to carry the struggle forward. That is why I have given such emphasis to the importance of a liberating educational approach. Only though such an egalitarian. open-ended approach to learning do we, Homo sapiens, have a hope of living in balance with our own intrinsically loving nature and the inseparably diverse nature of the Universe.

"SUMAK KAUSAY" AND THE DREAM OF HEALTH FOR ALL

For too long, the dominant concepts of "development" and "progress" have been tethered to the capitalist paradigm of unlimited growth through the exploitation of people and the unbridled extraction of resources from the environment. But this acquisitive approach to development -- as if the Earth belonged to us, rather than us to it -- is now returning like a boomerang.

Ultimately, what our common struggle comes down to, in Latin America and worldwide, in the not-too-distant future, is Health for All or Health for No One.

I would like to reemphasize that today, on our endangered planet, when we speak of Health for All, "All" doesn't mean only us (more or less) hairless apes. It means Health for ALL, in the most inclusive sense. We humans are one small but disruptive part of an astounding universe where everything is interwoven as a vibrant living whole. We are a thread in the web of life on this beautiful planet: a participant in the ecological balance of all biologic and non-biologic things: a part of Earth, Air, Fire, and Water, of Warm and Cold, of Yin and Yang, of which the mysterious cosmos is composed. Unless and until we learn to live in balance and compassion with one another, and with our critically-endangered ecosystem -- local and global -- health for any of us will remain a short-lived dream.

This larger vision of unity and empathy for all is, of course, the essence of the ancient Ecuadorian concept of Sumak Kausay or "Buen Vivir" (good living). The indigenous peoples of the Americas lived more in balance with the environment, and have a more intuitive understanding of the Oneness-of-which-we-are-all-part, than do most of us in our morbidly overdeveloped consumer society today. It is heartening that Ecuador, with its long history of indigenous wisdom, built into its new Constitution, in 2008, a declaration of the universal rights not only of all people, but of the natural world. This affirmation of the "Rights of Nature" as part of "holistic living," or Sumak Kuasay, is a large but humble step forward toward the vision we share for the Health and Rights of ALL.

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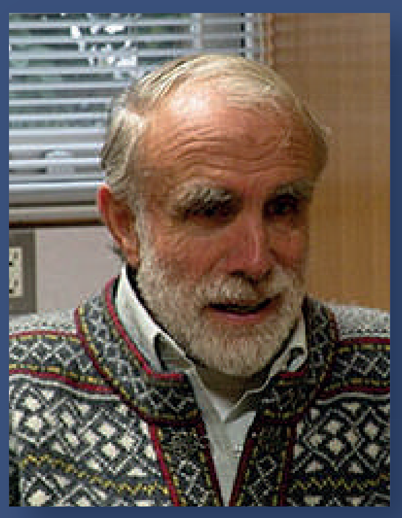
DAVID WERNER



David Werner, biólogo de formación, ha pasado los últimos 30 años trabajando por las familias campesinas pobres de las montañas de México occidental, para proteger su salud y sus derechos. El Proyecto Piaxtla, dirigido por los propios campesinos y del cual él ha sido promotor y asesor desde 1965, ha contribuido a la conceptualización y evolución de la Atención Primaria de Salud. Los tres principales libros que ha escrito e ilustrado -Donde No Hay Doctor, Aprendiendo a Promover la Salud y El Niño Campesino Deshabilitado- se encuentran entre los más ampliamente utilizados en el campo de la promoción de la salud comunitaria y la rehabilitación basada en la comunidad. Ha trabajado en más de 50 países -la mayoría del Tercer Mundo- ayudando a desarrollar talleres y programas de formación, y también como consejero.

En estos últimos años, David Werner se ha ido involucrando progresivamente en los factores sociales, políticos y económicos, tanto locales como mundiales, que afectan a la vida y a la salud de los menos favorecidos. David ha recibido varios premios por su trabajo de campo, incluyendo el primer Premio Internacional de Educación para la Salud de la Organización Mundial de la Salud, el «genius fellowship» de la Fundación MacArthur en 1991 y el Premio Christopherson de Salud Infantil Internacional de la Academia Americana de Pediatría. Es miembro fundador del Consejo Internacional para la Salud del Pueblo y de HealthWrights -Workgroup for People's Health and Rights (Equipo para la Salud y los Derechos del Pueblo).

Libros y Publicaciones en Salud y Discapacidades:

- Donde No Hay Doctor.
- Cuestionando la Solución: Las Políticas de la Atención Primaria de la Salud y la Supervivencia Infantil.
- Aprendiendo a Promover la Salud.
- El Niño Campesino Deshabilitado.
- Nada Sobre Nosotros Sin Nosotros: desarrollando tecnologías innovadoras para, por y con Personas Discapacitadas.

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