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communication as if PEOPLE mattered

adapting health promotion and social action to the
global imbalances of the 21st century

by David Werner

DEMOCRACY as a prerequisite for a HEALTHY SOCIETY

Why participation is essential – and how it is undermined

The well-being of an individual or community depends on many factors, local to global. Above all, it depends on **the opportunity of all people to participate as equals in the decisions that determine their well-being.** Unfortunately, history shows us that equality in collective decision-making—that is to say **participatory democracy**—is hard to achieve and sustain. Despite the spawning of so-called ‘democratic governments’ in recent decades, most people still have little voice in the policies and decisions that shape their lives. Increasingly, the rules governing the fate of the Earth and its inhabitants are made by a powerful minority who dictates the Global Economy. Thus **economic growth (for the wealthy) has become the yardstick of social progress, or ‘development,’ regardless of the human and environmental costs.**

And the costs are horrendous! The top-down ‘globalisation’ of policies and trade—through which the select few profit enormously at the expense of the many—is creating a widening gap in wealth, health and quality of life, both between countries and within them. A complex of worldwide crises—social, economic, ecological and ethical—is contributing to ill-health and early

death for millions. Increasingly, giant banks and corporations rule the world, putting the future well-being and even survival of humanity at risk. Driven more by hunger for private profit than for public good—the massive production of consumer goods far exceeds the basic needs of a healthy and sustainable society. Indeed, its unregulated growth compromises ecological balances and imperils the capacity of the planet for renewal.

Yet in a world where unlimited production and resultant waste have become a major health hazard, there are more hungry children than ever before. According to Worldwatch’s *The State of the World, 1999*, **the majority of humanity is now malnourished**, half from eating too little and half from eating too much!

Mahatma Gandhi wisely observed: ‘There is enough for everyone’s need but not for everyone’s greed.’ Sadly, **greed has replaced need as the**

driver of our global spaceship. Despite all the spiritual guidelines, social philosophies, and declarations of human rights that *Homo sapiens* (the species that calls itself wise) has evolved through the ages, the profiteering ethos of the market system has side-tracked our ideals of compassion and social justice. Humanity is running a dangerous course of increasing imbalance. To

further fill the coffers of the rich, our neoliberal social agenda systematically neglects the basic needs of the disadvantaged and is rapidly despoiling the planet’s ecosystems, which sustain the intricate web of life.

The dangers—although played down by the mass media—are colossal and well documented. Forward-looking ecologists, biologist, and sociologists sound the warning that our current unjust, un-



healthy model of economic development is both humanly and environmentally unsustainable.

‘Yes, we know that,’ say many of us who believe in Health for All and a sustainable future. ‘We are deeply worried.... But what can we do?’

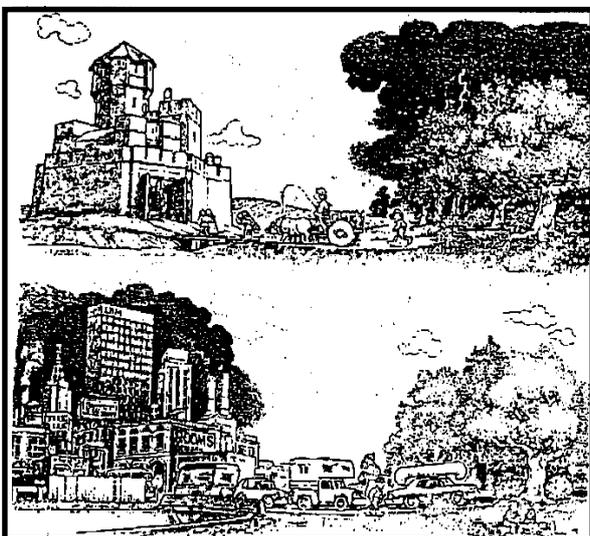
There are no easy answers. The forces shaping global events are gigantic, and those who accept them as inevitable so impervious to rational dissent, that many of us hide our heads in the sand like ostriches. And so humanity thunders headlong down the path of systemic breakdown—more polarisation of society, more environmental deterioration, more neglect of human rights and needs, more social unrest and violence—as if our leaders were incapable of thought and our populations anaesthetised.

What action can we take, then—individually and collectively—to change things for the better, for the common good?

The purpose of this background paper

The interrelated crises of our times—the ways that globalisation, corporate rule, and top-down, ‘development’ policies undermine democratic process and endanger world health—are discussed in other background papers for the People’s Health Assembly. The purposes of this paper are:

1. to examine the strategies used by the world’s ruling class to keep the majority of humanity disempowered and complacent in the face of the crushing inequalities and hazards it engenders;
2. to explore the methods and resources whereby enough people can become sufficiently aware and empowered to collectively transform our current unfair social order into one that is more equitable, compassionate, health-promoting, and sustainable.



TOP-DOWN

MEASURES of SOCIAL CONTROL

Disinformation

With all the technology and sophisticated means of communication now available, how is it that so many people appear so unaware that powerful interest groups are undermining democracy, concentrating power and wealth, and exploiting both people and the environment in ways that put the well-being and even survival of humanity at stake? How can a small elite minority so successfully manipulate global politics to its own advantage, and so callously ignore the enormous human and environmental costs? How can the engineers of the global economy so effectively dismiss the emerging risk of unprecedented social and ecological disaster?

In short, what are the weapons used by the ruling class to achieve compliance, submission, and social control of their captive population?

True, riot squads have been increased, prison populations expanded, and military troops deployed to quell civil disobedience. But far more than tear-gas and rubber bullets, **disinformation has become the modern means of social control.** Thanks to the systematic filtering of news by the mass media, many ‘educated’ people have little knowledge of the injustices done to disadvantaged people in the name of economic growth, or of the resultant perils facing humanity. They are unconscious of the fact that the overarching problems affecting their well-being—growing unemployment, reduced public services, environmental degradation, renewed diseases of poverty, bigger budgets for weapons than for health care or schools, more tax dollars spent to subsidize wealthy corporations than to assist hungry children, rising rates of crime, violence, substance abuse, homelessness, more suicides among teenagers—are rooted in the undemocratic concentration of wealth and power. Despite their personal hardships, unpaid bills, and falling wages, ordinary citizens are schooled to rejoice in the ‘successful economy’ (and spend more). They pledge allegiance to their masters’ flag, praise God for living in a ‘free world,’ and fail to see (or to admit) the extent to which the world’s oligarchy (ruling minority) is undermining democracy and endangering our common future. And our textbooks and TVs keep us strategically misinformed.

One dollar, one vote: private investment in public elections

One way 'government by the people' is undermined is through the purchase of public elections by the highest bidders. In many so-called democracies a growing number of citizens (in some countries, the majority) don't even bother to vote. They say it makes no difference. Politicians, once elected, pay little heed to the people's wishes. The reason is that wealthy interest groups have such a powerful political lobby. Their big campaign donations (bribes?) help politicians win votes—in exchange for political favours. The bigger the bribe, the more campaign propaganda on TV and mass media. Hence more votes.

This institution of legal bribery makes it hard for honest candidates (who put human need before corporate greed) to get elected. Democratic elections are based on one person, one vote. With the deep pockets of big business corrupting elections, results are based on one dollar, one vote. This makes a mockery of the democratic process.

The erosion of participatory democracy by the corporate lobby has far-reaching human and environmental costs. Hence the biggest problems facing humanity today—poverty, growing inequality, and the unsustainable plundering of the planet's ecosystems—continue unresolved.

Sufficient wisdom, scientific knowledge and resources exist to overcome poverty, inequity, hunger, global warming and the other crises facing our planet today. But those with the necessary wisdom and compassion seldom govern. They rarely get elected because they refuse to sell their souls to the company store. Winners of elections tend to be wheelers and dealers who place short-term gains before the long-term well-being of all.

To correct this unhealthy situation, laws need to be passed that stop lobbying by corporations and wealthy interest groups. In some countries, citizens' organisations are working hard to pass such campaign reforms. But it is hard to get them past legislators who pad their pockets with corporate donations. Only when enough citizens become fully aware of the issues at stake and demand a public vote to outlaw large campaign donations, will it be possible for them to elect officials who place the common good before the interests of powerful minorities.

But creating such public awareness is an uphill struggle—precisely because of the power of the corporate lobby and the deceptive messages of the mass media. To make headway with campaign



reforms, institutionalised disinformation must be exposed for what it is. To accomplish this, more honest and empowering forms of education and information sharing are needed.

Schooling for conformity, not change

It has been said that **education is power**. That is why, in societies with a wide gap between the haves and have-nots, **too much education can be dangerous**. Therefore, in such societies, schooling provides less education than indoctrination, training in obedience, and cultivation of conformity. **In general, the more stratified the society, the more authoritarian the schools.**

Government schools tend to teach history and civics in ways that glorify the wars and tyrannies of those in power, whitewash institutionalised transgressions, justify unfair laws, and protect the property and possessions of the ruling class. Such history is taught as gospel. And woe be to the conscientious teacher who shares with students 'people's history' of their corner of the earth.

Conventional schooling is a vehicle of disinformation and social control. It dictates the same top-down interpretations of history and current events, as do the mass media. It whitewashes official crimes and aggression. Its purpose is to instill conformity and compliance, what Noam Chomsky calls 'manufacturing consent.'

For example, although the United States has a long history of land-grabbing, neocolonial aggression and covert warfare against governments committed to equity, most US citizens take pride in their 'benevolent, peace-loving nation'. Many believe they live in a democracy 'for the people and by the people, with liberty and justice for all'—even though millions of children in the US go hungry, countless poor folks lack health care, prison populations expand (mainly with destitute blacks), and welfare cut-backs leave multitudes jobless, homeless and destitute.

the NEED for BOTTOM-UP approaches to communication

To see through the institutionalised disinformation, and to mobilise people in the quest for a healthier, more equitable society, we need alternative methods of education and information-sharing that are honest, participatory, and empowering. This includes learning environments that bring people together as equals to critically analyse their reality, plan a strategy for change, and take effective united action.

Fostering empowering learning methods is urgent in today's shrinking world, where people's quality of life, even in remote communities, is increasingly dictated by global policies beyond their control.

Alternative media and other means of people-to-people communication

There have been a number of important initiatives in the field of alternative media, communication, and social action for change.

The alternative press. While struggling to stay alive in recent years, the alternative press (magazines, flyers, bulletins, newsletters, progressive comic books) has provided a more honest, people-centred perspective on local, national and global events. Some of the more widely-circulating alternative magazines in English (often with translations into several other languages) include:

The New Internationalist
Z Magazine
Resurgence
The Nation
Third World Resurgence
Covert Action Quarterly
Multinational Monitor

Also, there are many newsletters and periodicals published by different watchdog groups such as the International Forum on Globalization, IBFAN, BankWatch, the National Defense Monitor and Health Action International, among others. It is important that we subscribe to and read (and encourage others to read) these progressive alternative writings.

Alternative community radio and TV. The role and potential of these is similar to that of the alternative press. Stations that do not accept advertising are less likely to belong to or sell out to

the controlling elite. But to survive they need listener support.

Internet. Electronic mail and websites have opened up a whole new sphere of rapid, direct communication across borders and frontiers. The Web is, of course, a two-edged sword. The Internet is currently available to less than 2% of the world's people, mostly the more privileged. And instant electronic communications facilitate the global transactions and control linkages of the ruling class. But at the same time, E-mail and the World-Wide-Web provide a powerful tool for popular organisations and activists around the globe to communicate directly, to rally for a common cause and to organise international solidarity for action.

The potential of such international action was first demonstrated by the monumental worldwide outcry, through which non-government organisations (NGOs) and grassroots organisations halted the passage of the Multilateral Agreement on Investment (MAI). (The MAI was to have been a secret treaty among industrialised countries, giving even more power and control over Third World Nations.) The primary vehicle of communication for the protest against MAI was through the Internet.

Mass gatherings for organised resistance against globalised abuse of power. The turn of the Century was also a turning point in terms of people's united resistance against global trade policies harmful to people and the planet. The huge, well-orchestrated protest of the World Trade Organization (WTO) summit meeting in Seattle, Washington (now celebrated worldwide as the 'Battle in Seattle') was indeed a breakthrough. It showed us that **when enough socially committed people from diverse fields unite around a common concern, they can have an impact on global policy making.**

The agenda of the WTO summit in Seattle was to further impose its pro-business, anti-people and anti-environment trade policies. That agenda was derailed by one of the largest, most diverse, international protests in human history. Hundreds of groups and tens of thousands of people representing NGOs, environmental organisations, human rights groups, labour unions, women's organisations, and many others joined to protest and barricade the WTO assembly. Activists arrived from at least 60 countries. The presence of so-many grassroots protesters gave courage to many of the representatives of Third World countries to oppose the WTO proposals which would further favor affluent countries and corporations at the expense of the less privileged. In the end, the assembly fell apart, in part from internal

disaccord. No additional policies were agreed upon.

Perhaps the most important outcome of the Battle in Seattle was that, despite efforts by the mass media to denigrate and dismiss the protest, key issues facing the world's people were for once given center stage. It was a watershed event in terms of grassroots mobilisation for change. But the activists present agreed that it was just a beginning.

The People's Health Assembly, with its proposed 'People's Charter for Health' and plans for follow-up action, holds promise of being another significant step forward in the struggle for a healthier, more equitable approach to trade, social development, and participatory democracy. For that promise to be realised, people and groups from a wide diversity of concerns and sectors must become actively involved around our common concern: the health and well-being of all people and of the planet we live on.

EDUCATION *for* PARTICIPATION, EMPOWERMENT, and ACTION *for* change

The term 'Popular Education,' or 'Learner-centered education,' refers to participatory learning that enables people to take collective action for change. Many community-based health initiatives have made use of these enabling methodologies, adapting them to the local circumstances and customs. Particularly in Latin America, methods of popular education have been strongly influenced by the writings and awareness-raising 'praxis' of Paulo Freire (whose best known book is *Pedagogy of the Oppressed*.)

Education of the oppressed—the methodology of Paulo Freire

In the mid-1960s the Brazilian educator, Paulo Freire developed what he called **education for liberation**, an approach to adult literacy training, (which proved so revolutionary that Freire was jailed and then exiled by the military junta.) With his methods, non-literate workers and peasants learned to read and write in record time—because their learning focused on what concerned them most: the problems, hopes and frustrations in their lives. Together they critically examined these concerns, which were expressed in key words and provocative pictures. The process involved identi-



fication and analysis of their most oppressive problems, reflection on the causes of these, and (when feasible) taking action to 'change their world'.

Learning as a two-way or many-way process

With Freire's methodology, problem-solving becomes an open-ended, collective process. Questions are asked to which no one, including the facilitator have ready answers. 'The teacher is learner and the learners, teachers.' Everyone is equal and all learn from each other. The contrast with the typical classroom learning is striking. **In typical schooling**, the teacher is a superior being who 'knows it all'. He is the owner and provider of knowledge. He passes down his knowledge into the heads of his unquestioning and receptive pupils, as if they were empty pots. (Freire calls this the 'banking' approach to learning because knowledge is simply deposited.)

In education for change, the facilitator is one of the learning group, an equal. She helps participants analyse and build on their own experiences and observations. She respects their lives and ideas, and encourages them to respect and value one another's. She helps them reflect on their shared problems and the causes of these, to gain confidence in their own abilities and achievements, and to discuss their common concerns critically and constructively, in a way that may lead to personal or collective action. Thus, according to Freire, the learners discover their ability to 'change their world'. (For this reason Freire calls this a 'liberating' approach to learning).

The key difference between 'typical schooling' and 'education for change' is that **the one pushes ideas into the student's heads, while the other draws ideas from them.** Typical schooling trains students to conform, comply, and accept the voice of authority without question. Its objective is to maintain and enforce the status quo. It is disempowering. By contrast, education-for-change is enabling. It helps learners gain 'critical awareness' by analysing their own observations, drawing their own conclusions and taking collective action to overcome problems. It frees the poor and oppressed from the idea that they are helpless and must suffer in silence. It empowers them to build a better world—hence it is 'education for transformation'.

examples of GRASSROOTS health programmes that have combatted ROOT CAUSES of POOR HEALTH

Community-based health programmes in various countries have brought people together to analyse the root causes of their health-related problems and to 'take health into their own hands' through organised action. In places where unjust government policies have worsened the health situation, community health programmes have joined with popular struggles for fairer and more representative governments. The following are a few examples of programmes where people's collective 'struggle for health' has led to organised action to correct inequalities, unfair practices and/or unjust social structures.

Gonoshasthaya Kendra (GK). GK is a community health and development programme in Bangladesh that began during the war for national independence. Village women, many of them single mothers (the most marginalised of all people), have become community health workers and agents of change. Villagers collectively analyse their needs and build on the knowledge and skills they already have. Repeatedly health workers have helped villagers take action to defend their rights.

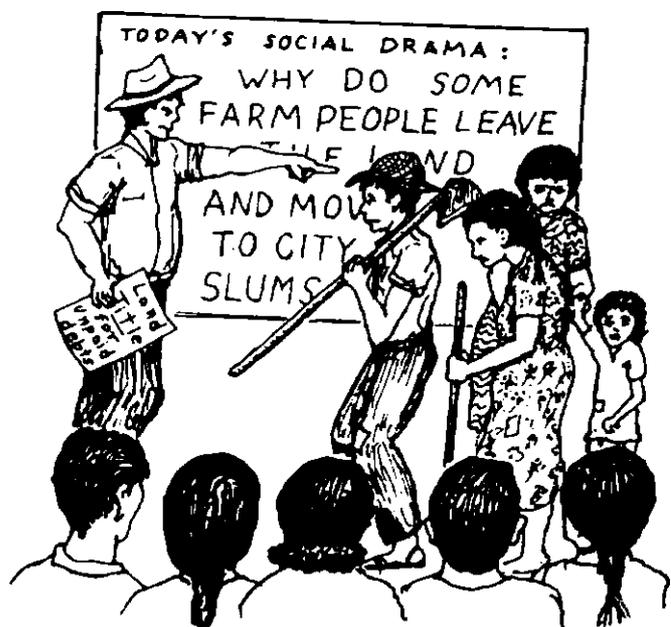
One example of this is over water rights. In analysing their needs, families agreed that access to good water is central to good health. UNICEF had provided key villages with tube-wells. But rich landholders took control of the wells and made people pay so much for water

that the poor often went without. Health workers helped villagers organise to gain democratic, community control of the wells. This meant more water and better health for the poor. And it helped people gain confidence that through organised action they could indeed better their situation.

Another example concerns schooling. Villagers know education is important for health. But most poor children of school age must work to help their families survive. So the GK communities started a unique school, which stresses cooperation, not competition. Each day the children able to attend the school practise teaching each other. After school these same children teach those unable to attend school. This process of teaching one another and working together to meet their common needs, sews seeds for cooperative action for change.

Jamkhed, India. For over three decades two doctors, Mabel and Raj Arole, have worked with poor village women, including traditional midwives. These health facilitators have learned a wide variety of skills. They bring groups of women together to discuss and try to resolve problems. In this way, they have become informal community leaders and agents of change. They help people rediscover the value of traditional forms of healing, while at the same time demystifying Western medicine, which they learn to use carefully in a limited way.

In Jamkhed, women's place relative to men's has become stronger. Women have found courage to defend their own rights and health and those of their children. As a result of the empowerment and skills-training of women, child mortality has dropped and the overall health of the community has improved dramatically.



The Philippines. In this island nation, during the dictatorship of Fernando Marcos, a network of community-based health programmes (CBHPs) evolved to help people deal with extreme poverty and deplorable health conditions. Village health workers learned to involve people in what they called **situational analysis**. Neighbours would come together to prioritise the main problems affecting their health, identify root causes and work collectively towards solutions.

In these sessions it became clear that **inequality—and the power structures that perpetuate it—were at the root of ill health**. Contributing to the dismal health situation were: unequal distribution of farm land (with huge land-holdings by transnational fruit companies), cut-backs in public services, privatisation of the health system, and miserable wages paid to factory and farm workers. The network of community-based programs urged authorities to improve this unjust situation. When their requests fell on deaf ears, they organised a popular demand for healthier social structures. These included free health services, fairer wages, redistribution of the land to the peasantry, and above all else, greater accountability by the government to its people.

The fact that the CBHP network was awakening people to the socio-political causes of the poor so threatened the dictatorship that scores of health workers were jailed or killed. But as oppression grew, so did the movement. The CBHP network joined with other movements for social change. Finally, the long process of awareness-raising and cooperative action paid off. In the massive peaceful uprising of 1986, thousands of citizens confronted the soldiers, putting flowers into the muzzles of their guns. The soldiers (many of whom were peasants themselves, acquiesced. After years of organising and grassroots resistance, the dictatorship was overthrown. (Unfortunately, the overall situation has not changed greatly. With persistent domination by the US government and multinational corporations, gross inequities remain and the health of the majority is still dismal. The struggle for a healthier, more equitable society continues.)

Nicaragua. Similar to the CBHP in the Philippines under Marcos, in Nicaragua during the Somoza dictatorship a network of non-government community health programmes evolved to fill the absence of health and other public services. Grass-roots health workers known as **Brigadistas de Salud**

brought groups of people together to conduct **community diagnoses** of problems affecting their health, and to work together toward solutions. As in the Philippines, the ruling class considered such **community participation** subversive. Scores of health workers were 'disappeared' by the National Guard and paramilitary death squads. Many health workers went underground and eventually helped form the medical arm of the Frente Sandinista, the revolutionary force that toppled the dictatorship.

After the overthrow of Somoza, hundreds of Brigadistas joined the new health ministry. With their commitment to strong participation, they helped to organise and conduct national 'Jornadas de Salud' (Health Days). Their work included country-wide vaccination, malaria control, and tuberculosis control campaigns. At the same time, adult literacy programmes, taught mainly by school children, drastically increased the nation's level of literacy.

As a result of this participatory approach, health statistics greatly improved under the Sandinista government. Since the Sandinistas were ousted with the help of the US government, health services have deteriorated and poverty has increased. Many health indicators have suffered. But fortunately, communities still have the skills and self-determination necessary to meet basic health needs and assist one another in hard times.

Project Piaxtla, in rural Mexico. In the mountains of western Mexico in the mid-1960s a villager-run health programme began and gradually grew to cover a remote area unserved by the health system. Village health promoters, learning in part by trial and error, developed dynamic teaching methods to help people identify their health needs and work together to overcome them.

Over the years, Piaxtla evolved through three phases: 1) curative care, 2) preventive measures, and 3) socio-political action. It was the third phase that led to the most impressive improvements in health. (In two decades, child mortality dropped by 80%.) Through Community Diagnosis, villagers recognised that a big



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cause of hunger and poor health was the unconstitutional possession of huge tracts of farmland by a few powerful landholders, for whom landless peasants worked for slave wages. The health promoters helped the villagers organise, invade the illegally large holdings, and demand their constitutional rights. Confrontations resulted, with occasional violence or police intervention. But eventually the big landholders and their government goons gave in. In two decades, poor farmers reclaimed and distributed 55% of good riverside land to landless farmers. Local people agree that their struggle for fairer distribution of land was the most important factor in lowering child mortality. And as elsewhere, people's organised effort to improve their situation helped them gain the self-determination and skills to confront other obstacles to health.

The practical experience of Project Piaxtla and its sister programme, PROJIMO, gave birth to 'Where There Is No Doctor,' 'Helping Health Workers Learn,' 'Disabled Village Children' and the other books by David Werner that have contributed to community-based health and rehabilitation initiatives worldwide.

networking and COMMUNICATIONS among GRASSROOTS programmes and movements

From isolation to united struggle

In different but parallel ways, each of the community initiatives briefly described above developed enabling participatory methods to help local people learn about their needs, gain self-confidence, and work together to improve their well-being. Each forged its own approaches to what we referred to earlier as **education for change**.

At first community health initiatives in different countries tended to work in isolation, often unaware of each other's existence. There was little communication and sometimes antagonism between them. But in time this changed, partly due to growing obstacles to health imposed by the ruling class. (Nothing solidifies friendship like a common oppressor.) Programmes in the same

country or region began to form networks or associations to assist and learn from each other. By joining forces, they were able to form a stronger, more united movement, especially when confronting causes of poor health rooted in institutionalised injustice and inequity.

National networks in Central America and the Philippines provided **strength in numbers** that gave community health programmes mutual protection and a stronger hand to overcome obstacles.

In the 1970s, community-based health programmes in several Central American countries formed **nationwide associations**. Then in 1982 an important step forward took place. Village health workers from CBHPs in the various Central American countries and Mexico met in Guatemala to form what became the **Regional Committee of Community Health Promotion**.

This Regional Committee has helped to build solidarity for the health and rights of people throughout Central America. Solidarity was particularly important during the wars of liberation waged in Central America (and later in Mexico), when villages were subjected to brutal and indiscriminate attacks by repressive governments and death squads.

Learning from and helping each other

One of the most positive aspects of networking among grassroots programmes and movements has been the cross-fertilisation of experiences, methods and ideas.

Central America. For example, in the 1970s, the Regional Committee and Project Piaxtla organised a series of '**intercambios educativos**' or **educational interchanges**. Community health workers from different programmes and countries came together to learn about each other's methods of confidence-building, community diagnosis, and organisation for community action.

At one of these Intercambios, representatives from Guatemala, in a highly participatory manner, introduced methods of 'conscientización' (awareness-raising) developed by Paulo Freire, as they had adapted them to mobilise people around health-related needs in Guatemala.



Likewise the village health promoters of Piaxtla, in Mexico, introduced to participants a variety of methods of discovery-based learning, which they had developed over the years (see below).

Reaching across the Pacific. An early step towards more global networking took place in 1977, when an educational interchange was arranged between community health workers from **Central America** and the **Philippines**. A team of health workers from Nicaragua, Honduras and Mexico visited a wide range of community-based health programmes, rural and urban, in the Philippines. In spite of language barriers, the sharing of perspectives and sense of solidarity that resulted were profound. Social and political causes of ill health in the two regions were similar. Both the Philippines and Latin America have a history of invasion and subjugation, first by Spain and then by the United States. Transnational corporations and the International Financial Institutions have contributed to polarising the rich and poor. And in both regions, the US has backed tyrannical puppet governments that obey the wishes of the global marketeers in exchange for loans and weapons to keep their impoverished populations under control.

Participants in the Latin American-Philippine interchange came away with a new understanding of the global forces behind poor health. They became acutely aware of the need for a worldwide coalition of grassroots groups and movements to gain the collective strength needed to construct a healthier, more equitable, more sustainable global environment.

the life and death of

PRIMARY HEALTH CARE

H **Health for All?** The United Nations established the World Health Organization (WHO) in 1945 to co-ordinate international policies and actions for health. WHO defined health as 'complete physical, mental, and social well-being, and not merely the absence of disease.'

But in spite of WHO and the United Nations' declaration of Health as a Human Right, the poorer half of humanity continued to suffer the diseases of poverty, with little access to basic health services. In 1987, WHO and UNICEF organised a watershed global conference in Alma Ata, USSR. It was officially recognised that the Western Medical Model, with its costly doctors in giant 'disease palaces,' had failed to reach impov-



erished populations. So the world's nations endorsed the **Alma Ata Declaration**, which outlined a revolutionary strategy called **Primary Health Care (PHC)**, to reach the goal of **Health for All by the Year 2000**. The vision of PHC was modeled after the successful grassroots community-based health programmes in various countries, as well as the work of 'barefoot doctors' in China. It called for **strong community participation in all phases**, from planning and implementation to evaluation.

Health for No One? We have entered the 21st century and are still a long way away from 'Health for All.' If our current global pattern of short-sighted exploitation of people and environment continue, we will soon be well on the road to 'Health for No One.' The current paradigm of economic development, rather than eliminating poverty, has so polarised society that combined social and ecological deterioration endangers the well-being of all. But sustainable well-being is of secondary concern to the dictators of the global economy, whose all-consuming objective is **GROWTH AT ALL COST!**

It has been said that Primary Health Care failed. But in truth, it has never been seriously tried. Because it called for and the full participation of the underprivileged along with an equitable economic order, the ruling class considered it subversive. Even UNICEF—buckling under to accusations by its biggest founder (the US government) that it was becoming 'too political'—endorsed a disembowelled version of PHA called **Selective Primary Health Care**. Selective PHC has less to do with a healthier, more equitable social order than with preserving the *status quo* of existing wealth and power.

The World Bank's take-over of health planning. The kiss of death to comprehensive PHC came in 1993 when the World Bank published its World Development Report, titled 'Investing in Health.' The Bank advocates a restructuring of health systems in line with its neo-liberal free-market ideology. It recommends a combination of privatisation, cost-recovery schemes and other measures that tend to place health care out of reach of the

poor. To push its new policies down the throat of poor indebted countries, it requires acceptance of unhealthy policies as a pre-condition to the granting of bail-out loans.

In the last decade of the 20th century, the World Bank took over WHO's role as world leader in health policy planning. The take-over was powered by money. The World Bank's budget for 'Health' is now triple that of WHO's total budget. With the World Bank's invasion of health care, comprehensive PHC has effectively been shelved. **Health care is no longer a human right. You pay for what you get.** If you are too poor, hungry and sick to pay, forget it. The bottom line is business as usual. Survival of the greediest!

COALITIONS for the health and well-being of HUMANITY

Primary Health Care as envisioned at Alma Ata was never given a fair chance,—and globalisation is creating an increasingly polarised, unhealthy and unsustainable world. — In response, a number of international networks and coalitions have been formed. Their goal is to revitalise comprehensive PHC and to work towards a healthier, more equitable, more sustainable approach to development. Two of these coalitions, which have both participated in organising the People's Health Assembly, are the following.

The Third World Health Network (TWHN), based in Malaysia, was started by the Third World Network, which has links to the International Consumers Union. The TWHN consists of progressive health care movements and organisations, mainly in Asia. One important contribution of the Network has been the collection of a substantial library of relevant materials, their lobby for North-South equity and the promotion of networking between Third World organisations.

The International People's Health Council (IPHC) is a coalition of grassroots health programmes, movements and networks. Many of its members are actively involved in community work. Like the TWHN, the IPHC is committed to working for the health and rights of disadvantaged people—and ultimately, of all people. Its

vision is to advance towards a healthy global community founded on fairer, more equitable social structures. It strives towards a model of people-centred development, which is participatory, sustainable, and makes sure that all people's basic needs are met.

The IPHC is not just a South-South network for underdeveloped countries, but also includes grassroots struggles for health and rights among the growing numbers of poor and disadvantaged people in the Northern 'overdeveloped' countries.

For the last two years the Third World Network and the IPHC have worked closely together in the preparations for the People's Health Assembly.



METHODOLOGIES of EDUCATION for CHANGE

One of the most rewarding activities of the IPHC was a post-conference workshop held in Cape Town, South Africa, on Methodologies of Education for Change. Health educators from Africa, Central America, Mexico, North America, the Philippines and Japan—most with many years of experience—facilitated group activities. Each demonstrated some of the innovative learning and awareness-raising methods they use in their different countries. The challenge of the workshop was **to design or adapt methods of education for action to meet the new challenges of today's globalised and polarised world.**

From micro to macro, local to global: ways of making and understanding the links
The Cape Town Workshop participants agreed that a global grassroots movement needs to be mobilised to help rein in the unhealthy and unsustainable aspects of globalisation.

To do this, learning tools, methods, and teaching aids must be developed to help ordinary people see the links between their local problems and

global powers:

- ⊗ People need to understand how their growing hardships at home (low wages, unemployment, rising food prices, cut-backs in services, growing violence, etc.) can be traced to the global forces that manage the flow of money and resources in ways that make the rich richer and the poor poorer.
- ⊗ Villagers and shanty-town dwellers in the South need to understand how decisions by wealthy, powerful men in Northern cities lead to hunger, diarrhoea and the death of their children.
- ⊗ They need to know who is responsible for the decisions that allocate vast amounts of money for weapons, pet food, tobacco, golf courses and trips to the moon, when millions of children don't get enough to eat.
- ⊗ They need to understand how the World Bank and IMF put the squeeze on poor countries to keep paying interest on their huge foreign debt...and how structural adjustment programmes imposed by the Bank and IMF—which force poor countries to cut-back on public services—make poor families pay for health care and schooling.

Having become aware of the links between their local problems and global policies, people need to learn ideas and information about what they can do:

- ⊗ They need to know what efforts are being made—locally, nationally and internationally—to oppose these harmful high-level policies and decisions.
- ⊗ They need to know what they can do personally and collectively at the local level to help work toward the changes at the global level that can shape a healthier world.

No one has a road map through these vital issues. That is why Education for Change needs to be open-ended and fully participatory. It is why the facilitator and the learning group need to look for solutions—or at least ways of coping—together. This kind of learning process, in which people learn from each other and look for a way forward together, as equals, itself becomes a microcosm of the kind of equity-oriented, people-centred, participatory environment we aspire to achieve at the global level.

Storytelling, role play and theatre for awareness-raising and change

Storytelling can be an effective way to help people understand and identify with problematic situations, and consider possibilities for strategic action. This is especially true if the story is a true one, based on something that happened in the participants' village or neighbourhood—something they are all familiar with and which concerns them deeply.

Stories for change. Stories can be told in many ways: by **storytellers**, as **skits**, as **role-play** or **socio-dramas**, or as **puppet shows**. Some of the best stories or socio-dramas for analysing situations and exploring options for action are open-ended and constructed through the participation of the entire learning group. After a key theme or problem is identified, someone starts the story around that theme, and develops it to a point of crisis or crucial choice. Then another person continues the story, up to another crisis point. Then yet another person continues it. And so on. Or after the story has been developed to a critical point, participants can divide into smaller groups, each developing the story in a different direction. Thus it becomes a way of brainstorming alternatives for action in which everyone thoughtfully takes part.

From stories to theatre to action. In Project Piactla, Mexico, sometimes participatory stories or role-play evolved into a plan for community action. Health workers in training would develop it into a theatre skit or puppet show and present it to the whole village as 'farm workers' theatre'. At times this resulted in a collective course of action to cope with the underlying problem. Below are four examples of stories or role-play that evolved into community theatre and finally into organised action.¹

- ⊗ **Problem-based story:** A few rich families illegally possess most local farmland, resulting in landlessness, exploitative share-cropping, hunger, and high child mortality.

Theatre skit (developed from story): Poor villages explore options of borrowing, renting, or invading and reclaiming unused illegally-held large land-holdings.

Consequent action: Poor farm workers collectively occupy and farm the large holdings. Eventually they demand legal title, and redistribute the land among the landless.

Results: Improved physical health (more food, fall in child mortality) and psychosocial health (self-confidence, empowerment, determination collectively to better

their lives).

- ⊗ **Problem-based story:** Alcohol. Frequent drunkenness of men leads to violence, family discord and malnutrition of children (money spent on booze).

Skit: 'Village Women Unite to Overcome Drunkenness.' Skit first shows miserable situation. Then women join together to close down the 'water holes' (illegal bars).

Action: After the skit, when a rich man opens a bar in the village, the women organise a protest, demand closure of bar and protest against alcohol-related corruption by authorities.

Results: Despite the brief jailing of health workers, the bar is shut down. Fewer killings. Better health. Newspaper articles inspire women in other villages to take similar action.

- ⊗ **Problem-based story:** Village midwives, mimicking doctors, inject hormones (pituiratin) to speed birth and 'give force' to mother. This causes needless deaths, or defects in babies.

Skit: Scene 1: Shows mother giving birth; hormone injected; baby born blue and dead. Scene 2: Same mother delivers without hormones. Baby healthy. Audience explains why.

Action: Midwives and mothers jointly decide: NO HORMONE SHOTS FOR NORMAL BIRTHS.

To reduce bleeding, mothers breast-feed newborn babies at once (to free natural hormones).

Results: Fewer ruptured uteri; fewer epileptic, dead or brain-damaged babies; demystification of modern medicines; more appreciation of the body's own abilities.

- ⊗ **Problem-based story:** Poor families borrow maize from the rich at planting

time, pay back triple at harvest time; this leads to big debts, increased poverty and hunger.

Skit: Shows how high interests on maize loans devastate poor farming families. Then families come together to form a co-operative grain bank—with success.

Action: Health workers help villagers start the co-operative maize bank, which loans grain at low interest rates. They also build rat and insect-proof storage bins.

Results: The maize bank pulls poor farmers out of debt. Eventually they are able to produce surplus grain and have no need borrow. Better fed, healthier children; fewer die.

Stories linking local problems to global policies

While the above stories and skits proved useful in their day, they are dated. They focused on local problems that to a large extent had local solutions. For example, landless villagers could join together and 'reclaim' land-holdings that were illegally large. But today many of the people's most disabling problems have their roots in international trade and the global economy. In preparation for the North American Free Trade Agreement (NAFTA), the Mexican government was forced to change its Constitution. Agrarian Reform laws, which had protected the land rights of poor farmers were annulled. As result, poor farmers are losing their ancestral land. Two million have migrated to city slums, where the glut of jobless workers has reduced real wages by 40%. Resulting hunger and despair have led to a wave of crime and violence. The village of Ajoya (where the above stories and skits helped people solve earlier problems) has had 10 kidnappings, frequent killings, and repeated hold-ups of buses. In their current 'community diagnoses', villagers see crime and violence as among their biggest health-related problems.

Similar situations now exist worldwide. A few years ago, when Mexican school-aged children did their own 'community diagnoses', they identified problems such as diarrhoea, coughs, skin sores and 'being too thin' as their biggest health-related problems. But today—whether in Mexico, the Philippines, Pakistan, South Africa, or the slums of Chicago (USA)—children tend to identify as their biggest health-related problems such things as crime, violence, drunkenness, drugs, fighting within families, beating of children and similar social issues. **These symptoms of system failure and social upheaval can often be traced to the global policies that are deepening poverty, undermining workers' rights, reducing jobs and**



wiphan news, vol 20, summer 1996

wages, and cutting back on public services.

People in poor communities around the world suffer the effects of these global policies, often without even knowing such policies exist. They have little awareness of how decisions made by overfed men in suits sitting around a table at the World Bank translate into fewer health services and more costly medicines for their sick children.

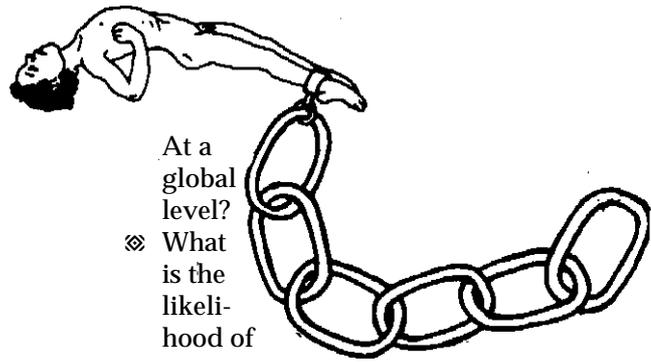
For the new ‘macro-problems’ of the 21st Century, new kinds of awareness-raising stories are needed—stories that make the links between local problems and global events; stories that build a chain of causes from shanty-town hardships to global boardrooms.

In preparation for the People’s Health Assembly, persons involved in community health activities (and in all sectors affecting the well-being of people or the environment) are being asked to **collect eye-opening stories that make this kind of ‘micro-to-macro’ or ‘local-to-global’ links.** One example of such a story—called ‘The White Death’—is included in the Preparatory Packet for the PHA (and is briefly summarised in this paper).

The ‘But why? game’ and the ‘chain of causes’—used with stories for situational analysis

Of various participatory learning methods to raise awareness of the root causes of poor health, ones involving **situational analysis of a true story** have proved successful in many countries. The process is in four parts:

1. The story portrays a series of events that lead up to a tragic ending, such as the death of a child. (People’s attention is captured better if the story is based on a recent, local sequence of events, which everyone is familiar with.)
2. After the story, participants play a (usually very serious) ‘But why?’ game, to itemise and analyzing the series of factors leading up to the child’s death.
3. Then they collectively build a ‘chain of causes’ linking the sick child to the grave.
4. Finally, the group discusses which links of the 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 informed action of a concerned individual?
 - ⊗ Which links require action at the family or community level?
 - ⊗ Which require action at a national level?



- At a global level?
- ⊗ What is the likelihood of successfully breaking different links?
 - ⊗ What are the preparations and resources needed? What are the risks?
 - ⊗ With which links can we most effectively begin to take action?

‘The Story of Luis’—presented in the handbook, *Helping Health Workers Learn*—has been used effectively as a teaching tool in health programmes around the world. Based in a Mexican village, this true story unveils the ‘chain of causes’ that lead to a boy’s death from tetanus.²

The ‘But why?’ game (an example analysing a child’s death from diarrhea). After the story to be analysed is told, the facilitator asks a series of questions and participants answer. In response to each answer the facilitator asks ‘But why?’. Here is an example of how the ‘But why?’ game might develop from a story of a child’s death from dehydration due to diarrhoea:

Juanita died from dehydration.... But why?
‘Because she had severe diarrhea.’ ... **But why?**
‘Because she swallowed harmful germs.’ ... **But why?**
‘Because the family didn’t have a latrine or clean water.’ ... **But why?**
‘Because her father had no money to install them.’ ... **But why?**
‘Because, as a share-cropper, he had to pay half his harvest as rent?’ ... **But why?**
‘Because he didn’t own any land himself.’ ... **But why?**
‘Because the government failed to enforce the Agrarian Reform laws.’ ... **But why?**
‘Because rich land barons bribe politicians, and no one stops them.’ ... **But why?**

When one series of causes is exhausted, the facilitator can ask questions exploring another series. A sequence of questions may lead from local to national factors (as above), or even international ones (as below). Note that answers need not come only from details of the story; participants can also draw on their own observation, knowledge and previous awareness-raising discussions.

Oral rehydration therapy (ORT) can help prevent death from dehydration. Yet Juanita didn't receive ORT ... But why?

'Because her mother couldn't afford commercial packets of oral rehydration salts (ORS), and hadn't learned to make a low-cost rehydration drink at home.' ... **But why?**

'Because the government, which used to give ORS packets free to poor families, now makes people pay.' ... **But why?**

'Because the World Bank required that health ministry introduce 'cost recovery' by charging for medicines and services.' ... **But why?**

'Because our country has a huge foreign debt and has to pay by cutting benefits to the poor.' ... **But why?** ... Etc.

Building the chain of causes. To extend the situational analysis of the 'But why?' game, the learning group can build a chain of causes. To make learning more dynamic, large links can be cut from cardboard. To add to the depth of the analysis, five categories of links can be labelled as:

- PHYSICAL (things)
- BIOLOGICAL (worms and germs)
- CULTURAL (attitudes and beliefs)
- ECONOMIC (money)
- POLITICAL (power)

To these five—because it is increasingly important in the causal chains—some folks add:

- ENVIRONMENTAL (nature of our surroundings)

Two additional figures can be made of cardboard, one representing the sick child and the other a tombstone. These figures are attached to a wall (or trees) about two metres apart. With the cardboard links, the group builds a 'chain of causes' from the child to her grave. Each participant has one or more cardboard links. The story is told again, using the method of the 'But why?' game. Each time a cause is stated, a person with a corresponding link (for example ECONOMIC) comes forward and hooks her link into the growing chain. Eventually the chain extends from child to grave.

The process of participatory analysis. Though the story may be based on the death of a real child and a sequence of real events, the process of analysis, with construction of the causal chain, can and should be somewhat open-ended. The sequence of causes (both in the 'But why?' game and using the cardboard links) can develop in a variety of directions, following the lead of the group. Partici-

pants may have knowledge of local events or factors not included in the original story. These add important new dimensions.

Discussion and debate—and the airing of different opinions—are encouraged. The purpose of the activity is to help participants explore issues in depth and form a comprehensive, multidimensional picture—like fitting together pieces of a puzzle.

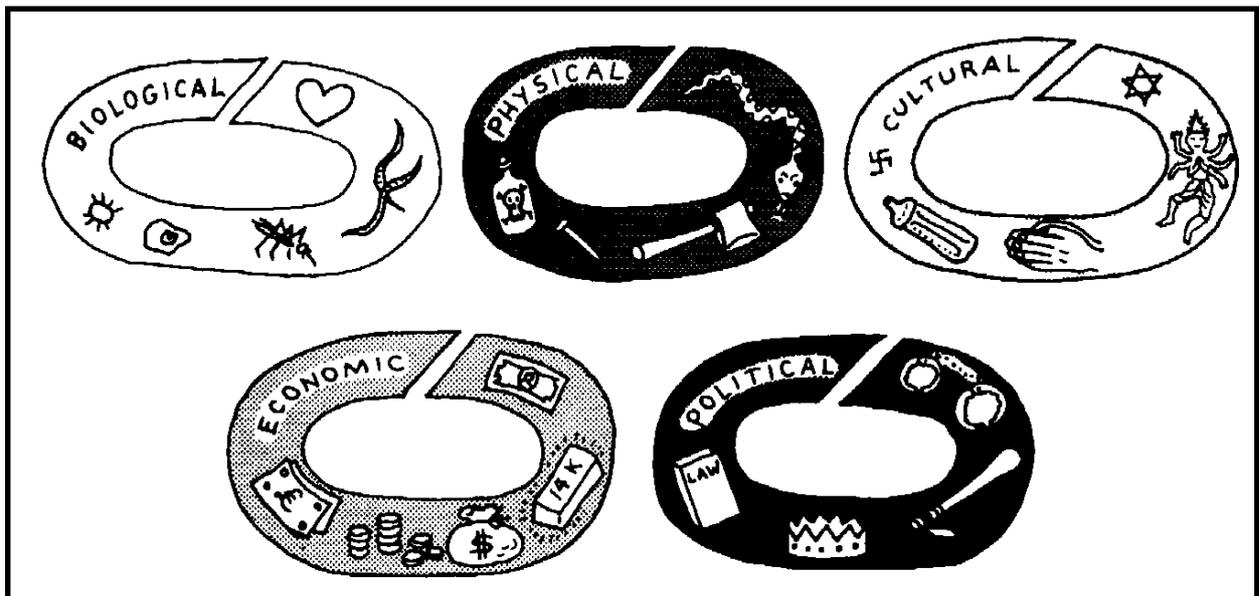
Some participants may argue that building a linear chain of causes is simplistic, that causal factors interlink in many ways, more like a web than a chain. Some programmes prefer to build a mosaic on a blackboard rather than connecting cardboard links. Teaching methods (like oral rehydration technology) can always be improved. Group criticism and collective improvement of the teaching methods should be actively encouraged. This, too, is 'education for change'.

Breaking the links. Perhaps the most important part of the 'chain of causes' activity is the follow-up discussion about WHAT TO DO. Studying the causal chain, the group considers **which links they may be able to break** and **what action to take**. Some links can be broken through individual action (such as a mother learning to make a homemade rehydration drink). Other links may require community action (such as putting in a communal potable water system). Yet others may require joining national or international networks or coalitions (such as participation in the campaign of Health Action International to restore the right to free essential medicines to families too poor to pay).

Examples of stories with local-to-global links: 'The White Death' and 'The Story of Sam'

The packet of materials for the People's Health Assembly titled 'Invitation to Participate in Pre-Assembly Activities,' includes as examples three stories that make local-to-global connections. The first two, 'The White Death' and 'The Story of Sam,' are designed to be followed by 'But why?' and 'chain of causes' activities.

'The White Death' is adapted from a story developed with village women in Sierra Leone, Africa. It tells of a woman who becomes ill and finally dies from 'weak blood' (anaemia), identified by the women as their most important health problem, and the biggest killer of women. Through group discussions and use of innovative teaching aids (such as a mosquito made from syringe and bits of a tin can) the women came to realise that 'weak blood' has many interrelated causes and to understand why it kills more women than men.



They found the causes for 'the white death' range from LOCAL to GLOBAL and from BIOLOGICAL (e.g., malaria) to CULTURAL (e.g. men have first grabs at available meat) to ECONOMIC and POLITICAL (e.g. to produce money for foreign debt payment, the country is required by the World Bank to cut down native forests that used to have iron-rich game animals and herbal cures for malaria).

By piecing together this story from their own collective experiences, and then retelling it using 'But why?' questions and a 'chain of causes,' the women gained better understanding both of their own bodies and of the links between their local health problems and global economics.

With their new knowledge about the multiple causes of weak blood, the women were better able to take *personal action* such as growing and eating blood-strengthening foods, and *collective action* such as joining the growing trans-African movement to require the World Bank to be more responsive to human and environmental needs.

Stories like 'The White Death' and 'The Story of Sam'—and other stories that are pieced together locally around common concerns—can help ordinary persons understand how their local hardships are linked to global forces. Analysis of the stories can help prepare people to take meaningful part in the growing worldwide debate about **how economic and development policies should serve human and environmental needs, and how to make high-level decisions more transparent and more democratic.**

DISCOVERY-BASED LEARNING—AND LEARNING BY DOING

The effort to make global policies socially just and democratic will be an uphill battle. The world is unwisely ruled in a selfish, shortsighted way by a tiny privileged minority with huge wealth and power. To change this situation for the common good will require a vast united front of concerned people. Folks from all races, nations and walks of life—farmers and labourers; the jobless and the underpaid; the poor, the hungry and the sick; prisoners; illiterates, students and academics; the middle class, and even the very rich who worry for their children's future—must understand the big issues and what is at stake.

But understanding the issues is not easy. As we have already pointed out, **institutionalised disinformation is the modern tool of social control.** Schools, newspapers, television and market propaganda are designed to keep those on top on top by 'manufacturing consent'. For people to find their way through the maze of politically filtered information, cover-ups, and the Siren-like incentives to conform without questioning, requires—above all else—**an ability to observe and think for oneself.**

To transform our top-heavy system will require a massive uprising of peace-loving fighters for social justice—people who can sort their way through the beguiling veil of disinformation, and discover for themselves what is happening around them, for better and for worse. For such a massive movement of thoughtful, well-informed people to be formed, a simultaneous educational revolution is needed, one that espouses **a less authoritarian, more liberating approach to teaching and learning than most of us were schooled by.**

We have mentioned the enabling educational methods of Paulo Freire and others. A related approach is called 'discovery-based learning', now much used in community health education.

Discovery-based learning encourages participants to make their own observations and arrive at their own conclusions. The facilitator does not push ideas into people's heads, but helps to draw them out. This action-packed, problem-solving approach helps people think for themselves and gain confidence in their own perceptions and experience. In many community initiatives this empowering methodology has become a basic tool in 'education for change'.

Discovery-based learning and learning by doing go hand in hand. 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 discover it, I use it.

When teaching methods enable learners to build on their own observations and discoveries, the knowledge they gain is their own. They can apply it, adapt it, and build on it more effectively. Also, it equips participants to learn about other things directly, to dig out the truth for themselves rather than to swallow unchewed what teachers and TV tell them. Thus it prepares people to be actors on life's stage, not just passive followers. It helps transform people living in quiet resignation into active agents of change.

The gourd baby—a tool for teaching that uses discovery-based learning

A classic example of discovery-based learning involves the 'gourd baby,' a teaching aid to help groups of mothers, school children, health workers, and others learn about diarrhoea and 'the return of liquid lost' (dehydration and rehydration). We include discussion of the gourd baby here, not because of the linkage of the high child death rate from diarrhoea to the global economy, but because the gourd baby is such a delightful tool for teaching community educators about an empowering and effective way of teaching.

The teaching aid is made from a hollow gourd, preferably the kind with a narrow neck separating two round ends. (A plastic bottle will also work.) The gourd, painted to look like a baby, has all the 'holes' that a real baby has (mouth, urine hole, butt hole, and two tiny eyeholes for tears. The mouth,

urine and butt hole are stoppered with small plugs. The round opening at the top of the gourd represents the baby's fontanel (soft spot) and is covered with a small cloth.

The challenge for the facilitator is to help the learning group discover the signs of dehydration, without telling them. To do this, the group experiments with the gourd baby. They fill it with water, pull the plug to give it diarrhoea, and watch what happens. They observe the soft spot sink in, then the eyes stop forming tears, and the urine flow slowing down. They conclude that these signs occur because water (diarrhoea) is flowing out. Thus they discover the signs of dehydration. Because they discover these signs in a hands-on way (learning by doing) and by drawing their own conclusions from their direct observations (discovery-based learning) they never forget it.

Through similar hands-on experimentation with the gourd baby, learners observe that to prevent the 'baby' from dehydrating when it has 'diarrhoea,' they must replace at least as much fluid as the baby is losing. (This discovery is extremely important, since studies show that village mothers taught in the typical top-down way ('Do what I say and don't forget!') often give rehydration drink to their dehydrating baby as if it were a liquid medicine, a spoonful now and then. When their babies die, they spread the word that oral rehydration therapy doesn't work. So the underuse of ORT and corresponding overuse of costly, useless anti-diarrhoeal medicines continue worldwide.

Many benefits derive from the gourd baby methodology. Mothers who learn about diarrhoea management from their own observations are in a better position to question the many puzzling things they are told. For example, following standard advice, many mothers spend their last food money on commercial packets of oral rehydration salts (ORS) when they could get as good or better results by giving their baby home-made rice or maize porridge with a little salt. It is important that mothers learn to value their own experience and to critically question directives from outsiders unfamiliar with mothers' day-to-day circumstances, limitations, and abilities.³

community diagnosis as INTRODUCTION to discovery-based learning

Many health-worker training programmes, as well as local gatherings to resolve unmet needs, use 'community diagnosis' or 'situational analysis' to start off the group process of identifying and prioritising health-related problems or other shared concerns.

There are many ways to conduct a community diagnosis. The most successful ones tend to be hands-on, action-based and designed to encourage full, thought-provoking participation.

One approach to community diagnosis that has been used effectively in many countries uses a flannel-board and small pieces of cloth with line drawings of different health-related problems. By using pictures rather than written words, non-literate people can participate in creating a graphic representation of the problems in their community and evaluate their relative importance.

First the group places on a large flannel-board (or blanket on a table tipped on its side) drawings of all the health-related problems they can think of. If there is no pre-existing drawing of the problem, the person who volunteers that problem creates a quick sketch to represent it. It is important the group include not just 'health problems' or 'sicknesses', such as diarrhoea and skin infections, but also 'health-related problems', such as poverty, smoking and unfair land tenure. (To help people understand the broad spectrum of 'health-related problems', it is often helpful to first tell a story using the 'But why?' game and 'chain of causes'.)

After the major problems affecting community



health are put in rows on the flannel-board, the group systematically analyses their relative importance. To do this, they use small flannel figures, representing the different characteristics that need to be considered when weighing the relative importance of each problem.

Little round faces represent **frequency**: how often the problem appears in the community, and how many people it affects. Everyone is given several little faces, which they take turns placing next to the problems they consider most common. As more faces are added, the group tries to agree on a pattern of relative frequency.

Skulls represent relative **severity**: how likely the problem is to cause life-threatening illness or death. Persons place skulls of different sizes next to problems, trying to arrange them according to how relatively dangerous or deadly they are.

Three little faces, with arrows from one face to the others, represent **contagion**. Participants place these figures on the problems or illnesses that spread from person to person.

A long wiggle arrow represents a problem that is **chronic**. Participants place these figures on the problems that are long-lasting, or have long-lasting effects (like polio).

This graphic portrait of the relative frequency, severity, contagiousness and duration of the problems helps the participants weigh their relative importance in the community.

However, another factor also needs to be weighed: **How are the different problems interrelated? Which problems that contribute to or lead to some of the others problems?** Participants place pieces of yarn between problems where they believe there are causal links. The end result is a complex **web of causes**. It becomes clear that **some of the problems listed are 'root causes', which contribute to many of the other problems.**

The final step in this process of community diagnosis is to discuss **where to begin**. The graphic representations help the group get an overall picture of the relative importance of interrelated problems affecting the community's well-being. In constructing a plan of action for improving their situation, the group needs to consider:

⊗ What is the relative importance of the different problems? (As investigated

above)

- ❖ Which are the underlying problems that contribute to many other problems? (Also investigated above)
- ❖ Which problems can be dealt with locally, safely, with limited investment and with positive, visible results? (It is often wise to start by taking action against problems that are likely to have fairly quick positive solutions that everyone can see and appreciate. Good early results help build confidence and bring more people on board, in order to tackle more difficult or risk-incurring problems at a later date.)
- ❖ What are the resources, human and otherwise, required to overcome the different problems?

Seeking answers to these questions helps the group decide where to begin. As discussed earlier, some problems can be resolved at the individual or family level, others at the community level. Many of the biggest, underlying problems that link back to the global power structure cannot be resolved at the local level. However, certain coping measures may help the community cope better with the hardships caused by the underlying global problems.

For example, faced with privatisation of health services or the introduction of user fees, a village might set up a community 'health insurance' plan. That way the whole community helps pay the emergency medical costs of one of its members, when disaster strikes.

Although it is often wise to begin by attacking



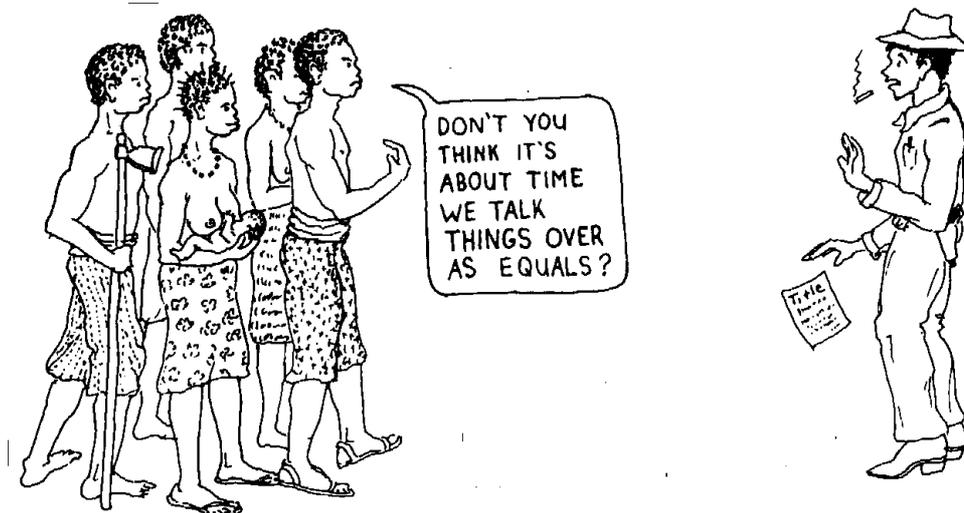
easy-to-resolve local problems when planning local action, it is important not to lose sight of the underlying problems at the macro (or global) level. However, strategies for taking local action on global issues require a different approach. They involve networking or joining coalitions and taking part in key demonstrations. They may involve educational campaigns to raise local awareness so that more people vote for politicians who dare to take a stand for the interests and needs of the common people.

child-to-child Empowering children to become CARING AGENTS of CHANGE

The children of today are the social architects of tomorrow. If children are to grow up to be independent thinkers and compassionate agents of change, they need to be encouraged to learn from experience and to draw conclusions from their own observations, not just to memorise lessons and do what they're told. If they are to help construct a more healthy, more caring world, children need a learning environment based on co-operation rather than competition, where helping one another to advance together—and giving friendly assistance to those who might fall behind—is valued more than getting top grades.

Child-to-Child is an innovative educational methodology in which school-aged children learn ways to protect the health and well-being of other children, especially those who are younger or have special needs. Launched during the International Year of the Child in 1979, Child-to-Child is now practised in over 60 developing countries as well as in Europe, the USA and Canada.

Child-to-Child does much more than impart information to kids about common health problems. At best, it is a liberating experience that helps children learn to think for themselves and work together to create a healthier, more caring environment. Children learn to reach out in a friendly, helpful way to those who are most vulnerable.



Child-to-Child emphasises learning through experience. (The gourd baby as a tool for 'discovery-based learning' was first developed through a Child-to-Child activity.) Rather than simply being told things, **children conduct their own surveys, perform their own experiments**, and discover answers for themselves. They are encouraged to think, observe, explore, analyse and invent. This makes learning an adventure, and fun. Children develop ways of looking critically and openly at life. The activities encourage independence of thought and co-operative spirit that helps form leaders in the process of change.

In Child-to-Child, children learn to work together and help each other. Older students organise to help teach younger ones. Younger ones conduct activities (storytelling, puppet shows, seeing and hearing tests) with pre-school children. Everybody teaches and everybody learns from each other.

Child-to-Child is pertinent to the process of social transformation. When introduced into schools as it has been in many countries, it can help make schooling more relevant to the immediate needs and lives of the children, their families and their communities. It introduces methods of 'education for change' into the classroom, counteracting and undermining the authoritarian, conformity-building, status-quo-conserving role of the conventional school system.

Latin America has taken the lead in introducing 'education for change' methodology into the Child-to-Child process. Typically, a group of children starts off by conducting their own 'community diagnosis' (as described above). Or they build 'chain of causes' stories (or draw composite pictures of 'our community' to explore the interrelated problems in which they live.

We mentioned above how children in many parts

of the world, in the process of their community diagnosis, now tend to say that **their most important problems affecting their well-being are violence, gangsters, drunken parents, fighting between parents, and cruel treatment by adults.** This 'diagnosis' makes it much more difficult for the children to take a lead in corrective action on their own. However, the mutual understanding and support that comes from sharing their common concerns can be of great assistance to children who fell lost and forgotten in a world where money rules and where democratic principals, human rights, and basic needs are grievously neglected.

Child-to-Child is important to the process of social transformation because it helps children develop skills and values based on kindness, understanding, defence of the underdog, and the joy that comes from working cooperatively for the good of all. It can help the children of today become more able and compassionate architects of tomorrow.

CONFIDENCE- BUILDING

To be fully healthy requires self-esteem. An internalised low self-image is one of the biggest obstacles to the full participation and involvement of people who have been marginalised, disempowered and kept in a subservient role. They have been told so often that they are worthless and ignorant and lazy that they begin to believe it. Their lack of respect for their own qualities prevents them from joining in the struggle for fairer social structures.

For this reason, 'education for change' puts a lot of

emphasis on confidence-building. It values and builds on the experience, ideas and opinions of participants. It helps villagers rediscover value in their traditional beliefs, customs and forms of healing. It demonstrates that the knowledge, understanding and compassion of individuals who cannot read or write can be as important to sustaining health as the knowledge and abilities of highly trained professionals.

People with little formal education to help them stand up for their rights must free themselves from the low self-image that has been thrust upon them. They need to discover that they have a wealth of knowledge, skills, and human qualities, which privileged folks often lack. To provide new insight and build the self-confidence of underprivileged people, stories that temporarily reverse social roles (as in Charles Dickens' 'The Prince and the Pauper') are especially helpful.

Fables for building confidence and self-esteem: an example. In the mountains of western Mexico, village health workers in training often began with low self-esteem. They saw themselves as too 'backward' to master even the most basic skills of health professionals. Doctors in the city hospitals—as if by God's will—were somehow smarter, better and more gifted than they were. From their limited exposure to school (for those who had any) they felt more comfortable passively memorising facts than actively learning through an open-ended, problem-posing process based on their own knowledge and experience.

For trainees with a low opinion of themselves and their abilities, the following fable—developed through group discussion—about a doctor in distress, proved enlightening.

Facilitator: Suppose a huge hurricane has destroyed the coastal city. Days later a doctor

who survived the disaster arrives at our mountain village. Exhausted and hungry, he has only the clothes on his back.... How would you treat him?

Villagers: Well, we'd give him something to eat. We'd probably invite him to stay in one of our huts until he figures out what to do.

Facilitator: Why would you do that?

Villagers: When a person needs help, we do what we can. Even for a stranger. If we didn't help each other in hard times, we wouldn't survive.

Facilitator: Suppose the doctor, lost without his medicines and hospital, decided to plant maize (corn) on the mountainside, like you folks do?

Villagers: He couldn't do it! Not without help. First, he'd have to cut down the brush with a machete, poor guy. I've seen those doctors' hands: their soft as silk! He'd get blisters in no time! And he doesn't know the poisonous snakes, scorpions and stinging trees. Or which wild fruits are edible. Or which cactus have drinkable water. Or how to keep the insects, birds and peccaries from eating his crops. Alone, he couldn't make it!

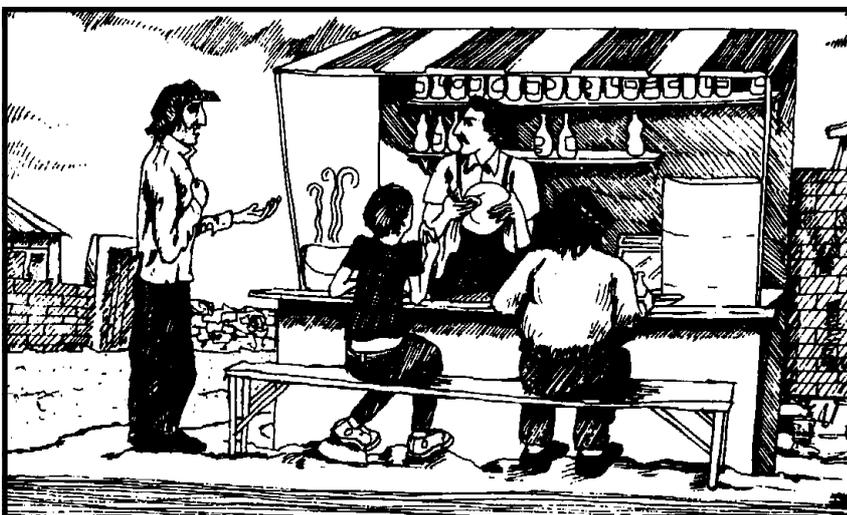
Facilitator: And would you help him learn to farm?

Villagers: It would be lots of work.... Like teaching a kid. It takes a person years to learn how to survive in these hills.

Facilitator: But you would help him?

Villagers: We couldn't just let him die!

Facilitator: For helping him



survive, how much would you ask him to pay you?

Villagers: To pay? How could we? You said he arrived with nothing.

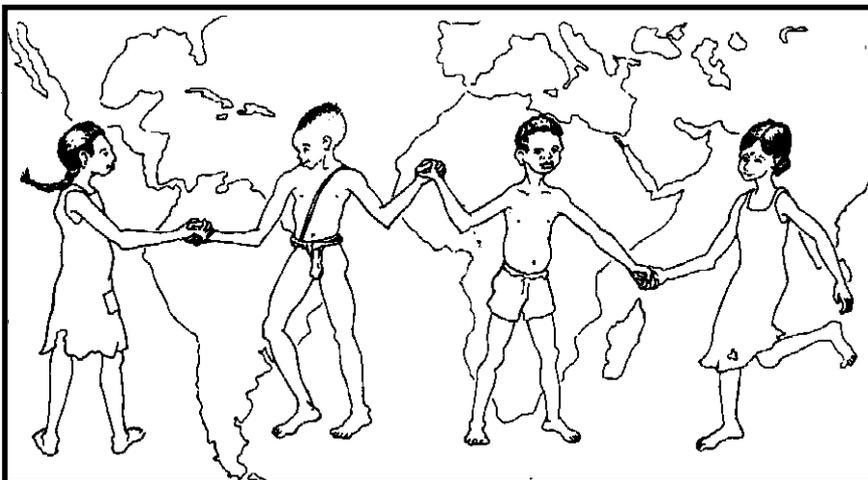
Facilitator: You are very kind! ... Now let us imagine that tomorrow one of you breaks a leg. So you go to a doctor in the city. If you don't have any money, will he treat you?

Villagers: No way! ... That's true. My mother died because we had no money to pay the doctor!

Facilitator: And yet you would help the doctor who has nothing, after the hurricane?

Villagers (after muttering among themselves):
 'Spouse so.

This sort of awareness-raising dialogue helps people with little formal education realise they have a wealth of life-protecting knowledge, skills, and values—different from the 'highly educated,' but no less important. It helps them discover a new sense of self-worth and take pride in their own qualities and experience. The self-confidence they gain lets them stand up to others as equals, and become actors in building a more equitable and compassionate society.



CONCLUSION: towards *interaction* to *transform* the **WORLD**

When, 40 years ago, Paulo Freire wrote that **with critical awareness disadvantaged people can 'transform the world'**, social scientists said he spoke metaphorically. 'Transform the world' meant to change and improve your local situation, your immediate surroundings. No doubt, our own back yard remains a good place to begin. In the words of E. F. Schumacher, 'Start small!'

But the world has changed since Freire's time. Globalisation—with its hazardous trade agreements, structural adjustment policies, cut-backs of public services, and institutionalised neglect of those in need—has made comprehensive change at the local level harder to achieve. Disadvantaged people—even nations—have less and less voice in decisions that shape their well-being.

Freire's insistence on 'transforming the world' was in some ways prophetic. Today, for local communities to overcome the injustices and inequities that diminish quality of life, they must join the growing international grassroots struggle literally to **CHANGE THE WORLD**. Not until the world's resources and power are more fairly shared, can sustainable well-being for all—or for anyone—be achieved.

To transform the world's power structure, we the world's people, in all our marvellous diversity, must learn to **respect our differences and embrace what we have in common**. We must work together as a family: locally, nationally and internationally. **To build the global solidarity we need, we must first of all find ways to communicate truthfully and directly, relying not on the mass media but on the media of the masses.**

The Internet, for those with access to it, provides an avenue for fast and free (potentially liberating) communication. No less important are the communication tools of less privileged folks: storytelling, street theatre, neighbourhood 'rags,' awareness-raising comics and novels, community radio and TV,

and the alternative press. As the Battle in Seattle made clear, well-planned protests, demonstrations, open forums and strategic civil disobedience also have their time and place. Such organised resistance serves not only to impede abuses of the power structure, but to raise awareness of more people.

We cannot transform the world in a day. Years of organised struggle will be needed to build the kind of compassionate, foresighted, global democracy in which solidarity defends diversity and safeguards the sustainable well-being of the planet and its people.

In building the foundations of action for change, education of children—and of us grown-ups, too—is essential. **The best education is not only free, but freeing.** It gives people tools for independent thought and social responsibility. It enables people to discover what makes our social order tick, and then to figure out a course of action to help improve the situation in which we co-exist.

The transformation of our schools (and colleges and universities) into centres of education for change is essential for social transformation. This is why Child-to-Child—with its participatory, problem-solving, child-led approach—is so important.

But we also need adult-to-adult (and adult-to-child) activities that bring diverse people together for the common good. At all social levels—cutting across the divisions of race, class, age, gender and areas of concern—people need to identify common ground and take collective action for change.

The role of non-government organisations is critically important. NGOs concerned with human well-being and with environmental protection need to work together. NGOs in a range of fields need to form networks and coalitions to take the unified action needed to have an impact on global decision-making. The International People's Health Council is one such coalition.

The People's Health Assembly promises to be a big step forward. But if it is indeed to contribute to creating a healthier world in these difficult times,

it must be much more than a single meeting of 600 or so people who fly to Bangladesh in December 2000. Preparatory activities and follow-up are as important as the December meeting itself, and need to be oriented towards education and action.

One of the most important aspects of the PHA, with its pre- and post-assembly activities, is what Paulo Freire called **critical awareness-raising**. Only when enough people from all countries and cultures and fields of endeavor become painfully aware of the enormous injustices and inequities of our present global system—and the dangers these inequities bear for our common future—can we collectively tip the scales of the global agenda to put the needs of the many before the greed of the privileged few.

Notes

¹ These short summaries are oversimplified. More detailed versions can be found in the book *Helping Health Workers Learn* by David Werner and Bill Bower.

² For details about the methods of story-telling for participatory analysis using the 'But why?' game' and 'Chain of Causes', we suggest you read Chapter 26 of *Helping Health Workers Learn*.

³ The gourd baby and discovery-based learning are discussed in the book *Helping Health Workers Learn*. The debate on oral rehydration therapy is covered in *Questioning the Solution: The Politics of Primary Health Care and Child Survival*.



A biologist and educator by training, *David Werner* has worked for the past 33 years in village health care, community-based rehabilitation, and Child-to-Child health initiatives in the Third World, mainly Mexico. He has authored the books "Where There Is No Doctor" (now in 86 languages), "Helping Health Workers Learn," "Disabled Village Children," "Questioning the Solution: The Politics of Primary Health Care and Child Survival", and "Nothing About Us Without Us: Developing Innovative Technologies For, By and With Disabled Persons." He has been a consultant for UNICEF, WHO, the Peace Corps, UNDP, and UN-ESCAP and has received awards and/or fellowships from the World Health Organization, the American Pediatric Association, The American Medical Writers Association, Guggenheim, and the Macarthur Foundation, among others. He is a founding member and North America coordinator of the International People's Health Council, co-founder and Director of HealthWrights (Workgroup for People's Health and Wrights), and a Visiting Professor at Boston University International School of Public Health.



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