CHECK LIST OF HEALTH EDUCATION MATERIALS

VOLUNTARY HEALTH
ASSOCIATION OF INDIA
40, INSTITUTIONAL AREA
SOUTH OF I.I.T., NEW DELHI-110016
PHONES : 668071, 668072, 665018

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Where There Is No Doctor—a village health care handbook

David Werner—revised for India by C Sathyamala, pp 510, 1986, Rs.60.00 VHAI

This is not a conventional medical book. The scope of this book with nearly 1,000 illustrations enables a reasonably educated person to acquire enough knowledge of:

*What to do in an emergency and

*What preventive measures can be taken to keep the village community healthy.

This book is for mothers, midwives, health workers, teachers, village leaders, social workers, religious leaders, doctors and everyone who is interested in health care. A must for all homes, sub-centres and dispensaries.

Jahan Dactor Na Ho—This is the Hindi version of Where There is No Doctor

The Feeding and Care of Infants and Young Children

Shanti Ghosh, pp 190, 1985 (5e), Ordinary Rs 18.00, Deluxe Rs.33.00 VHAI

This is a revised and enlarged version of the earlier edition. In this book the author authoritatively interprets the best ideas from recent Indian research on child care and nutrition. The advice given is practical, based on the author's many years of experience as Professor of Paediatrics at Safdarjung Hospital, New Delhi.

This will prove to be a good reference book for doctors, nurses, health workers and parents.

A Taste of Tears

Mira Shiva and Aspi B Mistry, pp 118, 1986, Rs 8.00, VHAI

This is the first in the Health Action Series. 'A Taste of Tears' was first conceived and published as a special issue of Health for the Millions. This book simplifies the concept of Oral Rehydration

Therapy in the treatment of diarrhoea. One of the main objectives of this book is to get hospitals and doctors accept the rationale of ORT and incorporate it even in the hospital situation. Consequently some stress is laid also on the more technical and theoretical aspects of the subject.

This book will come handy for middle level health workers and will expose them to information on diarrhoea management in their work in the community.

This book is now available in Hindi also.

Nada Chulha—a handbook

Madhu Sarin, pp 128, 1984, Rs 15.00, VHAI

This handbook has been specially prepared for use by workers involved in spreading the improved immovable chulha. An improved chulha helps women improve their daily lives. The Nada Chulha design, the method for promoting it have evolved out of a learning by doing approach. This handbook along with its companion publication will meet a long felt need for teaching and working documents on the improved chulha for field workers.

How to Make and Use the Nada Chulha — Chulha Mistry's Manual

Madhu Sarin, pp 73, 1984, Rs 8.00, VHAI

This is specially prepared for use by village women trained for work as Chulha Mistries, including those who cannot read or write.

A Manual of Learning Exercises—for use in health training programmes in India

Ruth Harnar, A.C. Lynn Zelmer and Amy E Zelmer, pp 70, 1983. Rs.15.00 VHAI

This manual is the outcome of years of experience in workshops

and short courses carried out in most of the states of India by the staff of VHAI.

Participative learning exercises have come to be a major part of these courses. Participatory methods are much more likely to change attitudes and lead to action in the field programmes of health care institutions and community health and development programmes. This manual should prove useful in preparing and motivating new health workers, others on the health team and anyone interested in working with the people and community.

Helping Health Workers Learn—a book of methods, aids and ideas for instructors at the village level

David Werner and Bill Bower, pp 640, 1983, Rs.72.00 VHAI

The book is based on 16 years' experience with a village-run health programme in the mountains of western Mexico. Although many of the teaching ideas described here were developed in Latin America, methods and experiences from at least 35 countries around the world are discussed.

The focus of this book is educational rather than medical, especially written for instructors and health workers who live with the people in villages.

Manual for Child Nutrition in Rural India

Cecile De Sweemer, Nandita Sen Gupta and others, pp 271, 1981 (2e), Rs.25.00 VHAI

Born of the famous Narangwal Project, Punjab, this manual of 12 chapters adequately covers the scope of nutrition in rural India.

The basic principles of nutrition are defined and thoroughly discussed with examples, illustrations, graphs and charts. Availability or non-availability of food and its reasons are discussed in detail, as also how to teach the family help itself in such situations.

Management Process in Health Care

S Srinivasan (Ed), pp 650, 1983, Rs 45.00, VHAI

This is a book on the management of health care institutions. Written by a team of people with training and experience in administration, it is meant for managers and those interested in the art of management. In fact it will be of interest to all involved in organising for health, be it in a hospital, a dispensary, a community or a special care home for the disabled.

The book is meant as a guide. It can be used as a textbook or a reference for basic principles and practices. It presents the Indian experience of health care management by putting together notes, cases and articles. The focus is more on the process of planning, activating and reviewing than on tools and techniques of management.

In Search of Diagnosis—an analysis of present system of health care

Ashvin J Patel (Ed), pp 175, 1985, Rs 12.00, MFC

This is the first anthology of the articles selected from the back issues of Medico Friend Circle bulletin. The articles attempt to evolve a pattern of medical education and methodology of health care relevant to Indian needs and conditions. Medico Friend Circle is a nation-wide current which critically analyses its own profession and tries to grapple with alternative strategies in the field of health, with a view to creating a just, rational and humanitarian medical system. Medical students as well as interested public will find this book thought-provoking.

Health Care Which Way to Go?—an examination of issues and alternatives

Abhay Bang and Ashvin J Patel (Ed), pp 256, 1985, Rs 15.00, MFC

This book is the second anthology of articles selected from the back issues (24th-52nd) of the Medico Friend Circle bulletin. It covers a wide range of topics with varied views and styles, touching vital issues about people's health.

Under the Lens—Health and Medicine

Kamala S Jaya Rao (Ed), pp 326, 1986, Rs 19.00, MFC

This book is the third anthology of articles selected from the back issues of MFC bulletin. The authors have tried to show the wrong paths in health care, traps on seemingly right paths and a frightening pattern of "no health". This book is an attempt to bring under focus issues which have hitherto been missed or ignored, to adequately magnify them and to put them in proper perspectives.

Teaching Village Health Workers—a guide to the process

Ruth Harnar, Anne Cummins, 1978, Rs 30.00, VHAI

This is a teaching kit in three parts. The first part contains the process of planning of the teaching of VHWs, the curriculum, lessons, ways of teaching and simple audio-visual aids to make in villages. The second and third parts contain a teaching guide/ curriculum charts/lesson plans etc.

A basic illustrated book about the concep an training of VHWs, the contents were drawn from prolonged discussions with village health workers, health teams, medical professionals, government officials, social workers and social scientists.

Banned and Bannable Drugs

Health Action Series-2

Catriona Robertson, Dr. Ali Mardanzai, Dr. Mira Shiva, pp. 68, 1986, Rs. 10.00, VHAI

Dangerous Medicines — The facts first of its kind brought out in India. This book gives details of which drugs should be banned or severely restricted. Drugs that have been recommended for banning but are allowed to remain, a list of banned drugs, guidelines for establishing a national programme for essential drugs and criteria for the selection of essential drugs etc.

The use of essential drugs

Second report of the WHO expert committee — Technical Report Series 722 pp. 50, 1986, Rs. 10.00, WHO

This book gives a model list of essential drugs based on WHO guide-lines. It furnishes a basis for countries to identify their own priorities and to make their own selection of essential drugs.

Rational Drug Policy

Mira Shiva, Dinesh Abrol, Narendra Mehrotra, Amitava Guha, W.V. Rane, pp. 163, 1986, Rs. 20.00, VHAI

This book was specially compiled for the drug policy campaign. It gives an overview of problems perspective and recommendations for a Rational Drug Policy. It deals with topics from National Drug Policy: Objectives and Guidelines to self reliance of the Drug Industry.

Rational Drug Policy for Rational Drug Use

A Drug information pack 1986, Rs. 15.00, VHAI

This drug information pack has the basic information about the hazardous and irrational medicines still produced and used in India while they are banned in the places of their origin. It also contains leaflets on Alma Ata declaration, the Bangladesh Drug Policy, WHO's Essential Drug List, the adequate production of essential drugs and a statement on Rational Drug Policy.

1. COMMUNITY HEALTH

Code number	Medium	Title and Author	Price in Rs.
CH:1	Reprint	Before and Beyond Objectives and Goals - a vision * David Werner English	0.50
CH:2	Book	Community Health * Helberg English	3.00
CH:3	Reprint	Guidelines for Success in Community Health * David Werner English	0.50
CH:4	Reprint	Health Care and Human Dignity * David Werner English	1.00
CH:5	Book	Jahan Doctor Na Ho * David Werner Hindi	60.00
CH:6	Book	Plan for a Village Health Programme Using VHWs * P.F. Wakeham English	3.00
CH:7	Reprint	Planning Dialogue in Community * Johnston English	1.00
CH:8	Book	Where There is No Doctor * David Werner English	60.00
CH:9	Book	Taking Sides - the choice before the health worker * Dr. Sathyamala, Nirmala Sundram, Nalini Bhanot English	75.00
CH:10	Book	Text Book of Preventive and Social Medicine * Park English	75.00
CH:11	Slides	Project Piaxtla English	80.00
CH:12	Book	Development with People * Walter Fernandes English	30.00
CH:13	Book	Learning from the Rural Poor * Henry Volken, Ajoy Kumar, Sara Kaithathra English	15.00

Code number	Medium	Title and Author	Price in Rs.
CH:14	Book	Participatory Research and Evaluation * Walter Fernandes English	25.00
CH:15	Book	Social Activists & People's Movement * Walter Fernandes English	30.00
CH:16	Book	Grameen Sevikayen Hindi	12.50
CH:17	Book	Prathmic Swasthya Karyakarta * Girard Hotekar Hindi	20.00
CH:18	Book	Practicing Health for All * David Morley, John Rohde, Glen Williams English	40.00
CH:19	Slides	Jamkhed - an innovative agricultural and health programme in India English	24.00

2. CHILD DEVELOPMENT

CD:1	Booklet	Better Child Care All Indian Languages	6.00
CD:2	Booklet	Breast Feeding and the Child * Dr. Shanti Ghosh English	1.00
CD:3	Slides	Feeding Your Baby on Correct Child Nutrition English	24.00
CD:4	Book	Feeding and Care of Infants and Young Children * Dr. Shanti Ghosh English	33.00
CD:5	Book	Health Care of Children Under Five English	5.00
CD:6	Reprint	Health and Sicknesses of Children (from WTND,**pp 341 to 368) * David Werner English	2.00
CD:7	+ Approp. Tech.	Indigenous Calander for Mother and Child Clinics (to calculate the date of birth, date of delivery etc) English & Hindi	1.00

Code number	Medium	Title and Author	Price in Rs.
CD:8	Slides	More about Child Care English	55.00
CD:9	Book	Shishuon aur Bacchon Ka Aahar aur Unki Dekhbhal * Dr. Shanti Ghosh Hindi	33.00
CD:10	Book	Shishu Palan * Dr. Shanti Ghosh Hindi	1.00
CD:11	Booklet	Stan Pan Hindi	1.00
CD:12	Filmstrip	The Child (a set of 4 filmstrips) - how a child grows - needs of the child - play - how a child learns English	48.00
CD:13	Filmstrip	The Balwadi (a set of 3 filmstrips) - environment in child care centre - organisation of Balwadi - freedom to grow English	36.00
CD:14	Filmstrip	The Balwadi or Anganwadi Worker (a set of 5 filmstrips) - role of the worker - working with the child - creating the right environment - helping children to grow socially - caring for the child English	60.00
CD:15	Flash card	When Your Child is Sick English Hindi & Nepali	10.00
CD:16	Flash card	Child Safety English & Tamil	25.00
CD:17	Flannel Graph	Child Health & Weight Record for Use in Class or OPD English	30.00
CD:18	Slides	Family Care of Disabled Children English	30.00
CD:19	Slides	The importance of Breast Feeding and not Bottle Feeding English	18.00

Code number	Medium	Title and Author	Price in Rs.
CD:20	Book	Studies on Pre-School Children English	6.00
CD:21	Book	Studies on Weaning English	6.00
CD:22	Book	Breast Feeding in Practice - a manual for health workers * E Helsing, Savage King English	45.00
CD:23	Book	Primary Child Care - a manual for health workers * M King, S Martodipoero, F. King. English	45.00
CD:24	Book	Primary Child Care - a guide for the community leader, manager, teacher * M King, F King, S Martodipoero English	65.00
CD:25	Book	Breast is Best English	16.00
CD:26	Slides	Breast Feeding English	24.00
CD:27	Slides	Charting Growth in Small Children English	24.00
CD:28	Slides	Development in the First Year English	24.00
CD:29	Slides	Management in Child Health English	24.00
CD:30	Slides	Newborn Care English	24.00
CD:31	Slides	Primary Child Care English	240.00
CD:32	Slides	Weaning Foods and Energy English	24.00

3. DISEASES

D:1	Book	A Taste of Tears * Dr. Mira Shiva, Aspy B.Mistry English & Hindi	15.00
D:2	Booklet	Better Care During Diarrhoea All Indian languages	5.50
D:3	Slides	Better Care During Diarrhoea English	48.00

Code number	Medium	Title and Author	Price in Rs.
D:4	Booklet	Better Care in Leprosy * M. Laugesen English, Hindi, Bengali, Telugu, Tamil and Nepali.	8.00
D:5	Booklet	Better Care in Venereal Diseases * O.P. Singh, J.S. Pasricha All Indian Languages	10.00
D:6	Slides	Better Care in Venereal Diseases English	55.00
D:7	Booklet	Better Eye Care All Indian languages	6.00
D:8	Booklet	Better Ear Care All Indian languages	6.00
D:9	Reprint	First Aid (from WTND, pp.87 to 123) * David Werner English	2.00
D:10	Reprint	Home Cures and Popular Beliefs (from WTND,pp.1 to 21) * David Werner English	2.00
D:11	Reprint	How to Take Care of a Sick Person (from WTND, pp.49 to 54) * David Werner English	1.00
D:12	Reprint	How to Examine a Sick Person (from WTND, pp. 35 to 47) * David Werner English	1.00
D:13	Flash Card	Lathyrism Hindi	15.00
D:14	Reprint	Prevention - how to avoid many sicknesses (from WTND , pp.155 to 179) * David Werner English	2.50
D:15	Flash Card	Rehydration Solution English	10.00
D:16	Flash Card	Sores English & Hindi	10.00

Code number	Medium	Title and Author	Price in Rs.
D:17	Reprint	Serious Illnesses that Need Special Medical Attention. (from WTND, pp 219 to 233) * David Werner English	1.50
D:18	Reprint	Some Very Common Sicknesses (from WTND, pp 181 to 216) * David Werner English	2.50
D:19	Reprint	Sicknesses that are Often Confused (from WTND, pp 25 to 33) * David Werner English	1.00
D:20	Reprint	Skin Problem (from WTND, pp 235 to 257) * David Werner English	2.00
D:21	Reprint	The Teeth, Gums, and Mouth (from WTND, pp 273 to 276) * David Werner English	1.50
D:22	Flash Card	Tuberculosis is Curable English & Hindi	10.00
D:23	Slides	Tuberculosis is Curable English & Hindi	15.00
D:24	Reprint	The Urinary System and the Genitals (from WTND, pp 278 to 288) * David Werner English	2.00
D:25	Reprint	The Medicine Kit (from WTND, pp 378 to 385) * David Werner English	1.00
D:26	Reprint	The Eyes (from WTND, pp 259 to 272) * David Werner English	1.50
D:27	Flash Cards	Control of TB English	25.00
D:28	Flannel graph	Early Signs of Leprosy English	30.00

Code number	Medium	Title and Author	Price in Rs.
D:29	Flash Card	Hands that Feel No Pain English	25.00
D:30	Flash Card	Head Lice English & Tamil	25.00
D:31	Flash Card	Painless Feet English & Tamil	25.00
D:32	Flash Card	Prevention of Diarrhoea English	25.00
D:33	Flash Card	Prevention of DPT English	25.00
D:34	Flash Card	Ramu Recovers from Leprosy English	25.00
D:35	Flash Card	Scabies English & Tamil	25.00
D:36	Flash Card	Sore Eyes English	25.00
D:37	Flannel Graph	Typhoid English	30.00
D:38	Slides	Teaching about Diarrhoea and Rehydration English	72.00
D:39	Slides	The Measles Monster English	25.00
D:40	Poster	Leprosy English	8.00
D:41	Book	Leprosy Diagnosis and Management * G.K. Job, A.J. Sehapandian English	12.00
D:42	Flash Card	Get Your Child Immunized English & Tamil	10.00
D:43	Book	The Complete Family Medicine Book * P.C. Dandiya, J.S. Bapna, S.K. Patni English	60.00

Code number	Medium	Title and Author	Price in Rs.
D:44	Book	Skin Diseases for Medical Auxiliaries. * Behl English	10.00
D:45	Book	Twacha Ke Rog * Behl Hindi	10.00
D:46	Slides	Cold Chain - target diseases English	24.00
D:47	Slides	Common Oral Diseases English	24.00
D:48	Slides	Diarrhoea Management English	24.00
D:49	Slides	Goitre and Cretinism English	24.00
D:50	Slides	Leprosy English	24.00
D:51	Slides	Malnutrition in an Urban Environment English	24.00
D:52	Slides	Malnutrition in Indian Children English	24.00
D:53	Slides	Management of Kwashiorkor English	24.00
D:54	Slides	Natural History of Childhood TB English	24.00
D:55	Slides	Periodontal Disease English	24.00
D:56	Slides	Protein Calorie Deficiency English	24.00
D:57	Slides	Primary Eye Care English	24.00
D:58	Slides	Xerophthalmia English	24.00
D:59	Book	Symptom Treatment Manual * M. Bomgars English	6.00

4. ENVIRONMENTAL HEALTH

EH:1	Book	How to Make and Use the Nada Chulha * Madhu Sarin English	8.00
EH:2	Book	Nada Chulha Kaise Bhanayen aur Opayog Karen * Madhu Sarin Hindi	8.00

Code number	Medium	Title and Author	Price in Rs.
EH:3	Book	Nada Chulha - a handbook * Madhu Sarin English	15.00
EH:4	Book	Nada Chulha * Madhu Sarin Hindi	15.00
EH:5	Poster	Nada Chulha Apnaiye Hindi	1.00
EH:6	Poster	Nada Chulha ka Pura Fayada Uthaiye Hindi	1.00
EH:7	Flash Card	Prevention is Better Than Cure English & Tamil	25.00
EH:8	Flash Card	Do's of Cookings Hindi & English	10.00
EH:9	Book	A Growing Problem - Pesticides and the third world poor * David Bull English	60.00

5. FAMILY WELFARE

FW:1	Reprint	Family Planning - having the number of children you want (from WTND, pp 330 to 340) * David Werner English	1.00
FW:2	Flash Card	Family Planning the Easy Way Tamil & English	25.00
FW:3	Flash Card	How Life Begins Tamil & - on sex education English	25.00
FW:4	Flannel graph	Modern Methods of Family Planning	30.00
FW:5	Flash Card	Pramila Grows up	25.00
FW:6	Flash Card	The Cost of An Another Child	25.00
FW:7	Slides	Contraceptive Devices English	24.00

Code number	Medium	Title and Author	Price in Rs.
6. HEALTH COMMUNICATION			
HC:1	Leaflet	Aiming and Teaching at What is Most Important (From HHWL pp. 5-9 to 5-11) * David Werner English	1.00
HC:2	Book	Manual of Learning Exercises * Ruth Harner, Lynn Zelmer English	15.00
HC:3	Book	Helping Health Workers Learn * David Werner, Bill Bower English	72.00
HC:4	Leaflet	A Learning from, with, and, about the Community (from HHWL, pp. 6-6 to 6-17) * David Werner English	1.00
HC:5	Slides	Learning through Role Playing English	41.00
HC:6	Slides	Learning to Draw and Use Pictures English	72.0
HC:7	Slides	Home-made Teaching Aids Principles and Examples English	80.00
HC:8	Slides	Teaching Ideas Using Flannel-Boards English	50.00
HC:9	Book	Mahilaon Ke Liye Anaupcharik Shiksha Tatha Aaya Vriddhi * J.T. Nayak Hindi	15.00
HC:10	Slides	Communication in Health English	24.00
7. HEALTH RECORDS			
HR:6	Book	A Manual on Health Records English	6.00
HR:13	Apprpte Techgy.	Anaemea Recognition Card All Indian languages, English & Nepali.	1.00
HR:1	Card	Child Health and Weight Record	0.35
HR:7	Card	Eye Records Hindi, English & Punjabi.	0.35

Code number	Medium	Title and Author	Price in Rs.
HR:4	Card	General Records for School Children and Adults All Indian languages, English & Nepali.	0.35
HR:9	Card	Immunization Record English & Hindi	0.15
HR:10	Card	Insert and Continuation Card to go with other Records All Indian languages	0.15
HR:12	Card	Married Women's Health Record English & Hindi	0.35
HR:2	Card	Mother's Record for Pregnancy and After All Indian languages	0.35
HR:3	Card	TB Records Oriya, Telugu, Hindi, Marati, Malayalam, Nepali, kannada Bengali, and English.	0.35
HR:0	Cover	Plastic Cover for Health Records	0.25

8. NUTRITION EDUCATION

NE:1	Flash Card	Feeding Your Baby English & Hindi	10.00
NE:2	Apprpte. Techgy.	Mid-Arm Circumference Measuring Tape All Indian languages	2.00
NE:3	-do-	Mid-Arm Circumference Measuring Strip	1.00
NE:4	Book	Manual for Child Nutrition in Rural India English	14.00
NE:5	Slides	More about Child Care - child care before birth - diagnosis of under nutrition - causes of under nutrition - treatment of under nutrition English	55.00

Code number	Medium	Title and Author	Price in Rs.
NE:6	Reprint	Nutrition - what to eat to be healthy (from WTND, pp 125 to 153) * David Werner English	2.50
NE:7	Flash Card	Super Porridge English & Hindi	10.00
NE:8	Flash Card	Baby's Diet from Birth to One Year English & Tamil	25.00
NE:9	Flash Card	Balanced Diet for the Family English & Tamil	25.00
NE:10	Flash Card	Better Nutrition Healthier Nation English & Tamil	25.00
NE:11	Flash Card	Supplementary Feeding for Babies Hindi	10.00
NE:12	Book	A Manual of Nutrition English	2.50
NE:13	Book	Menus for Low Cost Balanced Diet and School Lunch Programme English	2.00
NE:14	Book	Nutrition for Mother and Child * P.S. Venkatachalam English	5.00
NE:15	Book	Nutritive Value of Indian Foods * C. Gopalan, Rama Sastri, S.C. Balasubramanian English	9.00
NE:16	Slides	Nutrition Rehabilitation English	24.00

9. RATIONAL THERAPEUTICS

RT:1	Reprint	Antibiotics (from WTND,pp 68 to 70) * David Werner English	1.00
RT:2	Book	A Rational Drug Policy * Mira Shiva, Dinesh Abrol, Narendra Mehrotra, Amitava Guha, Dr. W.V. Rane. English	20.00

Code number	Medium	Title and Author	Price in Rs.
RT:3	Book	Banned & Bannable Drugs * Catriona Robertson, Dr. Ali Mardanzai, Mira Shiva. English	10.00
RT:4	Poster	Ban Bannable Drugs English	2.00
RT:5	Leaflet	Bangladesh Drug Policy English	0.50
RT:6	Poster	Can you Understand the Small Print ? English	2.00
RT:7	Pack	Drug Information Pack * Mira Shiva and Radha Holla Bhar English	15.00
RT:8	Poster	Drug Can be Dangerous too English	2.00
RT:9	Poster	Don't Judge a Medicine by its Packaging English	2.00
RT:10	Leaflet	Do I Really Need All These ? English	2.00
RT:11	Leaflet	Drugging of Asia English	1.00
RT:12	Leaflet	Essential Drugs * Mira Shiva English	0.50
RT:13	Reprint	Healing Without Medicine (from WTND, pp 56 to 57) * David Werner English	0.50
RT:14	Reprint	How to Measure and Give Medicine (from WTND, pp 71 to 76) * David Werner English	1.00
RT:15	Leaflet	Hazardous, Bannable and Dumped Drugs * Mira Shiva English	0.50
RT:16	Reprint	Instructions and Precautions for Injections. (from WTND, pp 76-86) * David Werner English	1.00
RT:17	Poster	Murder in the Name of Medicine English	3.00
RT:18	Leaflet	Our Concern About Drugs English	0.50
RT:19	Poster	Profit Before People English	3.00
RT:20	Reprint	Right and Wrong Use of Modern Medicine (from WTND, pp 61 to 66) * David Werner English	1.00
RT:21	Leaflet	Rational Drug Policy Statement English	1.50

Code number	Medium	Title and Author	Price in Rs.
RT:22	Leaflet	The Drug Issue and the National Drug Policy. * David Werner English	1.00
RT:23	Reprint	Tonics - How Much an Economic Waste * David Werner English	1.00
RT:24	Leaflet	The Courageous Bangladesh Drug Policy * Mira Shiva English	0.50
RT:25	Leaflet	WHO - Essential Drugs English	0.50
RT:26	Book	Aspects of Drug Industry in India * M. Bhagat English	19.00
RT:27	Poster	Drugs for the People or People for the Drug ? English	3.00
RT:28	Book	Insult or Injury ? * Charles Medawar English	25.00
RT:29	Book	Drugs and World Health * Charles Medawar English	59.00
RT:30	Book	Pharmaceuticals and Health Policy English	78.00
RT:31	Slides	Useless Medicines that Sometimes Kill English	24.00
RT:32	Book	Multi-nationals and the Pharmaceutical Industry in India English	10.00
RT:33	Book	Bitter Pills * Dianna Mebrose English	35.00
RT:34	Leaflet	Bad Information Means Bad Medicine English	3.50
RT:35	Book	The Wrong Kind of Medicine English	104.00
RT:36	Leaflet	WHO says Lomotil has No Value English	1.00
RT:37	Leaflet	The Declaration of Alma Ata English	0.50
RT:38	Book	The Use of Essential Drugs English	10.00

Code number	Medium	Title and Author	Price in Rs.
RT:39	Book	Pills, Policies, and Profits * Francis Rolt English	59.00

10. SCHOOL HEALTH

SH:1	Slides	CHILD-to-Child Activities English	65.00
SH:2	Slides	Schools a resource for primary health care English	24.00

11. SYSTEMS AND STRUCTURES IN HEALTH CARE ADMINISTRATION

SA:1	Book	An Accounting Guide for Hospitals and Nursing Homes. * EE Nabert English	10.00
SA:2	Book	Directory of Voluntary Health Care Institutions and Programmes in India English	15.00
SA:3	Book	Management Process in Health Care * S Srinivasan English	45.00
SA:4	Book	Self Appraisal and Goal Setting Guide English	2.00
SA:5	Book	Seminar on National Health Policy English	5.00
SA:6	Book	Health Care in India * George Joseph, John Desrochers, M Kalathil English	5.00
SA:7	Book	Rakku's Story - structures of ill-health and source of change * Sheila Zurbrigg English	10.00
SA:8	Book	Health for All - an alternative strategy * ICMR & ICSSR English	Soft- 18.00 Hard - 65.00

Code number	Medium	Title and Author	Price in Rs.
SA:9	Book	In Search of Diagnosis - an analysis of present system of health care * Ashwin J Patel	12.00
SA:10	Book	Health Care: Which Way to Go? - examination of issues and alternatives * Abhay Bang, Ashwin Patel	15.00
SA:11	Book	Under the Lens - health and medicine * Kamala S Jaya Rao	19.00

12. VILLAGE HEALTH WORKER

VH:1	Slides	Training of DAIS English	24.00
VH:2	Book	Teaching Village Health Workers - A guide to the process English	30.00
VH:3	Reprint	Village Health Worker - lacky or liberator * David Werner English	1.00
VH:4	Reprint	Words to the Village Health Worker (from WTND, pp w.1 to w.29) * David Werner English	2.50
VH:5	Book	Handbook of Laboratory Techniques for Community Health Workers * E Simon English	7.00
VH:6	Book	A Teaching Guide of Trainers of Village Health Workers * P.F. Wakeham English	60.00

13. WOMEN AND HEALTH

WH:1	Booklet	Gharelu Prasooti Karya for Women Health Workers Hindi	2.50
WH:2	Reprint	Information for Mothers and Midwives (from WTND, pp 291 to 328) * David Werner English	2.50

Code number	Medium	Title and Author	Price in Rs.
WH:3	Flash Card	Maternal Child Health Clinic English & Hindi	10.00
WH:4	Flash Card	Planning for a Safe Delivery English & Tamil	25.00
WH:5	Slides	Teaching about Mothers and Children's Health English	80.00
WH:6	Flash Card	Mahila Mandal Hindi	10.00
WH:7	Slides	Physiology of Women English	24.00
	Book	Basics of Documentation English	104.00
RT	Book	Rational Use of Medicines English	14.00
	Posters	Anti-Smoking Posters (set of 4 Posters) English	16.00
SH	Book	School Health Programme English	9.00
SH	Book	School Health Curriculum English and Hindi	9.00

Davaiyon ka Vivekpurna Prayog	Rs 14.00
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Better Care of Malaria	5.00
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Child-to-Child	20.00

NON-VHAI PUBLICATIONS

Hamara Paryavaran	200.00
Baljanma Sachitra Pustak	15.00

Prices subject to change without prior notice.

HFM

HEALTH FOR THE MILLIONS is the official VHAI magazine published every two months (6 times a year). Extensive and indepth coverage is given to a health topic in every issue of the magazine. Nearly 3,000 copies are circulated among health professionals, activists and resource centres. Besides very useful articles, the magazine also carries news from the State VHAs, job opportunities, training programmes, new publications and other useful information.
Contributiions are welcome.

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We try to collect the best available and most appropriate items for distribution which are aimed at helping even those working in remote areas. We hope this educational and information service will keep them uptodate with the latest information on community health and comprehensive development.

Please visit us at our office. We are open from Monday to Friday 9 a.m. to 5.30 p.m.

VHAI

VOLUNTARY HALTH ASSOCIATION OF INDIA assists in making community health a reality for all the people of India, with priority for the less privileged millions, with their involvement and participatioin, through the voluntary sector.

VHAI is a federation of voluntary health associations at the level of States, Regions and Union Territories, linking over 3,000 health institutions and community health programmes. Its services are also available in non-affiliated areas.

Membership in VHAI and opportunity for its services are in principle open to all health institutions and associations in the voluntary, non-profit sector of health care irrespective of religious affiliations.

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VHAI trains various groups in producing health learning materials.

VHAI provides information on various health and related issues and trains various groups in information collection, documentation and dissemination.

Health and Popular Education

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INDIA

Edited with support from CIDA - CANADA

EDITORIAL INTERAMERICANA LTDA.

Many of you will have missed receiving the Health Bulletin for nearly a year. This prolonged silence has been difficult and detrimental for us too. We went through a long period of financial uncertainty, which made it impossible for us to maintain the continuity of this important communication. But now we're back and, with the support of the International Council for Adult Education, we hope to strengthen the Health Network and move ahead with publications and encounters.

This Newsletter Nº 14 contains all the information accumulated since the end of last year, with the exception of news and announcements that are now out-of-date. It does include, however, a substantial list of bibliographic references and educational materials.

We hope to stay in touch, and we are always at your disposition, ready to receive your contributions for the next Health Bulletin.

A TRAINING WITH WOMEN'S

The Health Area of the Manuela Ramos Movement stems from our work in sexual education at the beginning of the 1980's. We approached the issue of sexuality in basic courses for low-income women in the marginal neighborhoods of Lima, because we considered sexuality to be one of the pillars of gender oppression.

In 1987, we began working in the Health Area from a broader perspective aimed at responding to the health care needs and demands of the women we were working with. The care available to them through the health services was inadequate due to the lack of specific women's health programs and community health programs that could take advantage of women's role as health care providers within the family.

We made a critique of existing programs that only consider the mother-child pair, in which women are seen only in terms of "producing" adequately rather than in terms of their own needs. On the other hand, women's unpaid work is used, forgetting that "health for all in the year 2000" also includes women and therefore demands specific actions to this end.

The Health Area of the Manuela Ramos Movement proposes to provide comprehensive gynecological services; develop an educational component that emphasizes prevention; promote health care actions for women at the community level that go beyond the mother-child pair; and help build a women's health movement.

Within this framework, in 1988, we set up the Women's Community Health Service in the San Juan de Miraflores district of Lima.

EXPERIENCE

HEALTH PROMOTERS

Movimiento Manuela Ramos
(Manuela Ramos Movement)

This primary health care program for women is run by 18 women from the comunity who were trained as Women's Health Promoters.

This experience in women's health has been incorporated as part of the Social Emergency Program of the San Juan de Miraflores District, Southern Cone of the City of Lima. An effort is being made to expand this experience and broaden some of the services by setting up a "Women's House" as a birth center where women can be attended by local midwives who have received prior training.

OUR EXPERIENCE

In August 1989 we began to provide health care for women in the Human Settlements of Ollantay and Antúnez de Mayolo, at the Community Clinic in Ollantay.

These human settlements were chosen because they include a low-income female population needing health care, whose experience of struggle and organization provided the conditions for them to become multiplying elements in their community.

The proposal was presented to neighborhood leaders with whom we initiated the selection process. All block-level social workers or health delegates, and anyone else with any kind of experience in the area of health, were invited to apply. Through an evaluation process, the women selected were those in the community who were in the best condition to take on the work of health promoter.

The twenty-two women selected went through a four-month training cycle from May to August 1989. Topics covered included female identity, primary health care, community diagnosis, anatomy and physiology, reproductive rights, birth control, pregnancy, women's diseases, first aid, first aid kit management and monitoring the growth and development of children.

Following the training, a final selection of 18 promoters was made, and, with them, the Community Women's Health Clinic was organized. The community provided a space for them to work, where a series of actions benefitting women's health are now carried out.

The experience began with a massive campaign to attract the attention of pregnant and lactating women throughout the community, culminating with an educational talk for 26 of the 80 women identified in these conditions.

Services provided include health monitoring, prevention and treatment of minor injuries. All cases requiring more specialized care are referred to the clinics or hospitals of the Health Ministry. These include medium and high-risk pregnancy, tuberculosis and infantile malnutrition.

Making referrals presupposes constant coordination with the health services in the area, which has not been fully achieved due to resistence on the part of both health service personnel and the promoters themselves.

The promoters are also attempting to establish a more direct relationship with other local organizations, such as the Neighborhood Councils and the District Health Committee, where they are working to incorporate women's health as an issue.

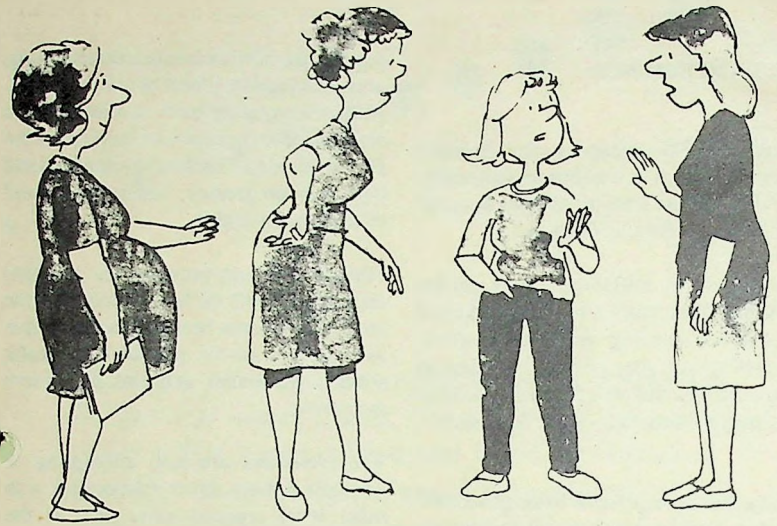
Pre-natal care consists basically of making a nutritional diagnosis and determining level of risk, and evaluating the overall situation of the pregnant woman in order to identify signs and symptoms of alarm. This involves an initial clinical evaluation with professional support.

The woman is then given detailed information about her condition and dietary recommenations, general precautions, etc. Iron supplements are provided, and she is referred to local health services if she presents either medium or high risk conditions.

Women for whom no risk is found continue to receive regular check-ups during their pregnancy and weight control check-ups during the first six months of lactation.

Certain instruments are used by the Clinic to maintain order in the provision of services, and a file is kept on the health situation of the women attended. The instruments used include the following:

1. A census and registry of pregnant and lactating women, consisting of a form used to identify such women in house-to-house visits.



2. A pre-natal control chart, containing basic information about the woman and her living conditions, criteria of obstetrical risk, nutritional state and follow-up of her pregnancy and lactation period.

3. A file of all the women attended by the promoters, indicating their characteristics and follow-up provided.

4. A pre- and post-natal control card, given to each client, that includes her basic health data, appointments and referrals when necessary.

5. A weekly client list of the women attended during that period, used to prepare progress reports on the clinic for the health center.

In one trimester, 265 people received attention out of a total of 300 families in the two settlements closest to the clinic.

Services most frequently provided are for pre-natal care, birth control and different types of vaginal infections. Less frequent services include growth and development monitoring of children, first aid and respiratory infections.

OUR PROPOSAL: HEALTH AND WOMEN

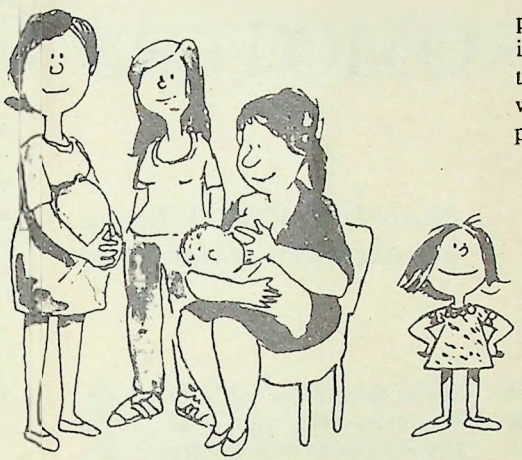
An interpretation of the reality of health from a women's perspective implies valuing ourselves differently as health subjects. This requires recovering our everyday knowledge of what it means to provide health and being able to put this into practice through a program and a service that puts fundamental emphasis on self-help and self-examination by and for women.

Improving the situation of women's health requires making significant changes, both in the health services and in questioning the living conditions and the marginal situation of women in society.

We understand women's health care as comprehensive throughout our entire life cycle. We have given priority to initiating our action with pre- and post-natal care, because this is one of the most critical periods for women in the popular sectors, when their serious problems are likely to become manifest.

For this reason, we have designed a program that considers the following components:

1. Involving pregnant women in observing their own gestational process, leading them to assume the care of their own health and to manage information about their bodies and their state of being.



2. Pre-natal care needs to be assumed by the community, assuring that it is provided by trained women, incorporating adequate technologies, and using a variety of educational activities.

3. Recovering and according real value to women's knowledge about themselves by including traditional midwives in childbirth care, given that they currently assist 20% of births in the neighborhoods.

4. Coordination with official health services must be sought to obtain support for the implementation of primary level care and to generate a system of information that creates awareness of women's specific health needs.

5. Providing neighborhood organizations with diagnostic elements on the situation of women's health, leading to changes in the quality of life and the social value accorded to women as people.

6. Recognizing women's work as health agents by paying them for their work as promoters.

7. Ultimately, de-medicalizing health care through the recovery and use of traditional medicine.

OUR METHODOLOGICAL PROPOSAL

We see training as a permanent ongoing process and as the product of frequent interaction between the people we work with, those that administrate the program and the women that we want to reach through the program.

We are a part

As a team, accompanying the promoters in the administration of a community health service program, we are part of the group to the extent that we share the same needs, health problems and demands in terms of our gender, although recognizing our differences because we belong to distinct social groups.

Going from Manuela Ramos to accompany the health promoters in their daily work is necessary, especially in the initial phase. However, we also want them to generate their own relationships with the different groups and organizations in the neighborhood, the district and the country, avoiding as much as possible a dependent relationship.

This means that from time to time, the health team needs to take time to reflect, restate and unify some basic concepts, and give continuity and creativity to our activities.

Knowing the social context

We begin by studying the socio-economic and cultural conditions and characteristics of the population that will be reached by this experience. The promoters have been trained to do this through the preparation of a diagnosis of the human settlements in which they work, that will provide us with knowledge about the living conditions and the specific needs of the women, particularly in relation to their health problems.

These diagnoses are presented to the Neighborhood Councils so that they will be aware of the issue and propose the best solutions.

Training is an ongoing activity

Our educational action is conceived as a continuous process with three clearly defined periods:

An initial training period in which the most important issues for opening the Community Health Service are developed.

Training in action, learning by participating in the daily activities of the Clinic, in which the promoters, the women from Manuela Ramos and the clients all gain expertise in specific women's health issues. It is in this phase that we put most emphasis on recovering the women's own knowledge about health.

Responding to women's needs

Our program aims for women to achieve or recover the possibility for self-examination and self-help in caring for their own health. We realize, however, that this is a long process that begins with women's most urgent needs and demands. This is why our work in the Community Clinic began with providing care for pregnant and lactating women. This is the period in which the problems pertaining to their health and living conditions become most evident and in which they are most receptive to learning about their bodies, as part of an effort to improve their living conditions and recover their sense of value as people.

Time and space

All women perform many tasks in the course of a day, especially in times of crisis like the present. We participate in community kitchens, in mothers' clubs and in neighborhood organizations; we do housework and paid work, etc. There are so many demands on our time that we are frequently distracted and uninterested in education.

Nevertheless, we have found a space and a time. We get together on Mondays, bringing our children, and we talk about ourselves, tell our stories, reflect on the work we have done all week and discuss a topic that we want to know more about. At the last meeting, the promoters said, "We can't miss a Monday, because this time is ours and we're learning...nobody has permission to be absent."

An easy task

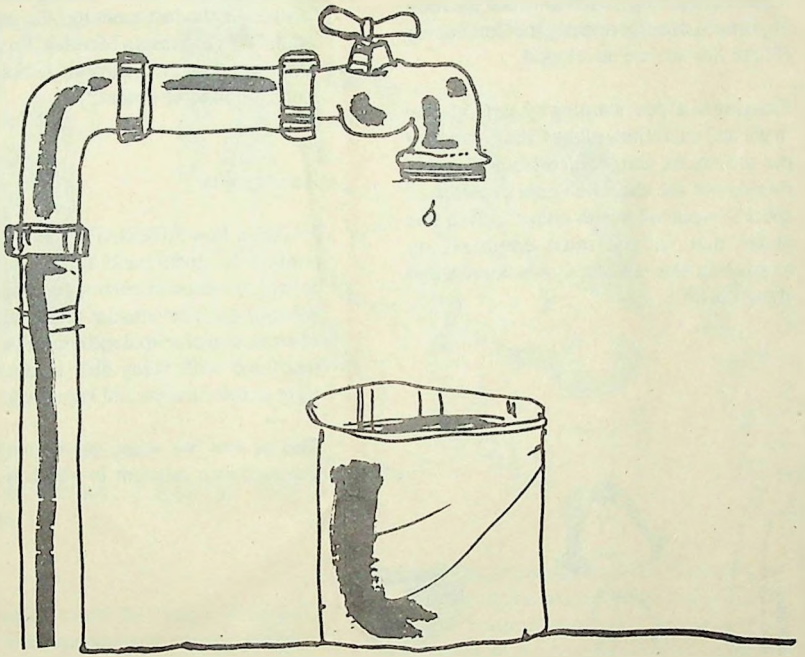
We know how difficult it has been for many women to understand their teachers in school, so removed, such difficult language, so hostil, etc. This situation often contributed to a rejection of school and education, which interfered with being able to defend our right to information and knowledge.

This is why we want our training to be assumed as a moment in which we come together to share our life experiences, lose the fear of speaking out, be able to touch what we didn't dare touch before, know and control our bodies, express our feelings, laugh, cry, etc.

Our techniques

We use whatever initially enables us to break the ice and achieve good communication, such as an interview; activities in which everyone can participate and that don't make unnecessary distinctions between certain people, such as working in small groups; activities that encourage us to express our feelings about a subject as well as our knowledge, such as dramatization and, to keep active and not get tired, we think it is important to introduce elements like music and games that make us move, or dynamics to break the routine.

CHOLERA EN PERU: EXPER



Pedro Mendoza Arana
Physician, Coordinator of the Health Promotion Program,
Centro "ALTERNATIVA". Lima, Peru. April 1991.

As of April 1991, cholera had caused the death of 1,088 people in Peru, with nearly 150,000 cases officially reported. In the following weeks, the epidemic reached Brazil and Chile, while cases continued to multiply in Ecuador, Colombia and Bolivia. The Director of the Pan American Health Organization, Carlyle Guerra de Macedo, predicted in Lima that the epidemic would probably affect 6 million people in Latin America, 42,000 of whom would die in the best conditions of care.

We are not going to expand here on the socioeconomic considerations that led to the appearance and spread of the epidemic. Nor will we analyze the medical components of the problem. Rather we will attempt to reflect on some of the experiences that have accumulated during the first 12 weeks of the epidemic in Peru, at the time of this writing.

The social response to cholera deserves an initial reflection. There is no precedent for a health problem that has brought death to such diverse sectors of the population. The educational sector has given its foremost attention to children's health. Popular grassroots organizations, organized labor, civil institutions and non-governmental organizations have worked together with local government bodies and the health sector to meet the challenge. Many agents that, prior to this problem, would not readily have been willing to work with some of the others, have done so, thus gaining common ground and coordinated work experience that we will attempt to build on in the future. Much of this permeability has also come about by clearly recognizing the undisguised social determination of health, a recognition shared on all sides. The intricate relationships between production, economy and health were also clearly delineated.

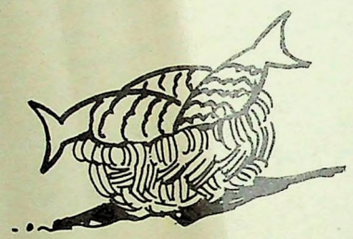
One important element in this process has been the participation of the communications media. During the first three weeks, radio, television and the press gave detailed coverage to the progress--although slight at that time--of the disease, as well as to the preventive measures to be taken by the population. This constituted a display of forces that demonstrated the tremendous potential of the mass media for taking action in the area of health. Nevertheless, when the "ceviche war" was unofficially declared in the middle of February, the press opted not to opt; that is, it covered up information and thus contributed to the generation of a false image of a "problem overcome", as reports were reduced to Sunday updates or small charts.

In effect, both morbidity and mortality from cholera doubled in the next eight weeks, after which, due to the spread of the disease internationally, it recovered space as news. An unavoidable element in this massive information effort was the appearance of "experts" on the subject, each pretending to contribute his/her version or emphasis to the dispersion of information, including some who took advantage of the situation for their own self-promotion. As a result, there were moments of great variety in the messages, many of which were contradictory, which was negative at such a time. In other areas, this criteria operated from the very beginning.

The non-governmental organizations working in health, grouped in the Intercenters for Health, perferred, despite discrepancies with official messages, to subscribe to them, precisely to avoid double messages, and to voice our observations about them in the Communications Commission of the Cholera Emergency Committee in the Ministry of Health, where we helped design the information campaign. However, the material printed by the Ministry and UNICEF was insignificant in the face of the informational needs, given the official sector's emphasis on the cost of care for the ill.

A correct strategy would have been (and could be used in other countries) for the Communications Office to centralize or expedite authorization of educational messages for dissemination, taking maximum advantage of news media space. One training session for journalists was essential, given that the resources available for advertising space was totally insignificant compared to the volumn and penetration of distorted information that could circulate simultaneously.

ENCES



recommendation disregarded two essential considerations. One, that for the Peruvian population, fish is the most economical source (and for a large sector, the only source) of protein; the other, that an important item in our domestic and international economy depends on fish. In the days that followed, we witnessed the mobilization of the fishing sector, demanding that the State respond to their crisis. In one meeting, we maintained the importance of a prompt counter-campaign to modify the message; the focus should have been, "Eat fish fried or braised." But this correction was made very weakly, and the President, in response to the fishing sector, had no better idea than to publicly demonstrate that ceviche wasn't harmful by personally eating a plate of raw fish before the TV cameras. Conclusions: one Health Minister deprived of authority, a discredited health sector, and cholera full steam ahead.

A third element is the approach to be used with food handlers. Several municipalities resorted to repression toward this phenomenon. As usual, the result has been practically nil: food vendors on the streets haven't changed, perhaps because the greater precariousness of their situation, offers them fewer possibilities for joining the fight against cholera. The experiences of several organizations has shown that an effort toward co-management is more useful in discovering the contributions that each social agent is able to make. The food vendors -paradoxically, the informal workers (organized) more than the formal workers (salaried, but unorganized)- are modifying their behavior and making proposals for joining the cause. This is also an experience to take advantage of.

Another priority, for the same reasons, is the designation of a command unit in the Anti-Cholera Campaign, at the highest level, while avoiding or carefully managing tension between sectors. Information management again demonstrated its capital role. In the Peruvian experience, initial confusion and the slight importance given to socio-economic factors of the problem were fatal. Any measure taken at the beginning of the epidemic should have been understood and elaborated (to be maintained) as a long-term measure.

This is clearly illustrated by the fish issue. During the first week of the epidemic, amid the previously mentioned confusion and unpreparedness, the Ministry and the infectious disease experts generated the message, "Don't eat fish." This

COURSE IN HEALTH EDUCATION AND PROMOTION, ENGLAND.

Liverpool School of Tropical Medicine. Department of International Community Health.

A 3-month course on health education and promotion oriented toward people with some experience in the field. Aims to provide health promoters with skills in creating, managing and evaluating health education/promotion programs.
The first course will begin in January 1992.

More information: The Course Organiser (Health Education/Promotion for PHC). Department of International Community Health, Liverpool School of Tropical Medicine. Pembroke Place L3 5QA, England.

IV SESPAS CONGRESS

The Sociedad Española de Salud Pública y Administración Sanitaria (SESPAS) is organizing a Congress in Valencia, Spain, October 24-26, 1991, on the theme, "From sanitation policies to health policies."

More information: Teresa Cebrián, Secretaría IV Congreso SESPAS, IVESP. Juan de Garay, 21. 46017 Valencia, Spain.

NEWS

NETWORK WORKSHOP

A workshop on PARTICIPATION AND TRAINING FOR LOCAL DEVELOPMENT IN HEALTH was held during the second CEAAL (Latin American Council for Adult Education) Latin American Assembly in November 1990.

A few days before the Assembly, 18 people representing NGO's in the region met in the El Canelo de Nos Center. All the workshop participants had experience in the areas of social participation and training for the development of local health systems.

The goal of the workshop was to provide an opportunity for exchange and debate on experiences in social participation and training for the development of local health systems in Latin America. Through this exchange, we hoped to identify key challenges that we can confront as non-governmental organizations, through CEAAL's HEALTH AND POPULAR EDUCATION NETWORK.

The workshop was organized with the full participation of those attending, all of whom had made important contributions to the planning by suggesting topics, methodologies and special activities.

The program included the exposition of experiences by all participants, organized in three subject areas: social participation, training, and development of local or national coordinating bodies. The presentation of each experience was followed by a debate and a synthesis.

Social Participation

The first part of the exchange and debate focused on experiences with social participation in health. Presentations included the following:

1. A participatory diagnosis with indigenous communities in Mexico, a program carried out by "Health in the People's Hands". This work involved twenty groups in seven regions of the country. It's goal has been to support training processes in primary health care, promote encounters and link-ups between different health groups in indigenous communities, and strengthen the popular health movement in Mexico.

2. Support the development of neighborhood clinics in Montevideo. The CLAEH (Latin American Center of Human Economy) is providing support to organized neighborhood groups for setting up a clinic.

3. Contributions to a strategy for social participation in health in Chile. There has been an effort to systematize and draw up proposals for unleashing a process of social participation in health policy during the period of transition to democracy.

4. A critical analisis of the work of private social development institutions, presented as a collective reflection by UNICRUZ (a coordination of NGO's in Santa Cruz, Bolivia). Raised a series of questions about the intended purposes, practices and tensions in health promotion projects.

5. Popular participation in health: new agents and new challenges, based on the experience of promotion and popular education in Peru. This work was presented by CESIP of Lima and is the product of a process of reflection among several institutions.

6. From the university, a multiprofessional experience with landless settlers in southeastern Brazil, promoted by UNIJUI in Rio Grande do Sul.

The exposition of these six cases, in their wealth of diversity, fed an extensive debate that brought out the concerns and challenges shared by the majority of the participants. Rather than conclusions, issues arose that require further examination and being put to the test in a variety of social and sanitary realities.

* The Right to Health: the question was raised, and the tension recognized, between the right to access to public services and the demands on the State or self-management policies. Self-management strategies are conceived as spaces for learning and organization, developing initiatives that enable the population to demand their rights.

* New actors in the practice of social participation in health: to the extent that new actors become incorporated, roles and identities need to be further clarified, especially between organizations, monitors, NGO's, and public functionaries and services.

* The definition of the NGO's role is a constant concern, especially if this is a role based on relationships with the State and social organizations; but this challenge is also latent in its own practice. The debate has cropped up recently in different countries in the region; however, the concern remains, probably due to the impact of social and political changes on the activities of civilian social organizations.

* The popular health movement: the debate on this issue needs to be furthered and studies undertaken to show its real dimension and potential. The "popular health movement" can mean many things without there being common or shared reference points. A number of questions were raised about the movement's presence, identity, projections, limits, challenges.

* The presence and leadership of women: the contribution being made by women in developing strategies for social participation have a qualitative and quantitave value as yet unmeasured. Their main contributions involve the gender dimension, new forms of management, the permanent articulation between public and private, the incorporation of subjective aspects. However, more exploratory work is needed that will show the impact of incorporating women in primary care activities at the community level, adjustments in power relationships, the inclusion of gender elements in daily tasks, etc. The question always arises as to whether giving priority to working with women is provoking new forms of exclusion and repercussions of violence at the domestic level.

* New contributions to strategies for social participation, accumulated experience, the role of NGO's, strengthening of popular organizations, the willingness of local governments to incorporate participatory practices, and the contribution of local health systems policies are all working to create a new setting. Naturally, local responses and contributions have also made a leap. The task at hand is to determine its magnitude and put it forward in this decade.

* The challenges facing us have to do with difining the meaning of strategies for social participation and, from there, the concern for defining the identities and roles of the different actors that enter into this process. From a popular education perspective, its contributions in methodologies and evaluation proposals need to be explored, in terms of measuring the impact of this process from different angles.

Training

In the second part of the workshop an exchange and debate were organized on training experiences for local development in health. The following experiences were presented:

1. A pedagogical proposal for popular action in health, presented by a group of NGO's in Colombia, convened and led by CINEP in Bogota.

2. A training experience with women's health promoters, carried out by the Manuela Ramos Movement in Peru, starting with an experience in sexual education developed by the institution.

3. Support for organization and training in health, in the context of the democratization and decentralization process carried out by the Montevideo city government; an experience developed by the Aportes-Emaus Group.

4. Training of a variety of actors in one community toward initiating development of local health systems, carried out in Chile by PIIE (Interdisciplinary Educational Research Program) and by the CEAAL Health Network.

5. Training of human resources in community health, carried out by CODESEDH (Commission for the Defense of Eithics, Health and Human Rights) in Argentina. This experience sums up a long history of thought, reflection, encounter and the constitution of a popular health movement in Argentina.

6. A community health program in Venezuela, developed by CESAP, involving an approach to health promoter training, implementing a campaign against malnutrition, setting up popular dispensaries, and supporting the organization of health professionals.

7. Training with women in the El Alto sector of La Paz, carried out by CIDEM. Presents the systematization and evaluation of a period of training and support of organized women in popular neighborhoods.
The presentation of this experience led to a debate on the contribution of training programs and the specific contribution of popular education in strategies for local development and primary health care. As a result of this exchange, some of the central elements of the nature of training work could be identified, including the following:

* Recognition of the importance of associated work in training programs, whether between different NGO's, with universities, health services or others.

* An understanding of training as an intervention strategy rather than as a goal in itself; this presupposes a pedagogical process in a broader area of work, with distinct purposes. Here lies the challenge of integrating the nature and meaning of popular education in different types of programs.

* Looking at training strategies in relation to processes of popular participation. In this perspective, their intended purposes is political and social in nature. Training experiences should give priority to articulation between different actors, in a way that creates favorable conditions for strengthening processes of social participation.

Several important challenges were then highlighted for consideration by the different programs:

* Systematization of training practices, taking into consideration the objectives, content, pedagogical processes, subjects involved, role of educators. Alternatives need to be identified for evaluating and measuring the impact of the training practices and their achievements--those expected as well as those unimagined.

* Reflection on the role of NGO's working in association with state institutions and universities in order to define their specific contributions and identify challenges. In this new setting, new purposes are intended, development occurs on a higher scale and at a different rhythm, a variety of social actors are involved, and classic parameters are used for evaluation. The question now arises as to how to translate and apply the proposals of popular education in a different context.

* Maintain a process of reflection on pedagogical processes, specifically learning processes in the areas of health and daily life. It is also important to resume the debate on the tension between the different forms of knowledge and representation of problems, that is, the articulation between technical and popular knowledge and the construction of new knowledge.

WORKSHOP PARTICIPANTS

Institutions	Country
CLAEH	URUGUAY
CODESEH	ARGENTINA
UNICRUZ	BOLIVIA
PRAXIS	MEXICO
CIAC	DOMINICAN REPUBLIC
CESIP	PERU
UNIJUI	BRAZIL
MANUELA RAMOS	PERU
EMAUS	URUGUAY
CINEP	COLOMBIA
CESAP	VENEZUELA
CIDEM	BOLIVIA
INFOCAP	CHILE
PIIE	CHILE
SOINDE	CHILE
SERVICIO SUR	CHILE
CAUQENES	CHILE

NETWORKS AND COORDINATORS IN DIFFERENT PARTS OF LATIN AMERICA

The workshop included a debate on the CEAAL Health Network, its potential and challenges. A presentation was made on the situation of the networks, coordinators or collectives that have been set up in different countries. The following is a summary of the principal conclusions:

1. VENEZUELA: different networks have been set up in different states; it hasn't been possible to create a national network. CESAP (a CEAAL affiliate) has given priority to internal coordination, since it already has programs in different states, making ties with other institutions and participating in a network organized by UNICEF and universities. The group has opted for participating in several processes, rather than taking leadership itself. These different existing networks are not part of CEAAL, but the link could be made at the right moment.

2. MEXICO: there is a Popular Health Movement that joins more than 600 groups, which maintains an ongoing debate on health policies and the role of the popular health movement. They have established a relationship with the state apparatus; the relationship with the universities is precarious; the NGO's are divided and dispersed. This movement is self-financed; solidarity and volunteer work prevail. The relationship with CEAAL was at first marked by distance and mistrust that has given way more recently to certain interest.

3. CHILE: the NGO's lack coordination as such; some coordination exists at the territorial level and around specific tasks in which there is common interest. In the present democratic context, work is being carried out in association with the public health services and social organizations. There is interest in greater coordination, but the process is slow after a long period of isolation.

4. BOLIVIA: there are four national networks that were founded as spaces of institutional defense, each one following a certain ideological line and its own objectives. There is also a national federation of health NGO's, which in turn has regional associations. This is a very broad organization united exclusively around the aspect of "health"; so broad as to be somewhat unmanagable. Two networks in particular maintain a relationship with CEAAL: UNICRUZ and AIPE.

5. COLOMBIA: there are regional coordinators but none that constitute a network. CINEP has convened a group of NGO's with related interests for coordinating activities and working together to provide support for grassroots health groups. This has led to joint experiences. They maintain ties with CEAAL.

6. PERU: "Intercentros Salud" was set up in 1988, joining twenty non-governmental institutions in Lima. Here, the debate continues, actions are coordinated, and criteria are unified, especially in terms of strengthening the popular health movement and defining perspectives for working with ministries and municipalities. Territorial "intercenters" have been formed according to need. Coordinators have also been organized around the issues of food, women and work. CEAAL maintains a relationship with Intercentros Salud.

7. URUGUAY: in 1989, several institutions called for an exchange of experiences and further analysis of issues of common concern. In the period since, workshops have been planned for reflection on popular education, primary health care and participation. An evaluation is scheduled soon in order to define the profile of this coordinating effort; in general, it has been recognized by the NGO's. There has been a tacit relationship with CEAAL; the groups have preferred to follow their own paths and in the future establish ties with the CEAAL network.

8. BRAZIL: there are no health networks at the national level, only strong national institutions with a great deal of presence that join intellectuals and academics. At the local level, UNIJUI maintains contact with CEAAL, but there is a need today to improve the articulation and thrust in this relationship.

9. DOMINICAN REPUBLIC: coordination between health NGO's is quite recent, but there is enthusiasm, and there have been some important achievements. CONGA serves as a coordinator, bringing together institutions with social interests. The health initiative is recent and a program is in preparation. There is experience with territorial and issue coordination, always arising out of a felt need.

CHALLENGES AND THE FUTURE OF THE HEALTH NETWORK

This group of presentations facilitated the definition of the Health Network's goals in order to set priorities for the next period. The principal agreements are summarized as follows:

The meaning and perspectives of the Health Network were defined as follows: a Latin American organization, capable of promoting debate and encounter; facilitating the processes of systematizing experiences in health and popular education; and proposing related policies and programs.

Priority has been given to tasks in the following fields:

- Communication and dissemination: this area includes primarily the Health Bulletin and the Experience Bank. Both are expected to make strides in the course of this year.
- Training: a training course is planned for 1991 on "Systematization and Policy Making in Health". A group of people from CESIP (Peru) and CINEP (Colombia) are in charge of preparing this work.
- Coordination with the Health Network: Norberto Liwsky (CODESEDH, Argentina) and Mina Madelengoitia (CESIP, Peru) will be acting as consultants in preparing the next election of the Network's Board of Directors, drawing up by-laws, and establishing critera for a stable relationship with national coordinators.

Bibliographic and Educational Materials

Sexuality

"CONTROL OF SEXUALLY TRANSMITTED DISEASES". World Health Organization; Geneva, Switzerland, 1985.

This book was edited by The World Health Organization to confront the rapid propagation of sexually transmitted diseases. It is a useful manual containing a great quantity of information on the strategies being used to deal with the problem. It also contains an appendix that describes methods that may be useful in prevention campaigns for these types of disease.
Available from: Office of Publications, World Health Organization, 1211 Geneva 27, Switzerland.

"AIDS. PREVENTION AND CONTROL." World Health Organization and the Pergamon Press; London, England, January 1988.

This publication is a product of the international conference, World Summit of Ministers of Health on Programmes for AIDS Prevention, organized by the World Health Organization and the British government. It contains a variety of AIDS prevention experiences from all over the world, indicates which general strategies are being used, technical aspects, the role being played by health workers and a general analysis of the issue.
Available from: Pergamon Press plc., Headington Hill Hall, Oxford OX3 OBW; England.

"PEOPLE. FREEDOM AND FERTILITY." International Planned Parenthood Federation (IPPF); Vol. 17 - No. 4. Edited in English and French. Birmingham, USA, 1990.

People is an international magazine reporting on programs being carried out in the family planning and development field. It contains articles on different experiences in this area from around the world.
Available from: People, P.O. Box 1584, Birmingham, AL 35201, USA.

"AIDS WATCH." International Planned Parenthood Federation (IPPF); No. 12, 4th Quarter. Published in English, French and Spanish. London, England, 1990.

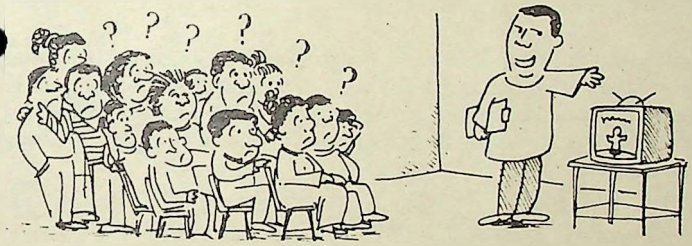
This publication shows the progress that has been made in the search for a vaccine to confront the rapid propagation of AIDS, as well as discussing the treatments that AIDS victims are currently receiving.
Available from: IPPF Distribution Unit, P.O. Box 759, London NW1 4LQ, England.

"FORUM." Vol. 6 No. 1, edited in English and Spanish, New York, USA, January 1990.

This is a magazine edited by the International Plannned Parenthood Federation, Western Hemisphere Region, Inc. It covers different experiences and activities being carried out in family planning in this hemisphere, and also includes a section of principal news items about the Federation.
Available from: International Planned Parenthood Federation, Western Hemisphere Region, 902 Broadway, New York, N.Y. 10010, USA.

"AIDS ACTION." Appropriate Health Resources and Technologies Action Group Ltd. (AHRTAG); Issue 11, London, England, August 1990.

This publication contains information about AIDS prevention programs and how AIDS is being combatted. It describes different experiences carried out to combat, prevent and control the disease.
Available from: AHRTAG. 1 London Bridge Street, London SE1 9SG, England.



"ANNUAL REPORT 1988." International Planned Parenthood Federation, Western Hemisphere Region, Inc. Edited in English and Spanish, New York, USA.

An evaluation of the activities carried out by the Federation's associates during 1988. Analyzes strategies and achievements in family planning, AIDS prevention and care, work with adolescents, etc. Discusses which goals were reached, principal experiences and perspectives for the following year.
Available from: International Planned Parenthood Federation, Western Hemisphere Region, Inc., 902 Broadway-10th floor, New York, NY 10010, USA.

"CRECIENDO." Asociación Salud con Prevención; Boletín Informativo; quarterly publication, Vol. 1 No. 4, Bogotá, Colombia, April 1990.

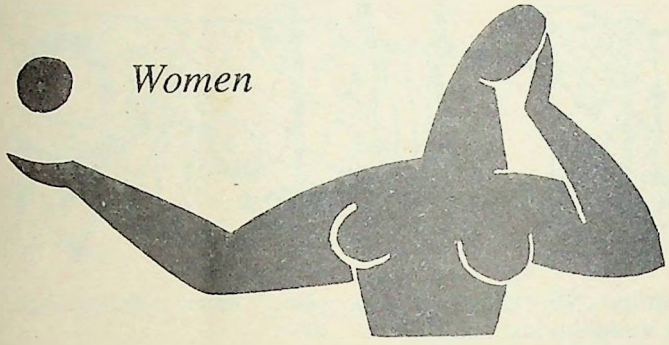
Publication dedicated to the subject of adolescent health and prevention in Colombia. Includes experiences working in the areas of sexuality, reproduction, contraception and in general a variety of articles related to the issue of Colombian youth.
Available from: A.A. 56192, Bogotá, Colombia.

MATERIALES ASOCIACION SALUD CON PREVENCION; Bogotá, Colombia.

This Association has published a series of sexual education pamphlets for adolescents. Titles include "Métodos anticonceptivos," "El condón y el espermicida," "Hablemos de responsabilidad sexual."
Available from: Asociación Salud con Prevención, Calle 54, No. 10-18, Oficina 901, Bogotá, Colombia.

"EARTHWATCH." International Planned Parenthood Federation (IPPF); No. 40, 4th Quarter. Edited in English, French and Spanish. London, England, 1990.

Earthwatch is a magazine about programs carried out in Asia on the theme of man-and-the-environment, the harmonious relationship between these two factors, ecological programs, optimum use of resources, etc.
Available from: IPPF, P.O. Box 759, Inner Circle, Regent's Park, London NW1 4LQ, England.



"WOMEN AS PROVIDERS OF HEALTH CARE." World Health Organization; Geneva, Switzerland, 1987.

This book was written by H. Pizurki, A. Mejía, I. Butter and L. Dwart; it analyzes the different roles played by women as important agents in promoting health. Discusses the contributions of women, both in formal and informal health settings, their contribution to national development and their status in this area.
Available from: Office of Publications. World Health Organization, 1211 Geneva 27, Switzerland.

"MUJER/FEMPRESS." Latin America; No. 109, November 1990.

Mujer/Fempress is a monthly publication designed to expedite communication among women. It is a Latin American magazine that contains a variety of articles on the condition of women in the continent, their work and their demands.
Available from: Mujer/Fempress, Casilla 16-637, Santiago 9, Chile.

"TEJIENDO NUESTRA RED." Year 2, No. 5, Quito, Ecuador, November 1990.

This magazine, edited by the Women's Popular Education Network (CEAAL), contains information about what is happening in women's popular education in Latin America, programs being developed, experiences, activities, international events and principal publications.

"WOMEN'S HEALTH JOURNAL." Latin American and Caribbean Women's Health Network, Isis International; No. 17, Santiago, Chile, January-March 1990.

This magazine about the work of women in the area of health contains information about programs, campaigns, etc. being carried out by women's health organizations at the local and community levels, in medical centers and government bodies.
Available from: Isis International, Casilla 2067, Correo Central, Santiago, Chile.

OTHERS AND CHILDREN." Vol. 9 No. 3. Edited in French, English and Spanish; Washington, D.C., USA, 1990.

This is a bulletin about infant feeding and maternal nutrition. It is edited by the Documentation Center on Infant Feeding and Maternal Nutrition of the American Public Health Association. The bulletin contains documents, news, experiences and bibliography on the subject.
Available from: Clearinghouse, American Public Health Association, 1015 15th St. NW, Washington, D.C. 20005, USA.

"A GUIDE TO NUTRITIONAL ASSESSMENT." World Health Organization; Geneva, Switzerland, 1988.

Written by I. Beghin, M. Cap and B. Dujardin, this is a guide for use by health workers in combatting malnutrition. It discusses important methodologies for use in prevention programs.
Available from: Office of Publications. World Health Organization, 1211 Geneva 27, Switzerland.

"CONSUMIDORES Y DESARROLLO." Regional Office of IOCU for Latin America and the Caribbean; Year IV - No. 7, Montevideo, Uruguay, September 1990.

Consumidores y Desarrollo is a publication containing news and information about the activities of the IOCU. The news section reflects the work being done in Latin America and the Caribbean around the issue of consumer protection and development.
Available from: IOCU, Regional Office for Latin America and the Caribbean, Casilla 10993, Suc. 2, Montevideo, Uruguay.

"LA CHACRA. PROGRAMA DE HUERTOS." Centro de Investigación y Promoción Educativa y Social (CIPES), Buenos Aires, Argentina.

An illustrated brochure explaining how to start a vegetable garden, basic varieties, primary techniques and methods of household gardening.
Available from: CIPES, Sede Central, Zabala 2677, (1426)Buenos Aires, Argentina.

"PARA QUE NUESTROS HIJOS CREZCAN Y VIVAN SANOS." Internaional Baby Food Action Network (IBFAN); Montevideo, Uruguay, October 1990.

Complete informational material about breastfeeding and infant feeding. Contains a series of leaflets explaining the importance of breastfeeding for adequate infant nutrition.
Available from: IBFAN c/o IOCU, Fax. 00592 - 950216. Casilla de Correos 10993, Sucursal 2, Montevideo, Uruguay.

Health Promotion

"NEWSLETTER FROM THE SIERRA MADRE." Nº. 21, California, USA, July 1990.

Edited by The Hesperian Foundation, this newsletter contains important testimonies about experiences in health education and programs designed to seek local solutions to health problems. All these experiences are related to programs carried out in small towns in western Mexico.

Available from: The Hesperian Foundation. P.O. Box 1692, Palo Alto, California 94302, USA.

"SALUD POPULAR. SUPERVIVENCIA INFANTIL." Instituto de Salud Popular (INSAP); No. 11, Lima, Perú, April 1990.

This issue is dedicated to an analysis of the situation of children in Peru. It contains a series of articles describing strategies being used to confront basic health problems affecting children.
Available from: INSAP, Av. Arenales 1080 Of. 301, Lima 11, Perú.

"LETTER." The Victorian Health Promotion Foundation; No. 7, Carlton South, Australia, August 1990.

In this magazine, the Victorian Health Promotion Foundation discusses its experiences with health promotion programs, covering different health problems that span the life cycle from birth to death; includes articles in the areas of biomedicine, clinical research and epidemiology.
Available from: Victorian Health Promotion Foundation, P.O. Box 154, Carlton South 3053, Australia.

"PLANTAS MEDICINALES." Ramirez, José F. Serie Salud Popular, Ediciones Cosalup; Santo Domingo, Dominican Republic, June 1990.

A practical guide that uses illustrations (charts, drawings, etc.) to explain the various uses of medicinal plants, their classification, attributes and how to find them.
Available from: Cosalup, Apartado Postal 30290, Santo Domingo, Dominican Republic.

"REFLEXION. DERECHOS HUMANOS Y SALUD MENTAL." Centro de Investigación y Tratamiento del Stress (CINTRAS); No. 109, Santiago, Chile, September 1990.

Quarterly magazine containing articles about mental health problems among vicitms of human rights violations in Chile and other Latin American countries.
Available from: CINTRAS, Miguel Claro 996, Santiago, Chile.

"ENFOQUES EN ATENCION PRIMARIA." PAESMI - Cooperación Italiana; Year 5 No. 2 and No. 3, Santiago, Chile, July and October 1990.

A magazine of analysis of a variety of issues in primary health care. Reports on experiences, programs and projects being carried out in this field in Chile.
Available from: Ediciones PAESMI Ltda., Casilla 121-A, Correo 29, Santiago, Chile.

"ACCION CRITICA." CELATS and ALAETS; No. 26, Lima, Peru, December 1989.

Semi-annual publication of the Latin American Social Work Center and the Latin American Association of Social Work Schools. Dedicated to the promotion, reflection and analysis of different social policies (health, education, development policies, etc.) being implemented in Peru.
Available from: CELATS, Jr. Jorge Vanderghen 351, Lima 18. Apartado 1262 Lima 18, Peru.

"CORREO DE AIS." Acción Internacional por la Salud; Boletín AIS-Lac, No. 11, Montevideo, Uruguay, July/August 1990.

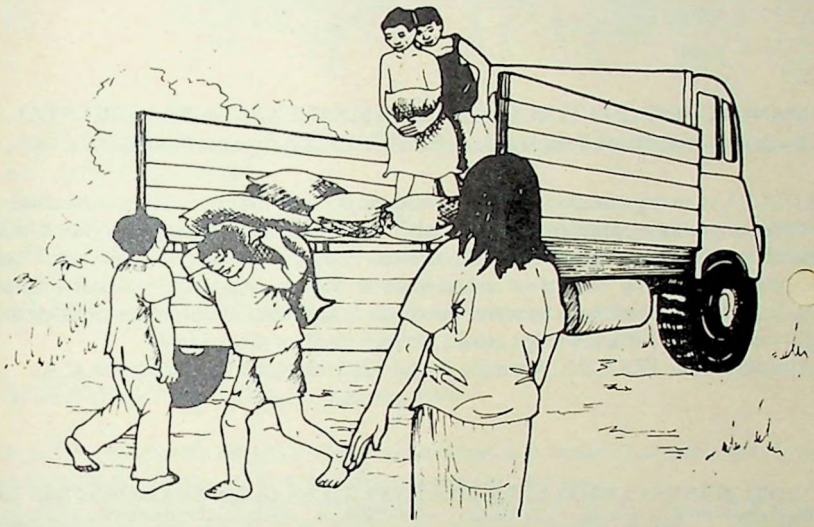
This bulletin contains brief news items, experiences and campaigns undertaken in the fields of health and the pharmaceutical industry.
More information: IOCU Regional Office for Latin America and the Caribbean; Elly Kerkvliet, AIS Executive Coordinator, Casilla 10993, Sucursal 2, Montevideo, Uruguay.

"SALUD AL DIA." Instituto de Salud Popular (INSAP); No. 5, Lima, Peru, May/July 1990.

Bulletin that compiles classified information appearing in several Peruvian newspapers; covers a wide variety of health-related items, including special programs, health policies and services, medicines, events, etc.
Available from: INSAP, Av. Arenales 1080, Of. 301, Lima 11, Peru.

"VHAI 1989-90 ANNUAL REPORT." Voluntary Health Association of India; New Delhi, India.

VHAI is a federation of more than 3000 health organizations from throughout India, working on health promotion issues. This is its annual report of activities carried out during 1989-90 at the local organizational level as well as the more general policy level. Available from: Voluntary Health Association of India. Tong Swasthya Bhavan. 40 Institutional Area, Near Qutab Hotel, New Delhi - 110 016 India.



"THE COMMUNITY HEALTH WORKER." World Health Organization; Geneva, Switzerland, 1987.

This guide for the primary health worker outlines the different problems that will present themselves in a given community (diseases, campaigns, etc.), the different viable strategies for use in each case, and ways of approaching an educational campaign. The material is illustrated with diagrams, drawings and charts.
Available from: Office of Publications. World Health Organization, 1211 Geneva 27, Switzerland.

"PROGRAMAS DE SALUD." CESAP; Caracas, Venezuela, 1990.

The CESAP health program has published a series of educational pamphlets for use in working with community health groups. Topics include infant health, nutrition, respiratory diseases, people's dispensary, diarrhea, health as a community problem, and others. Available from: Apartado 4240, Caracas 1010-A, Venezuela.

"BOLETIN EDUCATIVO LA CAÑADA." Colectivo de Salud Popular (COSALUP); Santo Domingo, Dominican Republic, 1990.

Educational pamphlets presenting the principal conclusions and experiences of workshop-seminars on Natural Medicine and Diagnosing Disease, articles and invitations to participate in its popular health education programs (child health, women's health, etc.). Available from: COSALUP, Apartado Postal 30290, Sto. Domingo, Dominican Republic.

"EDUCACION POPULAR Y SALUD. REFLEXIONES EN TORNO A LA ACCION POPULAR EN SALUD"; Centro de Investigación y Educación Popular (CINEP), Documentos Ocasionales No. 61, Bogota, Colombia, July 1990.

This is an interesting document containing four analytical articles on the need for new concepts and practices in community health work; the role of popular educators, the work of health promoters, the need for alternative practices and relationships in working with popular groups.
Available from: CINEP, Cra. 5a. No. 33A-08. Bogota, Colombia.

"MANUAL DE CAPACITACION POPULAR. SANEAMIENTO AMBIENTAL." Educación Comunitaria Para la Salud (EDUCSA); Tegucigalpa, Honduras.

EDUCSA is an organization that works with rural communities in Honduras, training and seeking strategic practices that will enable these sectors to confront the environmental health problems affecting them. The manual contains a series of basic sanitation measures, including control of water sources, vectors, excrement, liquid residue, garbage, food; and methods by which the educator and the community can evaluate and put into practice the knowledge gained through study of the manual.
Available from: EDUCSA, Apartado Postal 3312, Tegucigalpa, Honduras, C.A.

"BOTIQUINES COMUNALES. UNA EXPERIENCIA DE AUTOGESTION EN SALUD." Centro de Estudios y Promoción Comunal del Oriente (CEPCO), Serie Salud Comunal, Tarapoto, Peru, 1990.

This publication describes in detail the functioning of self-managed dispensaries in rural and marginal urban areas of Tarapoto, Peru, and the successful organizing and participatory experience of the health committees and mothers' clubs, supported and oriented by CEPCO. Also includes an evaluation of the health conditions of the population in the same areas and alternative proposals for solving these problems.
Available from: CEPCO, Jr. Progreso 512, Apartado 253, Tarapoto, Peru.

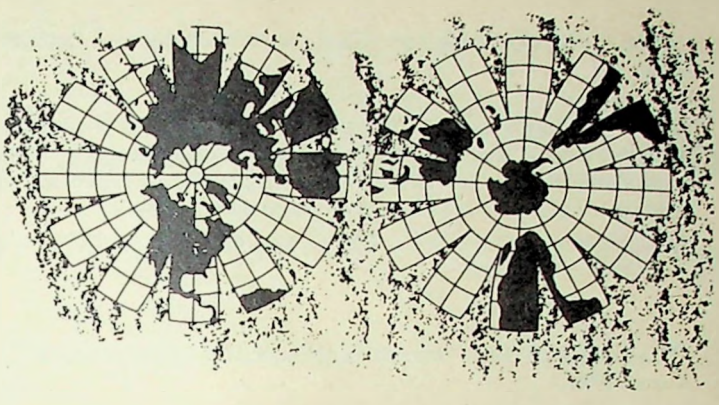
"LAS LAGUNAS DE LOS ENCANTOS." Mario Polia Meconi; second edition, Piura, Peru.

This book discusses traditional Andean medicine in northern Peru, analyzing its cultural implications, religious meanings and medical practices.
Available from: CEPESER, Arequipa 642, 6o. piso, Piura, Peru.

"HYGIE." International Magazine of Health Education; Vol. IX, 1990/2, English-French edition, Paris, France, June 1990.

Edited by the International Union for Health Education, this magazine contains articles on experiences and programs in health education; adolescent sexuality, educational campaigns for disease prevention, drug use, smoking, AIDS.
Available from: HYGIE, c/o ISD, 15/21, rue de l'Ecole de Médicine, F-75270 Paris Cedex 06, France.

International



"ASPBAE NEWS." Asian-South Pacific Bureau of Adult Education; No. 11, Sri Lanka, May-August 1990.

This magazine contains news from the field of adult education (meetings, regional activities, programs, financing, etc.), covering everything that's happening in South Asia, China, Southeast Asia and the South Pacific.
Available from: ASPBAE, 30/63 A, Longden Place, Colombo 7, Sri Lanka.

"ICAE NEWS." No. 3. Ontario, Canada, 1990.

Reports news and activities of the International Council for Adult Education. News from the Secretariat, subregions and the different program networks.
Available from: ICAE NEWS, 720 Bathurst St., Suite 500, Toronto, Ontario, Canada M5S 2R4.

"THE SPIDER." The Spider Newsletter of the African Association for Literacy and Adult Education; Vol. 4, No. 2, Nairobi, Kenya, July 1990.

This publication reports on the activities and programs of the members of the African Association for Literacy and Adult Education. Also includes news from the international field of adult education.
Available from: AALAE, P.O. Box 50768, Nairobi, Kenya.

"BOOKS AND PERIODICALS 1991 SUBSCRIPTIONS." World Health Organization; Geneva, Switzerland.

Bulletin containing all the necessary information about 1991 subscriptions to the books and magazines edited by the World Health Organization.
Available from: World Health Organization Publications, 1211 Geneva 27, Switzerland.

"ANNUAL REPORT 1989." Centre for Adult and Continuing Education (CACE); University of the Western Cape, Bellville, South Africa.

A report of activities carried out in 1989 by CASE, an institution that develops adult education programs in South Africa and also works to promote a society free of racial discrimination.
Available from: CACE, University of the Western Cape, Private Bag X17, Bellville 7530, South Africa.

"ANNUAL REPORT 1989-90." South-South Solidarity; New Delhi, India, September 1990.

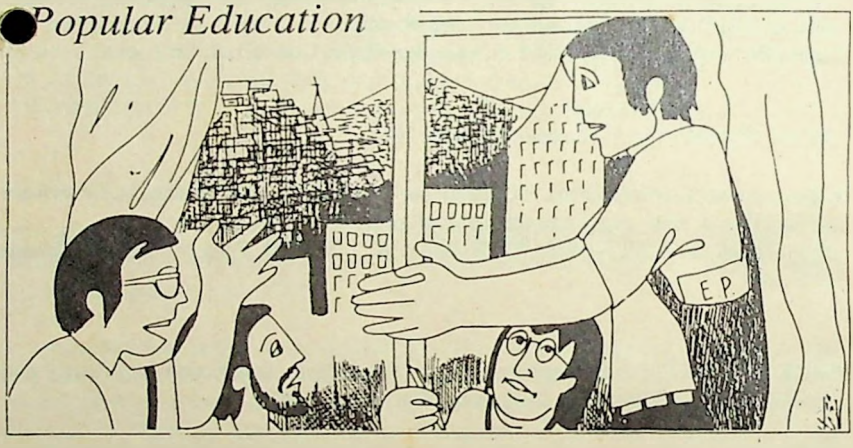
South-South Solidarity is an NGO seeking to increase relations between the countries of Latin America, Asia and the Pacific, and Africa for obtaining technical assistance, improving contacts and exchange. This report provides a review of activities carried out, progress made, and future projects proposed during 1989-90.

Available from: South-South Solidarity, Post Box No. 4590, New Delhi, India.

"ICAE DIRECTORY." International Council for Adult Education; Toronto, Canada, August 1990.

The ICAE Directory contains an address list of its members, cooperative bodies, committees, programs, projects, networks and secretariats.

Available from: ICAE, 720 Bathurst St., Suite 500, Toronto, Ontario, Canada M5S 2R4.



"JUNTOS EN LA ACCION POPULAR." CESAP; Year 1 No. 2, Caracas, Venezuela, July-August 1990.

This Venezuelan magazine reports on activities in community work and shows how community organizations resolve a variety of social problems.

Available from: CESAP, Apartado Postal 4240, Caracas 1010-A, Venezuela.

"DE SUPERMAN A SUPERBARRIOS. COMUNICACION MASIVA Y CULTURA POPULAR EN LOS PROCESOS SOCIALES DE AMERICA LATINA." Latin American Council for Adult Education, CEAAL, with support from the Centro de Estudios y Acción Social Panameño, CEASPA, Panama, Republic of Panama, 1990.

This book covers the main themes and papers presented at the Latin American Conference on Popular Culture and Communication, held in Panama, September 10-15, 1989. The different articles provide an overview of what is happening in popular communication in Latin America.

Available from: Programa de comunicación popular del CEAAL, Apartado Postal 6-133, El Dorado, Panama, Republic of Panama.

NEWSLETTER Nº 14 OF THE HEALTH AND POPULAR EDUCATION NETWORK

September 1991

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POPULAR PARTICIPATION IN HEALTH AS A PART OF FULL DEMOCRACY

Luis Weinstein

Amidst an unprecedented world crisis, with an exacerbated greenhouse effect, an accumulation of deadly bombs and the situation in the Middle East reaching its maximum tension, accelerated technological development modifies daily life and representative democracy co-opts it and contributes to disguise and seduce governments and civil societies with its market economies and its mutilated conception of the individual.

Supermarkets, cellular phones, enthralling television sets, make up an attractive landscape that doesn't allow us to see the forest of inequality and exploitation, ecological catastrophe and the cancerous growth of the weapons industry.

It is true that dictatorships are giving way to democratic regimes, but the underlying beliefs are competition, profit, abuse and the lack of creative solidarity in the face of injustice.

Incorrect development manifests itself in different pathologies such as the avid consumption and the escapism of drugs, the hunger of some and the voracity of others, loneliness within crowds, the lack of personalized communication amidst the explosion of technical means of communications, the paralysis of transportation when vehicles multiply.

In these conditions, when the real socialist experience disintegrates or dies, threatened by fundamentalism, with the possibility of an ecological fascism as an authoritarian solution to the crisis, the destiny of the species depends on the direction which democracy might follow.

Representative democracy, composed of elites of political, economic, military and cultural power, is incapable of solving the generalized discontent, the ailing social relationships, with nature within mental situations.

Democracy needs depth, revision of the paradigm of modernity, of instrumental rationality, of a lack of concern of ends, of values. The crisis calls for a culture of wisdom, of deepening, so that homo habilis might surrender his place to homo sapiens. Wisdom, needs an anthropological basis, to assume the needs, the contradictions of the species that has taken the planet and life to the moment of greatest danger. Human wisdom can no longer be anthropocentric, but rather it must be directed to an ecosophy, mental, social, with the environment.

An anthro-ecopolicy is a policy of comprehensive health.

Just as democracy is the political regime which in its rhetoric and its consensus gives the basis for alternatives, deep democracy, health, the existential, biologic, psychologic, spiritual, epistemological, economic, political, social, cultural, ecological dimension, is possible grounds for the convergence of sensibilities, ideas, social subjects, oriented towards a new development.

The public health discourse has opened up the way to the conception of comprehensive health, a category, of course, of more scope than comprehensive medicine or primary health care.

It is health care because it is the primary thing. The relationship with birth, the realization of potential and death. Love, hate and indifference. The operative problems and existential doubts, randomness and coincidences. The person, the group, society, Latin America, the planet. Health is an integrating initiative.

Popular participation in health starts from this value, this intuition, this conception. Health is integrated human development, both locally as well as globally. It isn't, obviously, only the absence of pathology. It necessarily includes the conflicts, the needs. It

expresses individual, social, community, national, Latin America and international capacities.

In practice, popular participation in health tends to identify with the integration of the citizen into state, municipal or private medical care. You "participate" effectively, as a neighborhood brigade member or as an advisor of a clinic.

There's also a form of autonomous neighborhood participation in organized groups that perform primary care or education.

Finally, from the specificity of the different ethnic groups, cultures or sex, one participates since you transcend the dominating cultural power and aboriginal forms of medicine are practiced, and popular wisdom about hygiene and therapy is assumed or a receptive diagonal emphasis is given to the meeting between professionals and the people assisted or educators and students.

At the present moment, nevertheless, popular participation in health should be carried out in the crucial problems. Our way of seeing reality, our epistemology, is sick with certainty and lack of subtlety. Our deep identity moves between the uncommunicative autism and giving ourselves to empty and diffuse interactions. Our relationship with nature is a disappointment and oscillates between continuing to rape it or to find some refuge in some trivial idealization. Human rights fill with incense and becomes respected like icons when rituals deem it convenient. And all of this is a fog that covers the real problems, the environmental, arms, social, mental health catastrophes amidst space travel and an opening towards the knowledge of the secrets of the atom and of consciousness.

Participation in health, now implies to "be a part" of the movement of comprehensive health, of development for the human being and ecology, lasting development at a human scale. It is participation in new social movements of a holistic bent, women, ecology, indigenous or oriental cultures, Christianity reincarnated into the social, the challenge of an economy of solidarity instead of competition.

In health participation we join personal and social development, beyond the old dichotomies of the individual and society, human being and nature, daily life and revolution.

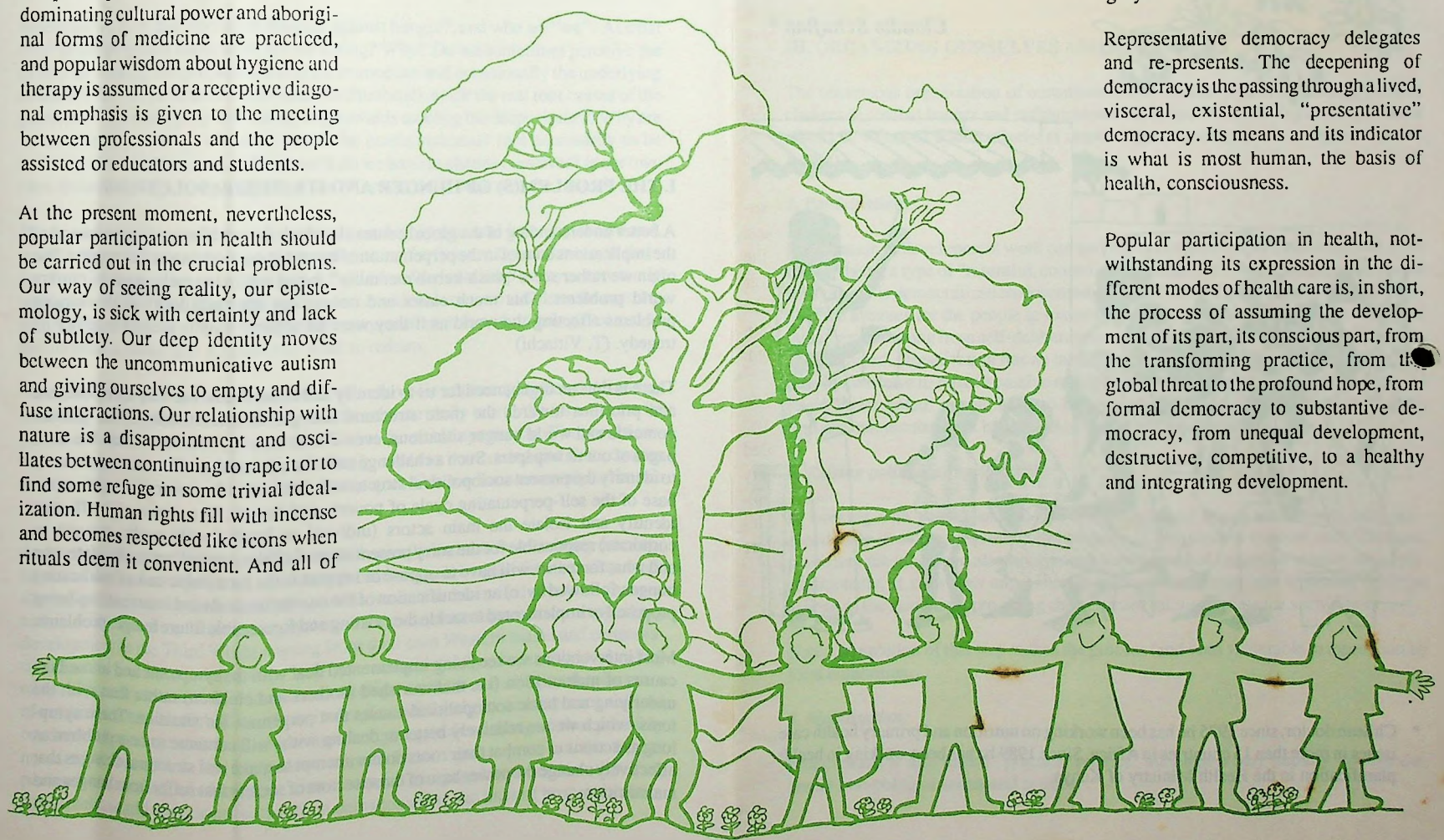
Participation in health is based on identity. In the basic tension between "the I and its circumstances." Along with the empirical I, linked by "mutual" and "external" relationships, there's a oneself, a profound I, "identified," integrated into the rest of reality. We participate, consciously or unconsciously, because we are a part of reality, of the "body" of nature. We participate consciously in health inasmuch that, from this "identification," we overcome our "separation" without losing our originality, our "usual" I.

Participation in health is updated in the struggle for change, to give a solution to the crisis deepening democracy, overcoming the diseased logic of the invasive market. This participation requires a constant work of consciousness raising and expansion, of what is most truly human.

Conscious participation is inseparable from participation in the development of consciousness. Critical consciousness is the result of an expanded consciousness, the healthy conscience which we open to the other and others, to a local relationships and the global imagery.

Representative democracy delegates and re-presents. The deepening of democracy is the passing through a lived, visceral, existential, "presentative" democracy. Its means and its indicator is what is most human, the basis of health, consciousness.

Popular participation in health, notwithstanding its expression in the different modes of health care is, in short, the process of assuming the development of its part, its conscious part, from the transforming practice, from the global threat to the profound hope, from formal democracy to substantive democracy, from unequal development, destructive, competitive, to a healthy and integrating development.



ACTIVISM TO FACE WORLD HUNGER:

EXPLORING NEW NEEDED COMMITMENTS

Why are we so often conciliatory when we should be confrontational?

Claudio Schuftan *

* Chilean doctor, since 1975 he has been working on nutrition and primary health care issues in more than 15 countries in Africa. Since 1989 he has been working in health planification in the Health Ministry of Kenya.

I. THE PROBLEM(S) OF HUNGER AND ITS (THEIR) SOLUTIONS

A better understanding of the global context in which the world around us works and of the implications thereof in the perpetuation of hunger in our midst are sorely needed. Too often we rather see a "shish-kebab mentality", being applied to make sense of current world problems. This much easier and convenient approach looks at the various problems affecting the world as if they were all separate events skewed together by tragedy. (T. Vittachi)

There is thus an urgent need for us to identify and better define our very own positions and priorities towards the more structural and global determinants of the present domestic and world hunger situations, even if both may have vanished from the front pages of our newspapers. Such a challenge calls for: a) an active effort on our part to try to identify the present sociopolitical structure(s) that lead to the major constraints at the base of the self-perpetuating cycle of poverty and hunger, b) a comparable effort to identify and isolate the main actors (indivual or institutional; public, private or corporate) responsible for the sorry present state of affairs -in an effort to elucidate who and what forces we will have to oppose or support in the formidable task of eradicating hunger, followed by, c) an identification of the current methods and interventions being proposed or implemented to tackle the existing and foreseeable future hunger problems.

Most interventions we see being implemented deal with the symptoms and immediate causes of malnutrition (i.e. malnourished mothers and children) rather than with the underlying and basic sociopolitical causes that perpetuate the situation. These symptoms -which we are relatively better at dealing with- will continue to be a problem as long as actions to combat their roots do not attempt to make real structural changes that effectively change the power base of those sectors of society that suffer from hunger and malnutrition.

However, involvement in health and nutrition can be an entry point to approaching the need for structural changes, i.e. be used constructively if health and nutrition interventions widen rather than narrow our horizons and lead us to take responsibility for the underlying and basic dimensions/factors that cause ill-health and malnutrition. We cannot just leave this for others to deal with. Don't "let George do it". It is our business.

Multidisciplinary approaches of the traditional type per se -just making professionals of different backgrounds sit together to discuss and decide- are not enough to refocus the attention on the need for changes that really tackle the more basic causes of malnutrition. These approaches, so much in fashion nowadays, are simply not leading us to aknowledge and work within a more ideological and political framework to get to where the real contradictions lie. Many people get "stuck" before reaching this crucial realization and cannot change the major focus of their work, because it literally takes "a second adolescent crisis" to change the outlook and the actual content of the work they routinely do.

II. LOOKING AT OURSELVES AND THE OTHER ACTORS IN THE BATTLE AGAINST HUNGER AND MALNUTRITION. INDIVIDUALS, INSTITUTIONS AND SOCIAL GROUPS

Where do we fit in this protracted struggle against hunger?, and who are "we"? At what level of the proposed framework are we acting? Why? Do we sometimes perceive the futility of working on symptoms and at the immediate and occasionally the underlying casual levels? Do our actions (individual/institutional) attack the real root causes of the problem? What is stopping us from moving towards tackling the deeper issues? Why are we so often conciliatory when we should be confrontational? (not necessarily to be understood in a violent sense...) How much do we have to change ourselves? Is our own class-bound ideology hampering us in our efforts to truly deal with the issues?

The answers to this set of relevant questions are highly personal by any measure and, not wanting to fall into unnecessary generalizations, I will leave the reader to sort them out. But, in any case, a word of wisdom is called for: We must keep our eyes constantly open or we will be "used" (in a national or an international context) to bolster the existing unfair system while trying to "help". Our energies may thus end up being devoted to maintaining a status-quo we basically want to redress.

An ethical motivation -which I assume all of us have- is not enough when confronting the status quo expressed in concrete situations in our daily work; the issues must be placed and dealt with in the political context that the world operates in. The powerlessness of the poor and hungry is what ultimately needs to be reverted and that requires some bold, decisive steps to break the status-quo. Can we become catalysts in this process?

A reform of development strategies is needed basically because most existing development institutions are hampered to take such bold steps due to the fact that they work through governments which have little genuine interest in the needed structural changes and prefer to "patch-up" the existing system. Moreover, these organizations are pushing development in the Third World coming from their own Western biases and conservative charters and the modules they "sell" are enthusiastically adopted by local ruling elites, especially because they do not erode their power base and still give them an aura of commitment to change. The whole issue of conditionaly in development aid (aid conditioned on some structural and/or human rights practices changes) thus probably needs to be brought to the foreground over and over again - provided the "right" preconditions are set, of which there is no assurance if imposed by the donors. All of us, colectively, could exert some pressure on demands along the lines of proper conditionalities by lobbying these agencies in our country and/or openly protesting and opposing some of their ongoing loans, grants or commodities disbursements.

Strategies to face transnational corportions and banks -also central actors in the determination and potential resolution of world hunger- are in dire need of being revamped as well, as much as possible using concerted approaches by as many as possible of the governments of the South adversely affected by these corporations' operations. Being watchful and militantly vocal on issues regarding transnational corporations, especially as relates to the foreign debt, is central to a committed activism on our part.

A number of grassroots organizations have begun springing up around the world becoming vocal and active on development issues. Cooperatives, labor and consumer unions, women's organizations and others have begun to look into health and nutrition issues. The potential of this emerging social movement is great and needs all our support. The World Food Assembly was organized in 1984 with the specific aim of pulling these movements around the world together into a network that could exert some pressure to change development schemes touching food and nutrition issues. The Institute for Food and Development Policy is also collecting information on these organizations trying to distill some of the pearls of wisdom that explain their success.

III. ORGANIZING OURSELVES AND OTHERS

The continuous organization of constituencies is the cornerstone of lasting, positive changes to combat hunger and malnutrition at its roots. The following are steps I think should be followed consecutively in organizing community work: (adapted from H. Bantje)

1. Participation:

Participation in development work can and has become an empty catchword and often ends up being a type of "resentful, controlled participation". What participation should really mean is democratization/decentralization of the decision-making process, opening the avenues for the people to excercise the right to choose and to take collective initiatives stemming from self-deliberation and leading to self-management of the tasks to be initiated. Organization has an instructional role per se when linked to organized activity. We have to reject a passive role for people; not only be indifferent about it. As Paulo Freire noted: people have to be present at the historical process as thinking activists, not maneuvered by the stablishment to think for them.

2. Raising political consciousness:

In working with people, one should always ask why things are the way they are - specifically avoiding to provide the answers...; this process exposes contradictions, politicizes the issues and also brings out a strong sense of collective identity in people. Additionally, it cultivates any existing spark of awareness into workable concrete actions at the same time providing the pertinent rallying points for such action.

Note: Completion of this step makes the process (and you) vulnerable to repression by local authorities...

3. Mobilization:

Mobilization is also called "practical politics" although it may initially involve distinctly non-political issues and actions.

Mobilization can be: for self-help, for lobbying, or for placing demands.

One should start with small, attainable goals, i.e. organizing unpretentious local voluntary work, posing relevant questions to or making specific demands from authorities. This by itself is a giant step forward.

Mobilization ultimately leads to a process of empowerment and some degree of control of the siatuation(s) through building confidence in the ability to act and make a real measurable or observable difference.

The existing discontent and anger can be mobilized creatively and can be used as a force to start proposing some structural changes.

Note: Attainment of this step is even more vulnerable to repressive actions.

4. Consolidation of movements:

a) Networking: Working together and organizing and coordinating work with others is of paramount importance in the process of empowerment. It helps create necessary support systems. Networking can also link together in coalitions a number of dispersed, existing single-issue constituencies, be it around limited or more general strategic or tactical objetives and be it temporarily or permanently. This facet of organization can be particulary relevant and positive in the First World, where single-issue constituencies have become more vocal and visible (i.e., environment, women's rights, consumer rights, antinuclear, etc.). b) Solidarity work: Supporting positive attempts at change by others -i.e. nationally or internationally as for example in Nicaragua or Southern Africa- is also vitally important.

IV. KEEPING OUR EYES OPEN BY CONSTANTLY LEARNING MORE ABOUT THE ISSUES AT STAKE

You cannot be an activist in the world of poverty and remain in it without some kind of preparation, without some kind of education, in a service which is not charity, not begging, but which demands justice. (P. Wresinski)

Continuously question yourself to what extent your involvement (or non-involvement) is used to maintain the status-quo. Question, for example, the role of foreign aid in perpetuating exploitative systems (aid cannot transform an antidemocratic srtucture of power into a democratic one; it can only reinforce what is already there...).

In this questioning, you have to keep in mind that, unfortunately, fundamental change is not possible without conflict with the powers that be. Whether we should help precipitate this conflict or face it when it comes remains an open question.

Critically explore why/how some countries have made progress in addressing the problem of ill-health, hunger, and malnutrition (i.e. China, Cuba, Costa Rica). Make it a habit to critically review the role of the World Bank, the IMF and other donor agencies (USAID, CIDA, etc.) in specific country and project contexts -always putting the foreign debt crisis in its proper perspective (an example of how debtor countries are now subsidizing the banking system at the expense of the wellbeing of their poor). Who is realy aiding whom when net flows of capital in the late eighties are towards the North...?

Last but not least, do not skip critically analyzing the role of particular NGOs (and some of you within them) working on hunger issues. In last instance, ask yourself if those NGOs are working for or against the best interest of the people. Our responsibility to the hungry and sick is not to go in and "do for" them, but to help remove the obstacles preventing people from providing for themselves. It is not for us to go into other countries and "set things right". (Food First)

V. SPEAKING UP!

Do not rely on others to do it; speak up! Each one of us must speak up and act at our very own levels. Every bit helps. Think globally, but act locally. Be forewarned, though, that when you move from charity to speaking out, you are liable to step on some toes. When you set out to "set free the oppressed" you risk being considered subversive and unamerican...

Keep asking why? Constantly expose and denounce contradictions you find in your analysis os specific situations and, most of all, do not be intimidated. The "silent majority" is probably behind you on most issues. We need to become change agents and effective advocates for social change leaving old fears behind.

If you are a student, influence your educational authorities to change or add courses on the topics of hunger and its resolution. Foster a continuing dialogue and debate through special workshops, seminars, guest lecturers or participation in World Food Day activities every October 16th.

Procrastination, remember, is the lifeblood of the status quo! (World Food Assembly).

Lastly, never forget that the role of science and technology in resolving the world hunger problem is, in fact, peripheral. (Yes!, as opposed to what some self-appointed "experts" want to make us believe). Such a focus and orientation -often calling for doing our technical work better and using more and more efficient training, management and supervision- only diverts the attention from the more basic political/structural issues which have to be addressed if we are serious about wanting to combat hunger as a sign of inequity. Efficiency is important. But not if only applied to the more technical aspects of combatting ill-health and malnutrition.

Bringing together people actively involved in changing/challenging the sociopolitical and economic structure(s) that perpetuate(s) a system in which people go hungry in a world of plenty is thus an urgent task.

Here are some suggestions on groups you can contact to count yourself in and consolidate your active participation into the type of major network we will be needing for the tough years to come:

- Institute for Food and Development Policy (Food First), 145 Ninth St., San Francisco, CA 94103.

- World Food Assembly (WFA), Secretariat: 5 Harrowby Court, Harrowby St., London W1H 5FA, England (c/o Robin Sharp).

- World Hunger Year (publishers of Food Monitor), 261 W 35th St., Nº 1402, New York, NY 10017-0374.

- Ten Days for World Development (Canadian education/lobbying group with current focus on food/hunger issues), 85 St. Clair Ave. East, Room 203, Toronto, Ontario M4T 1M8, Canada.

TWO MODELS FOR TRAINING HUMAN RESOURCES IN HEALTH

María Rosa Cataldo and Salomón Magendzo

One of the main obstacles to carrying out the Alma-Ata proposal and through it a new understanding of health, is the training of human resources who work in the field. Health care personnel although they have technical training, often lack methodologies and knowledge of the idiosyncracies of the popular sector, of how people in this sector think and act.

In order to achieve this new understanding, health care personnel need a special type of training that would serve as a means of exchange and a way to continually review of their practices. That is, in order to overcome the automatization that has been imposed on them in these last few years, they need to meet with other professionals who are thinking about solutions to this problem in health care with an alternative focus and building a movement for Primary Health Care.

It is indispensable that along with a solid technical formation, health care personnel begin to understand again the significance and value of the social and educational aspects that enter into what they do. This is even more important when all the members of our society are involved in a process of redefinition in a democratic social system. A process in which the participation of each and every person in the community plays a central role, a specific role which as it is fulfilled in the social dynamic makes a contribution to build a more free, just, and equalitarian society in a climate where basic democracy governs social relations.

Because of this, the health care team and the community will become involved in the development of different actions that they undertake with an understanding of the relationship of prevention to health, and with the consideration that integral health is a subject which concerns the total population.

Without a doubt, it is evident that community participation will not be possible without the implementation of an adequate educational strategy, and for this, personnel with technical and social training are needed.

The need for social change that our poor societies so urgently call for require a serious and profound commitment to human development and to the struggle for justice and equality.

In this task of promoting development, the training of personnel becomes an effective tool for generating change, as much at the individual level as at the structural level; a tool for mobilizing the political will to solve problems with adequate strategies of social development; to translate societal goals into educational objectives; to develop new personal and collective identifies and values, etc.

The development of training projects aimed toward social change implies unleashing a chain reaction of social participation that grows larger every day.

Without a doubt, developing the skills to initiate participatory actions requires basic change - in lifestyle, in socio-economic structures and policies, in the entire value system of a society. Therefore, training when it is understood this way, also leads to cultural transformation.

of

THE CONTRIBUTION OF POPULAR EDUCATION

The Program of Training in Popular Education Salud of the Interdisciplinary Program of Research in Education (Programa de Capacitacion en Educacion Popular y Salud en el Programa Interdisciplinario de Investigaciones en Educacion - PIIE) has developed methods of training and educating human resources that are primarily guided by the educational and methodological principals that underlie the concept of popular education.

In popular education, the act of educating takes the form of a process of building knowledge. The people involved in the process build this knowledge as they critically take possession of their own reality and start to change it.

That is to say, that what popular education aims to do is to provide the tools for the participants to discover the internal contradictions of a given reality, making it possible for them to draw conclusions and form their own opinions; and to go through a process where on the one hand, empirical knowledge leads to rational theoretical knowledge; and where, on the other hand, abstract ideas lead to action.

This task requires an ongoing dialectic attitude which enables the participants to unite practice and theory in a permanent and dynamic learning process.

It is essential that this process of building knowledge takes place with others, in a suitable group, where shared responsibilities, horizontal structures of relating to each other, creativity and compromise are able to develop.

Therefore, it can be concluded first of all, that training should facilitate a process of reflection-action where the educator plans and directs the process of training. Secondly, that this process is directed by certain pedagogic principals, which give the training its innovative character. These principals can be stated in the following manner:

- *Building knowledge from experience: those who have immediate and natural knowledge of a social and cultural situation are those who are part of that situation. Knowledge is a product of experience, of assigning meaning to what surrounds us.*

- *Knowledge and theory are conceived in an integrated form; in this way, all theoretical processes should arise in some way from practices that the participants develop.*

- *Participation as a factor in education: This principle is related to the requirement that those who are being trained become actively involved in the learning process. It is only then that participation becomes articulated as the fundamental idea of the educational process, finally translating itself into the distribution of power that is generated within the group, this implies involving the participants in building knowledge, giving them access to decision making and responsibility in the group dynamic, etc.*

- *Concern for the group process: all human groups that operate over a period of time need to value and be committed to a common goal, establish adequate channels of communication and solidarity, as this is finally what determines the level and quality of their human relations.*

- *Because of this, it is important which they create a climate where the members of the group get to know each other and develop democratic interpersonal relationships. To accomplish this, techniques of group dynamics and exercises can be used. This relaxes the participants, diminishes their fears and inhibitions and makes it possible for them to gradually get acquainted with each other - from getting to know each other's names to sharing aspects of their personal lives.*

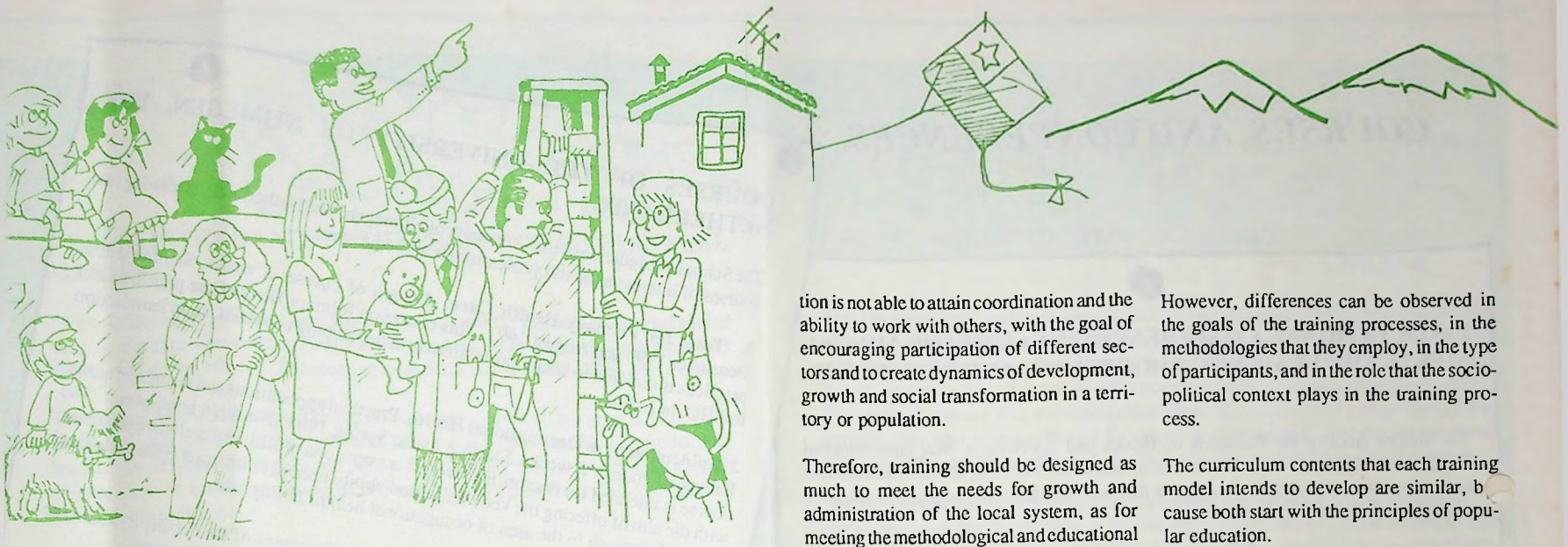
- *A social group is also of itself a learning situation. This is true as much as for the social interaction that develops within the group as for its ability to generate knowledge collectively through a process of group discussion and analysis.*

- *Considering the socio-political context in the development of training: The task of the participants is conditioned by a context determined by social and political structures. Therefore, continued reflection and analysis of this social dynamic with the aim of understanding its mechanisms of action and their repercussions on society as a whole and in smaller social contexts, is needed.*

TWO ALTERNATIVES FOR TRAINING

Experience in training human resources for social change has enabled us to form two models for training: 1) Long distance group self-teaching; 2) Training of human resources for local development.

As has already been said, these two models share certain basic principals about training. However, they differ in the strategies that they use as they are designed to meet different needs. Therefore, it is not so much that the use of one model excludes the use of the other. Rather a question of competition between models, it is a question of which one should be used to attain the desired goals.



That is why the first model, "Long-distance group self-teaching" is designed to satisfy certain basic needs that can be seen as essential when we speak about generating social change:

1. The growing need for an increasing number of people to be able to take advantage of a transforming style and concept of education. This need exists because social change requires that people who play the role of educators in society, and who therefore influence society, are able to have a democratic and liberating conception of the role they play.

2. The need for the training process to transmit a principle essential to social change: autonomy in the creation and building of knowledge. This would suggest that presential educational models should be discarded and with them the dependence on the educator that they create. The training model "Long-distance group self-teaching" was designed with this in mind.

The long distance educational system functions by means of an educational guide. This guide allows a group of individuals who are interested in being self-taught to take responsibility themselves for the role of planning and carrying out their own training. A kind of interaction is created between the tool that facilitates the process of self-teaching and those who undertake to train themselves.

Therefore, the educational guide replaces the teacher, and the participants themselves take on the entire training process.

It must be pointed out that the usefulness of this method of building knowledge for the participants depends on the participants themselves and on the context in which they develop their practices. That is to say, the circumstances of the place where the participants develop action as well as their country are what determine what they will do with their knowledge.

In this model, because it is self-taught, the participants are largely persons who are already sensitive to social change, and who see training as a means to perfect themselves in an educational aspect.

The second model of training, that of "Local Development" is based on a different premise than the first.

This model grows out of the intention to train human resources to generate or empower a process of local development. It must be pointed out that local development concerns itself with strengthening social organizations, as a strategy for increasing participation in the social, political, and cultural life of a country. It is not possible to achieve this strengthening, if the organization is not able to attain coordination and the ability to work with others, with the goal of encouraging participation of different sectors and to create dynamics of development, growth and social transformation in a territory or population.

Therefore, training should be designed as much to meet the needs for growth and administration of the local system, as for meeting the methodological and educational requirements of the different groups involved in the local development process. Therefore, this model views training as an indivisible whole, where there is concern for the ways groups are formed in the local, for participative diagnosis, for personal relationships, etc. as well as for reinforcing ideological aspects and educational strategies for action.

It should be pointed out that for this model to succeed, the existence of the political will to decentralize where basic democracy, intersectorial work and social participation are essential goals.

In this model, it is the trainers, together with other social actors in the community, who, while in action, detect what training is needed to allow them to continue the process of local development, in as much as the needs for training arise from action itself.

This model has a presential character, and those who benefit from it can have different levels of sensibility about social change. In this sense, the training takes on relevance as a strategy to reinforce a cognitive-attitudinal change, a fundamental step for persons involved in the dynamic of local development.

In short, these two models of training seek social change and are guided by principles and methodologies of popular education. Also, both take the socio-political context into consideration for their implementation. However, differences can be observed in the goals of the training processes, in the methodologies that they employ, in the type of participants, and in the role that the socio-political context plays in the training process.

The curriculum contents that each training model intends to develop are similar, b cause both start with the principles of popular education.

Therefore, the following subjects are suggested: Concepts and Methodology of Popular Education; Educational Planning, Organization, Popular Social Movement and Group Process, Principals for the Construction of Educational Materials; Participative Research; Systematization and Evaluation; and Community Development.

When it is considered that the second model has community development as its main concern, it can be pointed out that the treatment of the above mentioned themes have even more importance in training in action, a means of working which permits the carrying out of support activities y their fo llow-up with actions taken by the community itself.

It should be noted that both models have sufficient flexibility to make it possible to adapt their curriculum to the needs of the participants. This can be done by choosing the most pertinent subjects as well as by adding to the curriculum other subjects that meet specific needs. For example, in the area of health, all the subjects that have to do with community health, participative health education, training to create and develop community health systems, etc. are essential subjects and subjects which are complimentary to popular education.

COURSES AND CONFERENCES

INTERNATIONAL CONFERENCE: "HEALTH FOR MINORITIES IN THE YEAR 2000 - SHORTENING THE DISTANCES"

The Galilee Society for Research in Health and Services, a Non Governmental Organization that does work in the area of health for the Arab minority in Israel, is organizing this International Conference that will take place in Nazareth, Israel, from the 7th to the 10th of April, 1991.

During the conference, professionals and community leaders will share opinions and experiences about health conditions for minorities in developing countries. The aim of this meeting is to encourage and find ways to eliminate the inequalities in health care services for minorities in these countries.

For more information: Galilee Society for Health Research and Services, P. O. Box 92 Rama, 30055 Israel.

COURSES OF THE UNIVERSITY OF NIJMEGEN, THE NETHERLANDS

The School of Medicine of the University of Nijmegen, The Netherlands, is offering two courses of interest to health professionals and educators.

1. Tools for Primary Health Care. Length of course: 2 weeks. Starting dates: December 1990 and August 1991. This course on Primary Health Care principles and practices is directed to health professionals in developing countries, as an introduction to PHC. In English.

2. Epidemiology in Occupational Health. Practical applications and theoretical bases. Length of course: 2 weeks. Starting dates: Spring 1991 (Northern hemisphere). The course is intended for doctors involved in occupational health in developing countries, with the aim of offering the knowledge and ability needed to interpret epidemiological data and research in the area of occupational health. In English.

For more information: University of Nijmegen, Secretary of the Faculty of Medicine and Dentistry, P. O. Box 9101, NL-6500 HB Nijmegen, The Netherlands.

THIRD INTERNATIONAL CONFERENCE ON HEALTH PROMOTION: "ENVIRONMENTS FAVORABLE TO HEALTH"

This conference, which will take place June 9 - 15, 1991 in Sundsvall, Sweden, has been organized jointly by the WHO and the Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden), in collaboration with the United Nations Environmental Program.

The objective of the conference in Sundsvall is to identify practical formulas for the creation of physical, social and economical surroundings that favor health and are compatible with viable development, in developing countries as well as in the industrialized nations.

One of the things that is hoped to come out of the conference is a manual for improving public health and the environment.

For more information: Third International Conference on Health Promotion, Box 290, S-851 05 Sundsvall, Sweden.

LONG DISTANCE SELF EDUCATION GROUPS

PIIE (Interdisciplinary Program for Research in Education, Programa Interdisciplinario de Investigaciones en Educacion) organizes long distance self education groups. These courses are directed to community leaders, monitors, and professionals who are in training or perfecting skills in the theory and practice of popular education.

These long distance group courses (minimum 6 persons, maximum 10) make it possible for people to receive training, when for one reason or other they are not able to attend other courses or workshops. The total cost of each course for the whole group is $50.000 Chilean pesos or US$ 170 for the rest of Latin America.

The three courses being offered now are: Concepts and Methodology of Popular Education; Production of Materials and Educational Processes in Popular Education; and Research and Local Development in Popular Education.

For more information: PIIE, Brown Sur 150, Santiago, Chile. Telephones: 223-1940 - 496644. FAX (56-2) 2231940.

NEWS

HEALTH IN THE HANDS OF THE PEOPLE - SECOND ANNUAL MEETING

"With our feet on the ground.....building our future", was the theme of the second annual meeting of groups who make up Health in the Hands of the People, a program that trains health promoters in Mexico. The meeting took place last April 25 - 28 in Mexico City.

The meeting produced a rich exchange of experiences from all the groups. Five basic areas were covered: health and nutrition, health and culture, health and production, health and technology, and health and policy. The different ways that community health diagnosis can be carried out were examined, and materials from different parts of Mexico were exchanged.

For more information: Teresa Zorrilla, Salud en Manos del Pueblo, PRAXIS, Vesubio No. 57, Col. Alpes, 01010 Mexico D. F., Mexico

INTERNATIONAL VITAMIN A CONSULTIVE GROUP (IVACG)

The relationship between Vitamin A deficiency and infant morbidity and mortality was the focus of the XII Meeting of the International Vitamin A Consultive Group. The IVACG was formed in 1975 with the objective of guiding international activities aimed toward reducing Vitamin A deficiencies throughout the world.

At this meeting, experts from various disciplines presented and discused the results of numerous studies, and at the conclusion of the meeting, they presented a declaration based on the considerations of the Directive Committee on the available evidence.

- An adequate level of Vitamin A prevents nutritional blindness and significantly contributes to infant health and survival.

- The role of Vitamin A in the prevention of nutritional blindness is well documented and accumulated evidence exists that it also plays a role in the reduction of infant mortality. The mechanism or mechanisms that produce this effect are not clear.

- The impact of improved nutrition with Vitamin A will vary according to the severity of Vit. A deficiency and the contribution of other ecological factors.

- Therefore, improving the diet and elevating the level of Vitamin A is imperative when Vitamin A consumption habitually been chronically inadequate.

The Directive Committee of IVACG hopes that this declaration will be useful in the process of formulating national and regional policy and programs to combat Vitamin A deficiency.

For more information: International Vitamin A Consultive Group, The Nutrition Fundation Inc., 1126 Sixteenth St. NW, Washington, D.C. 20036, USA.

FIRST CONGRESS ON MEDICINAL PLANTS / CHILE 90

In the last few years, various economic, social, and ecological factors have favored the re-evaluation of the value of plants as a resource in Primary Health Care. The principal advantage of the use of medicinal plants lies in their low cost and low risk factor when compared with the high cost and the risks associated with the use of synthetic medicines. The medical efficacy that some medicinal plants have traditionally demonstrated for centuries has now been confirmed by scientific investigation. And medicinal plants have the further advantage of being easy to use and less toxic than synthetic medicines.

In Chile, people have also shown a growing interest in medicinal plants, due to the search for a solution to health problems with alternative medicines which are known to and shared with popular culture. This interest has been expressed by an significant proliferation of medical products based on plants which are available on the national market.

It was in this context that the First Congress on Medicinal Plants, Chile 90, was held on June 7, 8, and 9th. The event was sponsored by Caritas Chile, the SOINDE Clinic of Conchali, CETA, PAESMI, and the Department of Phytochemistry and Pharmacology of the University of Chile.

The 180 participants in this Congress came from different disciplines, which gave the gathering the interdisciplinary character that had been hoped for. Health professionals, doctors, nurses, nutritionists, botanists, anthropologists, sociologists, agronomists, as well as distributors of alternative medicines such as naturalists, "yerbateros" (herbalists), "veedores" (seers) and acupunturists all took part in working groups, discussions and meetings. Also among the participants were Latin American experts on medicinal plants, such as Lidia Girón, a member of the National Commission on the Use of Medicinal Plants of Guatemala, and Carlos Roersch of the Center of Andean Medicine in Cuzco, Peru, who were invited by CEAAL. This great diversity in participant produced a fruitful dialogue and demonstrated the need for future work with contributions from all the different professional perspectives.

A total of 38 reports, accounts of experiences, and conferences about the use of medicinal plants touched on a wide range of subjects. Of these, about half dealt with phytochemical and pharmaceutical studies [the hepatoregenerative properties of bailhuen, the antimicrobial properties of Allium Sativum (alicina) and of Berberis Vulgaris (berberina), among others]. Also discussed were the study of popular medicine and its use in different countries; techniques for drying and conserving herbs; the history of traditional medicine in China, India, and other ancient cultures; advances in the research about the properties of cocaine, the phenomenon of urban herb sellers; and using the stories and documents of travelers as a resource for studying botanical medicine. A proposal was also made for developing a national medical herbarium which would help to guard against the danger of extinction which menaces a large number of species of plants in Chile.

For more information: Adriana Fuenzalida, Consultorio SOINDE, Av. La Palmilla 3711, Conchali, Santiago, Chile.

THE COMMUNITY HEALTH AND POPULAR EDUCATION INFORMATION BANK

The Health and Popular Education Network intends to be a place where groups working to promote health in Latin America can establish contact with each other and communicate with others about their activities. In order to do this, we need to identify all of the groups in the network and learn about their programs and activities.

But we can only be effective as a network if our information about the latest activities in the area of community health and popular education on our continent is kept up to date.

It is for this reason that the Health Network proposes to create a Latin American Data Base of Experiences and Practices in Health and Popular Education.

We are interested in creating and developing an Data Base about community health and popular education programs in Latin America which will enable us to gather and distribute data about activities, attitudes, achievements and products.

The Data Base would, in short, be a catalogue of activities in the area of health and popular education which would have two fundamental goals:

1. Facilitate and make possible the exchange of information and experiences among groups and individuals who work in community health.
2. Stimulate and facilitate the growth of new community health projects and experiences.

This would also premit us to appreciate the true dimensions of the community health programs on the continent, giving them more visibility, and finally, more legitimacy in their practice and strategic propositions.

For all these reasons we are sending out this questionaire which we hope will receive a wide response from all of you. Once we have gathered sufficient information, we will start to send you periodic reports. We hope to be able to send you information three times a year. All the programs that send in the questionaire will recieve a list of all the projects that have already been catalogued with basic information about each program's activities.

QUESTIONAIRE TO RECORD COMMUNITY HEALTH AND POPULAR EDUCATION PROJECT AND PROGRAMS

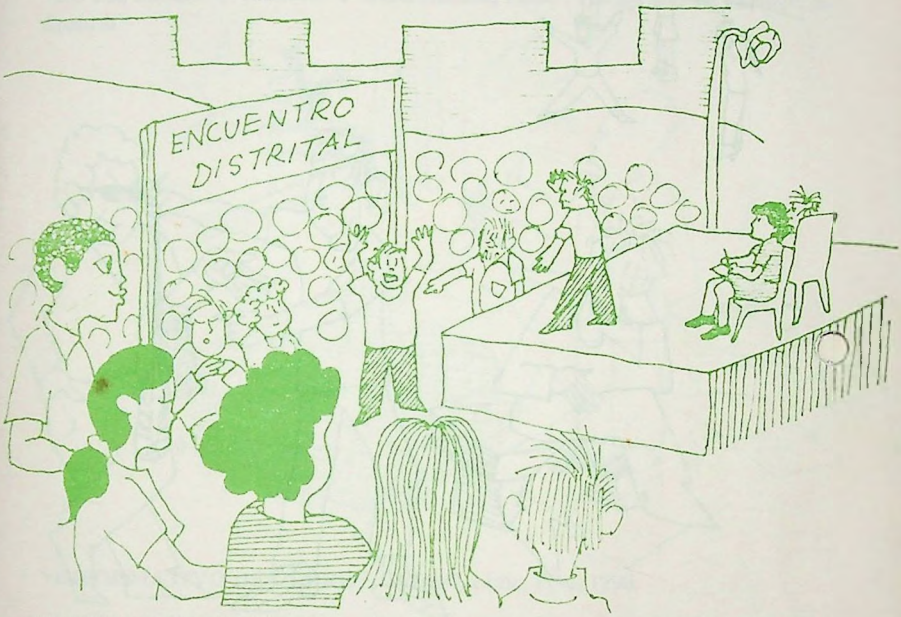
1. Name of the Program or Project . . . . . .
2. Type of activity (Primary Health Care, training, organizing, communication, research, production of educational materials, etc.) . . . . . .
3. Sponsoring organization . . . . . .
4. Complete address and telephone number . . . . . .
5. Name and profession of the person in charge of the program . . . . . .
6. Names and professions of the other members of the group . . . . . .
7. Objectives of the program or project . . . . . .
8. Work schedule (date of the beginning and end of the program) . . . . . .
9. Principal contents of the program . . . . . .
10. Brief description of the activities carried out . . . . . .
11. Organizations who support the work . . . . . .
12. Observations . . . . . .
13. Date, and signature of the responsible person . . . . . .

Send the questionnaire to:

Health and Popular Education Network - CEAAL
Perez Valenzuela 1634
Casilla 163-T
Providencia, Santiago, Chile

Bibliographic and Educational Materials

Health - Drugs



MATERIALS FROM CEDRO

The Center for Information and Education for the Prevention of Drug Abuse (CEDRO - Centro de Informacion y Educacion para la Prevencion del Abuso de Drogas) is a private Peruvian institution that provides information and education about the drug problem in Peru, indicating its causes and consequences, and trying to decrease the availability of drugs and drug abuse. CEDRO offers technical assistance and coordinates the efforts of institutions and organizations. In all its programs, CEDRO seeks to involve different sectors and groups in the community.

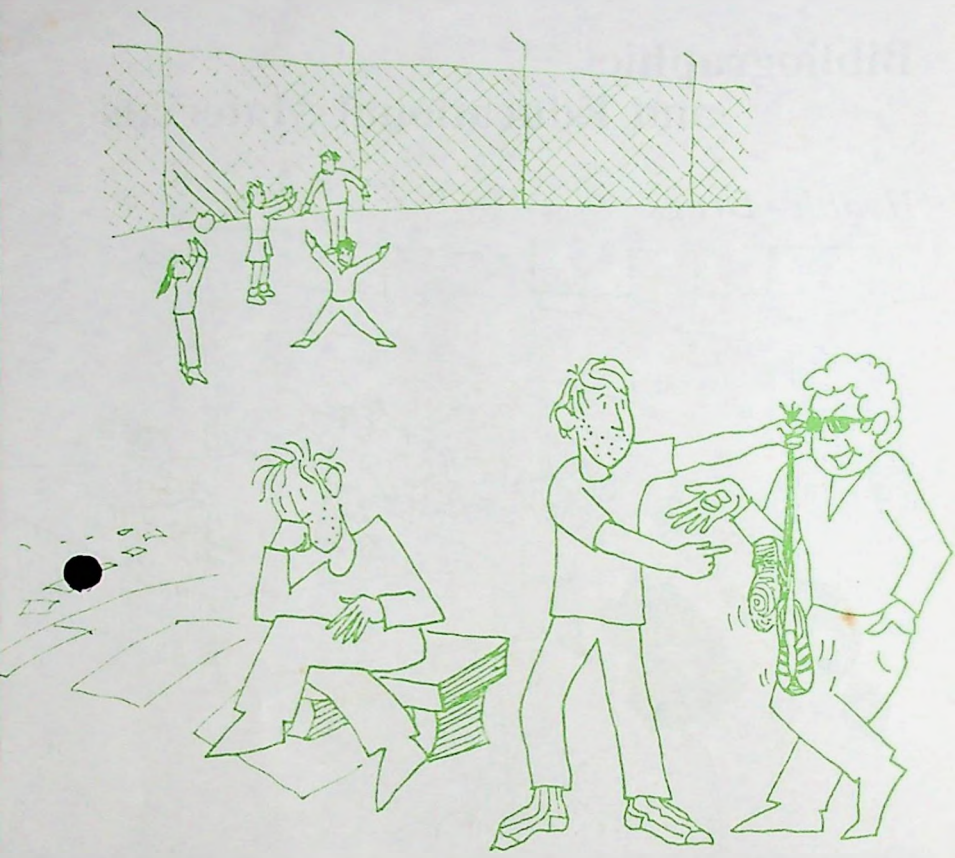
The CEDRO network, made up of the institutions which receive support from the center, is made up of 1250 different groups.

As part of their work in generating and publicizing knowledge, information and education about drugs, CEDRO produces an important and diverse series of educational and informative materials as well as research.

All of these materials can be ordered from: CEDRO, Sanchez Cerro 2101, Lima 11, Peru.
We will describe some of CEDRO's publication below:

"PSICOACTIVA". Scientific magazine of CEDRO. Lima, Peru, 1987-1989.

This magazine is published biannually and contains articles about psycho-active substances and their impact in different areas, based on empirical, theoretic, or applied studies. It also carries reviews of books, bibliographic resumes, and notes about scientific developments, and news of conferences and events. Resumes in English.



"PASTA BASICA DE COCAINA. UN ESTUDIO MULTIDISCIPLINARIO". Leon F. & R. Castro de la Mata (publishers). CEDRO. Lima, Peru, 1989.

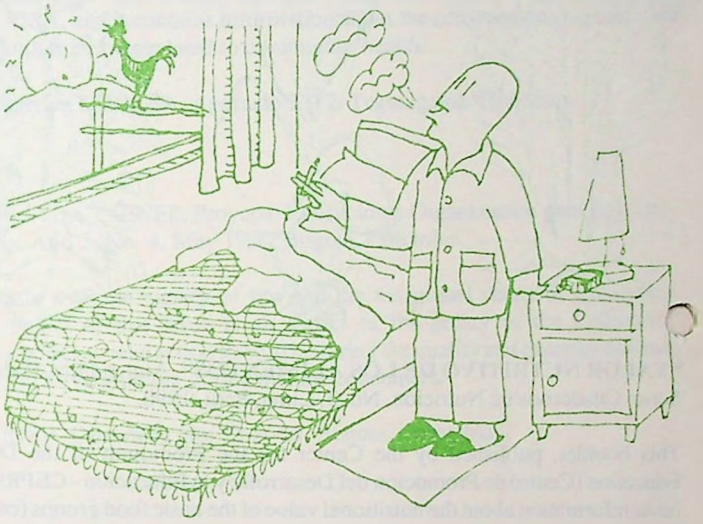
Basic Cocaine Paste (BCP) whose existence has been recognized in Peru for the last 15 years, has caused major social and scientific problems, much worse than could be imagined in the last decade. In this context, CEDRO organized an interdisciplinary seminar to share up to date information and draw attention to the debate on the most important aspects of the problem of cocaine paste in Peru. The seminar was held in Lima (May 1988) with 100 participants - pharmacologists, psychologists, anthropologists, educators, lawyers, economists, agronomists, ecologists, and politicians. This book publishes the principal contributions to this seminar in 13 articles.

"MONOGRAFIA DE INVESTIGACION". CEDRO. Nos. 1, 2, and 3; Lima, Perú, 1987-1989.

The results of diverse scientific investigations about the problem of substance abuse and its impact in Peru are the subject of this collection of monographs which CEDRO has published annually since 1987. The collection of monographs serves as a vehicle for reflection and information, an instrument to consult about a complex problem. The titles of the monographs which have been published to date are: "Use and Abuse of Drugs in Peru, (epidemiological research, 1987); Peruvian Legislation on Drugs From 1920 Until the Present (1988); A Study of Perceptions about Drugs in the Urban Population in Peru (study of public opinion, 1989). In Spanish.

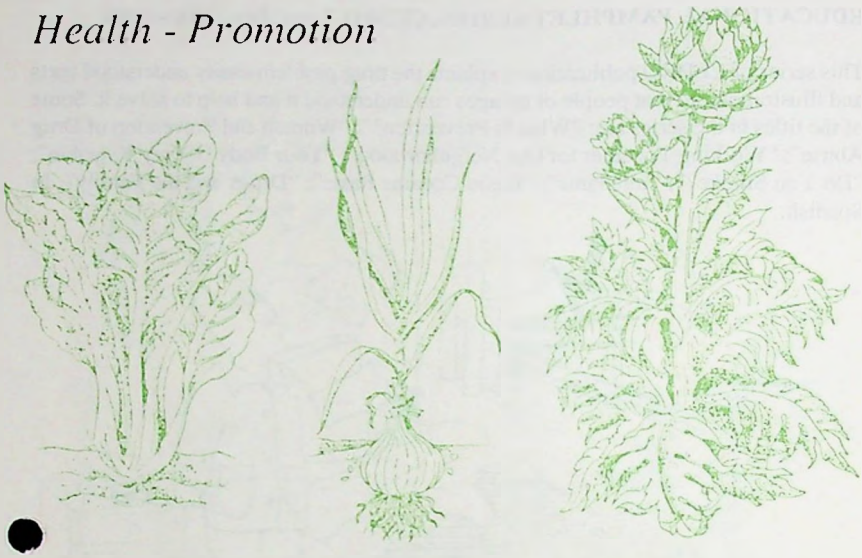
EDUCATIONAL PAMPHLET SERIES. CEDRO. Lima, Peru, 1989-1990.

This series of CEDRO publications explains the drug problem easily understood texts and illustrations so that people of all ages can understand it and help to solve it. Some of the titles in the series are: "What Is Prevention?"; "Women and Prevention of Drug Abuse"; "Working Together for Our Neighborhood"; "Your Body Is Very Valuable"; "Do You Smoke?"; "Inhalants"; "Basic Cocaine Paste"; "Drugs and the Family". In Spanish.



"INFORMATIVO DE CEDRO". CEDRO, Lima, Peru, 1990.

This bulletin periodically published by CEDRO contains articles of interest to the general public, as well as information about the numerous programs and activities carried out by CEDRO, and abundant facts, news, experiences and services offered to the those who are interested in or are effected by the serious problem of drug abuse. In Spanish.



"VALOR NUTRITIVO DE LOS ALIMENTOS". Almendáriz, Pedro. CEPRODE, Serie: Cuadernos de Nutrición. No. 3, Lima, Perú, 1990.

This booklet, published by the Center for the Promotion of the Development of Education (Centro de Promocion del Desarrollo y la Educacion - CEPRODE), contains basic information about the nutritional value of the basic food groups (cereals, legumes, fats, meats, fruits, dairy products, etc.), an evaluation of their contribution to diet, and recommendations for maintaining their nutritive value.

Order from: CEPRODE, Apartado Postal 18-1672, Miraflores, Lima, Peru.

"FACTS FOR LIFE. A COMMUNICATION CHALLENGE". Unicef, WHO, Unesco. Oxfordshire, United Kingdom, 1990.

This manual, which is directed to communicators, gathers abundant information about mother-infant health. This information, about pregnancy, childbirth, breastfeeding, the growth and feeding of the child, infectious diseases, diarrhea, malaria, AIDS, is written in a format that is easy to understand, so that it can be used in those countries that still haven't solved their basic sanitation problems. In English.

For more information: UNICEF, DIPA, Facts for Life Unit, 3 U:N Plaza, New York, NY 10017, USA.

"POLITICA DE POBLACION. MANUAL PARA PLANIFICADORES Y RECTORES DE LA POLITICA". Isaacs, S.; Cairns, G.; Heckel, N. Universidad de Columbia, Facultad de Salud Pública, Centro de Población y Salud Familiar, Programa de Leyes y Políticas en Desarrollo. New York, Estados Unidos, 1985.

This manual is a guide for policy makers, planners, and those interested in population policy. It analyzes the essence of the population policies of 20 countries; numerous common elements in these policies have been selected and compared so that the reader can form an idea of how similar problems are handled in different countries. The text of laws and policy documents are also included and analyzed. In English and Spanish.

Order from: Director, Development Law and Policy Program, Center for Population and Family Health, Columbia University, 60 Haven Avenue, New York, NY 10032, USA.

"XIGUAPATE". Bulletin of the Community Health Program of EDUCSA; Tegucigalpa, Honduras, 1990.

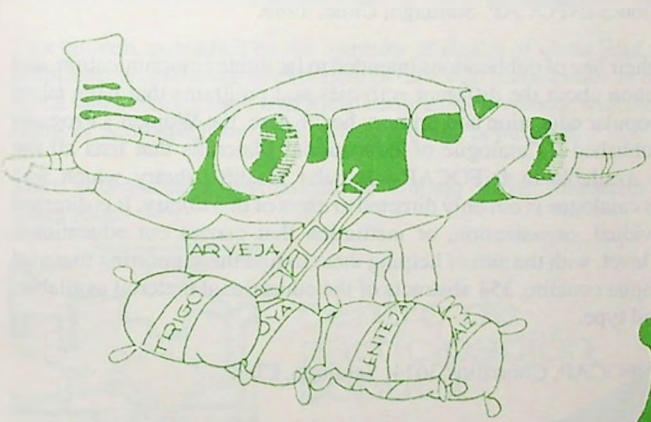
EDUCSA, Educacion Comunitaria para la Salud, is a Honduran organization whose purpose is to encourage and promote community development, by contributing to the improvement of education levels, social conditions, culture, and health to better people's lives. EDUCSA offers services in organizing, training, teaching literacy, primary health care, preventive medicine, and health education. "Xiguapate" is the bulletin of EDUCSA, and it contains information about the activities this organization carries out, and other themes related to community health.

May be ordered from: EDUCSA, Apartado 3312, Tegucigalpa, Honduras.

"CALIDAD DE VIDA". CINEP, Proyecto Educacion y Organizacion para Reivindicaciones Basicas. Ano 2, No. 4, May 1990, Bogota, Colombia.

This bulletin deals with the quality of life and the nutritional status of Colombian workers. The subject of this issue is an aspect of the policy of the Colombia Government: the policy to take action toward bettering the quality and quantity of foods and to improve the buying power of low income consumers.

Order from: CINEP, Carrera 5a No. 33-A-08, Bogota, Colombia.



"BOLETIN CERSO-CHILE". Centro de Estudios y Rehabilitacion Psicosocial. Nº 2, May-June 1990, Concepcion, Chile.

This quarterly bulletin of the Psychosocial Rehabilitation Studies Center seeks to exchange information with other institutions and individuals who develop initiatives for and work with children. The bulletin is also informs the national and international community about the activities of CERSO, which include programs to help street children, groups to support adolescent mothers, and an orphanage for boys and girls in the coal mining zone in the South of Chile.

For more information: CERSO, Casilla 1747, Concepcion, Chile.

"CATALOGO DE MATERIAL EDUCATIVE. BIBLIOTECA POPULAR DE SALUD". Instituto de Formacion y Capacitacion Popular, INFOCAP, La Universidad del Trabajador, Ediciones INFOCAP, Santiago, Chile, 1989.

As a continuation of their line of publications intended to facilitate communication, and exchange of information about the different activities and programs that have taken place in the area of popular education and primary health care, the Women's Program of INFOCAP has published a Catalogue of Educational Materials that lists all the materials which are available in INFOCAP's Popular Health Library which was recently opened. This catalogue is not only directed to users of this library. It is directed as well to any individual, organization, or institution that carries out educational activities at the local level, with the aim of helping them to find the supporting material they need. The catalogue contains 354 abstracts of the educational material available, in order of subject and type.

More information: INFOCAP, Chorrillos 3614, Santiago, Chile.

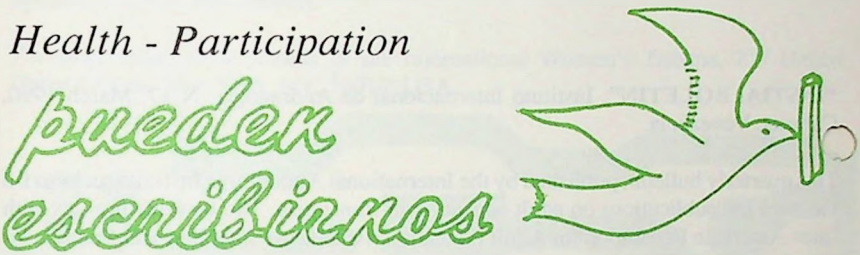
CESO. Center for the Study of Education in Developing Countries. Publications 1963-1990. The Hague The Netherlands, 1990.

CESO is an interdisciplinary studies center which studies and documents developing countries. The Center undertakes research and offers a number of services of information exchange. Among their various publications are books, articles, essays, reports, and a series called "Verhandelingen".
CESO has an exchange of references service that helps people working in the field of education for development to obtain both published and not yet published material. The series "Verhandelingen" contains abstracts of studies or projects that have taken place or are now being carried out. Their aim is to contribute to dialogue and stimulate future works.
A complete list of CESO's publications including prices can be ordered from:
CESO, c/o Badhuisweg 251, P.O. Box 90734, 2509 LS The Hague, The Netherlands.

"ORAL HEALTH SELF CARE PROJECT". AHRTAG, London, U.K. 1990.

This pamphlet describes the Oral Health Self Care Project (OHSEC) that AHRTAG has carried out in New Delhi, India, since 1983. Until now, the project has been functioning as a pilot program, evaluating educational materials for school teachers, in order to incorporate them into the curriculum. However, starting next year, it will be included in curriculum throughout New Delhi, at the request of the different municipalities, and it is ready to be incorporated into any school system as well. AHRTAG can supply more information about this project, and they would like to receive news of any similar projects being undertaken. In English.

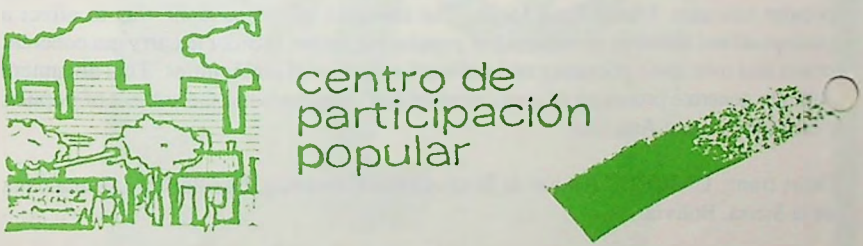
More information: AHRTAG, 1 London Bridge Street, London, SE19SG, United Kingdom.



"NOSOTROS". Informative Bulletin about Social Participation in Health. Department of Social Work, Ministry of Health, N 1, San Jose, Costa Rica, June 1990.

This bulletin, published by the Ministry of Health of Costa Rica, has the objective of promoting an exchange of experiences on social participation in health among institutional functionaries and Costa Rican community members, with the aim of enriching the forms of addressing the status of health of the population.

More information: Departamento de Trabajo Social, Ministerio de Salud, San Jose, Costa Rica.

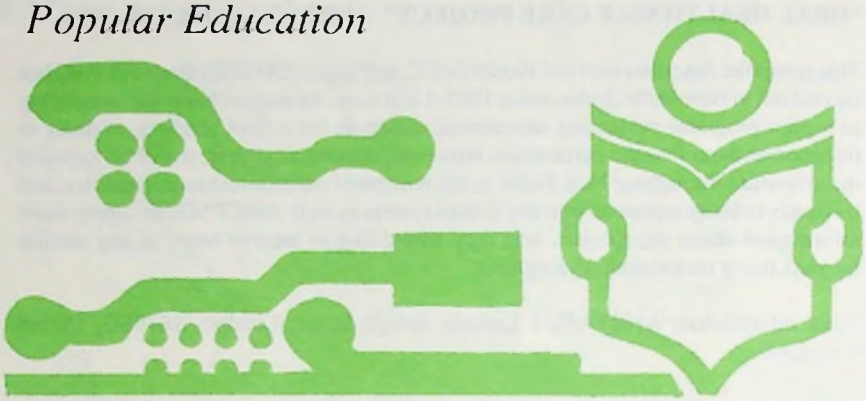


"DESCENTRALIZACION MUNICIPAL Y PARTICIPATION POPULAR". Centro de Participacion Popular. Montevideo, Uruguay, s/f.

In 1989, the Center for Popular Participation organized a cycle of meetings about municipal decentralization and popular participation, with the aim to reflect on, discuss, and debate this subject, to enlarge its scope and reach and to explore the different political concepts that exist in respect to it. They covered the role of neighborhoods, of neighborhood social organizations in municipal management, and the existing differences in the programs of political parties about the role neighborhood participation. This document contains the textual transcriptions of the conferences and round table discussions.

For more information: CLAEH, Zelmar Michelini 1220, 11100 Montevideo, Uruguay.

Popular Education



"INSTIA. BOLETIN". Instituto Internacional de Andragogia. N 17, March 1990, Caracas, Venezuela.

This quarterly bulletin, published by the International Andragogia Institute seeks to fill the need for publications on adult education in Venezuela. The Institute has ties with Inter-American Federation for Adult Education (Federacion Interamericana de Educacion de Adultos - FIDEA), an organization with representatives in almost every country on the continent. The bulletin mainly provides information about academic activities and congresses about adult education that take place in Venezuela.

Request from: Instituto Internacional de Andragogia, Avenida Veracruz, Edificio Capaya, piso 3, Urbanizacion Las Mercedes, Caracas,1060, Venezuela.

'EDUCACION POPULAR. HISTORIA. ACTUALIDAD. PROYECCIONES". Mejia, Marco Raul. UNICRUZ, AIPE, CEAAL; Santa Cruz de la Sierra, Bolivia, 1990.

This book comes out of a seminar held in La Paz and Santa Cruz with the Colombian popular educator, Marco Raul Mejia. The intention of the seminar was to effect a conceptual and theoretic re-ordering of popular education in order to carry out coherent praxis and overcome posturing and political-educational ambiguities. This document hopes to generate processes of confrontation and debate around the subject of popular education in Latin America.

Order from: UNICRUZ (Union de Instituciones Cruceñas), Casilla 4041, Santa Cruz de la Sierra, Bolivia.

"DESDE ADENTRO. LA EDUCACION POPULAR VISTA POR SUS PRACTICANTES". Muñez, C.; Caruso, A.; de Souza, J.; Osorio, J.; Rosero, R.; Fals Borda, O. CEAAL; Santiago, Chile, 1990.

This study is the result of an exercise in self-diagnosis in which popular educators participated. It is based on an active exchange of opinion and survey carried out in 1988 and 1989 among institutions and individuals who have made popular education their mission and vocation. It presents a series of reflections founded on concrete action in communities which help to deepen our understanding of this work.

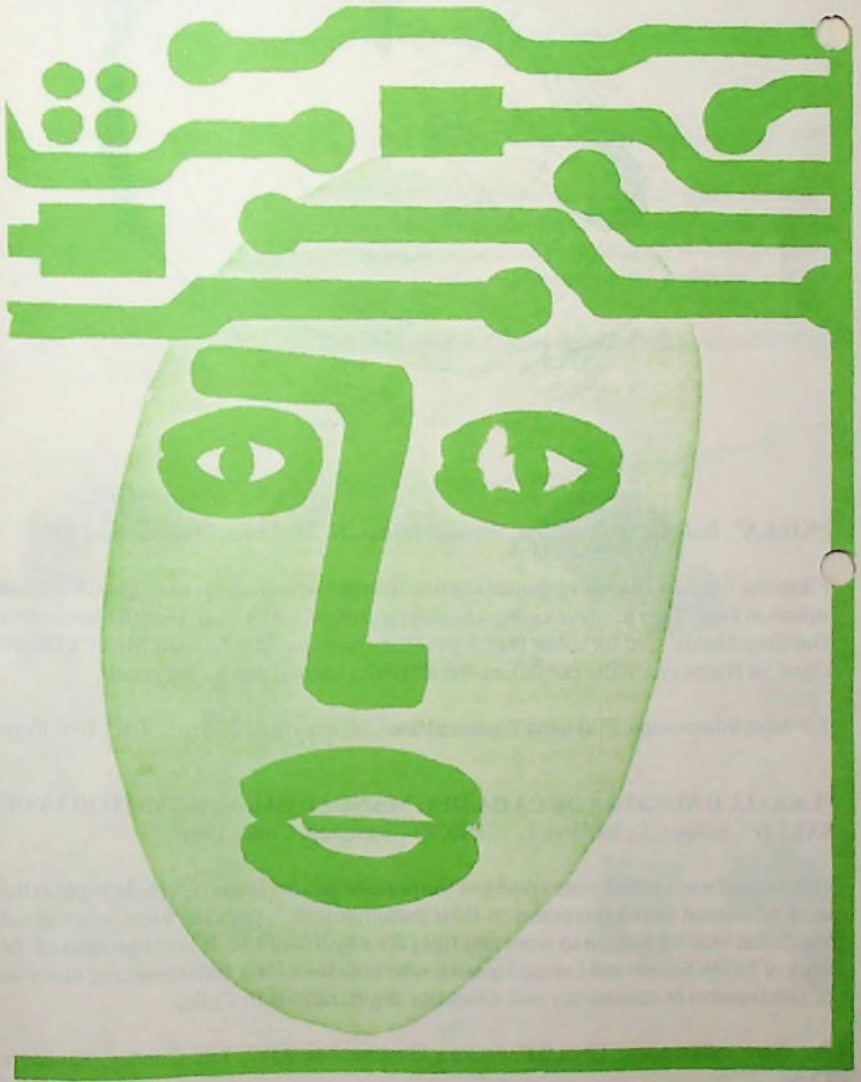
For more information: Secretaria General CEAAL, Perez Valenzuela 1634, Providencia, Santiago, Chile.

Health - Women

"THE TRIBUNE. A QUARTERLY BULLETIN ON WOMEN AND DEVELOPMENT". Center of the International Women's Tribune, N 38; New York, USA, July 1990.

The Center of the International Women's Tribune has been working with women and women's groups in the Third World since 1976, supporting initiatives, activities and programs in other countries which are committed to the struggle for women's liberation and the fight against the cultural, economic and political prejudices that oppress them. Each edition of the bulletin is devoted to a particular subject; this issue's is "Women and the New Technology". Earlier issues have dealt with: "Woman and Conscience", "Economy and the Home", and "Taking Over the Mass Media". (Publications in Spanish, English, and French).

For more information: Center of the International Women's Tribune, 777 United Nations Plaza, New York, NY, 10017, USA.



"CATALOGO DE PUBLICACIONES, 1990". Women's Institute; Madrid, Spain, 1990.

This catalogue includes all the publications that the Women's Institute, part of the Spanish Ministry of Social Services, has produced since 1984. There are brief descriptions of the contents of each publications, and the catalogue includes different types of material: research reports, documents that came out of meetings and seminars, publications that the Institute prepared itself, folders, booklets, and videos.

For more information: Instituto de la Mujer, Almagro 36, 28010 Madrid. Spain.

"KILLA". Bulletin of Filomena, Woman Miner. N. 22; Lima, Peru, August 1990.

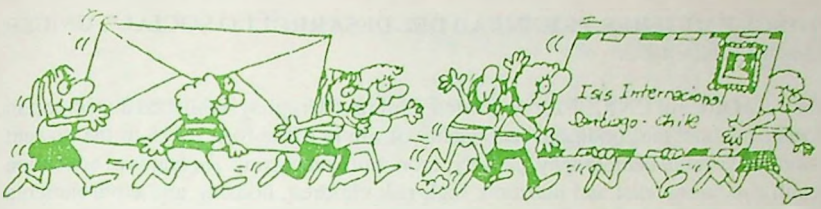
Filomena Tomaira Pasci is a group of women activists who work for the rights of women miners in Peru. They are developing a health campaign "Let's Take Health Matters into Our Own Hands" and for more than a year they have run the Women Miner's Health Clinic in Huancayo. Killa publicizes the activities carried out by the group.

For more information: Filomena Tomaira Pasci, Jr. Apurimac 224, of. 305, Lima, Peru.

"LA SALUD NUESTRA DE CADA DIA: MANUAL PARA PROMOTORAS DE SALUD". Salinas, J.; Jansana, L. . UNICEF, Santiago, Chile, 1989.

This manual was created with women of the popular sectors in mind, to help support the work of women health promoters in their communities. It presents knowledge about health that enables women to work and fight for a healthier life. It is the product of the work of Judith Salinas and Loreto Jansana, who both have long and interesting histories of involvement in community and solidarity organizations in Chile.

For more information: UNICEF, Isidora Goyenechea 3322, Las Condes, Santiago, Chile.



"MAGAZINE OF THE LATIN AMERICAN AND CARIBBEAN WOMEN'S HEALTH NETWORK". Isis International. Santiago, Chile; January, February, March, 1990.

This quarterly magazine of the Latin American and Caribbean Women's Health Network, published by Isis International, contains abundant information about women's groups and organizations that work in the area of health, bibliographic references, news, notices of conferences and meetings, campaigns, and the experiences of different groups. This issue includes a large amount of information about AIDS. The Network has developed a specialized data bank in the area of women's health and groups who work in the area of health care. Much of this interesting information is also contained in this magazine. In English and Spanish.

For more information: Isis International, Casilla 2067, Correo Central, Santiago, Ch

"QUIERO SER ALGO EN LA VIDA" Grupo de Trabajo Redes; Lima, Perú, 1990.

This publication is directed especially to young women under 20 years old, and is intended to help them to make decisions about the future. It has information about women's bodies, the menstrual cycle, what methods of birth control are most appropriate in what circumstances, where and with whom to seek help for problems, and why women should consider family planning.

Can be ordered from: Grupo de Trabajo Redes, Correo de Miraflores, Apartado Postal 1578, Lima 18, Perú.

"NIÑOS Y MUJERES. PRIORIDAD DEL DESARROLLO SOCIAL". UNICEF; Santiago, Chile, 1990.

The Area Office of UNICEF for Argentina, Chile and Uruguay published this important document about the conditions and quality of life in Chile form 1975 to the present. Information about demography, poverty, economic forecasting, the status of education, health conditions, diet and nutrition, high risk children, housing and environmental health, and the condition of women are presented through a series of complete and attractive cards. (Contains a brief summary in English).

Order from: UNICEF, Area Office for Argentina, Chile and Uruguay, Isidora Goyenechea 3322, Las Condes, Santiago, Chile.

"SALUD I, II, III AND IV". Ministry of Social Services, Women's Institute; Madrid, Spain, 1989.

This series of booklets edited by the Women's Institute in Spain is intended to inform women about subjects like methods of birth control and sex; pregnancy, birth, and postpartum; voluntary interruption of pregnancy; and sexually transmitted diseases. Each number is dedicated to a subject, and the material is supplemented with illustrative diagrams and drawings.

For more information: Ministerio de Asuntos Sociales, Instituto de la Mujer, Almagro 36, 28010 Madrid, Spain.

NEWSLETTER Nº 13 OF THE HEALTH AND POPULAR EDUCATION NETWORK

September 1990

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EDITORIAL INTERAMERICANA LTDA

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BANGALORE - 560 001

Health and Popular Education

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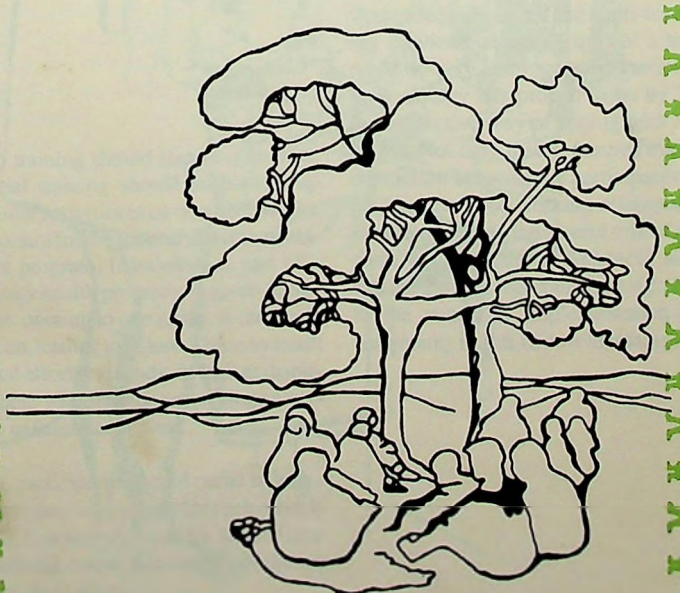
INDIA

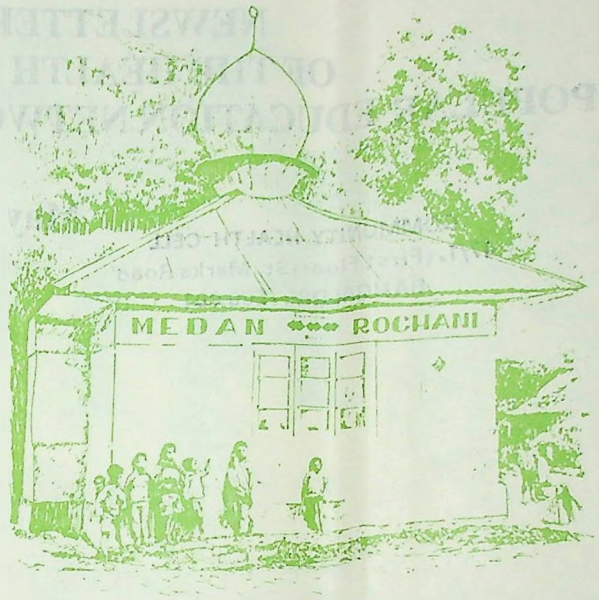


Publication whith support from CIDA (Canada)

TRAINING STRATEGY

Indonesia

Mary Johnson



This document emphasises the importance of organizing a training strategy, involving all the people who will be important in the success of the program., to increase their motivation and their skills. Leaders, or program managers must also be convinced of the importance of the program. It will be important too, to convince policy makers of the relevancy of a new approach or program so that they will provide support when required.

In the large community health program described in this paper, eight types of training were implemented at three levels of government. This strategy was designed to prepare all parties so that they would provide maximun support for the community health program.

Training is never an end in itself. It is basically a tool or strategy designed to facilitate change, and usually only one of several factors needed to achieve the required change. This applies to any training, and is undisputably true for participatory training which is aimed at beginning a process of change, or facilitating a process which is already underway.

If change is desired, it is clear that it is aimed to improve an unsatisfactory condition. An example may be a community which is suffereing from poor nutrition, with a high incidence of infectious diseases, a high infant mortality rate, and where the people appear powerless to overcome their situation. After studying such conditions the decision may be reached to begin with training. The aim would be to increase people's awareness and skills so that they would be better equipped to tackle their problems. However, a decision would then be needed on who should be trained. Should it be key people from the community, health workers associated with the community, or possibly the government officials responsible for planning programs for the community?

Yayasan Indonesia Sejahtera (YIS) faced this same problem several years ago. This NGO was working in Banjarnegara, a regency with a population of 678,000 who lived in 297 villages in 18 districts. Banjarnegara was one of the poorest regencies in Central Java, and severe health problems were common in most villages.

The first step of a strategy to improve the health status of the population was a cross sectoral management workshop run by the head of the Regency health service. As a result of this activity, the regency heads of all government departments involved in the development of the area became interested in greater community participation in the

development program. This program included community health activities. However, the managers who attended the workshop faced the problem of who should implement the program which they had planned at the workshop. Their plan adopted a new approach which was more community based than programs in the past, which were basically top-down.

It was at this point that YIS, with many years of experience in participatory training, was requested to assist. YIS decided to begin with training for field staff of the Community Health Centres form each district of the regency. This was the first time the health workers had experienced participatory methodology. They returned home with ambitious plans of how they would work with the village people.

At the following monthly meeting with the local doctor, their reports were rather downhearted. The response form the community was disappointing and most of the doctors in charge of the Community Health Centers had given little or no back up. They did not understand why or how the field workers were changing their approach. Some considered the regency service had bypassed them and therefore they were not responsible for their field workers actions. Both the doctors and the community were used to the Community Health Centers providing a service for the community at the Center. The idea of the community assuming the major responsibility for their health was foreign to them.

Facing this situation, it was decided training should be held for key people -formal and informal leaders- from the community. Perhaps in this way they could be convinced of the importance of preventive and promotive health measures and motivated to participate in appropiate activities. A series of training were held. Three reprsentatives from each village per district, made up a total of approximately 24 participants at each training. Once again, participatory methodology was a first and some changes in leadership style were noted several months later which were attributed to the training.

Implementation of the Plans of Action drawn up at the training began in most villages, after the training of volunteer health workers. However, it was not long before reports came in that the District Heads wished to be orientated to the new activities springing up in the villages. This in turn lead to training for the District Heads and later for field staff of other government departments whose participation in the community health activities was also essential. Soon after, the field workers requested training as trainers as they were expected to train an ever increasing number of volunteer health workers.

It is clear that the initial workshop for regency managers of Banjarnegara sparked off a series of seven trainings at three levels: province, district and village, covering from regency managers to formal and informal leaders at the village level.

Training at District and village levels has been an integral part of the community health/development program for more than 10 years. Even today refresher courses and training of new VHW and field workers continue to be held. The experience, which was confirmed by later experiences, has highlighted some important pointers on training.

First, no training should stand on its own. The initial training should be backed up with similar activities to cover all those who are important for the succesful implementation of a program. If training, as part of a community health program, is given in isolation, ie. once up to one group, it can cause frustration, leading to failure. This may result in wasted effort and funds, as well as dispirited people who may be umwilling to participate in future activities.

Second, participants should come in teams in order to provide support for each other in the field. It is very difficult for single fighters to introduce new, and maybe conflicting ideas, on their return.

At the Training Center these pointers can be implemented by inviting an organization to send their representatives in teams, preferably representing different aspects of their program, such as a health worker, agriculturist and teacher. At YIS we also had organizations sending multisectoral teams, including representatives from villages and from the districts and provincial government. In this way all levels were covered and each had many opportunities during the training to understand and appreciate the circumstances faced by those at different levels from them.

More comprehensive representation can be achieved if training is conducted close to the place of action, such as the office of an organization or in the field. Under these circumstances it is easier to ensure that participants represent all major aspects of the program, and, if appropiate, several levels.

This multiprofessional and multi-level strategy implies that participants of a training could be very heterogenous. Participatory methodology has proved to be by far the most effective way of coping with heterogenity. Not only that, it ensures maximum interaction between the participants which could mean good working relationships in the future. Hence the careful mix of participants is capitalised and chances are high that the training will contribute significantly to the succesful implementation of the community health, or development program.

Chile

ADOLESCENTS AND HEALTH: CHALLENGES

Four Chilean organizations, invited by the Popular Education and Health Network of CEAAL met during 1989 to confront the challenge of developing a program on sexuality and pregnancy for adolescents. This group was made up by the Comprehensive Health Program (Programa de Salud Integral) of Pirque, that functions in a rural area near the city of Santiago in primary health care programs; the Conchali Clinic, that carries out health and community participation activities in a popular neighborhood in the northern section of the city; the Maternal Child and Adolescent Program of the Hospital Parroquial de San Bernardo, which has implemented a comprehensive program for pregnant adolescents; and the Health and Social Policies Program of the University Academy of Christian Humanism, which studies social programs and policies.

This group had different experiences, which permitted a comprehensive and complex vision of the problem: there were the questions from the field of primary and secondary care, of the rural experience, of the psycho-social damage of youths from urban marginal areas and at the same time the challenges posed by comprehensive programs with an active community participation.

The reasons for this meeting were due to three consideration. First, the recognition of the increasing number of adolescent pregnancies in Chile, with serious consequences for the mother and child. Second, the accumulation of studies on the subject and the implementation of experiences and pilot programs undertaken by universities and non-governmental organizations. Third, the absence of policies and prevention and comprehensive care programs in the field of sexuality and adolescent pregnancy. These three facts, made it necessary to study further the subject and to think about a future that permits joint efforts, increase knowledge, disseminate results and propose policies and programs.

A PROFILE OF ADOLESCENTS IN CHILE

The group prepared a biodemographic profile of adolescents in Chile, with the aim of obtaining a description of the principal tendencies in the biodemographic changes of the adolescent population, using statistics at the national level.

This profile points out that the adolescent population (10-19 years of age) is 23% of the country's population. When observing the behavior of the population by sex according to urban-rural condition, you can observe a higher rate of masculinity in rural areas, which would indicate a tendency to emigration of the female population to urban areas. Different studies have underscored the preference of female migration towards urban areas that offer a job market in the service sector.

In the socioeconomic aspects it is pointed out that during the 70 to 82 period there's an increase of the adolescent economically active population; this change is especially significant in men (16.7% of the adolescent women are economically active, while for men the rate is 45.8%).

During the same period, there has also been an increase in the level of education of the adolescent population. Only 1.7% of this population doesn't have an education. Both in urban as well as rural sectors, the female population has more education than men at every level of schooling. In the 15 to 19 years of age group, 58% of urban youths has 9 years or more of education, while in rural areas only 17.2% have such a schooling level.

Another important change in social aspects is in regards to legal status, and an increase of married or cohabitating women is observed, especially in rural areas.

The biomedical profile shows that the mortality rate is very low; the principal cause of death are external causes such as trauma and poisoning (responsible for 59% of deaths in the 15 to 19 year old population), being higher in men.

As to fertility, it is necessary to recall the clear decrease which has occurred in Chile. Nevertheless this has not occurred with the adolescent population. Births from adolescent mothers are between 14 and 17% of total births and 98% of the births of adolescent mothers are for women 15 to 19 years of age.

Infant mortality in children less than one year of adolescent mothers has been higher that the national average. While the differences with respect to this average are important, they are even more so considering the age of the mother. In the group of mothers less than than 15 years of age, the infant mortality rate is substantially higher than in women 15 to 19 years of age (39.4 in 1985).

STUDIES ON THE SUBJECT IN CHILE

In Chile there has been a lot of research on the subject; nevertheless, most of them are descriptive or case studies.

In the area of sexuality, it is important to underscore the ignorance of adolescents, which increases in youths from popular sectors.

The education programs in the school system do not impart knowledge that permits adolescent to live their sexuality comprehensively. The training of teachers is weak or ambiguous. The family does not offer the possibility for training and communication in matters of sexuality. In this context, it is clear that adolescents don't have information, or adequate channels of communication. Nevertheless, adolescents initiate an active sexual life at an earlier age and with greater frequency, with the male's attitude and behavior being more permissive. On the use of contraceptives they believe myths and disinformation. The majority of them oppose abortion and don't consider themselves to be at risk for sexually transmitted diseases.

Biomedical research on adolescent pregnancy are also of a descriptive nature, and therefore it is difficult to extract conclusions or establish comparisons with other peer groups.

From a biomedical point of view, adolescents have an insufficient weight gain during pregnancy. There's a significant incidence of anemia. In other aspects of morbidity, doubtful gestational age is important. When looking for causes of morbidity in pregnancy, one of the hypothesis is that there's inadequate prenatal care, psychosocial factors (absence of a mate, broken families, sexual aggression, etc.) and that morbidity is not only due to the mother's age. There are no studies aimed at looking for biological, psychological and social risk factors of pathology in pregnancy, such a prematurity and intrauterine malnutrition.

As to the health of the children of adolescent mothers, there are no studies that permit any conclusions on morbidity, hospitalization, beatings, and accident risks.

The pregnant adolescent and mother from popular sectors is exposed to adverse psychosocial factors to her development: socioeconomic deterioration, broken or disorganized families, with the presence of conflictive adults (violent or excessive drinkers), early dropouts from the school system. Since the adolescentr is living through a training period and a search for identity in the psychosocial level, maternity is experienced in an unfavorable way: lack or limitations to her freedom, anger, resentment, guilt. These also impact on their personal development and in the raising of the child. In adolescent mothers, a high percentage remain unmarried -especially the more precocious- and their children have a high probability of being illegitimate, with the corresponding lack of protection on the part of the father

In these circumstances pregnant adolescents and mothers are subjected to a complex circle of psychosocial damage, which are serious impediments to development as a person in different spheres of life in society. The poverty in which they live deepens and exacerbates this psychosocial damage, putting them in a situation of greater vulnerability, since young poor women have less and weaker protective resources, such as a family, institutional insertion and information, and face greater risks.

THE EXPERIENCE IN CHILE

Comprehensive care programs were initiated for adolescent pregnant women more than eight years ago. All of them under university and non-governmental programs. They have been a response to the non existence of official national programs and policies. Each one has tried to "do something." Therefore, we find a great number of initiatives -more than 30- each one with a specific quality, trying to innovate, learn, obtain resources, legitimate initiatives. In this exercise, coordination, exchange of information, transmission of experiences, continuity, has been difficult. Nevertheless, some of them have shown their lessons and agree on the criteria to orient their programs and policies:

- *The need for primary prevention, with a comprehensive initiative at the intersectorial level (education, health, communications media, community).*
- *The need to place services at the level of primary health care, where it will be necessary to create a system that serves adolescents in a comprehensive and personalized manner.*
- *The need for training personnel to develop adolescent care programs, which permit creating communications skills, for a psychosocial approach, and for education and community action.*

The experiences which have achieved greatest impact have been those that have had greater resource stability, university presence, human resources training, follow-up systems and periodic evaluations.

These programs are at the present moment, an excellent basis to formulate comprehensive programs, and are a challenge to the health policies of the democratic government in Chile.

Ecuador

CAN CURATIVE CARE BECOME AN EDUCATIONAL EXPERIENCE?

The Popular Health Teams Coordinator (CESAP) in Ecuador coordinates several organizations that carry out health programs in rural areas of the country. For a Course-Workshop on Health and Popular Education (Chile, 1988), the team presented their experience that sought to give it curative care an educational, community and organizational perspective. In this article, they share their reflections on this interesting perspective.

When the shaman-priests implemented a magic ceremonial ritual to expel from the sick body the posession of bad humors that came from nature, they pointed out the important relationship between the individual act and the problems that arose within their social context, the intense relationship of man-nature and man-social being. Their curative practice was justified from the mythical power that the gods gave them.

It is impossible to deny the relationship between the conception of the process health-sickness and the forms of implementing curative care. Conception and practice hasn't been static in history.

Nowadays the medical act has turned into a segregationist practice. Thick chains and manacles, white walls, white clothes and metal, mystify of health practices. This is reflected in the stratification of health services and health agents.

The structure produced by scientific and technological progress segregates diagnosis, treatment, recovery and the rehabilitation of the population.

In countries like Ecuador, there is a conflict between a national health system and the meager socio-economic resources for its implementation.

When capitalist development begins, decentralization of services, increased coverage, and universalization of curative care is stimulated. Infrastructure exists, but when a resolution of health problems is required, it is limited by the lack of human, technical and therapeutical resources. The population has no other alternative but to go to the more developed hospital centers, to private practice or to traditional popular forms.

The great majority of patients who individually request care in hospital centers, begin a pilgrimage of interminable administrative red tape to obtain an appointment, which sometimes takes weeks. When he is finally able to see the "all powerful and omnipotent physician," they are treated as an object, a clinical case, who doesn't have the right to be heard, be seen or informed about his ailments, but rather he should present himself submissively to the ceremony of the clinical examination, complementary tests, case study, and he must be willing to receive an unintelligeble paper, where he is indicated the therapeutic resources, which are almost always unaccesible to his memory.

It is much more tragic when this patient has to enter a health house. There, all considerations as to the social rank of the patient are broken, and the patient becomes inmeshed in the gears of hospital rules. Cultural aggression begins with the sudden separation from his family, with the abrupt change in his habits, food, hygiene, a shcedule for rest and sleep, medications and unusual treatments with respect to his local peasant and neighborhood reality.

On the other hand, the conflcitive situation that health workers have because of their limited labor rights, added to the frustration of daily work, has put the debate on their role of giving health services to the population by the wayside.

The people or teams that implement joint work projects with popular organizations, chose a democratizing model of medical practice, which is still marginal, but which little by little has acquired strength and representativity.

Within the framework of these alternative experiences we ask ourselves about the possibility of making curative care a space for popular education and organization. Our proposal arises from observing the fundamental problems of curative care.

First, the open clinic. We propose the direct participation of the community in all the activities of the health center. Participation that must be the integration in all of the process, from the admission of the patient to the home follow-up.

Second, the preconsultation. It will be the people in charge of the admission of the patient who will fill their clinical chart and his admission to the office. This first step is of capital importance. It breaks down the resistance and distrust towards the health institution, gives the neccessary time for getting closer and preparing the patient and his family, and the utilization of the waiting period, opens a dialogue between the health team and the patient and between patients.

To apply this process, the role of every member of the team and the relationship between themselves must be defined. We then have the collective participation of the team and coordination between all activities is achieved.

The principal educational objective is transforming the resistance of the population into integration; the social history of the patient is recorded and in the post visit stage, the team can be projected towards the community, encouraging community educational activities on problems detected and which are relevant to the area. This community organization is implemented by means of local organizational work and forms of participation.

Third, the medical visit. It must begin with the concenrns of the patient, being open to the subjective and objective elements. In this sense, the health agent must avoid using an interrogation framework. Once we have given a little time for the patient to air his ailments freely, we can proceed with the guided questioning. And after that, we go on to the physical examination.

At this time, due to respect for the patients intimacy, curtains are closed, but we keep personal family participation, explaining to them the various actions which will be undertaken. The explanation by the person carrying out the physical examination for the rest of the people, has an educational objective, body recognition, identification of pathology, of the patient as well as the person responsible for local health (community agent). Therefore, the physical examination must be as detailed as possible.

Once the exam has ended, our diagnostic systematization must be explained as clearly as possible to the patient and his family, relating the individual problem with community resolution. We are conscious of the educational potential that this final step of the medical visit has, since this is the moment of truth, of hope on the part of the patient that his case will be solved. Since we have opened up the clinic to the community present in the waiting room, we are guaranteed projecting ourselves towards the community.

Health agents must develop a work style that allow for the explanation of the problems, so that they dont generate contradictions within the patient, the family or the community.

Fourth, post-visit. The guarantee of success to finish this educational process, is an adequate treatment of the post-visit. It is not only a question of giving therapeutic indications, but also of an efficient follow up. This begins with an explanation in the post-visit office directed to the patient but also to the rest of the population which is at the center or clinic. It tries to link efforts at the family level with community education processes.

The responsibility for follow up must be carried out with the team's aprticipation, the family nucleus, the health committee or brigade and the community at large. The principal health team directs the follow up process. Its importance is greater when this must link local activities with external referall and counter-referall levels.

Fifth, referall and counter-referral. This section must take into account the impact provoked by facing an established health system.

We must take into account the patient's shock when confronted by an unknown world view. Here, the reason why the patient came to the city must be resolved as responsibly and seriously as possible.

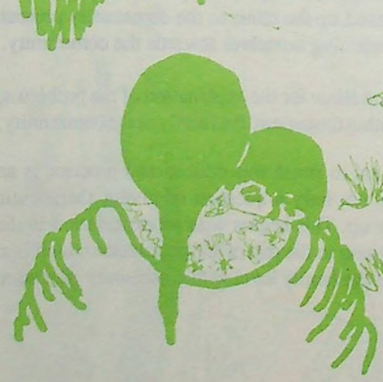
In conclusion, we must underscore that the activities of an open clinic requires an adequate infrastructure. An infrastructure that takes into account the organization of physical space, creating an atmosphere which permits the community to be actors in the educational process.

The adequate management of the open clinic permits a greater knowledge and relationship with the community. The levels of trust gained through this practice, facilitate treating the problems of the community and a better level of communication. It facilitates the evaluation of the impact of the project and the educational processes.

The lack of knowledge of the communities' reality when a health project is initiated can be overcome, systematizing the information given by curative care, complementing them with bibliographic and field research. Clinical histories becomes a permanent survey that feed a central data base. Our concern should be to link this information with date coming from community educational practices and bibliographic studies. This research process makes the formulation of policies and team work possible.

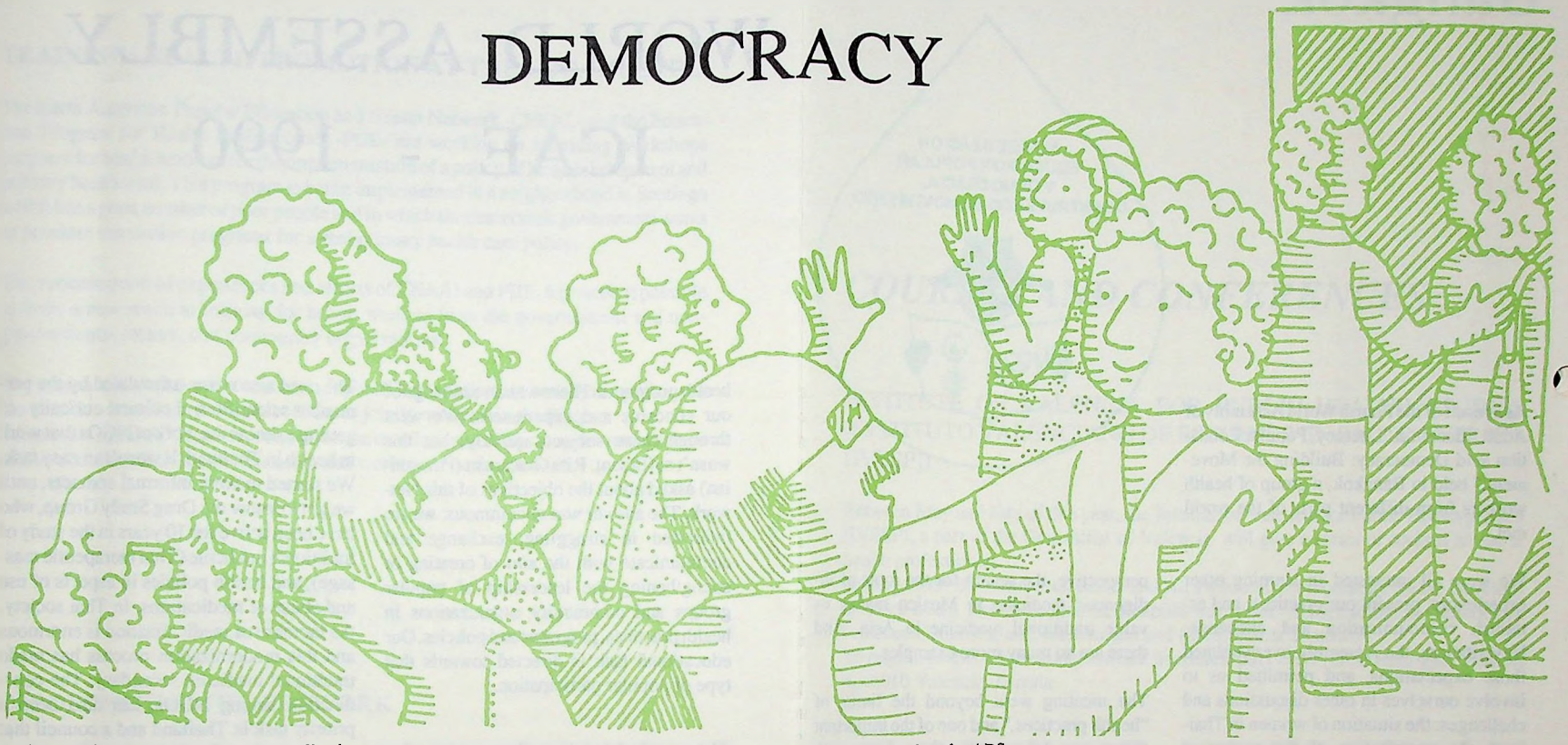
CESAP has accepted this ambitious challenge. For many this will seem utopian. A practice which goes against the grain. But we are certyain that local work and community corresponsibility can screen and solve the greater part of curative requirements.

Our educational program has not restricted access to knowledge on the part of the population. Let us proceed from the simple to the complex. Health committees are progressively solving larger problems. The achievements of these activity avoids the concentration of patients in the community center and creates an invaluable moment for achieving a real curative care as an educational opportunity.



Chile

NGO, HEALTH AND DEMOCRACY



With the aim of discussing the contribution of non-governmental organizations to the health policies of the democratic government in Chile, 25 institutions met called by the Working Group of Non Governmental Organizations of the Coalition of Parties for Democracy (March, 1990).

The debate began with the elaboration of a profile of health NGOs in Chile. The majority of them were founded during the dictatorship and in 16 years they have accumulated experience in different fields.

They have put together high level professional and technical teams, which have developed the expertise in the formulation, administration and evaluation of projects.

They have carried out programs that have been proved at the community level and they have used popular education methodologies, promotion and articulation of popular participation and coordination at the local level. They also implemented medical care systems, based on a humanized office and nourished by community participation, especially in emergency situations, repression and violation of human rights.

The work of the NGOs has permitted the promotion of a health concept based on the quality of life and democracy, develop a participative and intersectorial practice and to mantain a reflection, formulating thought and strategies based on action. It is from this set of skills, that we hope to contribute to the development of democratic health practices.

The contributions of health ONGs refer to their accumulated skills. The following areas are identified as possible areas of collaboration:

- *Participation strategies, strengthening different forms of organization and methodologies for community participation, contributing from a democratic perspective the APS.*
- *Training programs, as a contribution to the development of human resources policies at the primary and secondary care levels.*
- *Intersectorial work, in which the NGOs have developed confronting different challenges: nutrition - consumption - organization - medical care - production - appropiate technology.*
- *Innovative projects, in which experience and thought have accumulated; in which it is possible to coordinate different contributions: participation, training, technical assitance, intersectoriality and implementation of decentralized programs at the local level.*

Through these ideas, health NGOs hope to be able to cooperate, contributing a renewed conception of health, within the perspective of quality of life, democratization of policies and leadership of the grassroot organizations.

At the same time, the change in the political scene poses new challenges for health NGO's. Now it is more urgent than ever to strengthen coordination around specific areas (training, participation, assitance, etc.) to coordinate the contributions, keep thought and strategies for longer periods of time. Mantain a dialogue with government organizations and international assitance institutions. Advance towards a legitimization of NGO health programs, as a place where one can undertake a career and as a place for the training of university students. And finally, encourage strategies to mantain, strengthen and diversify international cooperation to health NGOs.

Bangkok

WORLD ASSEMBLY

ICAE - 1990

As a result of the Fourth World Assembly of Adult Education "Literacy, Popular Education amd Democracy: Building the Movement," held in Bangkok, a group of health workers from different parts of the world met.

We were all interested in learning other experiences, present our practices, and establish communication and exchange. Nevertheless, the Assembly overwhelmed those expectations, and permitted us to involve ourselves in other discussions and challenges: the situation of women in Thailand, the contribution of the ecological perspective to adult education, the situation of education programs of countries at war or occupied territories. And much more. The Assembly was a space for the meeting, recognizing ourselves as educators, workers, activists, militants in such distant contexts, but marked by the same injustices and hopes. And in this fashion, the struggle for human rights and health which has been undertaken in Argentina is very close to the challenges of the struggles in Palestinian territory occuppied by Israel. From another perspective, the search for the roots of indigenous medicine in Mexico makes us value traditional medicine in Asia. And there are so many more examples.

The meeting went beyond the limits of "health practices," and one of the important things was debate with others. First, with women's organizations, concerned with abuse and the sexual traffic of women in South East Asia, a subject which has heatlh implications (ETS, AIDS, violence, abandoned children, etc.). With other educational initiatives, the need to value the contribution of health initiatives in literacy, community development, strengthening of grassroots popular organizations.

But we also had a moment to find ourselves among those of us who work directly with health programs. There was an exchange of our concerns and experiences. We went through these subjects quickly; but this wasn't sufficient. Rita Giacaman (Palestinian) asked about the objectives of this Network. The answer was unaninmous: we are interested in struggling, exchange and communicate with the aim of creating or strengthening the leadership of popular groups and community organizations in health practices, programs and policies. Our educational task is directed towards that type of popular participation.

The we asked ourselves the meaning of an international initiative in the adult education movement. There were many answers to this question. Health subjects are a starting point for educational action, they are a permanent demand in the community. From health we can reach the other social, political and cultural areas. The reverse also occurs. Finally, the causes of deterioration of health conditions of the people are not only found within national borders. An intrnational struggle to learn beyond each border or culture is required.

The need also arose -stimulated by the permanent scientific and cultural curiosity- of getting to know the work of NGOs that work in health in Thailand. It wasn't an easy task. We started making informal contacts, until we got to know the Drug Study Group, who have been active for 10 years in the study of traditional medicine (Thai therapeutic massage), and health policies in aspects of use and abuse of medications. In Thai society, the increase of medicalization is enormous and this modernization process has made traidtional medicine secondary. The coordination among NGOs, has also been a priority task in Thailand and a council that represents them has been formed.

Finally, after this long trip, we asked ourselves the challenges for the Health Network at the international level. The experience of the Network in Latin America is an example and motivation. Now we must strengthen links, identify regional leaders and initiate a road that will lead us to create regional coordination, exchange and communication initiatives.

NEWS

TRAINING: HEALTH PROMOTION AT THE LOCAL LEVEL

The Latin American Popular Education and Health Network -CEEAL- and the Education Program for Health Professionals -PIIE- are working on a training workshops program for health workers for the implementation of a policy of local development and primary health care. This program is being implemented in a neighborhood in Santiago which has a great number of poor people and in which the democratic government wants to promote innovative programs for a real primary health care policy.

The concentration of experiences and efforts of CEAAI and PIIE, has made it possible to open a new space in training for health workers from the governmental and non-governmental sectors, and community organizations.

The present political context has made it possible to implement new health policies at the local level and has invited all NGOs to jointly accept this challenge.
In the near future we'll have more news on the development of this program and we hope to share it with other health educators and workers in Latin America.

MODERNIZING THE NETWORK

In a short time the network has grown to regional and international levels. Communications and exchange demands have diversified and expanded. With each passing day more groups have become interested in contacting colleagues in other places of the region or the world.

This process demands modernization. We must be more efficient and must respond giving and exchange and communication service, making it possible to learn from the different experiences.

We are going to establish a computerized Network of health experiences and popular education, which will be an "active catalogue" of activities carried out in this field. The Network will have three main objectives: reception, filing and dissemination of information.

In a first stage we will start with Latin American experiences and then we will try to expand this service to other regions. The incorporation to this Network will make it possible to have a quick and systematic link with other experiences in the region; and at the same time, find other health promotion networks (for example, the Andalucian School of Public Health Network in Spain) or popular education (such as the Women's Network of ICAE). Questionnaires will soon be distributed to begin this daunting task.

COURSES AND CONFERENCES

INSTITUTE OF VALENCIA FOR PUBLIC HEALTH STUDIES (INSTITUTO VALENCIANO DE ESTUDIOS EN SALUD PUBLICA [IVESP])

Between May and July of this year, the Institute of Valencia for Public Health Studies (IVESP), a part of the Generalitat of Valencia, will give a series of courses aimed at health professionals.
Among them: Environmental health and Air Pollution; Methodology for the Development of Infant Health Programs; Hospital Infections; Epidemiological Methods in Infectious Diseases; and, Information and Management Systems.
To request further information, contact: Secretaria del IVESP, c/Dr. Rodriguez Fornos, 4, 46010 Valencia, España.

INTERNATIONAL UNION FOR HEALTH EDUCATION (UNION INTERNACIONAL DE EDUCACION PARA LA SALUD [UIES])

The International Union for Health Education (UIES) is organizing two important events this year. On the one hand, the XIV World Conference on Health Education, which will be held from June 16 to 21 of this year in Helsinki, Finland. This year's motto for the conference will be "Health -A Joint Effort." On the other hand, in Rio de Janeiro, Brazil, the III Inter American Symposium on Health Education will be held on July 15 to 20. The principal subject of the symposium will be: Health Challenges in the Americas in the Year 2,000.
For more information: Inter American Symposium: U.I.E.S./O.R.L.A. Noemia Kligerman, Regional Director. Nutes, Box 8082, Rio de Janeiro, Brazil. World Conference: Congrex, P.O. Box 1031, SF-00101 Helsinki, Finland.

INTERNATIONAL ASSOCIATION FOR ADOLESCENT HEALTH

The International Association for Adolescent Health will hold its Fifth Congress in Montreux, Switzerland on July 3 to 6. Reproductive health, nutrition, use and abuse of drugs, violence, youth and sports, sexual behavior and other subjects will be discussed.
For more information: Office du Tourisme, Case postale 97, 1820 Montreux, Switzerland.

Educational and Bibliographical Materials

Health - Promotion

"CORREO DE AIS. ACCION INTERNACIONAL POR LA SALUD". Red Accion Internacional por la Salud/ IOCU, Montevideo, Uruguay, 1989.

The newsletter is published bimonthly by the International Action Network for Health (Red Accion Internacional por la Salud <AIS>). AIS is an informal network with members if the majority of Latin American and Caribbean countries. It tries to stimulate the rational use of medications, the application of the Essential Medications Program of WHO and promote non medical solutions caused by precarious living conditions. The newsletter is an information and exchange instrument between people and institutions interested in health matters.
For more information, write to: AIS/IOCU, Casilla 10993, Sucursal 2, Montevideo, Uruguay.

"EL APORTE DE LAS ORGANIZACIONES DE LA SOCIEDAD CIVIL A LAS POLITICAS DE SALUD EN CHILE". Salinas, J.; Vergara, C.; Solimano, G. PROSAPS, Docuemnto de Trabajo No. 1, Santiago, Chile, Noviembre 1989.

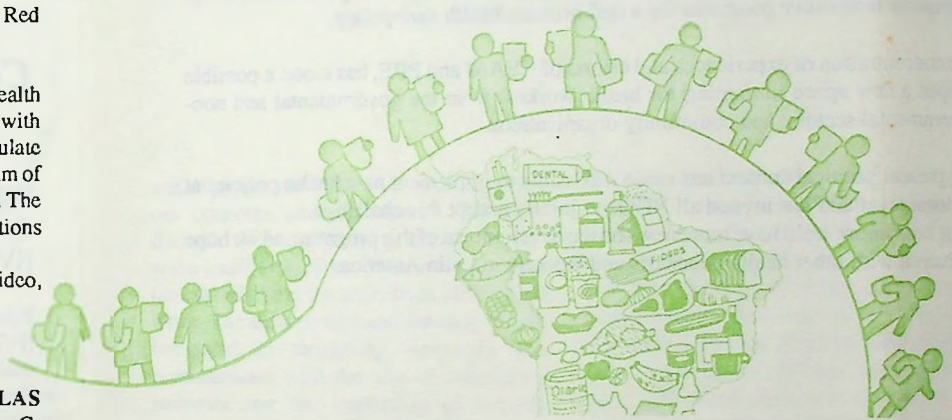
This document contains the preliminary results of the project "Contributions of civil society Organizations to Health Policies in Chile." It contains a brief historical outline of public health policies in the country, a general description of 107 health non governmental organizations and the results of case studies, through a description of each experience.
Request from: PROSAPS. Programa de Salud y Politicas Sociales, Universidad Academia de Humanismo Cristiano, Maria Luisa Santander 0329, Santiago, Chile.

"CMA BOLETIN." Centro de Medicina Andina, Cusco, Peru, 1989

The bulletin is a bimonthly publication of the Andean Medical Center (Centro de Medicina Andina), with information and short news for health professionals on traditional medicine, medicinal herbs, medications and health policies; it also contains reviews on publications and materials on the subject.
Rquest from: CMA, Jr. Ricardo Palma N 5, Santa Mónica, Cusco, Perú.

"REVISTA BIBLIOGRAFICA. PROGRAMA INTERAMERICANO DE INFORMACION SOBRE EL MENOR Y LA FAMILIA". Instituto Interamericano del Niño. Volumen 3, No. 6, Serie sobre Salud, diciembre 1989, Montevideo, Uruguay.

The Inter American Program on Information on Minors and the Family (PIIMFA) contributes to the dissemination, exchange and transfer of information on minors and their families. The Program publishes this magazine every six months, in which the information is published in an automated way by thematic series. This issue deals with health; other series are: Social Issues, Legal Issues, Education and Drug Addiction. PIIMFA date base now has 14,000 bibliographical references, and 1,200 institutional users in 29 countries.
For more information and subscriptions: Institute Interamericano del Niño, Av. 8 de Octubre 2904, Casilla de Correo 16212, Montevideo, Uruguay.

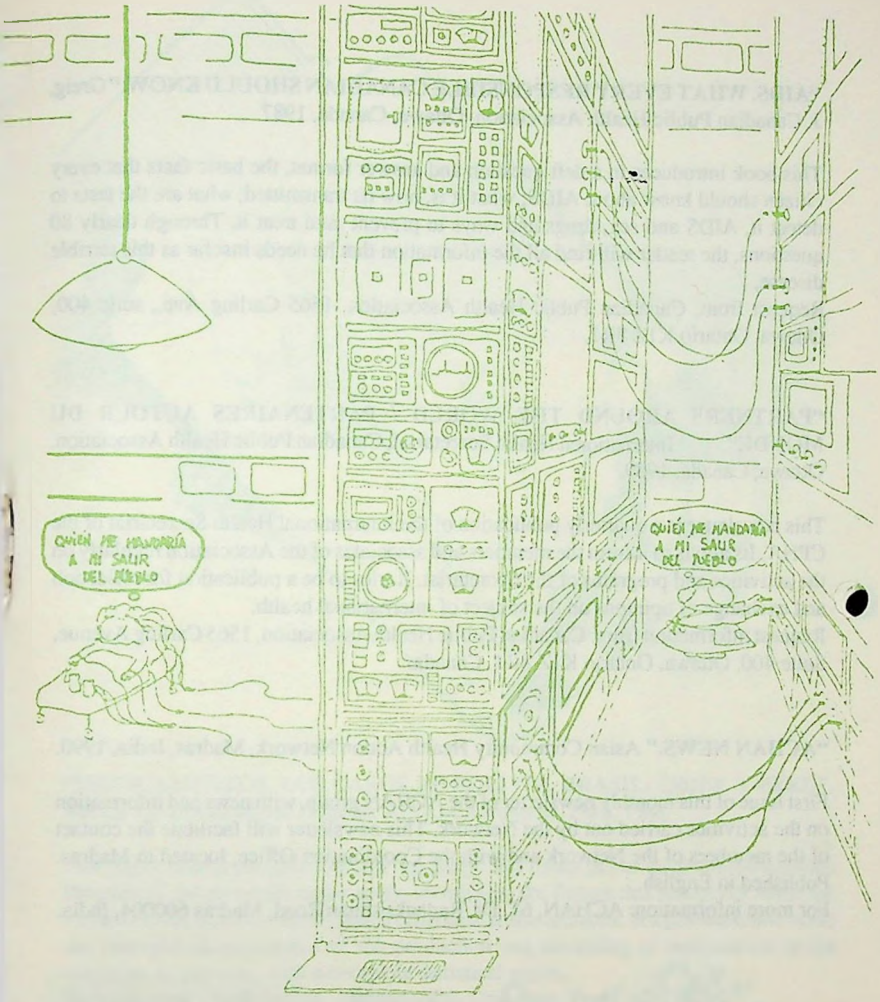


"DERECHOS DE LOS CONSUMIDORES, PROBLEMAS Y DESAFIOS". Alternativa, Cesip, Fovida, Lima, Perú, July 1989

In June 1989, 32 Peruvian NGOs met to think collectively about the struggle and organization from the consumers perspective. This publication is proof of the diversity of subjects and concerns centered around the defense of consumers in present Peru, althoguh it doesn't contain all the materials which were dealt with at the event.
Request from: CESIP, Coronel Zegarra 722, Jesús María, Lima, Perú.

"ETNODESARROLLO Y MEDICINA INDIGENA ECOLOGICA". Guevara, J. Servicio Seccional del Vaupes, Colombia, n/d.

This publication introduces the presentation on ecological medicine in Vaupes and its relationship to etnodevelopment, presented by the author in the First Seminar of Primary Health Care, held in 1984. The paper presents the status of the participative research process of the relationship of indigenous and/or ecological medicine with western medicine, proposing certain alternative solutions to improve it.
For more information: Ministerio de Salud, Sistema Nacional de Salud, Servicio Seccional de Salud de Vaupés, Colombia.



"RED DE ACTIVIDADES DE PROMOCION DE SALUD". Escuela Andaluza de Salud Pública, Año 1, No. 1, Septiembre 1989, Granada, Spain.

This magazine presents a list of health promotion activities, ordered according to the type of institution or group which carries them out. From each experience, basic information to facilitate the exchange of knowledge among them is given. The Health Action Promotion Network (Red de Actividades de Promocion de Salud) represents a valauble effort to create a space for linking and exchanging ideas among groups that, from different social sectors, are carrying out health promotion activities in Spain.
For more information, write to: Escuela Andaluza de Salud Pública, Avda. del Sur, 11, 18014 Granada, Spain.

"MEDICAMENTOS Y SALUD POPULAR". Servicio de Medicinas Pro Vida, Lima, Perú, 1989.

This periodical publication of the Pro Life Medication Service (Servicio de Medicinas Pro Vida) is especially aimed at health professionals as a vehicle for information, reflection and exchange of experiences in all that refers to medications, policies and research on the subject.
Request from: Servicio de Medicinas Pro Vida, General Garzón 2170, Jesús María, Perú.

"AIDS. WHAT EVERY RESPONSIBLE CANADIAN SHOULD KNOW." Greig, J. Canadian Public Health Association, Ottawa, Canada, 1987.

This book introduces in a deft question and answer format, the basic facts that every citizen should know about AIDS; what it is, how its transmitted, what are the tests to detect it, AIDS and sex, drugs and ways to prevent and treat it. Through nearly 80 questions, the reader will find all the information that he needs insofar as this terrible disease,
Request from: Canadian Public Health Association, 1565 Carling Ave., suite 400, Ottawa, Ontario K1Z 8R1.

"PARTNERS AROUND THE WORLD / PARTENAIRES AUTOUR DU MONDE". International Health Secretariat, Canadian Public Health Association, Ottawa, Canadá, 1989.

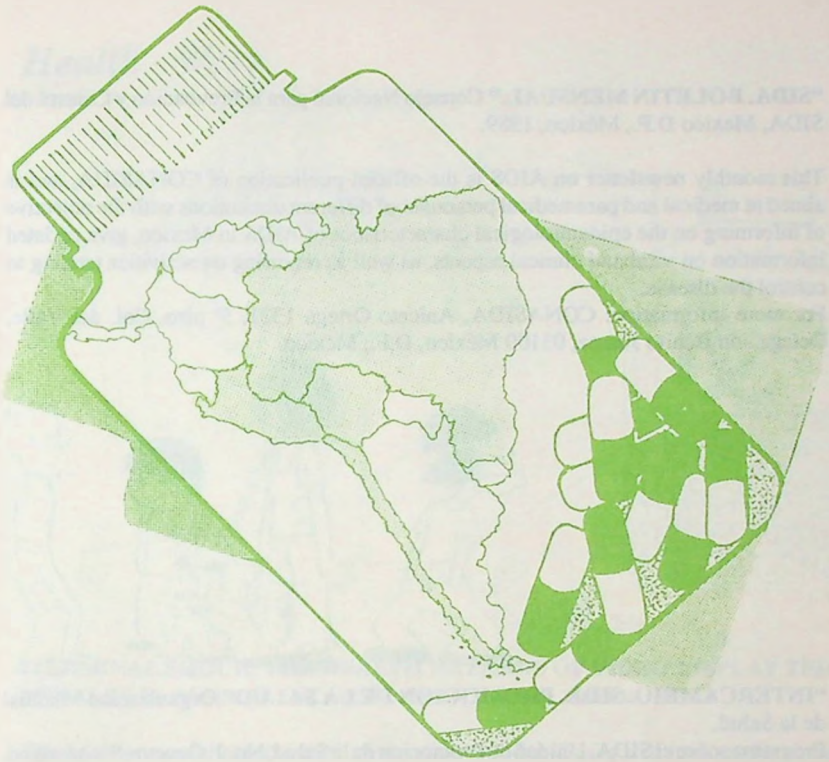
This newsletter is a quarterly publication of the International Health Secretariat of the CPHA. Its aim is to inform the members and associates of the Association regularly on the activities and programs of the Secretariat. It tries to be a publication for reflection and exchange of opinions on the subject of international health.
Request information from: Canadian Public Health Association, 1565 Carling Avenue, Suite 400, Ottawa, Ontario K1Z 8R1, Canada.

"ACHAN NEWS." Asian Community Health Action Network, Madras, India, 1990.

First issue of this monthly newsletter of the ACHAN group, with news and information on the activities carried out by the Network. This newsletter will facilitate the contact of the members of the Network and with the Coordination Office, located in Madras. Published in English.
For more information: ACHAN, 61, Dr. Radhakrishnan Road, Madras 600004, India.

"ONE COUNTRY." Office of Public Information. Baha'i International Community. New York, USA, 1989.

One Country is a bimonthly publication produced by the Office of Public Information of the Baha'i International Community. This community works as an international NGO that represents the members of this faith throughout the world. The programs carried out by the community in the Third World are reported, which deal with, among others, health and agriculture.
For more information: Office of Public Information. Baha'i International Community, Suite 120, 866 United Nations Plaza, New York, NY 10017, USA.



"MEDICAMENTOS. LOS CASOS DE BOLIVIA, BRASIL, CHILE Y PERU". Acción Internacional por la Salud. AIS-LA, Chimbote, Peru, 1988.

This paper makes possible to know the scope and limits of the Essential Medication Program of the countries under study, identifying the factors that hamper or favor the implementation and consolidation of programs. It also includes, as a general framework, the principal characteristics of the production and marketing of medications in the countries in question, with a complete statistical annex.
Request from: Tierra Nueva, Apartado 126, Chimbote, Perú.

"APUNTES PARA TRABAJO SOCIAL". Colectivo de Trabajadores Sociales, No. 17, 2º semestre, 1989, Santiago, Chile.

In this issue of Apuntes there are, among others, two reflections on future practices in social work with women and with health; an experience from Costa Rica on policies on community participation is also included, an experience with Latin American women exiled in Belgium, a round table on social work and human rights and an article on the changes of social work in the academic field.
For more information: Colectivo de Trabajadores Sociales, Casilla 178-11, Santiago, Chile.

"HYGIE. REVISTA INTERNACIONAL DE EDUCACION PARA LA SALUD". Unión Internacional de Educación para la Salud, Paris, Francia, 1989.

Hygie is the official organ of the International Union of Education for Health. UIES is a non governmental organization of professionals dedicated to the promotion of health through education. The magazine, which is published 4 times a year, contains theoretical information on research and experiences, and includes news on events and meetings at the international level; eventually it will publish issues dedicated to specific subjects of health education. Published in English and French with a Spanish abstract.
For more information on how to join UIES: Union Internationale d' Education pour la Santé, c/o ISD, 15-21, rue de l'Ecole de Medicine, 75270 Paris CEDEX 06, France.

"SIDA. BOLETIN MENSUAL." Consejo Nacional para la Prevencion y Control del SIDA, Mexico D.F., México, 1989.

This monthly newsletter on AIDS is the official publication of CONASIDA, and is aimed at medical and paramedical personnel of different institutions with the objective of informing on the epidemiological characteristics of AIDS in Mexico, give updated information on viral and clinical aspects, as well as reporting on activities tending to control the disease.
For more information: CONASIDA, Aniceto Ortega 1321, 5º piso, Col. del Valle, Delegación Benito Juarez, 03100 México, D.F., México.

"INTERCAMBIO. SIDA. PROMOCION DE LA SALUD". Organizacion Mundial de la Salud,
Programa sobre el SIDA, Unidad de Promocion de la Salud, No. 1, Geneva, Switzerland.

Intercambio is a publication of the World Program on AIDS of WHO. It is the publicity body of said program, with news on the subject, work projects and evaluation. It is published in English, French and Spanish.
For more information: Intercambio, OMS/PMS, 1211 Geneva 27, Switzerland.

"CD. CONSUMIDORES Y DESARROLLO." Oficina Regional de IOCU para América Latina y el Caribe, Montevideo, Uruguay, Año III, 1989.

Cosumidores y Desarrollo is a newsletter published 10 times a year, that reports on the development of the consumer movement in Latin America and the Caribbean and the activities of IOCU in the world, giving information on the most varied topics that interest the consumer. Published in Spanish.
For more information: IOCU, Oficina Regional para América Latina y el Caribe, Casilla 10993, Sucursal 2, Montevideo, Uruguay.

'TERMINAL SHOCK. THE HEALTH HAZARDS OF VIDEO DISPLAY TERMINALS." De Matteo, B., NC Press Limited, Toronto, Canada, 1986.

This book is an excellent source of information on video display terminals, and is aimed at workers or employers, and at all users in general. It presents all the available information on the potential risk of working with video display terminals, and it offers concrete suggestions on what can be done. This is an indispensable source for all of those who work with personal computers, and despite the fact that it has been four years since it was first published, it hasn't lost its relevance. Published in English.
For more information: Occupational Health Centre Inc. 98 Sherbrook St., Winipeg, Manitoba R3C 2B3, Canada.

"WORK IS DANGEROUS TO YOUR HEALTH. A HANDBOOK OF HEALTH HAZARDS IN THE WORKPLACE AND WHAT YOU CAN DO ABOUT THEM." Stellman, J.M; Daum, S.M. Vintage Books Edition, United States, 1973.

Just as the title indicates, this manual, which was published 17 years ago, informs us on the health hazards in our work environment and what can be done about it. Its aimed especially at industrial workers; it teaches us how to detect risks and how to handle them. Published in English.
For more information: Occupational Health Centre Inc. 98 Sherbrook St. Winipeg, Manitoba R3C 2B3, Canada.

"OCCUPATIONAL REPRODUCTIVE HAZARDS." Ontario Federation of Labour, Occupational Health and Safety Training Centre, Jon Mills, Canada, n/d.

Its been proven that certain chemical compounds, processes and work conditions can affect our reproductive system and, therefore, our children. This manual gives complete information to identify and control our exposure to hazardous work conditions, which not only endanger our lives, but also the health of future generations. In English.
Request from: OFL, Occupational Health and Safety Training Centre, 15, Gervais Drive, Suite 703, Don Mills, Ontario, Canada.

"A WORKER'S GUIDE TO SOLVENT HAZARDS." Wright, C. and the Waterloo Public Interest Research Group, WPIRG, Waterloo, Canada, 1985.

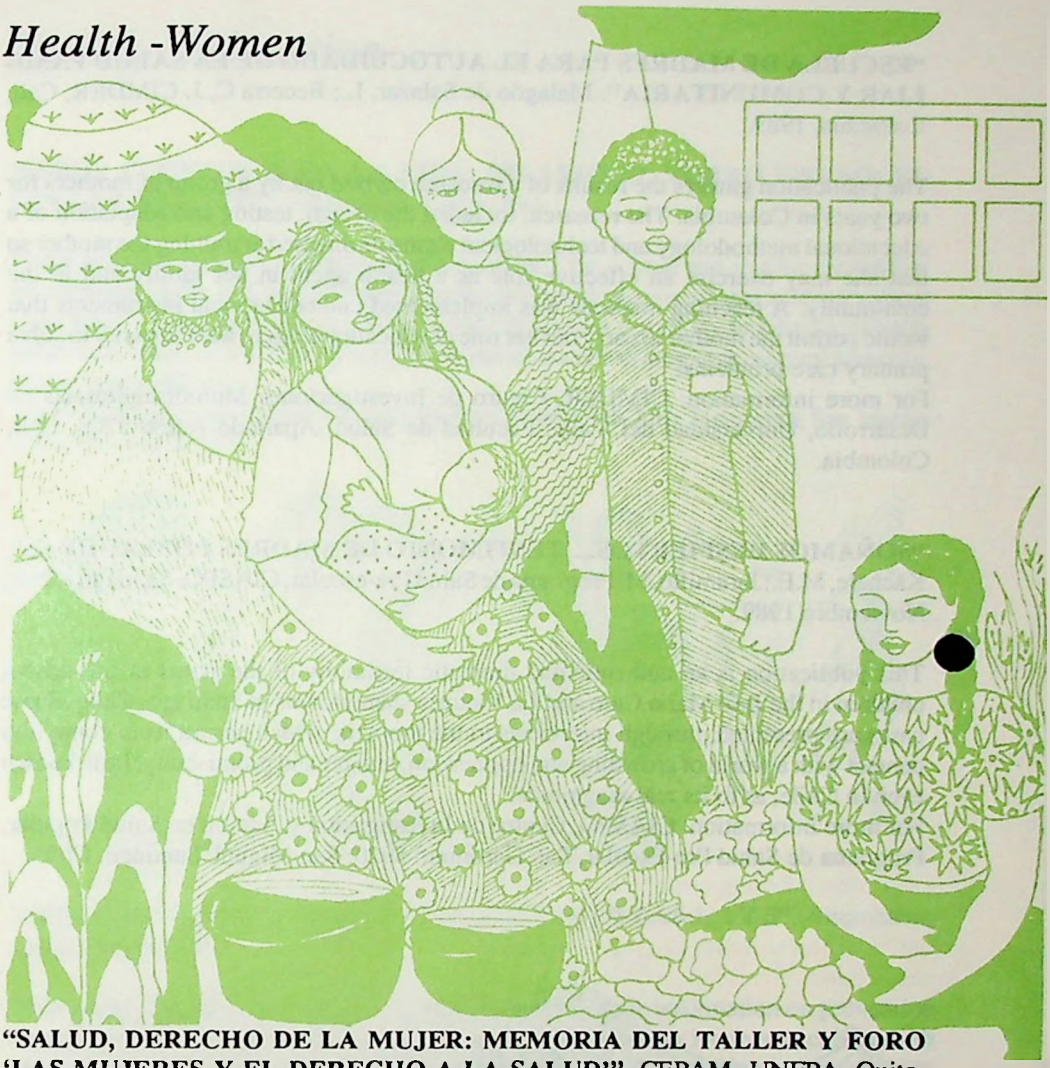
This guide gives excellent information to workers on organic solvents which are widely used in small and medium sized industry, the hazards they pose to health and the appropriate measures to protect ourselves against their effects. In English.
Request from: Waterloo Public Interest Research Group, University of Waterloo, Ontario N2L 3G1, Canada.

"L' ERGONOMIE AU TRAVAIL / ERGONOMICS AT WORK." National Research Council, Ottawa, Canada, n/d.

Ergonomics is the application of scientific knowledge to work, with the aim of improving the welfare and efficiency of the workers and the organization. This pamphlet, drafted by the National Canadian Research Council, gives basic information on this science, its applications and benefits. In English and French.
Request from: Bureau du Developpment Industriel, Conseil National de Recherches du Canada, Ottawa K1A 0R6, Canada.

"CAUTION: ASBESTOS." Manitoba Environment and Workplace Safety and Health, Winnipeg, Canada, n/d.

Asbestos is very common mineral, that when processed has the tendency to give off a very fine powder. Asbestos is used the manufacture of more than 3,000 prodcuts, but despite its usefulness, permanent exposure can mean serious hazards to health. This manual gives a brief but precise information on its risks and prevention.
Request from: Manitoba Environment and Workplace Safety and Health, 1000-330 St. Mary Avenue, Winnipeg, Manitoba R3C 3Z5, Canada.



"SALUD, DERECHO DE LA MUJER: MEMORIA DEL TALLER Y FORO 'LAS MUJERES Y EL DERECHO A LA SALUD'". CEPAM -UNFPA, Quito, Ecuador, 1989.

This publication presents the papers and debates of the workshop and forum entitled "Women and the Right to Health," organized by CEPAM in June and July of 1989. Among some of the subjects dealt with were, sexuality, reproductive rights, health policies, and women as agents, promoters and consumers of health.
Request additional information from: CEPAM, Centro Ecuatoriano para la Promocion y Accion de la Mujer, Apartado 182-C, Sucursal 15, Quito, Ecuador.

"LA MUJER CARIBEÑA EN LA AGRICULTURA". Organización de las Naciones Unidas para la Agricultura y la Alimentación, Oficina regional para América Latina y el Caribe, Santiago, Chile, 1989.

This publication is the results of a Cooperation Project of FAO in English speaking Caribbean countries and Suriname, in the framework of a sub-regional study on the situation of peasant women in those countries. In this study, whose documents are presented here, four general subjects were analyzed: the macro-social and economic context with respect to peasant women, analysis of femenine productive activies, study of governmental and non governmental programs for peasant women in the Caribbean and identification of public policies towards women. There are, also, five case studies. It can be requested from: FAO, Santa María 6700, Las Condes, Santiago, Chile.

"ESCUELA DE MADRES PARA EL AUTOCUIDADO DE LA SALUD FAMILIAR Y COMUNITARIA". Malagón de Salazar, L.; Becerra C, J. CIMDER, Cali, Colombia, 1989.

The publication gathers the results of a research carried out by a group of mothers for two years in Colombia. The research, included the design, testing and adaptation of a educational methodology and technological elements directed at training the mother so that she may exercise an effective role as a health agent in her family and in the community. A teaching methods was implemented and educational instruments that would permit the mother to carry out her role of educational agent with capacity to solve primary care problems.
For more information: CIMDER, Centro de Investigaciones Multidisciplinarias en Desarrollo, Universidad del Valle, Facultad de Salud, Apartado Aéreo 3708, Cali, Colombia.

"SOÑAMOS DESPIERTOS.... TESTIMONIO DE MADRES POBLADORAS". Kachele, M.E.; Jaramillo, M. Programa de Salud Pre-escolar, CIASPO, Santiago, Chile, Noviembre 1989.

This publication is an authentic and dramatic testimony of the status of pre-school children in the Jose Maria Caro and La Victoria shantytowns in Santiago, Chile. Some cases are presented, through interviews to the mothers, which permit us to come into contact with a world of crowding and oppression, hunger and promiscuity, little known even in Chile, as to its real magnitude.
For more information: CIASPO, Centro de Investigacion y Accion en Salud Popular, Programa de Salud Pre-Escolar, San Geronimo 5020, San Miguel, Santiago, Chile.

"SALUD GINECOLOGICA". CESIP - Area Mujeres, Lima, Perú, 1989.

Salud Ginecologica is a series made up of five pamphlets produced by the Women's Area of CESIP. They are: 1. Our bodies; 2. Always women; 3. Keeping healthy; 4. Its better to prevent; 5. A visit to the gynecologogist. These materials are aimed at giving a better knowledge of our bodies and how to take care of it, to permit us to reflect jointly on our situation as women and to concern ourselves of our physical and emotional well-being.
Request from: CESIP, Centro de Estudios Sociales y Publicaciones, Coronel Zegarra 722, Jesus María, Lima 11, Perú.

Health - Education

'SERIE: CUENTOS PARA LA VIDA: HILARIO EL ZORRO ENANO; EL COLLAR DE RAMU". Alternativa, Lima, Perú.

These stories are part of a series called Stories for Life, whose aim to give the teacher instruments which will help him structure his pedagogical-educational activities about child health, either in or out of school. These children's stories try to introduce health subjects in every school course, incl;uding subjects such as language, natural sciences, history and arithmetic.
For more information: Alternativa, Jr. Emeterio Perez 348, Urb. Ingeniería, San Martin de Porres, Lima, Perú.

"SERIE: EDUCACION PARA LA SALUD. CARTILLAS 1, 2 Y 3". Alternativa, Lima, Perú, 1989.

This series of pamphlets produced by alternativa give basic information on prevention and promotion of child health in the classroom. Pamphlet No 1 refers to child health (growth and child development, diarrhea, respiratory infections and inmunizations), the second deals with the subject of nutrition and school diet, and No. 3 with balanced meals and nutritional compounds.
For more information: Alternativa, Jr. Emeterio Perez 348, Urb. Ingeniería, San Martin de Porres, Lima, Perú.

"BETTER CARE OF MENTALLY DISABLED CHILDREN." Voluntary Health Association of India, New Delhi, India, 1989.

This manual teaches us how to discover if a child is mentally incapacitated, how to teach him how to move and take care of himself. It also teaches us how to avoid the birth of a mentally incapacitated child and how to avoid after birth problems of this type.
Request from: Voluntary Health Association of India, 40 Institutional Area, behind Qutab Hotel, New Delhi 110 016, India.

"SALUD POPULAR". Revista del INSAP, Nº. 10, julio 1989, Lima, Perú.

This new issue of Salud Popular (Popular Health), "Communications and Health Education," presents some approaches and experiences that are being done in the field of health education and communications. The summing up of the conclusions of the meeting of educators and communicators who work in health projects is also included, and who met to exchange experiences and discuss the different existing approaches on this subject.
Request from: INSAP, Instituto de Salud Popular, Av. Arenales 1080, Of. 301, Lima 11, Perú.

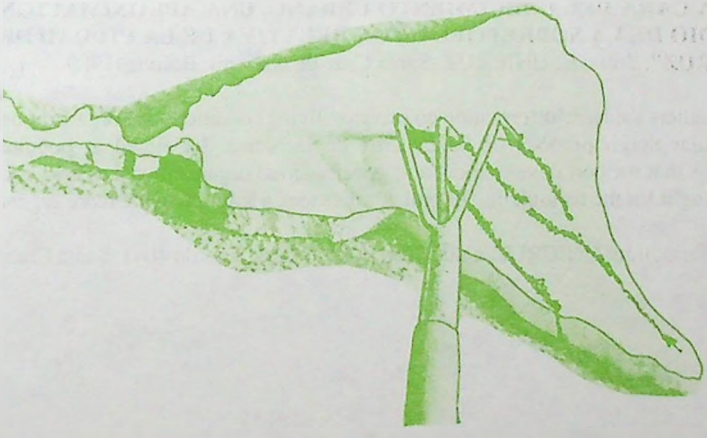
"BOTIQUIN COMUNITARIO". CIPROC -Area de Salud, Bogotá, Colombia, s/f.

Educational pamphlet with instructions to implement a community dispensary, drafted by the Health Area of CIPROC. It contains basic instructions on its functioning, basic materials that the dispensary must contain and minimum precautions on the use of medications.
For more information: CIPROC, Apartado Aereo 38545, Bogotá, Colombia.

Other subjects

"LOS HIJOS DE LA POBREZA". Dejo, F. Centro de Investigacion Social Económica, Octubre 1989, Lima, Perú.

This publication presents the results of a research carried out in 1989 in different communities in Lima on children who begged or worked. Interviews were carried with 133 children between 8 and 12 years of age, with the aim of finding out their socio family conditions, as well as their nutrition, health, education, and work. The results are presented statistically.
Request from: CISE, Centro de Investigacion Social Economica, Universidad Nacional Agraria La Molina, Apartado 456, La Molina, Lima, Perú.



"LA DEUDA GIGANTE DEL TERCER MUNDO. HISTORIA, ARGUMENTOS, PROPUESTAS". Bowen, S.; Cavanagh, J.; Iguiñiz, J.; Sulmont, D.; Yañez, A.M. (editores). ADEC/ATC, Lima, Perú, 1989.

This work presents a series of extraordinary photographs, oral and statistical testimonies on the subject of the foreign debt in Latin America and the rest of the Third World countries. The reader will find abundant material to continue to discuss and reflect on this troubling problem. Interviews to Peruvian specialists on the subject are included.
Request from: ADEC/ATC. Leon Velarde 890, Lima, Perú.

"CONVERGENCE / CONVERGENCIA". ICAE< Consejo Internacional de Educacion de Adultos, Toronto, Canada, 1989.

Convergence is a quarterly publication of the International Council on Adult Education, that contains subjects, practices and experiences in the field of non formal and adult education. Its a link for information and expression for researchers, administrators, teachers and students. It contains international articles in three languages: English, French and Spanish.
For more information: Karen Yarmol-Franko, ICAE, 720 Bathhurst St. Suite 500, Toronto, Ontario M5S 2R4, Canada.

"LA OTRA CARA DEL CRECIMIENTO URBANO. UNA APROXIMACION AL ESTUDIO DE LA SOBREPOBLACION RELATIVA DE LA CIUDAD DE SANTA CRUZ". Soliz, E. UNICRUZ, Santa Cruz de la Sierra, Bolivia, 1989.

This work gathers the basic information on services, living conditions and organization of the popular neighborhoods of Santa Cruz de la Sierra. Its aimed at popular organizations that support development and governmental organizations, as a way to promote thought for the formulation of policies that seek a solution to the more urgent problems.
For more information: UNICRUZ, Calle Pero Veléz Nº 282, Casilla 4041, Santa Cruz, Bolivia.

NEWSLETTER #12 OF THE HEALTH AND POPULAR EDUCATION NETWORK

May 1990

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Health and Popular Education

Publicación con apoyo de ACDI (Canadá)

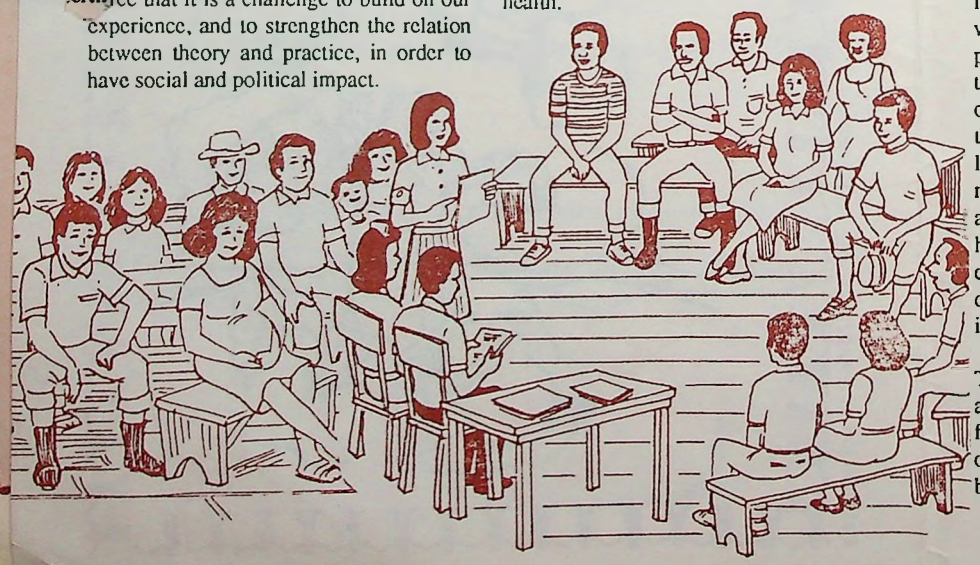
Echos from the First Latin American Course/Workshop on Health and Popular Education

I. LOCAL DEVELOPMENT AND HEALTH

In this issue we would like to share some of the discussions which took place during the Latin American Workshop on Health and Popular Education which was held in Santiago, Chile in November 1988. Here you will find two different outlooks on the problems facing those who want to make a political and social impact on the health situation in Latin America today. First we will present the opinions of Sergio Galilea, cautioning about the advantages and risks involved in local development strategies; then an analysis by Carlos Montes, who questions the political scope of our practices and formulates some hypothesis. Both certree that it is a challenge to build on our experience, and to strengthen the relation between theory and practice, in order to have social and political impact.

I. Health and Local Development: Promises and Concerns. Sergio Galilea

Talking about health is complex. In Latin American cities today, health problems are much more severe than they were 10 to 20 years ago - conditions in general have worsened. There has been an increase of new pathologies and it has become increasingly evident that market forces are incapable of providing the coverage or the efficacy to resolve these problems. There is general criticism in Latin America of health ministries or of public institutions. There is a categorical and critical opinion of, and an enormous debate about the institutional deficiencies which exist in the area of health.



Also, in examining the principal manifestations of the crisis in Latin America, we find these elements: a decrease in the real minimum wages, increasing informal modalities, and a growing similarity between the critical conditions in different countries of the region. A few years ago the problems found in Montevideo today did not exist. From this point of view, it can be said that Montevideo and Buenos Aires are becoming more Latin American every day, and are increasingly less of an exception to the norms that apply to the rest of the hemisphere.

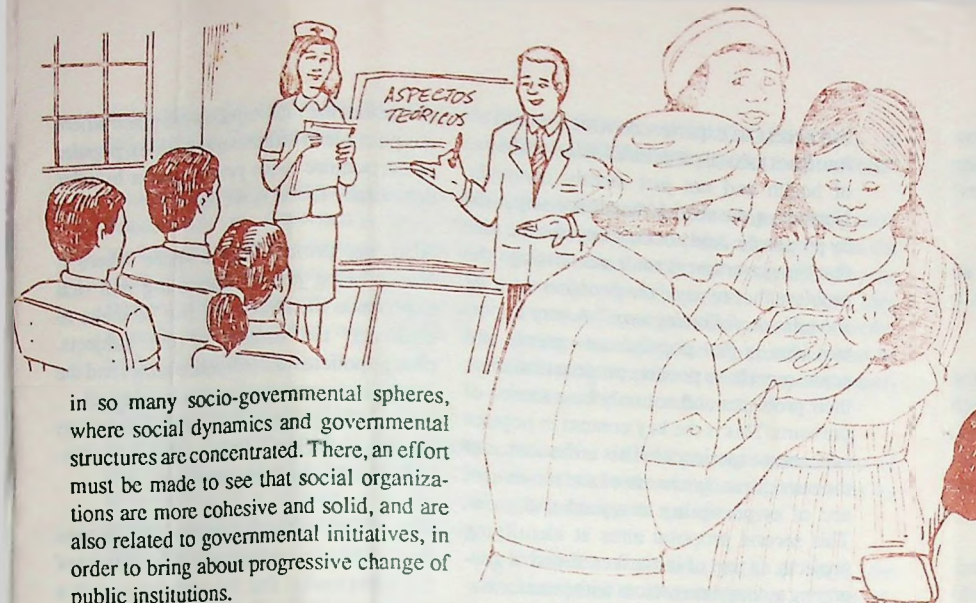
Since health problems have become more complex, then trying to address these problems is evidently more difficult than it once was. This has to do with resources, with new problems, with the relative unpopularity of technical solutions and with the magnitude of the crisis which has especially effected the quality and conditions of life for the larger part of the population. Today, in the majority of Latin American countries, there are heterogeneous forms of poverty. We have poverty that is associated with political exclusion, poverty which is consolidated and unstable poverty, as well as an impoverished middle class.

There are obviously some situations which are more dramatic than others. Probably, from an international perspective, the case of Lima, Peru is one of the most dramatic; but so is Central America, where wars have created a migration to the large cities. We find explosive situations and burgeoning urbanization in almost all of the countries in the region. We have more problems today, and more people with more problems.

What has this meant for local development? Well, I would say that in the last few years, speaking about local development has become fashionable. There has been progress from the theoretical point of view and in the methodology of work.

The value of local development is in its recognition of a scale which is closer to daily problems and subjective elements, where participative approaches can be more effective, where multisectorial relations are perhaps more fluid, circumventing rigid sectorial bureaucracies. This can be an interesting benefit to countries with a great deal of institutional rigidity. It also constitutes a kind of transformation vision at the local level, which could be superior to a transformation perspective at the general level.

Others hold that it creates a field where forms of technology and supply of services can be practiced with originality and efficient forms of social activism. And, finally, others state that at the local level it is possible to produce a democratic revitalization,



in so many socio-governmental spheres, where social dynamics and governmental structures are concentrated. There, an effort must be made to see that social organizations are more cohesive and solid, and are also related to governmental initiatives, in order to bring about progressive change of public institutions.

These factors have produced the discovery of and justification for local development scenarios. However, in many Latin American countries, we have a limited concept of region or of local space. In practice, we are strongly centralized. Therefore, if there were a series of ideas or proposals that would impel us to value local development, we should look at those effective possibilities we have in the different countries of the region to put forms of local development into practice. We must recognize that there are many limitations. The first of these is the absence of a local tradition. The second important constraint, are institutional structures, particularly municipal governments. In Latin America, these are the most useful institutions because of their service to the community, but they are also the institutions which are most stale and full of prejudices.

Therefore, I feel that the transformation of municipal government is an important concern, and that the ideas of local development would most likely be in sharp conflict with these institutional constraints. They would also be in conflict with cultural restrictions, and with policies that are strongly centralist. Local development therefore, has a great deal of promise, but many limitations.

If we accept that local development holds promise, then we must ask what role health has in this process.

The public feels that health is of high priority. Moreover, it is important to note that when people unite to solve health problems there is a high degree of appeal, and when these problems begin to be solved, popular organizations are strengthened. There is a dynamic relationship between initiating local development activities and finding out what health needs exist in the first place. It is possible to carry out activities in the field of health on the local level with social activism; that is to say, that the people organize themselves to confront health problems which are relevant to them. The active organization of the people becomes a real resource that has proved itself to be effective for the efficiency of health programs in numerous situations in Latin America

Because health problems have priority at the local level, carrying out health programs at the local level is more efficient. It makes it possible to lower the cost of the supply of services, to recognize of the nature of problems more easily and, therefore, to adequately adapt the solution to the problem.

At the local level, health programs have the potential to be creative, and technological, social and organizational innovations could be introduced.

At the local scale, some health programs could establish real and effective ties between social and government organizations, and in this way advance the democratic potential of this type of program.

Finally, it is important to add that a more multisectorial approach in relation to health service is possible at the local level.

I have proposed a group of hypothesis on what could occur. Now a way must be found to compare them with practices, and practice is even more important than any methodological approach.

The question is, in what ways do local experiences of health that you have led or that you have observed show that the aforementioned questions are true? That is the most important point: that we systematize or that we have a better capacity to organize our actions to draw important conclusions.

II. Don't Forget Politics.
Carlos Montes

Popular education experiences have interesting potential and a mission (especially for Chileans today) to contribute to the democratic reconstruction of the country. It means relating to political and alternative approaches in a different manner, especially when planning projects to meet social demands.

The movement of pedagogical renovation is a movement with great potential, but it isn't capable of projecting itself further than local working groups. There have been self-management projects in the field of employment and basic needs which are very stimulating in themselves, but which face many problems. Something is happening. Therefore, I want to formulate two hypothesis on this situation.

First hypothesis: Frequently these processes have a serious problem as to the political, with regards to power, both national as well as local. There's a problem there, a blockage in the relationship between these projects and the political and the question of power. It is very common to find defensive attitudes with regards to this problem, which are normally a result of experience.

I've perceived a defensive attitude toward social reform movements, a fear that the richness of a project, for instance in health, could be transformed into little more than a point on a political platform. There's fear in being associated with more radical political movements.

There is a great deal of apprehension about associatiate with political parties. It is very common to engage in the discussion that our work is not represented in politics. There's no political party which expresses the type of transformation discourse, the kind of praxis which we are carrying out. There's fear of being manipulated.

The state, in general, is seen as an agent of deformation, since it accepts what we are doing, distorting and altering it.

This defensive stance towards the political leads us, in practice, to take part in political

processes without contributing our own unique perspective.

Consequently, my first hypothesis is that the limited political dimension of these projects and the scant will to influence political power, makes them lose strength and has the tendency of relegating them to a specific reality.

Second hypothesis: these projects tend to have an extra-institutional character, these projects have difficulty in recognizing the real movement of things. These projects are far removed from the problem of institutionality. Different aspects influence this. There's conceptual factors: an idea of the state as purely an apparatus of domination, or, a perception of civil society very different from that of the state, as if it were possible to generate a project not linked to the state in civil society .

There are also political matters. This endless discussion which began in the 30's, about reform and revolution, that influences how we approach the institutional problem and the concept of the extra-institutional.

It's acknowledged that the institutional doesn't seem to elicit revolutions. In other cases, there's distrust of the capacity of popular actors to incorporate themselves autonomously into institutional processes. It is thought that to commit oneself to institutional processes implies a loss of identity and experiences. Nevertheless, not to acknowlege institutions is a divorce from common sense and a failure to recognize the potential which exists in people. In the Chilean case, for example, people have exercised more power when they act within the law. The problem in Mexico is similar: a search for alternative forms, without looking at or asking how to empower autonomous actors. This extra-institutional character condemns them to a certain marginality, producing low political productivity in every initiative.

These two hypothesis have a lot of influence on the difficulty of projecting the richness of the projects, in debate, public policy and social practices.

Bearing this in mind, I must ask myself how can I increase and deploy the transforming potential contained in these experiences? It's a difficult question to answer.

I attempt to formulate three proposals, all related, which can contribute to debate this dilemma.

First, it is important to acknowledge the territorial approach in its totality, which takes into account the pattern of social, economic, cultural and political relationships, which exist within the local community in which we are working.

But the territorial approach has to be wedded to a class approach, which means working with the neediest. Since social structure in territories where popular sectors are varied is complex, one must not lose sight that the most important task is to address the problems of poorer sectors. And its a question of acknowledging a multi-class reality and empowering middle-class sectors and professionals who are interested in and capable of contributing to solving community problems.
Therefore, the first proposal is directed at examining the territory in its complexity, trying to simultaneously influence a specific problem, in all of territory and its power structure.

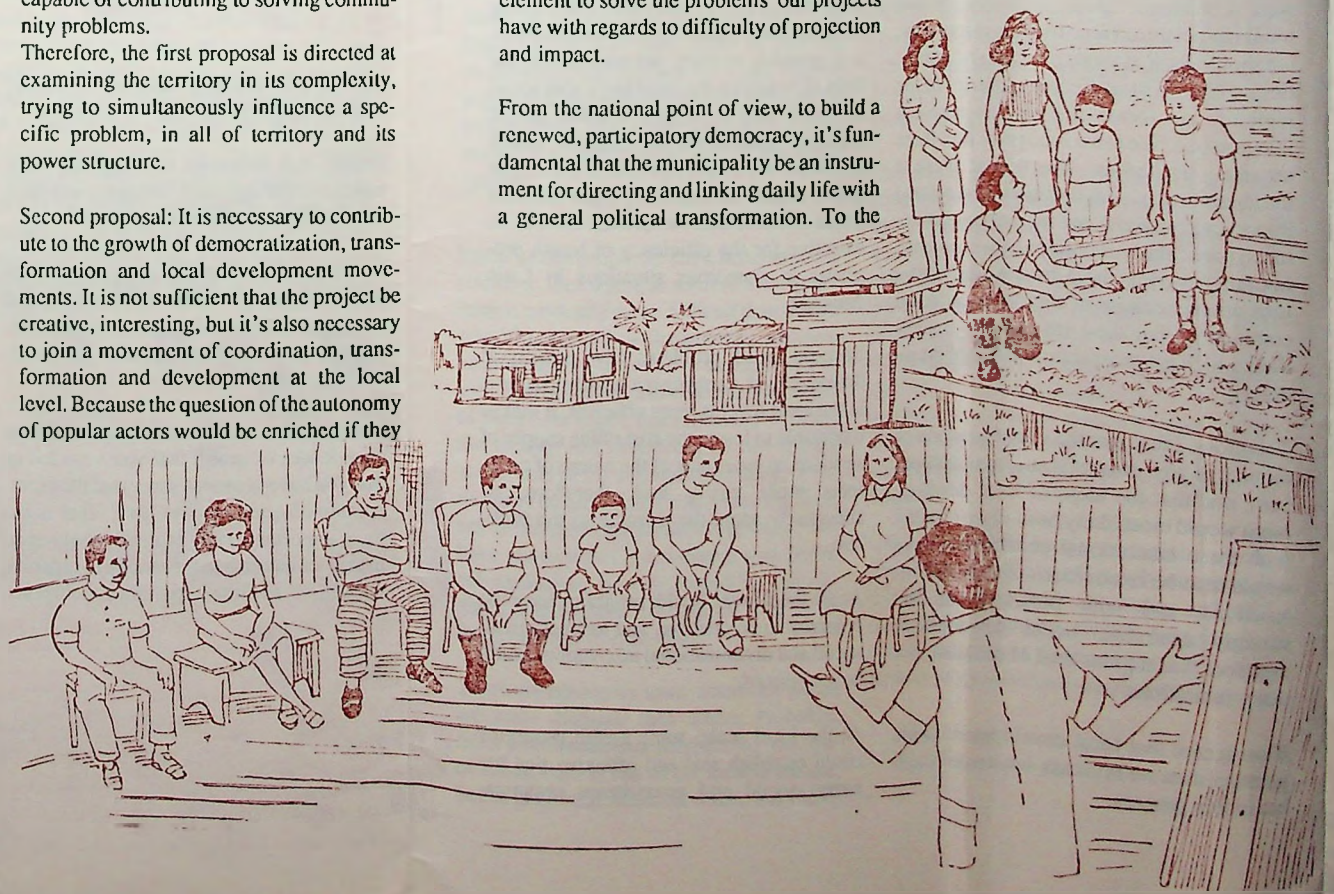
Second proposal: It is necessary to contribute to the growth of democratization, transformation and local development movements. It is not sufficient that the project be creative, interesting, but it's also necessary to join a movement of coordination, transformation and development at the local level. Because the question of the autonomy of popular actors would be enriched if they had access to experiences which would allow them to have proposals for the problems of health and not just merely demands. Nowadays, we need demands accompanied by proposals. And not only express the idea that the government must acknowlege the problem, but to say *"the problem must be solved in the following way."* A very important idea is that popular movements and actors must have positive proposals to solve their problems and not only be a source of pressure. This is the key content in popular education experiences. This is the source of the strength and richness of the movement and of its possibility to spread and grow. This second proposal aims at identifying projects, as part of initiatives aimed at generating autonomous actors with transformation potential.

The third point of the proposal, refers to the need of appropriating the struggle for political democracy. In particular I want to refer to the decentralization of the state and to political reform at the local level. Because the problem of the municipality can be a key element to solve the problems our projects have with regards to difficulty of projection and impact.

From the national point of view, to build a renewed, participatory democracy, it's fundamental that the municipality be an instrument for directing and linking daily life with a general political transformation. To the extent that the municipality is a place where it is possible to influence problems, popular actors acquire more power, and a broader democratic fabric is woven.

Also, our project finds a space where it ceases being just an interesting and rich experience microsocially, but it seeks to challenge the content of the subjects, change policies and influence actors and the institutions generated at that local level.
It's true that projects face many limitations to solve problems, but they also have potentials that merit efforts at reform.

The reform of these municipalities means that public administration is at the service of the community; that the community has a real possibility of controlling public administration, with forms of democratic representation in the local government and with channels for participation. It's also a question of having resources, of being more modern administratively, with greater technical capacity, with clear responsibilities to be able to confront problems, that is, a clear



articulation of responsibility between central and local governments.

I wanted to point out these three proposals because it is very important to know what we can contribute to a new city. How our work can support processes for a popular reappropriation of the city, making the city a more collective space, and, in the last analysis, humanizing it.

These three lines of thought can also help us to rethink the articulation of the political and not to fragment it, because we have a lot to contribute to a broader, more societal political movement, linked to the everyday problems of people.

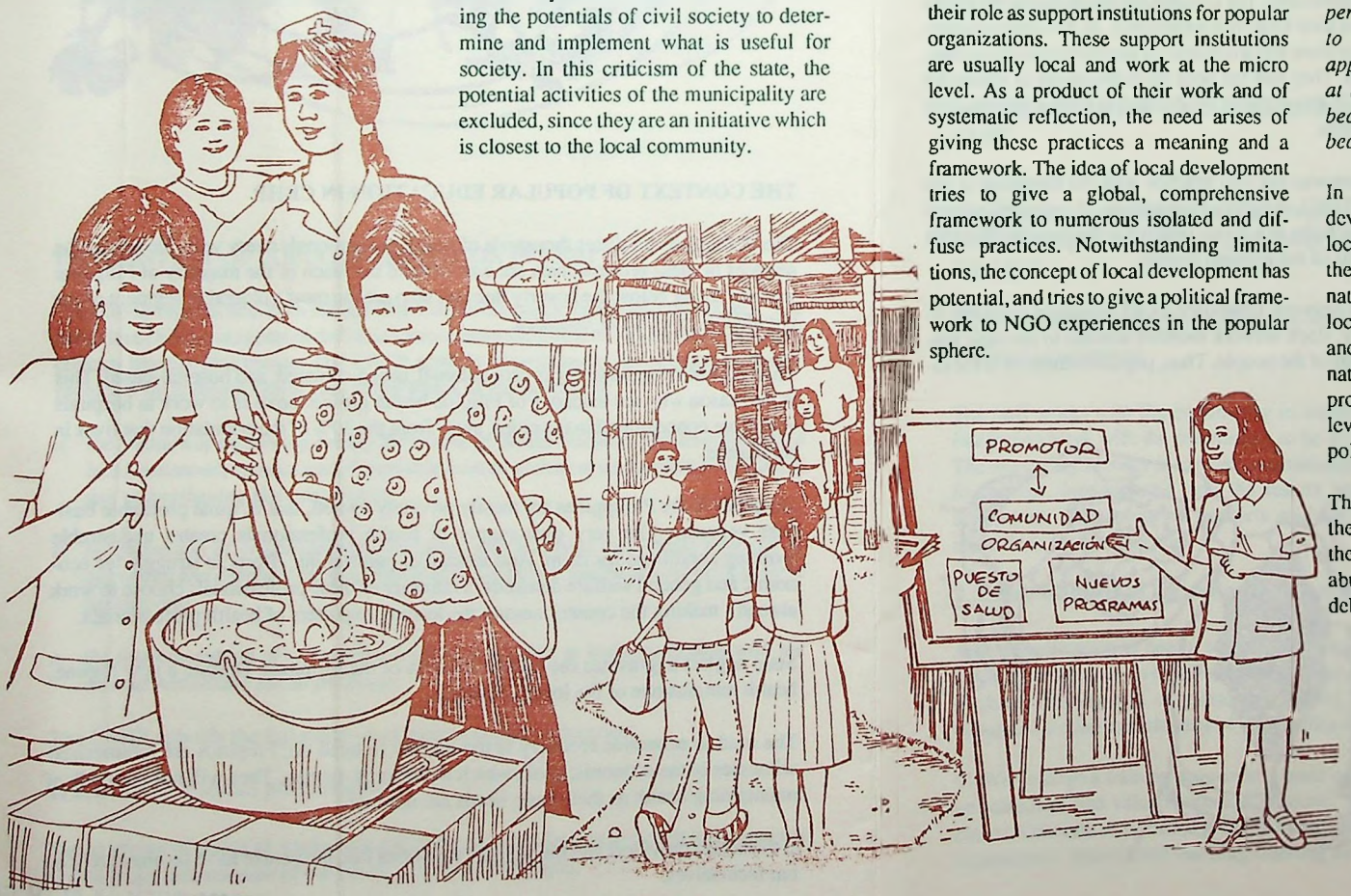
Let me reiterate that these microsocial efforts are tremendously valuable, but I think that they could be richer and more productive if we can incorporate them within a larger transformation movement.

2. LOCAL DEVELOPMENT: A STRATEGY FOR SOCIAL CHANGE?

The subject of local development as a strategy for social and political change was the focus of the debate, and was enriched by the participant's experiences. This core idea was questioned as to the potential of mobilizing local popular organizations and its link with the growth of the popular movement at the national level.

Hereafter we will present some aspects of this discussion, using some comments by the participants and speakers.

From the theoretical point of view, the concept of local development tries to address several problems of our society. There's a critical vision of the state, as a bureaucratic apparatus, distant from people, as an entity that decides for the community. There is concern for discovering the potentials of civil society to determine and implement what is useful for society. In this criticism of the state, the potential activities of the municipality are excluded, since they are an initiative which is closest to the local community.



Another source that delineates the origin of this concept is a criticism of capitalism and industrial society, that alienates and quantifies people. It is a criticism to a more general contemporary phenomenon: a mass production industrial society, of global decision-making, of rationalizing everything. The concept of local development is closer to the idea of a human scale, of creating human dimensions and local decision making. The subject of neighborhood, of smaller spaces, of more local areas, arises.

This line of thought, underscores the idea that social transformation and that spaces for participation must also be sought within the territorial realm, where people live and work. That is to say, the territories where one lives must be considered as spaces for intervention and social initiatives.

NGO's have contributed to formulate the concept of local development, through their role as support institutions for popular organizations. These support institutions are usually local and work at the micro level. As a product of their work and of systematic reflection, the need arises of giving these practices a meaning and a framework. The idea of local development tries to give a global, comprehensive framework to numerous isolated and diffuse practices. Notwithstanding limitations, the concept of local development has potential, and tries to give a political framework to NGO experiences in the popular sphere.

When support institutions are involved in matters of health, housing, education, and production at the local level, the question arises of the meaning of these initiatives and the question of development and social change.

It's no longer sufficient to continue with health programs, improving methodologies, discussing the experiences of popular education, but rather the question arises of the health problem as a whole, and, therefore, of how we can develop our societies from a democratic perspective and with popular leadership.

In that sense the concept of local development is relevant. Nowadays, the questions are: *what potential do local spaces have to confront a national problem? What can the municipality do? What can organized communities do? What are the relationships between the local and national levels that permit those conditions of local operations to increase? In what way can the state apparatus facilitate development initiatives at the local level, where the human scale becomes real and where direct democracy becomes a possibility?*

In this way we are trying -through local development strategies- to avoid separating local and national practices, trying to relate the initiatives of popular organizations with national demands. The point is that these local experiences must not remain at the anecdotal level without a connection to national processes, and that popular approaches that deal with health at the local level, have an influence in public health policies.

These ideas of local development, both in their ideological components as well as their concrete social practices, contain an abundance of questions that stimulate the debate in Latin America.

POPULAR EDUCATION AND HEALTH:

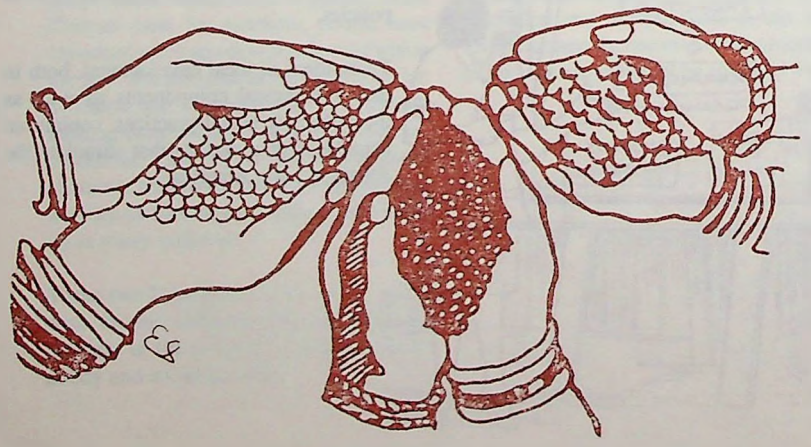
Community Based Health Programs in the Philippines

Gerardo P. Andamo

Barely a year after the Alma Ata conference, the community-based health programs (CBHPs) in the country met to assess their four-year experience. At this time programs had a rapid rate of expansion and thus there was a demand for improvements in training, research, and program management. They saw the need for publications as venues for sharing of trends and experiences. In this context we decided to form a coordinating body which would answer these needs.

In the following year, this resolution was put into practice with the formation of the Council for Primary Health Care (CPHC), -a national consortium of community-based health programs and institutions which aim to actively respond to the basic health needs and to improve the health conditions of the Filipino people.

Currently the CPHC coordinates a network composed of 83 programs covering 46 provinces and 9 cities in the country. Each network member adheres to the basic philosophy of putting health in the hands of the people. Thus, popular education is the essence of CBHP work.



THE CONTEXT OF POPULAR EDUCATION IN CBHP

The Philippines produces thousands of health professionals every year. However, the services of these professionals are way beyond the reach of the majority of Filipinos who are living below the poverty line and who are the most vulnerable segment of the population, in terms of deceases.

Their education and training is very colonial, urban-centered, and hospital-based. This is the reason why the tendency of Filipino health professionals is to work in hospitals which are concentrated in the cities, away from the 70% of the population that lives in rural areas.

Hospitals in the Philippines are mostly privately owned, that is, quite profitable business ventures. The very over-supply of health professionals creates undesirable working conditions for them. And instead of painstaking efforts to struggle for economic and general welfare demands, a majority of these professionals choose to work abroad - making the country among the leading exporters of health professionals.

State neglect aggravates the health situation of the Filipinos. Despite a new regime, health remains one of the lowest priorities.

The road to economic recovery is too narrow to tread on. Filipinos are mesmerized witnesses of the economic crisis which worsens by the day. They will not even talk of maintaining health as their basic needs are not met.

If the health providers and the support structures fail, the people have no one to rely on but themselves.

THE CONTENT OF POPULAR EDUCATION IN CBHP

The CBHP regards health as related to the socio-economic conditions of society. The ill health of Filipinos is part of the basic socio-economic problems of an underdeveloped country like the Philippines. The CBHP actively contributes to the solution of health problems by bringing health care to the hands of the people by:

a. *the creation of awareness among the people of social realities, the development of local initiatives, optimal use of available human, technical and material resources, and strengthening their capacities;*

b. *the formation of organizational structures which uphold their basic interests as oppressed and deprived sectors of society and as people united in their work to serve people; and*

c. *the implementation of responsible actions addressed to holistically deal with the various health and social problems.*

The CBHP upholds the following principles in popular education:

1. Health as a social phenomenon.

The interplay of political, socio-cultural, and economic factors to health is recognized as one major determinant of the health status of the people.

2. Health and development are interrelated.

Good health depends on the progressive improvements of living conditions and the quality of life of the population. Development which is defined as an upward and gradual movement bringing about change from the status quo to something higher and better, is measured by the capacity of the people to satisfy their basic needs - food, clothing, and shelter. Since these basic needs are also determinants of good health, bad health is to be expected in a country where people are enslaved by poverty. Thus, working towards improvements in health means intensifying the commitment to the creation of a society which provides equal access to opportunities and benefits to its members. Moreover, health work means enabling the people to develop their appreciation of their capacities and the enhancement of their innate potentials as they work towards a genuine people's development.

3. Genuine people's participation is essential.

People are the center, subject and object of development. Thus, the success of any undertaking with the aim of serving the people, is dependent upon people's participation at all levels of decision-making: planning, implementing, monitoring, and evaluation of such an undertaking. In general, health work is starting where the people are and building on what they have. It is enabling people to participate and get involved and to act as a unified community

.METHODOLOGIES AND STRATEGIES IN POPULAR EDUCATION IN CBHP

In the last national consultation of CBHPs (February, 1988), these centers describe their methods in popular education as participatory, experiential, dialogical, democratic, and suggestive.

Popular education work in CBHP entails the following phases:

1. Need assessment

The staff works with the community in identifying their needs. This entails a lot of integration work with the community to be accepted as one of them.
The customary strategy is to make a community diagnosis, whose design and tools are formulated, implemented, and the results analyzed and interpreted by the people themselves. This requires a concrete analysis of specific conditions with the people identifying their real needs.

2. Establishment of formulas/mechanisms to respond to needs

After identification of needs, structures are established to carry out an action program for their satisfaction. In CBHP, this means having a team of potential community health workers (CHWs), and an initial structure of a village health committee. Usually, a village is divided into clusters of 10 families who elect their own CHWs.

CHWs undergo a training sequence: a basic course on health skills with an equal dose on attitudinal and value formation sessions. What a CHW learns is passed on to his cluster. Concrete activities (e.g. direct services) are carried out to apply them as learning experiences. Appropriate teaching-learning methodologies are applied.

A set of advanced CHWs attends additional courses (e.g. program management, leadership skills, campaign management, etc.) in preparation for full-blown health program directly managed by them.

3. Integration with support structures

Health program/committee is made up of other community programs such as women, youth, cooperatives, functional literacy, etc. within the basic organization (peasant, workers, fishermen or organizations of urban poor).

This guarantees direct community support to the health structure as it complements other community programs. It integrates popular education work in health with the efforts of other sectors.

4. Consolidation through actions

Aside from the on-going health education work along the lines of the basic elements of primary health care and the forms of services it entails, the health program through CHWs gets involved with community problems. Campaigns on community issues (e.g., land tenure, livelihood, etc.) are carried out by the program.

Direct actions are forms of consolidation as they test the preparedness of the program and its strength; and they provide learning experiences for the people.

5. Evaluation of efforts

Community evaluation of all efforts summarizes the impact of the program. It is always the community who will recognize and appreciate the extent of accomplishments, the joys of success, the limitations and lessons from the weaknesses and failures.

POPULAR EDUCATION WORK IN CBHP: WHERE TO GO FROM HERE?

An indicator of success in popular education work is the rise of critical awareness among the people. When the culture of silence and apathy is destroyed, popular education starts to bloom.

This is the moment when other health professionals, particularly when private physicians experience and complain of the decrease of their patients and the articulateness of their patients as they begin to question procedures and methods.

This is also the time when the people themselves, in a collective spirit, implement responsible actions towards improving their living conditions.
This also the time when government structures get paranoid and think that people are destabilizing the state. At this point, the state apparatus begins to crush the popular movement, which is a result of popular education.
Despite some gains, so much has to be done in popular education work. After 13 years, CBHP reaffirms its commitment. **It will carry on!**

NEWS

ARGENTINA

II NATIONAL SEMINAR ON PRIMARY HEALTH CARE AND COMMUNITY PARTICIPATION IN ARGENTINA

The II National Seminar on Primary Health Care and Community Participation in Argentina took place in Alta Gracia, in the Province of Cordoba from May 25-28th this year. The seminar was sponsored by the Committee for the Defense of Health, Professional Ethics and Human Rights of the Argentine People (Comité para la Defensa de la Salud, la Etica Profesional y los Derechos Humanos del Pueblo Argentino - CODESEDH) and the Movement for a Comprehensive Health System, (Movimiento por un Sistema Integral de Salud - MOSIS) of Cordoba.

More than six hundred persons participated in the seminar. Among them were hundreds of community health agents who were elected and sent by the communities they represented. Also in attendance were health promoters and educators; community health professionals; popular healers (curanderas); traditional midwives; representatives of community organizations, universities, and NGOs; and government sanitary and education officials from all over the country. Sanitary agents from different ethnic groups played a special role.

CODESEDH and MOSIS were asked to accept the challenge of organizing the Seminar at the Meeting of Health Teams from 16 provinces of Argentina which took place in May 1988, a responsibility they readily assumed. At this same meeting, the Popular Health Network of Argentina was also formed. It is now part of the Latin American Health and Popular Education Network of CEAAL.

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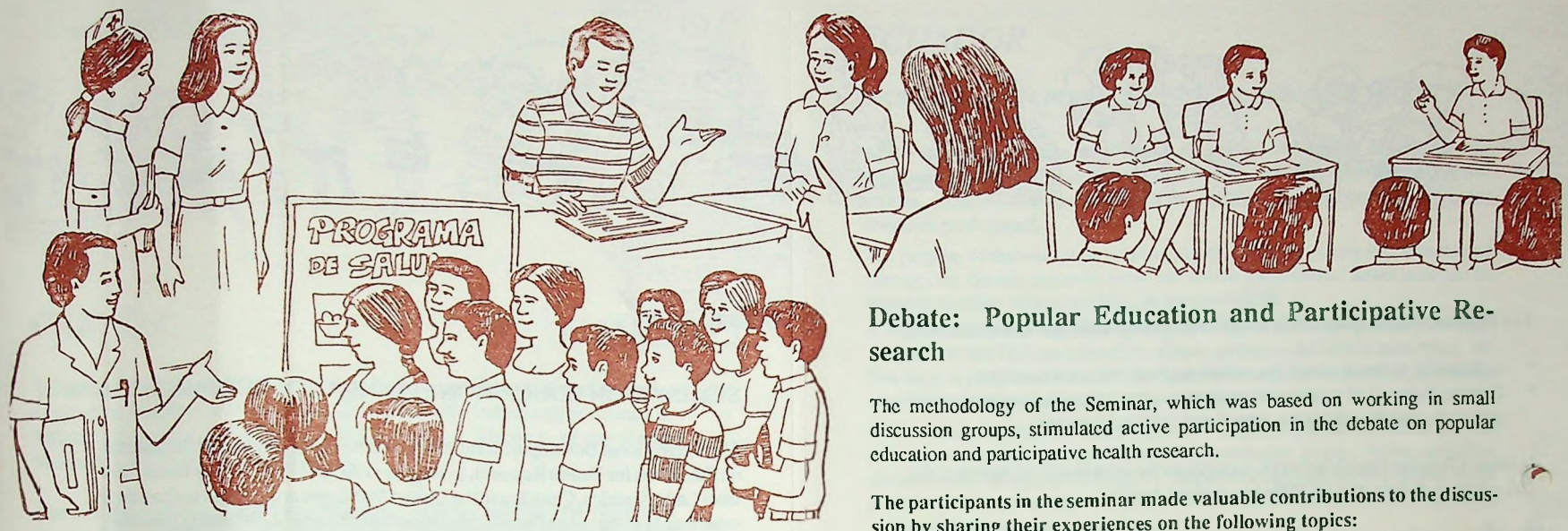


The Seminar had the following objectives:

a. To initiate an active dialogue between the public sector and the communities regarding their different experiences.

b. To review past actions in order to arrive at agreement on proposals and recommendations to develop and expand strategies and actions to promote popular health.

c. Devote part of the meeting to technical training related to the needs and objectives of health teams.

Popular education in health was a topic of discussion. This allowed the seminar participants to acquaint themselves with and deepen their understanding of the special features offered by popular education:

* It is a learning process oriented toward action to change the status quo.
* It is a teaching and learning process which tries to achieve horizontal relationships and equality among the participants to acquire knowledge.
* It stimulates collective learning and critical consciousness.
* It is a participative process.
* It is derived from practice, from the experiences of everyone in the group and the community.
* It takes advantage of learning that is to be had in every setting, in a continuous way and at any age; it is not the sole responsibility of institutions of instruction such as schools and universities.
* It is a process that grows by progressively joining and uniting with more people, through democratic ties of solidarity in learning and action.

Reflection on participative research in health has pointed out the following characteristics and contributions:

* It is a social means of research which starts in the community and aims at the full participation of everyone involved.

Debate: Popular Education and Participative Research

The methodology of the Seminar, which was based on working in small discussion groups, stimulated active participation in the debate on popular education and participative health research.

The participants in the seminar made valuable contributions to the discussion by sharing their experiences on the following topics:

- Grass roots organization.
- Community organization for preventive health care.
- Relating popular health projects to those of the health teams at the level of state provided primary care (Health Centers).
- Progress in popular participation.
- Implementation of curative health care assistance with education and health promotion.

An advance in the development of the Popular Health Network of Argentina

This Seminar demonstrates the high level of qualitative and quantitative development and evolution which the Popular Health Network of Argentina and the social and health movement that supports it.

Coordinators of the Health and Popular Education Network of CEAAL were present at the Seminar so they can attest to the effort it took to organize the event in the midst of the grave economic and political crisis which affected the country at this time, and which increased the administrative and financial difficulties of preparing for and holding the seminar. An enormous effort was made to respond to the great demand to participate in the seminar - a demand which came from every corner of every territory of Argentina. **It should be pointed out that in overcoming this challenge the event showed:**

* The powerful response to the idea of Popular Health Network in Argentina in response to the invitation to participate in the seminar.
* The vitality of the popular health movement in Argentina, which gives the Network the necessary social energy and which is organized at the local level even in the most remote provinces.
* The clarity shown by the participants when discussing a large number of different practices which share the basic orientation towards health care with social justice, popular participation and democratically generated.
* A high level of cooperation among those involved in health care - grass roots social organizations, health agents, NGOs, the State, universities, and union and trade organizations.

The Popular Health Network is a way to overcome isolation and dispersion.

* It allows us to break out of the isolation of our own communities.
* Creates channels of continuous exchange, cooperation, critical analysis of our work, and the setting for formal and informal training.

In short, a Popular Health Network strengthens the growth and expansion of the task we have chosen and identified as popular health.

We want to make very clear that the Network does not mean to overlook the different structures and jurisdictions of the formal system of Public Health. On the contrary, by playing a role in it, government could recognize its errors and its faults and actively contribute to making it meet the right to health of our people.

The Health Network is an association of diverse horizontal democratic, popular organizations who share the commitment to better the health of our country. This association permits us to create simple, agile and non-bureaucratic ways to communicate, meet, carry out research, and publish.

Its principal actors are community members themselves, grass roots and intermediate organizations, scientists, students, professional associations, etc. This is to say, anyone who can contribute to our experience and analysis in order to change the reality of health care in service of our people.

The Latin American Health and Popular Education Network of CEAAL has watched the development of Argentina's Popular Health Network with a great deal of interest. It is an example of the significant advances which can be made by a social movement for popular health, and this makes it important to take a close look at the strategy followed by the people who built and put the network into effect. Their experiences can help others who are trying to develop similar networks in other Latin American countries.

Note: More information about the documents and conclusions of the Seminar, as well as the development, activities and projects of the Popular Health Network "Dr. Ramon Carrillo" can be requested from:

Norberto Liwsky
CODESEDEH
Rodríguez Peña 236, 6o B
1020 Buenos Aires
Argentina

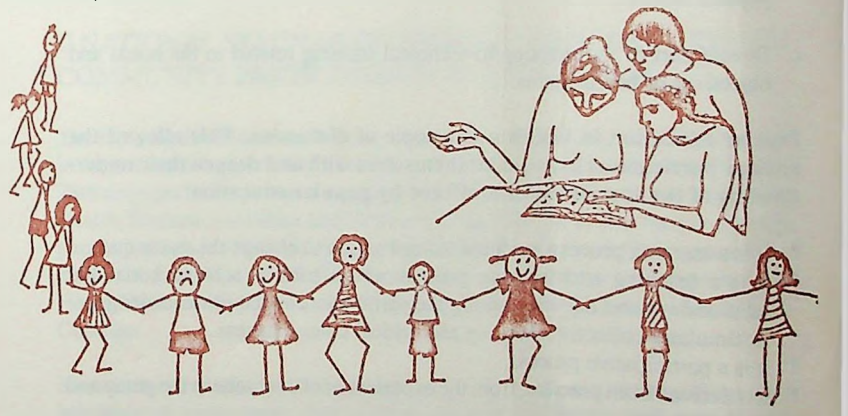
Horacio Barri
MOSIS - Coordinadora Córdoba
Avda. Vélez Sarsfield 4093
5000 Córdoba
Argentina

COLOMBIA

SEMINAR ON EDUCATION FOR HEALTH RESEARCH

The International Development Research centre (IDRC) organized the Seminar on Education for Health Research in Bogota in April, 1989. Twenty researchers from Latin America, Canada and the United States met at this event to share their experiences in the area of health education with the aim of discussing priorities, methodological approaches, and criterion for the selection and training of researchers. Among the items that were discused were the importance of educational and promotional work in health programs and the need to deploy different investigative and systematizing efforts in order to take advantage of the richness of local experiences.

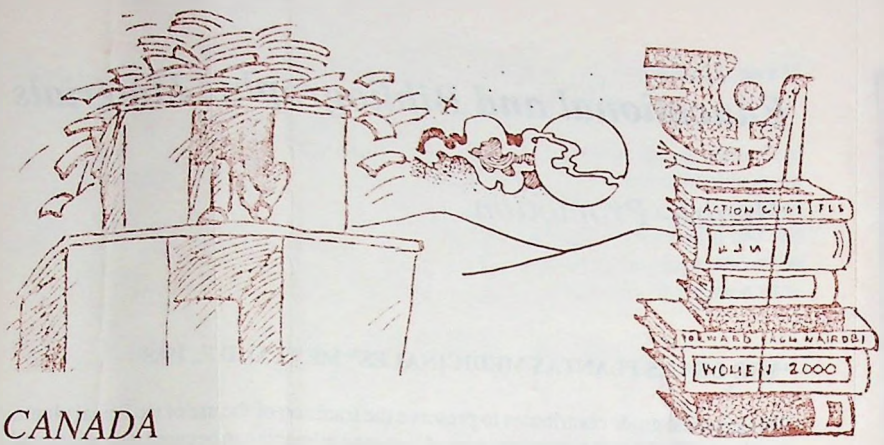
More information about the meeting can be obtained from:
Jane Mac Donald, IDRC, 250 Albert Street, PO Box 8500, Ottawa, Ontario, CANADA, K1G 3H9



CHILE

Chilean Non-Governmental Organizations which work in programs to promote health met to reflect on the role they will play in the future democratic government. In April, the first national meeting was held, where the importance of the real participation of the people in future policies was emphasized. The role of the NGOs will be fundamental in this area.

Documents published as a result of this meeting can be obtained from:
CIASPO, San Geronimo 5050, San Miguel, Santiago, CHILE

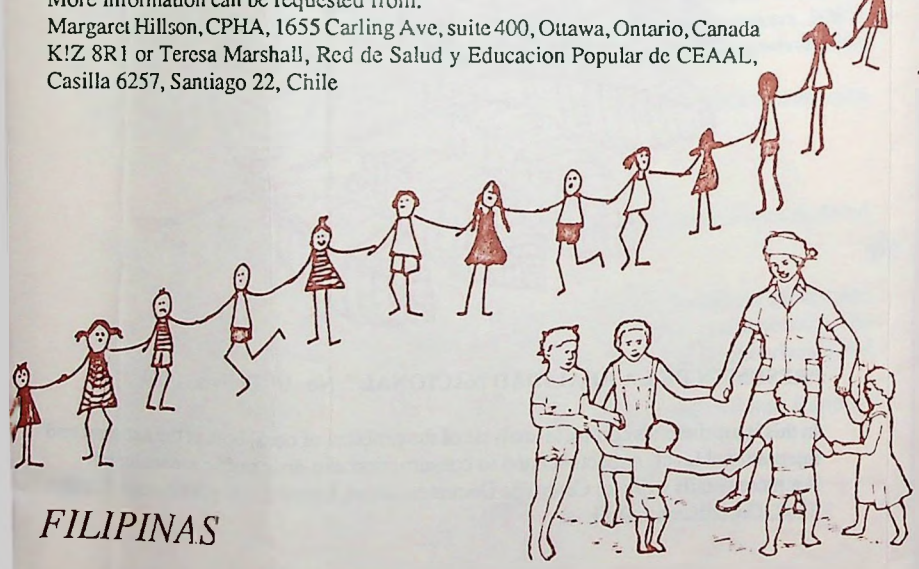


CANADA

In June, the Canadian Public Health Association organized a study and exchange visit in which representatives of Asia, Dr. Rustamadji (Indonesia); of Africa, Dr. Mduma (Tanzania); and of Latin America, Teresa Marshall, of the Health Network, CEAAL (Chile) participated.

The exchange visit included three provinces: British Columbia, the Northwest Territories and Alberta. In each place contact was made with groups dedicated to community work, the promotion of health and community health care programs. The itinerary permitted comparing experiences and orientations, acknowledging the importance of debate and solidarity in common struggles.

More information can be requested from:
Margaret Hillson, CPHA, 1655 Carling Ave, suite 400, Ottawa, Ontario, Canada K!Z 8R1 or Teresa Marshall, Red de Salud y Educacion Popular de CEAAL, Casilla 6257, Santiago 22, Chile



FILIPINAS

INTERNATIONAL FORUM ON THE CRISIS IN CHILD NUTRITION

An International Forum on the Crisis in Child Nutrition was held from October 9 - 14, 1989. The subject of the forum was the struggle for child survival. The forum was organized by the International Network for Child Nutrition Groups.

For more information:
IBFAN IOCU, PO Box 1045, 10830 Penang, MALAYSIA

ECUADOR

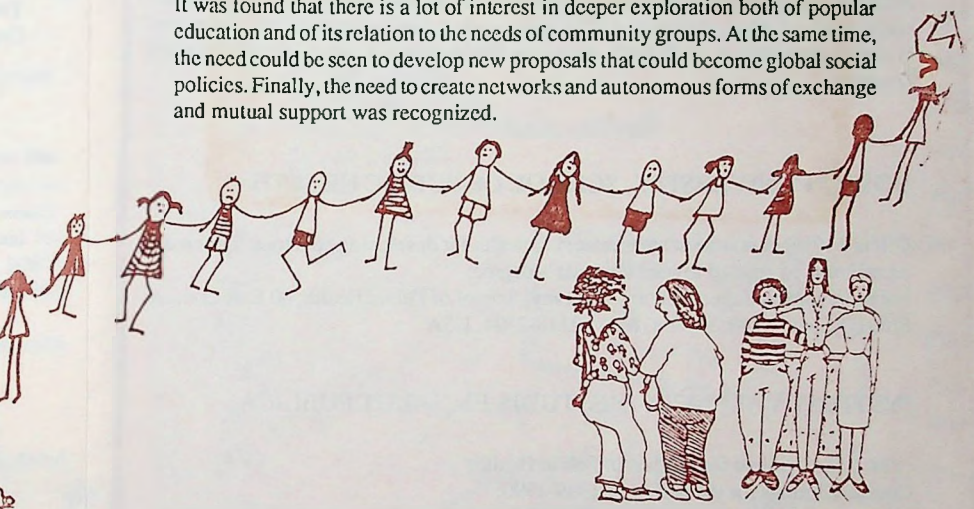
WORKSHOP ON POPULAR EDUCATION AND HEALTH

At the beginning of June the Popular Education and Health Workshop was organized in Quito. Representatives of NGOs, universities, international organizations, churches, communities, and government agencies from 30 different countries participated.

The purpose of the workshop was to promote dialogue, share experiences and perceptions, discuss common goals and needs, and to break down isolation by bringing together groups working in the same field.

It was evident from this brief encounter that the different groups who have programs in this field are often distant from, or even unknown to each other, and that there is great need to establish regular exchange between them, especially when their programs address similar problems.

It was found that there is a lot of interest in deeper exploration both of popular education and of its relation to the needs of community groups. At the same time, the need could be seen to develop new proposals that could become global social policies. Finally, the need to create networks and autonomous forms of exchange and mutual support was recognized.



ADULT EDUCATION WORLD ASSEMBLY

Between the 8 and 18 of January, 1990, the International Council of Adult Education (ICAE) will hold the Fourth Adult Education World Assembly in Bangkok, Thailand. This event will also signal the initiation of the Literacy International Year.

The principal subject of the meeting will be "Literacy, Popular Education and Democracy: Building the Movement." It is hoped that representatives of adult education and literacy movements of more than 100 countries will participate in workshops, plenary sessions, exhibitions and planning meetings. The World Assembly will begin with solidarity visits to different grassroots educational programs in different parts of Thailand.

At this time, the International Health Network of ICAE will meet to deal with strategies and perspectives that strengthen and promote its international tasks in the following years.

For more information:
General Secretariat, ICAE, 720 Bathurst st., suite 500
Toronto, Ontario, Canada M5S 2R4

TRAINING WORKSHOPS

SHORT TRAINING COURSES FOR HEALTH WORKERS (1989-1990).

AHRTAG has published a booklet with detailed information about training courses for health workers. Many institutions offer undergraduate and Masters Degree programs.
For more information: AHRTAG, 1 London Bridge Street, London SE1 9SG, United Kingdom.

BOSTON UNIVERSITY, SCHOOL OF PUBLIC HEALTH

Offers a 12 week course in areas related to health for developing countries. The credits earned may be applied toward a master's degree.
For more information: Boston University, School of Public Health, 80 East Concord Street, Room A-310, Boston, MA. 02118-2394, USA

INSTITUT VALENCIA D'ESTUDIS EN SALUT PUBLICA

(Valencian Institute for Studies in Public Health)
Course offerings for the period of 1989-1990:
-Certificate in Community Health Education
-Masters in Public Health
-Certificate in Health for School children
-Course in community action and intervention
For more information contact: Secretaria I.V.E.S.P., c/Rodriguez Fornos, 4. 461010 Valencia, Spain

MANCHESTER UNIVERSITY

Postgraduate studies in primary health care, rural development, and functional literacy education. The courses focus on educational and organizational aspects.
For more information: The Secretary, CAHE, Manchester University, Oxford Road, Manchester, M13 9PL, United Kingdom.

Educational and Bibliographic Materials

Health- Promotion

"USO DE LAS PLANTAS MEDICINALES" MEXICO, D.F., 1988

This practical guide contributes to preserve the tradition of the use of medicinal plants, bearing in mind that the great majority of common ailments can be cured with medicinal plants. The following subjects are treated: how to gather, dry and store medicinal plants; how to prepare them; index of the conditions and diseases and, finally, fifty plants and their use.
You can order from: Arbol Editorial, S.A. de C.V. Av. Cuauhtemoc 1430, Col. Santa Cruz Atoyac, Mexico, D.F. 03310, Mexico.

"RESUMEN DE LA REALIDAD NACIONAL" No. 16, Bolivia, 1989

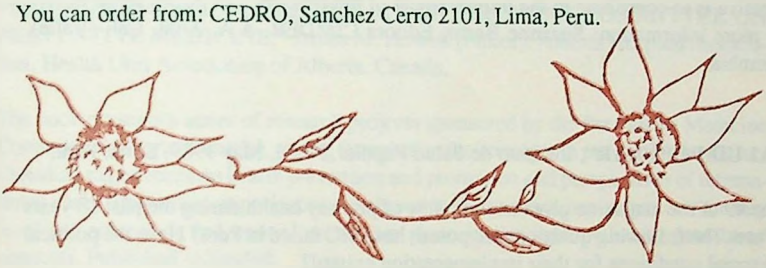
In this issue there's a complete analysis of the problem of coca, both at the national and international level. Aspects related to consumption and drug traffic are included.
For more details write to: Centro de Documentacion, Informacion y Biblioteca, Casilla 3302, Cochabamba, Bolivia.

"BOLETIN CETAAR." Centro de Estudios sobre Tecnologias Apropiadas de la Argentina .No. 3 December 1988, Buenos Aires, Argentina.

The bulletin reports on activities that have been carried out on different subjects that help the balance of the ecosystem, as well as the activities and workshops which will be carried out in 1989.
For more details write to: Centro de Estudios sobre Tecnologias Apropiadas de la Argentina, Casilla 5182, Correo Central, 1000 Buenos Aires, Argentina.

"RESUMEN DE INVESTIGACION." Centro de Informacion y Educacion para la Prevencion de Abuso de Drogas, CEDRO, May 1989, Lima, Peru.

This summary published the results of a public opinion survey on drugs, carried out between May and September 1989 in the 13 Peruvian cities of 100,000 inhabitants or more. 3,046 people were interviewed on the following subjects: Substances considered drugs, most consumed drugs, degree of addiction they cause, more harmful and less harmful drugs, reasons for drug consumption, effects of drug use on people and on the country, national problems and the problem of drugs and, finally, prevention campaigns.
You can order from: CEDRO, Sanchez Cerro 2101, Lima, Peru.



"ORGANIZANDOSE PARA EL DESARROLLO" Institute for Development Research Periodical (IDR), USA, 1988.

IDR is a non-profit research and consulting organization, aimed at organizations that promote social and institutional change and which train underprivileged people to actively participate in projects that improve their quality of life. In the 1988 summer issue there are articles on the strategic role of voluntary organizations in and for development, a program on the strategic management of private volunteers, IDR's history and the program for leaders with scholarships from Asian non-governmental organizations.
For more information write: Institute for Development Research, 710 Commonwealth Avenue, Boston, MA. 02215, United States of America.

"BOLETIN DE GRUPOS DE SALUD". Organizacion Distrital de Grupos de Salud de Bogota, Colombia, 1988.

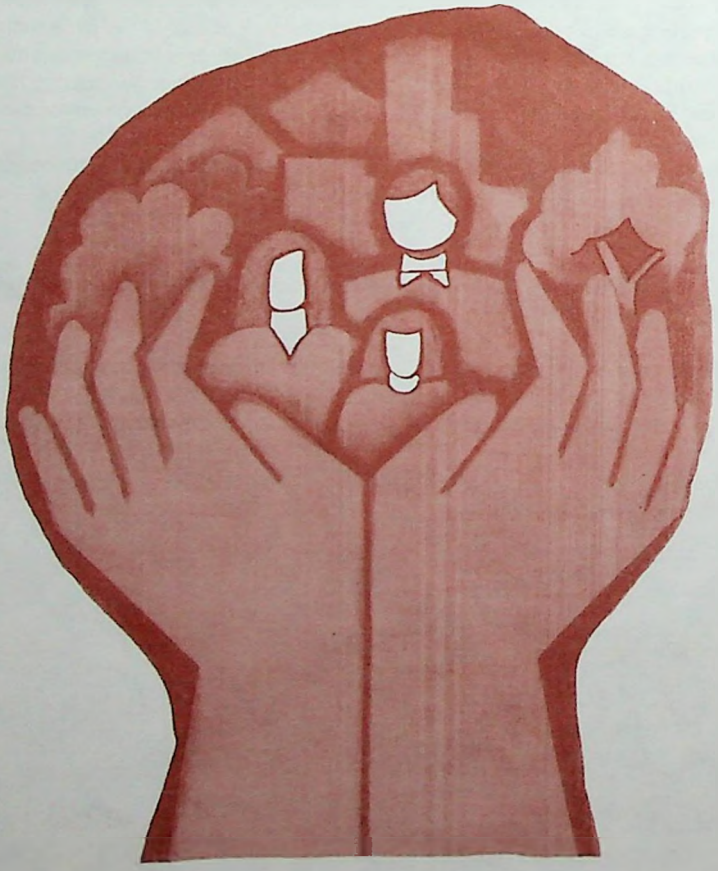
This bulletin promotes communication between the different grassroots groups and support institutions that work towards coordination of activities in health districts. The bulletin gives news of the districts, the situation in the Bogota neighborhoods and training experiences.
You can request it from: CINEP, Organizacion Distrital de Grupos de Salud, Carrera 5 No. 33A-08, Bogota, Colombia.

"BOLETIN CINDER". April 1989, Colombia.

This purpose of this bulletin is to promote the exchange of scientific information. Three publications are announced: "Let's talk about our health: prevention and cure at home" (Hablemos sobre nuestra salud: soluciones para prevenir y curar en casa.); "Manual for the Administration of Supplies in Health Institutions" (Manual para la Administracion de Suministros en Instituciones de Salud); "Primary Health Care for Large Cities: Manual for the use of the Family Card (Atencion Primaria en salud para las grandes ciudades: manual para el diligenciamiento de la Tarjeta Familiar). It also reports on the First Institutional Seminar-Workshop on Health Plans in Barrancabermeja, whose objective is to contribute to the improvement of the efficiency of health services.
For more information: Suzanne Bazar, Editora CIMDER, A.A. 3708, Cali (Valle), Colombia.

"SALUD POPULAR". Instituto de Salud Popular, No. 9, May 1989, Lima, Peru.

Issue #9 of the magazine gives an overview of primary health during the past 10 years in Peru. The following questions are posed: has PHC failed in Peru? Have the political and social conditions for their implementation existed?
The problems and experiences of PHC, of the popular movement, local health services, and of participation strategies are analyzed. The declarations of Alma Ata, Harare and Riga are included.
You can request it from: INSAP, Av. Arenales 1080, Of. 301, Lima 11, Peru.



"TRANSFORM-ACTION/TRANSFORMATION." Ottawa, Canada.

Bulletin of the Canadian Project for Healthy Communities, an initiative that rounds up efforts stemming from municipal urban areas, public health and local projects that are being implemented in Canada. It analyzes the subject and the status of local projects. Published in English and French.
It can be requested at: Transform Action, 126, Rue York, #404, Ottawa, Ontario, K1N 5T5 Canada.

"THINK PREVENTION. THE REPORT OF THE JOINT COMMITTEE ON PREVENTIVE MEDICINE." James M. Howell (Editor). Alberta Hospital Association, Health Unit Association of Alberta, Canada.

The book presents a series of research projects sponsored by the Preventive Medicine Committee (Alberta, Canada), giving thoughts on the concepts in preventive medicine, Canadian experiences on health prevention and promotion and perspectives of international cases. Prevention experiences developed at the primary, secondary and tertiary level are presented, and new elements are given in the light of health promotion concepts. Published in English.
You can request it from: Alberta Hospital Association, 10025 108 St., Edmonton, Alberta T5J 1K9 Canada.

"HEALTH PROMOTION: HEALTH AND WELFARE." Ottawa, Canada.

Periodical publication of the Directorate of Health Promotion of the Canadian Government. The winter issue 1988/89 gives information on the subject of mass media for the promotion of health, news from Canada, community initiatives, audiovisual resources and publications for health promotion work. Published in English and French.
It can be requested at: Editor, Health Promotion: Health and Welfare, Ottawa, Ontario, Canada K1A 1B4.

"THE MULTIPLIER. Strengthening Community Health Programs." Canadian Public Health Association. Ottawa, Canada, 1989.

Newsletter of the Canadian Public Health Association, in charge of the program of strengthening community health programs. This newsletter encourages activities of local Canadian groups in the fields of promotion and community health initiatives.
For further information contact: Dr. Tariq Bhatti, Canadian Public Health Association, 1565 Carling Ave., Suite 400, Ottawa, Ontario, Canada K1Z 8R1.

"A MIRACLE IN THE MAKING." Canada's International Immunization Program, Ottawa, Canada, 1989.

Newsletter of the International Immunization Program of the Canadian Public Health Association, which is cooperating with volunteer and private organizations in 42 countries, through 89 specific projects. The newsletter reports on the achievements of this important program. Published in English and French.
It can be requested at: CIIP-CPHA, 1565 Carling Ave., Suite 400, Ottawa, Ontario, Canada K1Z 8R1.

"TALC: TEACHING AIDS AT LOW COST." Newsletter, TALC, England, 1989.

TALC newsletter with information on important and recent publications on AIDS, vaccines, rehabilitation, games for children, existing medications, etc. Published in English.
It can be requested at: TALC, P.O. Box 49, St. Albans, Herts AL14AX, United Kingdom.

"LA SALUD: DIALOGOS DEL PUEBLO". CODESEDH, Buenos Aires, Argentina, 1989.

Presents the dialogues on the course of primary health care and popular participation. It gathers different perspectives and struggles around the issue of health for all in Argentina, expressed in presentations, group work and opinions of participants in this course.
You can request it from: CODESEDH, Rodriguez Peña 236, 6o. B, 1020 Buenos Aires, Argentina.

"DEVELOPMENT MIRROR." A MAGAZINE ABOUT EVALUATIONS." Diakonia, Sweden, 1989.

This issue is devoted to the subject of evaluation and thinking about the subject of NGO's, development, and North-South international cooperation. Three evaluation experiences are included: health problems in Bangladesh; a communications project in Uruguay and in Tanzania, an education for health project. Published in English with Spanish and French abstracts.
It can be requested at: DIAKONIA, Alvsjo Gardsvag 3, S - 12530, Sweden.

PUBLICACIONES DEL COLECTIVO DE ATENCION PRIMARIA DE SALUD (CHILE). Santiago, Chile, 1989.

After many years of work in the Chilean scene, the Collective has disseminated the results of its work in several publications. One refers to the Metropolitan Congress of Professionals and the other to the National Workshops of Health in Shanties.
You can request it from: Colectivo de Atencion Primaria de salud, Constitucion 125, Santiago, Chile.

"SALUD Y PROMOCION SOCIAL" REGISTER OF INSTITUTIONS IN SANTIAGO, CHILE (Catastro de Instituciones de Santiago, Chile)" INFOCAP, Santiago, Chile, 1989.

The document includes information on the non-governmental institutions which support the activities of the popular movement in Santiago. This document is a contribution to establish communication and exchange between different programs that work to improve the health conditions of the population.
It can be obtained from: INFOCAP, Chorrillos 3614, Santiago, Chile.

"DESDE LAS BASES" INDEPENDENT PERIODICAL AT THE SERVICE OF THE POPULAR MOVEMENT." CEDEPO, Vol. VI, Buenos Aires, Argentina, 1989.

This bi-monthly periodical has interesting information on the status of popular organizations in Argentina and proposals for education and promotion work.
You can subscribe from: CEDEPO, Carlos Calvo 642, 1102 Buenos Aires, Argentina.

"BETTER CARE OF MALARIA." Voluntary Health Association of India, New Delhi, India, 1989.

Educational pamphlet with information aimed at health workers and promoters. It emphasizes information and forms of prevention. In the same collection of pamphlets there are issues devoted to leprosy and sexually transmitted diseases. Published in English.
It can be requested from: VHAI, 40, Institutional Area, New Delhi, 110016, India.

"PESTS AND PESTICIDES. FACTS AND ALTERNATIVES." Voluntary Health Association of India, New Delhi, India, 1989.

Educational material with general information on pesticides, organic agriculture alternatives and advice for health initiatives. Published in English.
It can be requested from: VHAI, 40, Institutional Area, New Delhi, 110016, India.

"CHILD TO CHILD. AN APPROACH TO LEARNING." Aarons, Audrey; Hawes, Hugh and Juliet Gayton (Editors). Voluntary Health Association of India, New Delhi, India, 1988.

This book presents a strategy for working with school children and the community in child to child programs. This program was conceived by the Child Health Institute (London) in 1979, and contains a proposal for health education that can be used by the children themselves. At present, the program is carried out in different parts of the world. The book is aimed at schoolteachers and contains information and methodological recommendations to begin the work at the school and community level.
It can be requested from: VHAI, 40, Institutional Area, New Delhi, 110016, India.

"COMMUNITY INTERVENTION STRATEGIES." B o J.A. Haglund; Per Tillgren (Editors), 1988, Sweden.

The book gives an account of the conference held in April, 1986 on the role of community analysis and focus groups in intervention studies in the community, with the participation of scientists from the U.S., Brazil, Finland and Sweden. The documents presented give a frame of reference on the subject of self-diagnosis of the community and of appropriate technology to carry out effective intervention programs. Published in English.
It can be requested at: Karolinska Institute, Department of Social Medicine, Kronan Health Centre, Sundbyberg, Sweden.

"ERITREA: PRIMARY HEALTH CARE IN DROUGHT AND WAR SITUATION." Eritrean Public Health Programme, Eritrea, 1988.

Report of the Second International Conference on Health in Eritrea held in April 1988 in London. It collects the presentations and papers presented by the participants on the status of health services in Eritrea, laboratory programs, sanitation, incorporation systems, vaccination and technology. Published in English.
You can request it from: ERA - Public Health Programme, BCM Box 865, London WC1 V6XX, United Kingdom.

"HEALTH FOR MILLIONS." Voluntary Health Association of India. February 1989, Vol. XV #1 and #2, New Delhi, India.

Issue number one presents different experiences, among which are local culture and its thought processes. Readers are invited to share their experiences in the fields of agriculture, health, construction, education, etc. The second issue is devoted to sexually transmitted diseases and AIDS.
For more information: Voluntary Heath Association of India, 40, Institutional Area, South of 11T, New Delhi 110016, India.

Health - Education

"MANUAL DE CAPACITACION, SUPERVISION Y EDUCACION CONTINUA PARA EL TRABAJADOR DE ATENCION PRIMARIA EN SALUD". Elsa Villafradez L., Programa de Atencion Primaria de Salud, Bogota, Colombia, 1989.

This is a book aimed at health teams interested in training and educating people for local and community initiatives. It is based on experiences carried out in this field over a six year period. It gives general and theoretical concepts on the training of health promoters, supervision methodologies and continuing education.
It can be requested from: Grupo de Atencion Primaria, Centro de Documentacion, Calle 14 #8-27, Piso 3o., A.A. 056896, Bogota, Colombia.

"EDUCACION EN SALUD DESDE LA ATENCION CURATIVA". CESAP, Cuaderno No. 5, Quito, Ecuador, 1989.

This document contains the presentation given at the Latin American Course on Health and Popular Education (Curso Latinoamericano de salud y Educacion Popular), organized by CEAAL, on the experience of CESAP in curative and educational action.
It can be requested from: CESAP, Casilla 91 B, Quito, Ecuador.

"GUIA PARA LA CAPACITACION EN EDUCACION POPULAR". PIIE, April 1989, Santiago, Chile.

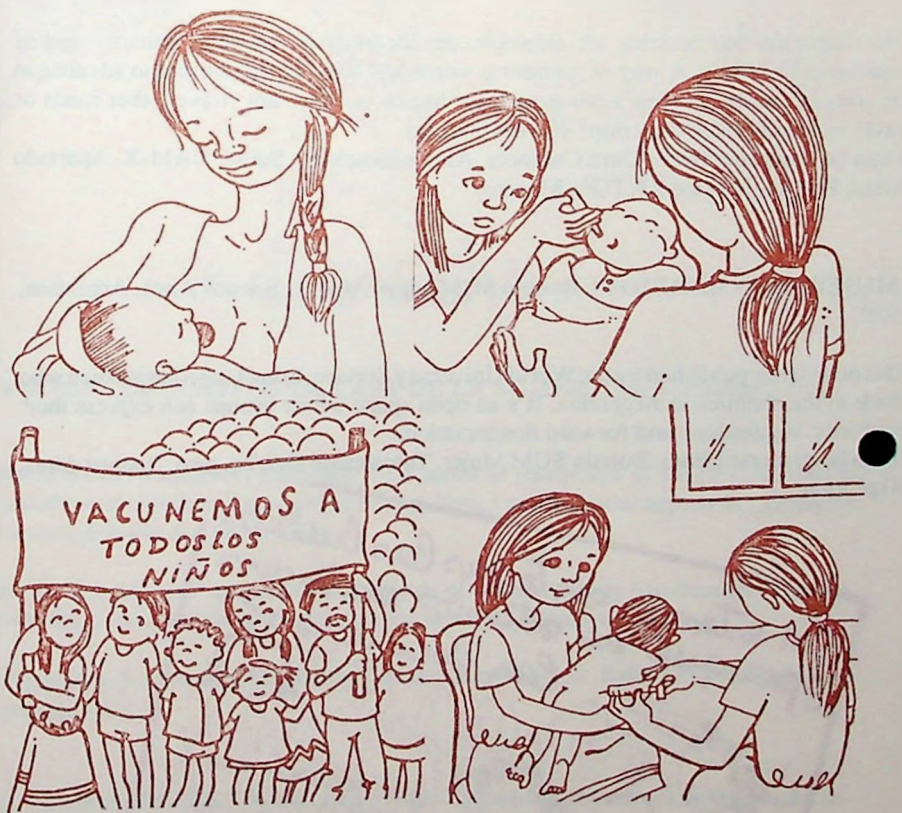
Module 1: An experience applied to the field of health .
This training guide is the result of three workshops on popular education in health during 1988. This first module has two units: popular education and health and the methodology of popular education.
Module 2: Training for the revision of practices: one method.
With an experience similar to the previous module, this one offers a series of considerations and questions on our practices and the challenge of their systematization.
For greater information: PIIE, Brown Sur 150, Santiago, Chile. Telephone: 2231940 - 496644.

MANUAL DE SALUD ESCOLAR. UNA TAREA PARA TODOS". Guzman, M. Paz; Moore, Rosario y Luz Maria Perez. Programa Salud Integral, Pirque, Chile, 1989.

This manual is the result of four years of experience, whose aim has been to improve school children's level of health. It aims to assist teachers in improving children's health. It provides material to carry out health diagnosis and health educational work in the school community.
It can be requested from: Programa de Salud Integral, Parroquia de Pirque, Pirque, Chile.

"PROGRAMA DE CAPACITACION DE SALUD PARA NIÑOS DE EDUCACION PRIMARIA EN LIMA". EDAPROSPO, Lima, Peru, 1988.

Strategies for a program for teaching primary school children about health are set out in this series of pamphlets. The program's objective is incorporating children as active members in health care, elevating the levels of participation in health programs. It [redacted] publication that is directed towards both children and teachers.
It can be requested from: EDAPROSPO, Jr. Octavio Bernal 598, Jesus Maria, Lima, Peru.



"SALUD INFANTIL". Alternativa, Cartilla No. 1, Lima, Peru, 1989.

Through the series "Educacion para la Salud," the Alternativa center offers pamphlets to educate schoolteachers and heads of families, principally aimed at work in the school.
It can be requested from: Alternativa, Jr. Emeterio Perez 348, Urb. Ingenieria, San Martin de Porres, Lima, Peru.

VSLETTER." Women's Health and Reproductive Rights Information Center, No. 3.

s issue warns against medication abuse and the failure to control pharmaceutical npanies - companies which have the highest profitability at the world level while oducing medications which induce dependency and, in some cases, harm the popu- lion. It denounces the present tendency which is not towards prevention but rather to ependence on some medications.
Different articles appear on cases of specific medications and news on health in general, lactation, fertility, contraception, and abortion.
For more information write: 52 Featherstone St. London, EC 18 RT, United Kingdom.

"MUJERES Y MEDICINA: COMO SON LAS COSAS". Dora Cardacci (Compiladora). Universidad Autonoma Metropolitana, Xochimilco, Mexico, 1989.

The magazine has articles on abortion, psychoanalysis, feminist clinics, women workers in hospitals. A way of gathering words and lives of women and to advance in the struggle of the women's movement for health, so as to not "travel other roads or travel in the opposite direction" (G. Berlinguer).
It can be requested from: Dora Cardacci, Area educacion y Salud, UAM-X, Apartado Postal 23-181, Mexico 23, D.F., Mexico.

"MUJERES EN BARRIOS". Boletin SUM Mujer. Año 1, Buenos Aires, Argentina, 1989.

This newsletter published by the World University Service, brings together women who work in the shanties in Argentina. It's an open space where groups can express their concerns, suggestions and forward denunciations.
It can be requested from: Boletin SUM Mujer, Talcahuano 889, 2o. piso, Buenos Aires, Argentina.

MATERIAL EDUCATIVO LA CASA DE LA MUJER. 1989, Chimbote, Peru.

"Abuso sexual a menores de edad". is a series of pamphlets of the problem of the sexual abuse of children. It gives legal information, a psychosocial approach, guidelines for action, defense and prevention.

"La voz de la mujer," presents the problems of women's daily life through cartoons; it gives legal information and resources for women's organizations.

Both pamphlets can be requested from: La Casa de la Mujer, Jr. Balta 275, Apartado 216, Chimbote, Peru.

"MUJER/FEMPRESS." No. 92, Junio 1989. Unidad de Comunicacion Alternativa de la Mujer.

This Latin American newsletter aims at supporting the work of those who are striv to improve the condition of women and to raise their consciousness, within a framew of social justice and political democracy. There are articles and news from al countries in the region. Published in Spanish.
For more information write: Mujer/Fempress, Casilla 16-637, Santiago 9, Chil

"THE MOON ALSO HAS HER OWN LIGHT. THE STRUGGLE TO BUILD A WOMEN'S CONSCIOUSNESS AMONG NICARAGUAN FARM WORKERS." The Women's Program of the ICEA and the Nicaraguan Association of Rural Workers. Toronto, Canada, 1989.

This book presents the struggle of Nicaraguan peasant women to strengthen consciousness and the women's movement. It was produced by the International Women's Program of ICAE and the Association of Peasant Workers (ATC) of Nicaragua. The book presents the capacity of Nicaraguan women to simultaneously struggle against gender oppression, develop class consciousness and construct the women's movement. Published in English.
It can be obtained from: Women's Program of ICEA, 394 Euclid Ave., Suite 308, Toronto, Ontario, Canada M6G 2S9.

"LA MUJER Y LA SALUD COTIDIANA". RESULTADOS DEL 1ER. ENCUENTRO DEPARTAMENTAL "MUJERES Y SALUD". Arequipa 22, 23, 24, abril 1988. Editado por Flora Tristan, Centro de la Mujer Peruana, Lima, Peru.

This publication presents the results of the work carried out at the First Departmental Women and Health Meeting in Arequipa Peru in 1988 in two workshops - diagnosis of women's health and women and traditional medicine. There are also interviews with traditional midwives and the results of a panel on community medicine.
It can be requested from: Flora Tristan, Centro de la Mujer Peruana, Parque Hernan Velarde 42, Lima 1, Peru.

DA MAGA, ESPACIO DE REFLECCION FEMINISTA. Año. 2, Nos. 1 y 2, Guayaquil, Ecuador.

This Ecuatorian magazine presents different articles that underscore women's problems from different angles. Among them are: women and power in an article "To Politicize the Private;' women and work; women and divorce; women and maternity; "What is the present feminist movement doing?"; "Shinning Solitude." A report on the III Continental Meeting of women is presented, and there is a large annex on violence.
For more information write: Cecilia Torres, Bogota 400, Casilla Postal 10201, Guayaquil, Ecuador.

LETTER Nº 11 OF THE HEALTH AND POPULAR EDUCATION NETWORK

October 1989

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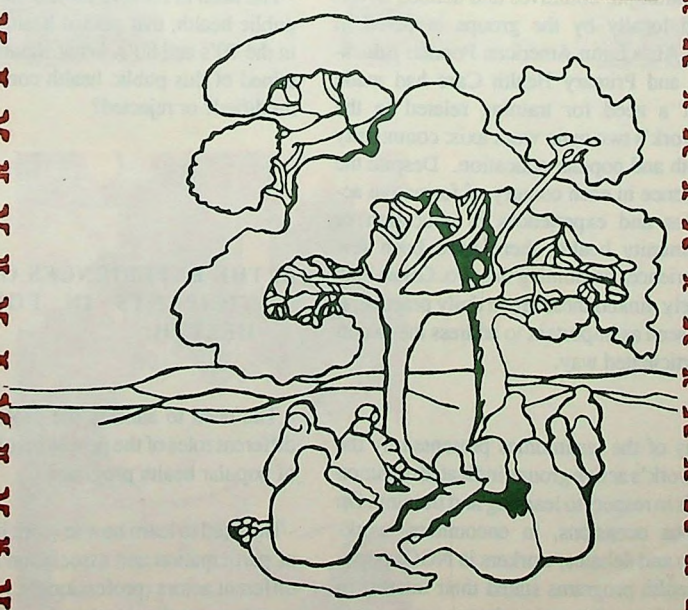


Publicación con apoyo de ACDI (Canadá)

First Latin American Course/Workshop on Health and Popular Education

In November last year the First Latin American Course/Workshop on Health and Popular Education was held, organized by CEAAL's Popular Education and Primary Health Care Network. Twenty five educators and health workers spent a month together at El Canelo de Nos (San Bernardo, Chile), analyzing and sharing their experiences on community health. They came from Per, Bolivia, Ecuador, Venezuela, Brasil, Panam , Mxico, Dominican Republic, Argentina, Uruguay and Chile.

The multiple initiatives and actions developed locally by the groups involved in CEAAL's Latin American Popular Education and Primary Health Care had made clear a need for training related to the network's two main work axis: community health and popular education. Despite the existence in each country of formative activities and experiences in education or community health, there have been few experiences combining the two. Given how closely linked these are in daily practice, it was seen as important to address the two in an articulated way.

Many of the testimonies presented by the Network's active groups indicated common needs in respect to learning and training. On various occasions, in encounters, workshops and debates, workers in NGOs popular health programs stated their interest in discussing and in going deeper into:

A. HEALTH CONCEPTS AND POLICIES:

- The need to arrive at a common concept of "health"; the lack of concept clearness is admitted and the following question arises: with which kind of health concepts are we working (community, popular, traditional)?

- The need to put this theoretical debate in the context of the present stage of Latin America's history.

- The need to retrieve the classic debate on public health, that guided health programs in the 70's and 80's. What should be maintained of this public health concept? what modified? or rejected?

B. THE EXPERIENCES OF PARTICIPANTS IN POPULAR HEALTH:

- The need to address the problem of the different roles of the people involved in part of popular health programs.

- The need to learn how to work in a climate of participation and association among the different actors (professionals, institutions, popular organizations) and programs.

C. THE CONTEXT WITHIN WHICH THESE PROGRAMS EVOLVE:

- The need to understand the health reality of popular sectors.

- The need to analyze the organizational problems popular sectors face.

- The need to incorporate the debate on the concepts of local development and interconnection of popular organizations and State institutions in order to develop a more global vision of specific projects.

- The need to understand the connection between local action and global context.

D. HEALTH AND POPULAR EDUCATION PRACTICES:

- The need to enhance technical contents of health programs at the same time as promoting response, which raise the voice of social and political organization and transformation.

- The need to converge therapeutic and educational actions; how can these two approaches nourish one another?

- The need to develop appropriate tools, to combine health and education in health programs.

This set of questions constituted the foundations for constructing the curriculum. Two central objectives articulated the activities.

The first attempted to broaden the vision and analysis of participants experiences and concerns, their challenges and proposals. The second attempted to deepen the popular health debate in Latin America, from its concept bases to its program strategies.

Five steps formed the major learning units: knowledge and interchange among participants; the debate on health concepts and policies in the region; analysis of the contexts and actors in health programs; the exchange of education and health methodologies at the grassroot level, and finally, the synthesis and the concrete proposals for future work.

These learning units were achieved on the basis of a broad range of activities:

- theoretical and concept expositions
- exchange of experiences
- visits with popular organizations
- conversation, debates and panels on polemic subjects and current national issues
- readings
- corporal expression and cultural promotion

These and other activities responded to a methodological design that compiled and gave priority to:

- current theoretical, political and technical debates;
- participants' experiences key successes and current challenges;
- the creation of affective and deep communication bonds among the participants, the coordinators and the popular groups concerned;
- the elaboration of synthesis and proposals to feed back to ongoing practices.

Throughout the experience much valuable material was collected, which we will transmit through future Health Letters. The minutes containing the most significant dialogues and proposals will be published in 1989. The presentation on popular education (Jorge Osorio) and the conclusions of the workshop resulting from the analysis of the primary health case strategy are presented below.

Popular Education: The Polemic in Latin America

Jorge Osorio

The main purpose of this presentation is to put forward a series of reflections on the current debate regarding popular education in Latin America.

In recent years, we in Latin America have come to understand popular education as an experience of rupture and estrangement from traditional adults education, especially that which was implemented in the 50's and the 60's. In this way, we are expressing a categorical denial to an education addressed to popular groups as compensatory answer to maintain important peoples's sectors outside of the scholastic education. Popular education asserts the possibility of an education for the people, and also the need to transform the entire educational project starting from the view point of the popular sectors.

Thus, in the 80's, popular education clearly abandoned its position of being only an emergent model of education to become a political-educational practice, whose starting point is the popular movement and its organizations. We will include six remarks that characterize Latin America's popular practice in the 80's.

First, popular education defines itself as a social practice that, working within the scope of knowledge, has a political intention and objective. Popular education is an educational space and a tool destined to define como una práctica social que, tra-

promote the capacity of popular groups to enable them to become the subject of their own educational process and of their own historical and political destiny. Consequently, education is an instrument at the service of such groups' liberation.

Secondly, popular education is a process which aims to contribute to social transformation, with a view to constructe a new society which will satisfy the interests and ambitions of the popular sectors.

Third, the adjective "popular" in "popular education" refers to objectives that are oriented to the construction of a political- social project in accordance with popular interests. As well "popular" refers to popular movements as"subjects" taking the educational action. "Popular" then relates to both the political objective and also to the dimension of subject as acquired by the popular sectors as such. However, it should be noted that there is a controversy about how best to link popular education experiences with the organic experiences of the popular movement.

There are two significant positions: the first affirms that this relation should be organic and that the popular education centers should have a more subordinated role, as elements of support and advisory of popular las experiencias orgánicas del movimiento popular?

movements. A second position advocates a more autonomous role for popular education centers, and sets forth a political and cultural bond nature which also implies a strong burden of autonomy for the popular movements organizations.

Fourthly, popular education relates to a democratic educational model that seeks a rupture with verticalism, authoritarianism and, specially, with what Paulo Freire describe as "banking practices" in the teaching and learning.relationship.

The fifth feature of popular education is that it is conceived as a process, as an activity which evolves during the life of popular organizations and that is nourished by their experiences. It is implemented based on participants requirements, practical knowledge and personal experiences and, therefore, is not restricted to events, workshops or meetings. In this way, although popular education is defined as an essentially political experience, it is not limited only to a narrow version of politics. It is education that attempts to feed, to provoke the emergence and to create awareness about the integral dimension of human experience. It aims to connect the particular processes of individuality with social processes, articulating daily life with political realities, the-

ory with practice, the personal with the social, cognition with intuition, etc.

To think of popular education in terms of production, elaboration or of taking possession of knowledge is complex. Collective production and appropriation of knowledge are things that go beyond the mechanical exercise, the group work, a blackboard, a plenary and a synthesis made by the promotor. We are setting forth to ourselves issues of the learning and of production of knowledge that the traditional teacher solves in a quite routinary and practical way because at school the problem lies in formalizing a knowledge, in packing it and distributing it.

This mechanics of the traditional teacher is not the same mechanics of the popular educator; the popular educator does not satisfy himself by constructing its package from outside and then dropping it into the participants arena so that they can digest it, in the way they deem is the best.

Finally, an ending note to stress that popular education is a practice requiring systematic and scientific rigor. Popular education does not imply an inorganic, disorderly, or solely intuitive process. By necessity, popular education should mean a systematic process, whereby certain key points can be scientificly assumed, for instance the evaluation, systematization, planning and, above all, the learning process itself. This is a polemic currently being carried out in Latin America. This debate states as a central problem the divorce between the speech and the practice of popular educators.

Rosa Mara Torres (Ecuatorian popular educator) started this controversy but now we are all discussing it. She has obliged us to turn our practices into problematics, to be more systematic and to give scientific rigor to the popular education debate. She states that popular educators are too normative in their speech and that this ends up asfixiating the reality of our practice. When we say popular education is, we should say popular education should be, which calls to our attention the need to have a critical conscience vis-a-vis our practices.

Another criticism concerns the relationship between turning into problems the specific processes lived by people and that which we ourselves do in the course of our educational activities. We say that popular education promotes the critical conscience but, unfortunately, we are gradually realizing that we do not always count on instruments which permit us to generate conditions and methodologies destined to produce critical thinking.

This debate furthers some questions on the political intentionality of popular education. It is said that popular education is linked to popular movements, that its contents are articulated in terms of those practices, however, it is pointed out that we lack a teaching speech, that we are not yet capable of taking up the experiences being generated in Latin America in order to formalize a true popular teaching. How do the people learn? How do the people teach and learn? How is it possible to concretely lead popular sectors towards that general politic intentionality?

When reviewing the question of the intentionality of popular education, we question ourselves about what sense popular education practices have?, towards which horizon do they tend? It is important here to express four basic criteria that permit us to clarify the contribution of this educational practice:

- To reject the methodological malformation present in many of our popular education projects that basically reduces popular education to a question of methodologies.

Without denying the fundamental character that the handling of participative techniques and methodologies has in popular education, it should be indicated that the central element of the popular education definition is its political intentionality. Popular education is not defined through its teaching techniques, the definition element is not only its capacity for being more participative than other educational schools, it is its political intentionality.

- Recognize that today popular education is obliged to take a qualitative leap forward, that we have 25 years of important experiences in Latin America as a whole and that we are capable of showing that popular education is no longer an emergent model, but rather has a consolidated experience. It is institutionally recognized for its innovation, for its capacity for developing educational processes with marginal sectors. This legitimacy of the movement should be combined with a theoretical qualitative leap forward, that should give more consistency to its educational and political proposal.

Popular education of today should acquire quality not only in its methodological proposal but also in its political profile.

Where is the central contribution of popular education in Latin America of today? We are working in CEAAL so that popular education today should essentially contribute to the democratization processes, not only within the State scope, but also in civil society.

- To understand the popular educator not as a common activist, but as an organic intellectual capable of systematizing and investigating the processes of learning and knowledge being developed within the popular movements; we think that there lies the main role, the major task of popular educators. The popular educator becomes then not only a promotor, an expert in social promotion techniques, but someone who has to convert him or herself into an intellectual, capable of generate conditions for organizing and systematizing learning proc-

esses. This is a rather important point as it visualizes the educator as a kind of intellectual capable of systematizing, investigating and organizing learning processes.

It is urgent at present to make a profile of the role of the technician, of the professional expert in popular education processes.

We verified the need to demystify the technician. It is a matter of defining the insertion of the professional in the popular sectors. The technical cooperation process is stated as a process of mutual interaction in which everybody participates: those facing the problems, the one that knows the technique, the technicians, and those who in one or another way and with different perceptions participate in the same process.

We understand professionals as facilitators of participation, encouraging reflection and turning conflicts and general processes into problems that are developed in the popular sectors; and not only facilitating participation, but expanding as well the capacities inherent to settlers, thus contributing the required methods and techniques so that they can, by themselves, diagnose needs and problems and prepare the strategies for facing them. We, the technicians, should understand cooperation processes as processes destined to contribute technicians or techniques to popular demands. We are at present faced with the need of forming new technicians, by no means a simple matter because technical formation takes place in a space of ideological and cultural conflict.

- Finally, to determine that political projection is related to the contribution of popular education to social movements. We know that popular education has contributed to the emergence of the social movements and works today with a great strength. We should state a question, how does popular education continue contributing to these processes? How does popular education continue furthering the consolidation of these movements that are not only beginning to emerge, but to consolidate themselves particularly in the popular areas of our countries?

Alma Ata: Plenary

The discussion on the Alma Ata document carried out among the course's participants led to two main conclusions.

1. The recognition of Alma Ata as a great step forward in respect to prior health statements and policies. In particular, mention should be made of:

- the affirmation that health is a basic right;
- the admission of the considerable unequality that exists and its appraisal as unacceptable socially, politically and economically;
- the relation between the people's health level and their economic and social development levels;
- the recognition that a medical approach is insufficient for solving health problems and that there is a need for the intervention of other social and economic forces (political, multi-sectoral);
- promotion of active linking between health worker and community, underlining the importance of social participation.

The Declaration of Alma Ata reflects the agreement -at least in writing- of a large number of nations on the basic tenets of a health strategy, leaving to each government and people the responsability for establishing standards and putting these concepts into policy and practice.

We, the people working in community health, consider Alma Ata as a useful reference for promoting a vision of health as a right.

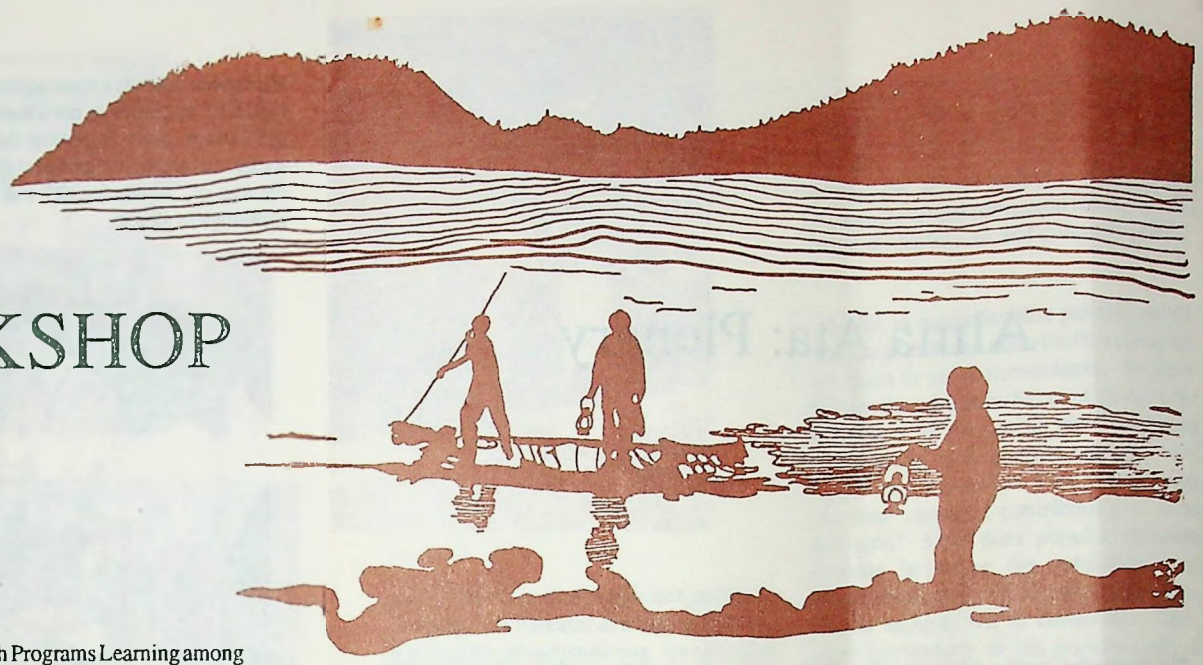
2. Ten years after this declaration, we can verify the gap between general policy and the realities field of, and more generally, of people's life quality in our countries.

Primary health care is viewed more as a third or fourth category for attention than as an integrate part of the national health system for which -it is said- it constitutes the central function and the nucleus, including for social and economic development of the community.

If progress towards a more equitable distribution of resources in our countries is not achieved in order to reduce the dramatic social, economic and political differences, the aim of "health for all" will become a meaningless slogan.

Alma Ata is aware that it needs to overcome serious obstacles to become a reality. But in our opinion, the mechanisms proposed for confronting these obstacles are to a large extent. While there is recognition that primary health care can only emerge from a spirit of justice and social equity, the magnitude of the opposition coming from the dominant sectors is not sufficiently appraised.

From this perspective our doubts about the Alma Ata contents are valid. Have they constituted a strategy for change in the sense of our peoples liberation, the dignifity of human beings and improvement in the quality of life? Or has this strategy become an instrument used by the dominant sectors to promote their interests?



ASIAN WORKSHOP

The Asian Workshop on "Non Formal Education and Health Programs Learning among Adults" took place in Penang, Malaysia in October 1988. It was organized by ICAE (International Council for Adult Education), ACHAN (Asian Community Health Action Network) and ASPBAE (Asia and South Pacific Bureau of Adults Education). The objective was to exchange experiences and discuss adult education's contribution to the strengthening of health actions undertaken by popular groups.

Non governmental organizations in Asia had come to recognize the existence of innovative efforts in this field and felt the moment had come to exchange and elaborate common strategies. There was also concern about the lack of forum at the Asian regional level involving NGOs, health workers and adult educators. Thus the workshop was organized in an attempt to get together activists, philosophers and academics to:

- *initiate a more fruitful exchange of experiences;*
- *discuss problem areas and successes;*
- *identify key and relevant themes;*
- *create mechanisms for better regional coordination.*

Twenty five persons participated in the workshop, representing India, Bangladesh, Sri Lanka, Nepal, Malaysia, Indonesia, Korea, the Philippines and Australia.

The program was prepared jointly with the participants and the following priorities identified:

- *introduction to the different contexts of each of countries represented;*
- *presentation and discussion of the participants' experiences;*
- *discussion of key concepts: non formal education, community health work and relationship between the two;*
- *proposal of perspectives for future work at the regional level.*

The reports on each country's situation allowed participants to understand the context within which the community health programs were developing. The existence of social classes, ethnic division and great opression and exploitation of women was shressed by all.

The health situation is characterized by programs based on "colonialist" needs and priorities rather than on the people's needs. Traditional health systems continue to be practiced by the people, but the dominion of the western model prevails. High morbi-mortality rates are directly related to the life conditions of the poor. Medicines and drug policies are kept under multinational control except in Bangladesh. Given this context, Health for All by the year 2000 is totally unrealistic. A mention should be made of the role played by volunteers' and non governmental movements, especially in India; also the development concept, as a circular perspective involving the different aspects of the Asian societies life, should be underlined.

Concept debates on community-based health and adult education added to the experiences presented.

Five elements were agreed on as defining community-based health actions:

1. Meet the people's needs.
2. Attend to health in a comprehensive and integral manner, promoting it within a development perspective.
3. Promote people's self-organization around health issues.
4. Focus, promote, prevent and cure, in harmony with nature.
5. Demystify medical care and use adequate and more accesible technologies and traditional medicine.

The following points emerged during the discussion of strategies and methodologies to achieve such community health concept:

- *work with the peoples's volunteers within a perspective of promoting the people's organizations;*
- *promote educational and research actions, and make efforts to document these experiences;*
- *demand from the State the people's rights and promote community health insurances.*

The discussion of non formal education made use of the concepts and contributions of Latin America's popular education. For example,

- the need to recognize "our own educational malformations and to re-learn in order to work with the people" ;
- education's contribution to the processes of social transformation;
-the political dimension of popular education.

Related to this it is clear that there is a need to analyse more deeply in order to find a concept suitable for the region's practices. The notion of "adult education" as such does not reflect what is done, but also "popular education" is apparently more linked to the political dimension as it is understood in Latin America than the nature of the experiences described.

The workshop allowed a fruitful interchange based on the valuable experiences of participants and the different organizations' trajectories. We will share some of them through the Health Letter. We start this journey with the work carried out by Dr. Hari John in India.

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Health through Education and Empowerment

Dr. Hari M. John

Background and Evolution of the Organisation

The Deenabandu Health Centre started in 1969, with the "simple and straightforward" aim of treating the sick in the villages, when my husband and I started work there, fresh from medical school. A small village 120 km west of the city, Deenabandu was started by my father-in-law, a Ghandian pastor, and by the time we began work there, the village was already well-accustomed to the tradition of free service and charity that had been practised by the pastor and his wife, who was a medical doctor. We began our practice, charging for services, and from that beginning evolved the health program as its stands today -without a doctor, based on education and empowerment of women in the communities and the use of indigenous and available resources and strongly geared towards community self-sufficiency in health care.

The process began when we found that it was only the rich and educated who used our services as doctors. In an attempt to make our services more accesible to the rest of the villages, we began to operate a mobile clinic, taking drugs to the villages once a week. However, we continued to observe the same phenomenon of being accesible only to the rich. Another disturbing trend we noticed was that the patients we treated for kwashiorkor or malnutrition, would invariably return to us with the same problem six weeks later. All this provoked us to reflect seriously our methods: thus emerged the Community Health Program, wherein we trained Village Health Workers (identified by the local power structure -the Panchayat), to identify and treat simply illnesses in the village with western drugs which they carried with them. In spite of the fact that these women were from the villages, this strategy still did not make a dent in the problem, as it was only the rich who could afford to pay for the medicines they dispensed.

This led us to another stage of serious re-examination and questioning of our relevance as healers in the community. Having failed thus far, we realised that we needed to learn from the people themselves in order to be relevant to them. We began to ask them what they did when they fell ill and discovered that they had a resource of indigenous methods and medicines with which they helped themselves before seeking medical help. Fascinated by this first glimpse, we began to systematically learn more about the medicines and methods they used for all the simple illnesses. We discovered that many of the herbs they used posessed an active ingredient that was common to western medicine. For instance, they commonly treat scabies with neem leaves, which contain sulphur. Sulphur ointment is what western doctors prescribe for scabies!
Thus began the exciting process of identifying herbs and treatment methods with the

help of community, and then researching the ingredients by looking them up in the "Wealth of India", a publication that comprehensively list plants, minerals and other raw materials of India. We also studied whether and how these herbs were used in other systems of medicine. We also did studies along with medicine students working on similar subjects, to compare the efficacy of western medicines against indigenous remedies for specific aliments such as, for example, hook worm, scabies, eye infection, etc. We also studied the efficacy of the medicines from responses of patients treated by the VHWs. What we found was that results were often dramatic for cases in which western medicine could offer no specific cure. These findings we then communicated back to the community who had taugh us, re-inforcing the knowledge they posessed with scientific coroboration, and helping to strengthen their confidence in their own resources.

The Training Program

Women formed the centre and focus of the program, both because we strongly believed that their role as catalysts and agents of behavorial change was crucial, and also because we wanted to build up their assertiveness and self-confidence after centuries of male domination, oppression and voicelessness.

Our original approach, when we began training VHWs to treat simple aliments in the villages with western medicine, was a top-down one, the handing down of our knowledge to those who did not posess it. The hierarchy in the training reflected that of the medical system, it served, where the doctor remained at the pinnacle of the relationship, and the direction of communication was one-way. A pre-formed curriculum that covered all that we thought they should learn guided the course.

When the VHWs trained in this way they failed to really reach the people in the villages. However, the second phase of training was the turning-point in our approach. By beginning to learn from the VHWs, a two-way communication was opened up from which there could be no turning back. Our courses became more and more "participatory". Although we had no notion then of the term and its now widely-celebrated concepts, these concepts had forced their way into our scheme of operation in a very natural and inevitable process.

Our original training programs were in the natural of "crash courses" -a week or two of continuous sessions after which the women would be deployed in the field. As our ideas changed towards more learned-based training, we changed this to one-day-a-week, on-the-job sessions, whereby the actual situations, problems and experiences encountered by the VHWs in the field in the course of their work formed the basis of the training. Thus the session would begin by finding out what the most common concern of the women was, and the training would focus on that. The VHWs would first share all that they knew and believed about the disease, its causes, manifestations, different types of treatment, etc., and these would then be discussed, with our scientific or theoretical knowledge helping to strengthen or sometimes rationalise, but often times being modified by their rich store of experiential knowledge. The women were then able to put into practice almost simultaneously what they had discussed. This approach builds up commitment to the trainingand faith in themselves and in their capacity to learn and change.

Health as Socio-Economic Entity

As a result of our own evolving perception of health as a socio-economic and political phenomenon, the training programs began to provoke discussions among the VHWs about the root causes of ill-health in the communities, and, from their own perceptions, tracing it to poverty, deprivation and social injustice. With the help of inputs from a macro-perspective that we were able to give, the health workers understanding of health thus began to be modified. They began to feel the necessity of tackling the economic, environmental and social handicaps in the communities in order to bring about effective changes in health behaviour and status.

Consequently, the program began to take on added aspects. Organising women into women's associations or "Sanghams", starting credit cooperatives, and initiation of social forestry and goat-rearing schems became part of the movement towards self-reliant health care. The credit-ccoperatives operated through the Sanghams: each member contributed a few rupees to create a small community fund, from which members could then borrow when they needed, thus reducing their dependance on the exploitative money-lender or the rich landlord. They paid back with an interest of 10%, creating a small surplus which belonged to the community and could be used for common purposes. Some villages have used this money to build drainage pipes and to clear their roads of garbage and slush. More importantly, running of the credit-cooperative helps to build up women skills in collective management of funds and collective decision-making. It also helps women, who were never credit-worthy with banks before, to get loans on the strength of their Sangham membership.

The Sangham is also intended to be a forum where women come together to discuss their problems and to build a unified force for action to tackle local oppressors. In one instance, women jointly demonstrated in front of the local authority's office to secure a water-tap for their village.

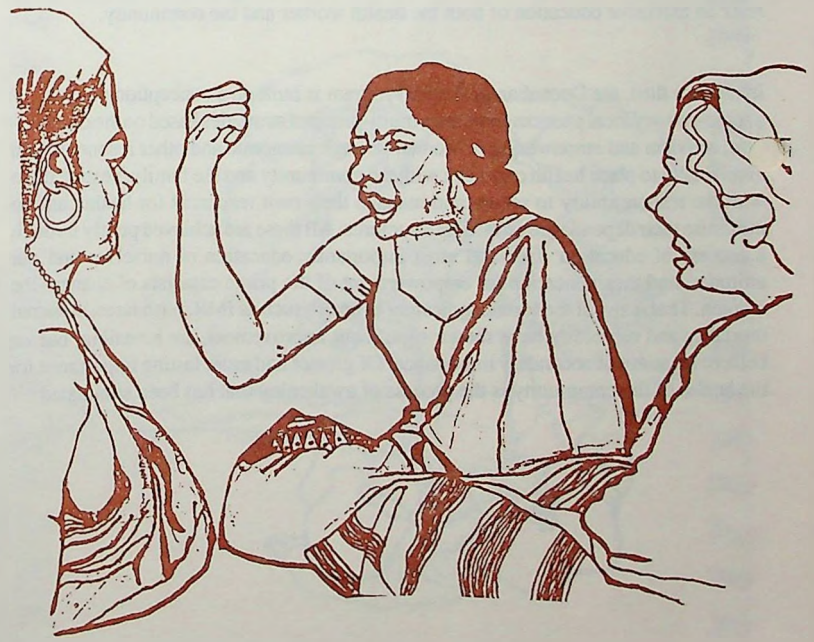
As part of the attempt to restore the degraded ecology of the villages, health workers also try to promote cultivate of Subabul (lucaena) trees in the village for fuel, fodder and fertiliser. Tied to this is a scheme that encourages people to use this fodder to supplement their nutrition and improve their economic status.

Towards Empowerment

The immediate fruits of the training was VHWs increased confidence in themselves and in their knowledge. They began to recognise their own contribution to the process within the sessions itself, while their ability to cure people in their communities without having had any formal education (several of the VHWs cannot even spell their own names) re-inforced their faith in their indigenous resources and practices. This was definitely a step towards self-sufficiency in health care. The communities no longer needed to depend on the vagaries of the government's Primary Health Care centres or on charity-dispensing doctors coming to the villages.

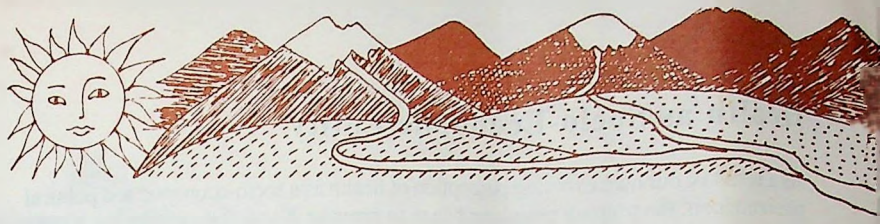
More interestingly, the women, all from the landless outcaste "harijan" groups and considered untouchable in rural societies, began to find themselves sought out even by higher caste groups for their cures. Their traditional skills at mid-wifery, upgraded by the training, began to prove a tool that could dissolve cast-barriers or be used to bargain for better social positions in the villages. Their own dependance on the higher castes for water, right-of-way, employment and other things could thus be off-set against the high caste people's dependance on them. This produced a "reciprocal dependance", a step forward in the road to cast liberation.

This increased confidence and assertiveness of the health workers was communicated to other women in the Sangham and, combined with the new awareness of the forces of oppression, has created an atmosphere of activism that is one of the prime requisites of a community based health care movement. Women that were voiceless have acquired the strength to stand up to their male oppressors in the community as well as to demand their rights from the government. And a certain level of economic self-sufficiency through the credit-cooperatives has also allowed these women to bargain with their menfolk and with other caste people who often seek to borrow money from the Sangham through its members.



A process has been initiated whereby the health workers are made accountable to the Sanghams. In many instances they are identified, supervised and monitored by the Sanghams. A process of getting the Sanghams to financially support them is also under way. This accountability of the health worker to the community is one of the essential ingredients of community self-reliance in health. It is a long and difficult process that rests on extensive education of both the health worker and the community.

In essence then, the Deenabandu Health Program is built on a conception of health as a socio-eco-political phenomenon, uses multi-pronged strategies based on the organisation, activism and empowering of women through economic and other resources, and aims finally to place health care back with the community and the family, vesting them with the responsability to secure and manage their own resources for health, and to minimise their dependance on outside structures. All these are achieved purely through a process of education -first and most importantly education of ourselves and our attitudes, and then education for empowerment of the prime catalysts of change -the women. That many of the formal indicators of health such as IMR, birth rates, maternal mortality and morbidity have shown significant improvement, are revealing, but we believe these are of secondary importance. Of greater and more lasting importance for the health of the community is the process of awakening that has been stimulated.



NEWS

FIRST LATIN AMERICAN SEMINAR ON THEORY AND PRACTICE IN THE APPLICATION OF TRADITIONAL MEDICINE TO FORMAL HEALTH SYSTEMS

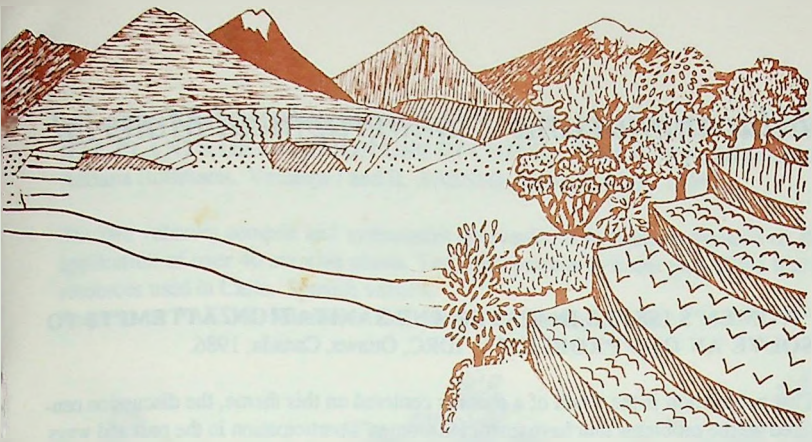
Thé Centro de Medicina Andina commemorated its seventh anniversary by organizing the First Latin American Seminar on the Theory and Practice in the Application of Traditional Medicine to Formal Health Systems, The Seminar was held on November 16- 18, 1988, in Cuzco, Perú; with the collaboration of the Universidad Federal de Paraiba, Brasil.
Requests for further information to: Centro de Medicina Andina, Apartado 711, Cuzco, Perú.

WORKSHOP ON HEALTH AND POPULAR EDUCATION IN BOLIVIA

The Latin American Network on Popular Education and Primary Health Care and AIPE and UNICRUZ in Bolivia jointly organized a workshop on training and interchange in the cities of La Paz and Santa Cruz, which took place in August, 1988.

POPULAR EDUCATION FOR A LATIN AMERICAN DEMOCRACY

The Latin American Council for Adult Education has launched a strategic three-year program to mobilize popular education groups and networks to promote Popular Education for a Latin American Democracy.
Further information: Diego Palma, Secretaría General de CEAAL, Casilla 6257, Santiago 22, Chile.



1990: INTERNATIONAL LITERACY YEAR

A campaign has been initiated to involve NGO's and base organizations in plans for International Literacy Year, 1990.
Contact: ICAE, 720 Bathurst Street, Suite 500, Toronto, Ontario, Canada M55 2R4.

WORKSHOP FOR HEALTH PROFESSIONALS

The PIIE, Programa Interdisciplinario de Investigaciones en Educación, has organized a Worshop on Popular Education for Health Professionals in Chile to take place between April and September, 1989. The course is designed for professionals working in Primary Health Care.
Further information: PIIE, Brown Sur 150, Santiago, Chile. Tel.: 496644 - 2231940.

Educational and Bibliographical Material

"WOMEN'S ISSUES IN WATER AND SANITATION. ATTEMPTS TO SOLVE AN OLD PROBLEM". IDRC, Ottawa, Canada, 1986.

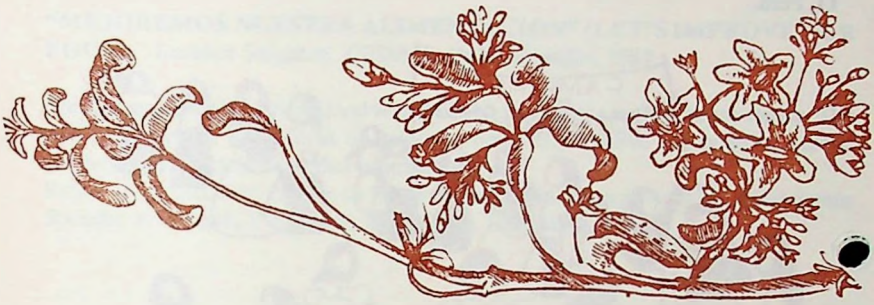
This publication is the result of a seminar centered on this theme, the discussion centered on the problems that have restricted women's participation in the past and ways for improving this in the future. It includes an outline of women's past efforts in this, summaries of ongoing research efforts and preliminary proposals for future investigation subjects. The seminar was attended by representatives from Africa, Latin America, the Middle East and Asia. Spanish, English and French versions are available.
Requests to: IDRC (International Development Research Centre), Apartado Aéreo 53016, Bogotá, Colombia.

"PARTICIPACION Y MOVILIZACION EN SALUD. ALGUNOS APORTES A PARTIR DE EXPERIENCIAS BARRIALES" (HEALTH PARTICIPATION AND MOBILIZATION. SOME CONTRIBUTIONS BASED ON NEIGHBOURHOOD EXPERIENCES). Ana Pérez; Ana Sollazo. Programa de Salud, Grupo Aportes - Emaús, Montevideo, Uruguay.

After analyzing the prevailing concepts in health and the role of technicians, the paper reviews certain experiences about neighbourhood groups, polyclinics and university extension. Reference is made to housing cooperatives and trade unions.
Requests to: Grupo Aportes - Emaús. Javier Barrios Amorin 1168, Montevideo, Uruguay.

"PLANTAS MEDICINALES DE USO COMUN EN CHILE" (MEDICINAL PLANTS OF COMMON USE IN CHILE). Cristina Farga; Jorge Lastra; Adriana Hoffmann. Volumes I and II. PAESMI, Santiago, Chile, 1988.

The two volumes compile and systematize the results of exhaustive research on the application of over 40 curative plants. The work permits to know part of the health resources used in Chile. Spanish version.
Requests to: PAESMI, Miraflores 113, oficina 73, Santiago, Chile.



"SALUD Y DEMOCRACIA. LA EXPERIENCIA DE BOLIVIA (1982-1985)" (HEALTH AND DEMOCRACY. BOLIVIA'S EXPERIENCE, 1982-1985). Javier Torres Goitia, M. D. ILPES/UNICEF, 1st ed., Santiago, Chile, 1987.

With the purpose of analyzing the health policy implemented in Bolivia in 1983, the volume compiles various documents, separately conceived, and the Bolivian experience on primary health care. Mention is made to: Economic Dependency and Health; Defense of Health and Responses to Illness; Primary Health Care and Social Demands, and a Report on the Bolivia's Ministry of Social Welfare and Public Health work team between 1982 and 1985.
Requests to: UNICEF, Isidora Goyenechea 3322, Santiago, Chile.

"PROCESO SALUD - ENFERMEDAD" (THE HEALTH - ILLNESS PROCESS). Asociación de Organizaciones no Gubernamentales en Salud. La Paz, Bolivia, 1988.

Journal published by Bolivia's Asociación Nacional de Organizaciones No Gubernamentales en Salud. Addresed to NGOs working on health and to health teams, this report reflects health problems in Bolivia, from the perspective of the popular movement, social medicine and primary health care.
Requests to: ASONGS, Casilla 356, La Paz, Bolivia.

"SALUD MUJER" (WOMEN - HEALTH), Instituto de Salud Popular, No. 8, July 1988, Lima, Perú.

The articles of this issue of "Salud Popular" link descriptions of pathologies affecting women with the precarious life conditions which women live. The articles present experiences and reflections in connection with the axis women-life conditions-sickness. The attempt is to further debate, inform and promote changes in the health conditions of women.
Requests to: INSAP (Instituto de Salud Popular), Av. Arenales 1080, oficina 301, Lima 11, Perú.

"LA MUJER Y LA SALUD EN NUESTRAS COMUNIDADES" (WOMEN AND HEALTH IN OUR COMMUNITIES). CEPLAES, Quito, Ecuador, 1988.

These "cahiers" document the experience of the community health promotors training program. The materials were conceived as educational tools to share what was learned with other women. This series is part of a CEPLAES series of support materials for the training and the organization of peasants and urban - popular sectors.
Requests to: CEPLAES (Centro de Planificación y Estudios Sociales. Casilla Postal 6127 - CCI, Quito, Ecuador.

"MEJOREMOS NUESTRA ALIMENTACION" (LET'S IMPROVE OUR FOOD). Eurídice Salguero. CEDIME, Quito, Ecuador, 1987.

This is a guide for improving food with products indigenous to the Andean region. The aim is to support the process of training women from native and popular sectors. Furthermore, an ideal basic diet is proposed.
Requests to: CEDIME (Centro de Documentación e Informacióon de los Movimientos Sociales del Ecuador), Apartado 18-C, Quito, Ecuador.

"EL PROGRAMA DE HUERTOS POPULARES" (THE POPULAR ORCHARDS PROGRAM). CIPES, Buenos Aires, Argentina, undated.

A descriptive leaflet of the CIPES Popular Orchards Program, which supports groups of families from neighbourhood organizations and institutions to produce their own vegetables, on the basis of the family and community orchards. A simple method is proposed for obtaining vegetables with minimun work and no money expenses but which will achieve good yields.
Requests to: CIPES, Zabala 2677, 1426 Buenos Aires, Argentina.

"EXPERIENCIA DE PROMOTORES DE SALUD EN CAILLOMA (THE EXPERIENCE OF HEALTH PROMOTORS IN CAILLOMA). Alejandro Vela Quico y Celso Anco Yucra. Acción Social y Desarrollo (ASDE), Arequipa, Perú, 1988.

The document, in addition to reporting on the health situation in the Cailloma province, documents the work of health promotors within the framework of ASDE, emphasizing training and the recuperation of traditional health techniques.
Requests to: ASDE, 13 de Abril 104-A, Arequipa, Perú.

"LA SALUD ES NUESTRO DERECHO" (HEALTH IS OUR RIGHT), Asociación Perú - Mujer, Lima, Perú 1988.

Educational leaflet for women to raise their awareness and promote their self-organization to defend and demand their rights in health. It is part of a Popular Education series, published by the Women and Health Area of the Asociación Perú-Mujer.
Requests to: Asociación Perú-Mujer, Apartado Postal 949, Correo Central, Lima 100, Perú.

"POR LA VIDA" (FOR LIFE), FOVIDA, Lima, Perú, 1988.

Monthly bulletin of the Health - Life Promotion Program, in which experiences of health and nutrition programs are as well as other information and news related to these areas.
Requests to: FOVIDA, Jr. Camaná 780, oficina 503, Lima, Perú.

"INFORMATIVO" (INFORMATION BULLETIN). CIAC, Santo Domingo, República Dominicana, 1988.

CIAC's monthly bulletin, dealing primarily with their work in the field of popular education. It includes information on the projects in health and alphabetization, plus diverse news and bibliographic material.
Requests to: CIAC (Centro de Investigación y Apoyo Cultural), calle Sánchez # 254, Zona 1, Santo Domingo, República Dominicana.

"SALUD Y TRABAJO" (HEALTH AND WORK), Red de Salud y Trabajo, Santiago, Chile, 1988.

Information bulletin of the Health and Work Network, a panamerican group of NGOs that support labour organizations in their activities in defense of health and work conditions from the occupational health viewpoint. It contains information on various Latin American countries, work groups and publications.
Requests to: Red Salud y Trabajo, Casilla 52604, Correo Central, Santiago 1, Chile.

"SYNERGY - CANADIAN INITIATIVES FOR INTERNATIONAL HEALTH". Association of Universities and Colleges of Canada, Ottawa, Canada, 1988.

Quarterly publication of the Canadian Associations of Universities and Schools which provides information on health at the international level with an emphasis on Canadian initiatives. It encompasses various themes, such as international cooperation, the university scene, AIDS, etc. In addition, it offers information on employment and experiences of Canadian students. Available in English and French.
Requests to: Association of Universities and Colleges of Canada, 151 Slater street, Ottawa, Canada K1P 5N1

"DIALOGOS DE SALUD POPULAR" (DIALOGUES ON POPULAR HEALTH).
Red de Grupos de Salud de la Mujer y el Niño, México D.F. México, 1988.

Periodical publication addressed to popular groups as an instrument of information and training for the organization and defense of rights in health matters. It includes testimonies, articles and information on workshops and meetings.
Requests to: REGSAMUNI, A.C., Apartado Postal 22-443, Tlalpán 14000, México D.F.

"MADRES Y NIÑOS". BOLETIN SOBRE ALIMENTACION INFANTIL Y NUTRICION MATERNA" (MOTHERS AND CHILDREN. BULLETIN ON INFANT FOOD AND MATERNAL NUTRITION).
Asociación Americana de Salud Pública, Washington, U.S.A.

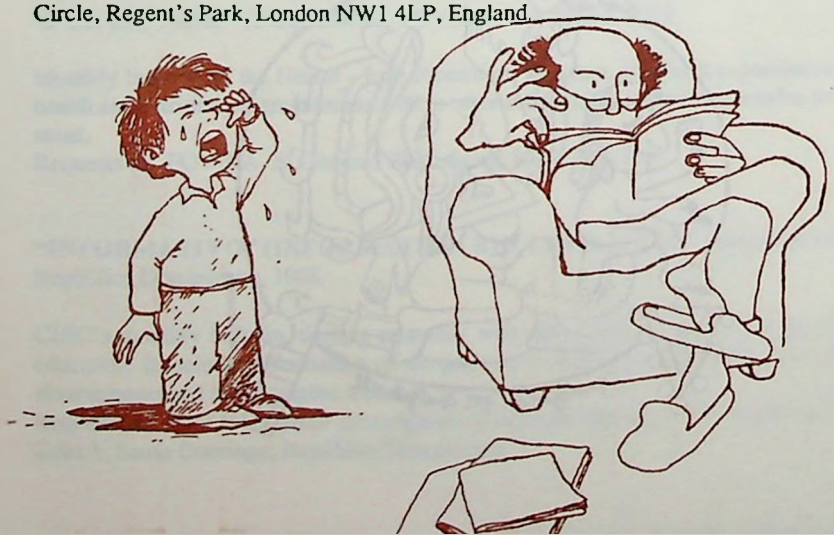
Published every four months, edited and produced by the Documentation Center on Infants Food and Maternal Nutrition. The Center works in the distribution of materials and information on these subjects. It contains information on programs, educational materials and publications. Available in Spanish and French.
Requests to: Asociación Americana de Salud Pública, 1015 Fifteenth Street, N.W. Washington, D.C. 20005, U.S.A.

"AIDS ACTION", AHRTAG, London, England, 1988.

International information bulletin on AIDS prevention and control, published in English by AHRTAG. It contains detailed information on AIDS and its treatment, seminars and workshops on the subject (including the global AIDS program of WHO), and bibliographic and educational material.
Requests to: AHRTAG, 1 London Bridge Street, London SE1 95G, England.

"PEOPLE". IPPF, London, England, 1988.

Quarterly publication edited in English and French by the International Planned Parenthood Federation (IPPF). Its basic subject is the promotion of planned parenthood and sharing information about efforts to balance resources and population at the world level. Includes news, bibliography, projects, life stories, etc.
Requests to: IPPF (International Planned Parenthood Federation), P.O. Box 759, Inner Circle, Regent's Park, London NW1 4LP, England.

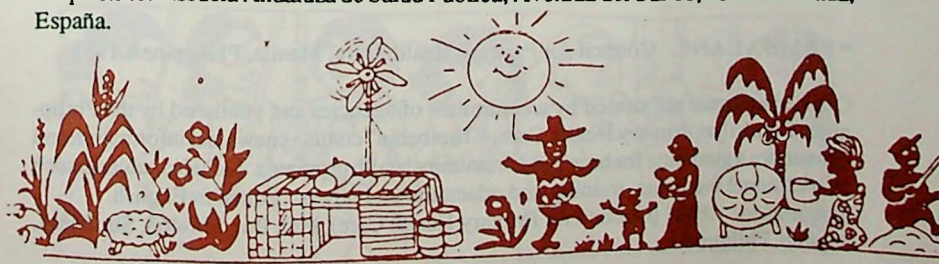


APPROPRIATE TECHNOLOGY FOR HEALTH. Division of Strengthening of Health Services, World Health Organization, Geneve, Switzerland, 1988.

Quarterly publication of WHO, edited in English and Spanish (separate volumes). Each issue includes a large variety of articles on various subjects concerning health: community organization, utilization of resources, primary health care, etc. Includes news and bibliographic material.
Requests to: Division of Stregthening of Health Services, WHO, 121 Geneve 27, Switzerland.

"NOTICIAS DE SALUD PUBLICA Y ADMINISTRACION SANITARIA" (NEWS ON PUBLIC HEALTH AND SANITARY ADMINISTRATION). Escuela Andaluza de Salud Pública, Granada, España, 1988.

Periodic publication of the "Escuela Andaluza de Salud Pública", the objective of which is to establish communications among persons and institutions concerned with Public Health. It includes abundant information on spanish and europeans seminars, projects development and bibliographic material.
Requests to: Escuela Andaluza de Salud Pública, Avenida del Sur 11, 18014 Granada, España.



"CHETNA NEWS". Chetna, Ahmedabad, India, 1988.

Quarterly information bulletin of Chetna, an Indian NGO working in the field of popular education, primary training related to nutrition. The bulletin focuses on the programs of Chetna and other Indian institutions.
Requests to: Chetna, second floor, Drive-in Cinema Building, Thaltejroad, Ahmedabad 380.054, India.

"CONSUMER CURRENTS", International Organization of Consumers Unions (IOCU), Penang, Malaysia, 1988.

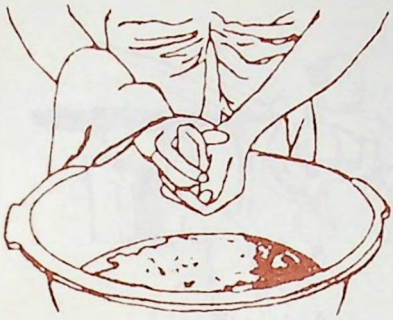
Periodic publication appearing 10 times per year, edited in English by IOCU, a foundation serving as liaison for some 170 groups in 55 countries. It includes information on subjects such as agriculture, communications, environment, health, food, housing, etc. of interest for consumers, specially those in the Third World.
Requests to: IOCU (International Organizations of Consumer Unions), Regional Office for Asia and the Pacific, P.O. Box 1045, 10830 Penang, Malaysia. (Oficina Regional para América Latinay el Caribe, Casilla 10933, Sucursal 2, Montevideo, Uruguay).

"NEWSLETTER". Non-formal Education Service Center, Kathmandu, Nepal, 1988.

Semi-annual bulletin published by NFESC, a NGO which has been working since 1984 in the field of education and community development, particularly in Nepal's rural areas. The first issue includes information on various NFESC projects in alphabetization, potable water and other areas.
Requests to: NFESC (non-formal Education Service Center), GPO Box 2986, Kathmandu, Nepal.

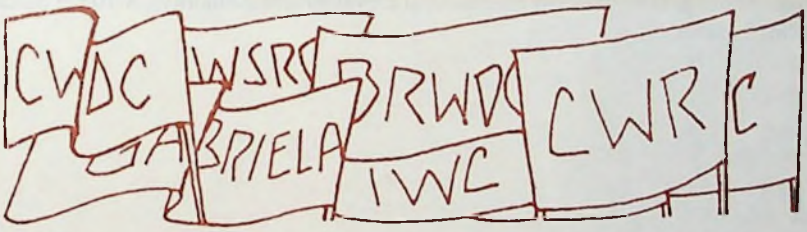
"TAMBALAN". Council for Primary Health Care, Manila, Philippines, 1988.

Quarterly journal elaborated by a committee of agencies and published by the Philippines Council on Primary Health Care. "Tambalán" contains news and information and constitutes a guideline for base and community health programs. Includes subjects such as traditional medicine, training and education and others. Edited in English.
Requests to: CPHC (Council for Primary Health Care), P.O. Box SM-463, Sta. Mesa, Manila, Philippines.



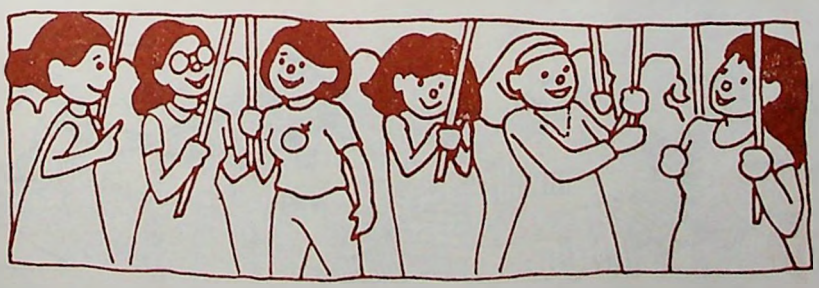
"THE ROLE OF HEALTH EDUCATION AND COMMUNICATION IN SANITATION PROGRAMMES". John Hubley, Barry Jackson and Thabo Khaketla. UNESCO/UNICEF/WFP, Paris, France, June 1988.

The paper presents a case study on the sanitation improvement program in Lesotho which describes the work of the Sanitation Improvement Team of Lesotho's Ministry of the Interior and its activities in the educational and communications field. Edited in English.
Requests to: Urban Sanitation Improvement Team of the Ministry of the Interior. Private Bag A41, Maseru, Lesotho.



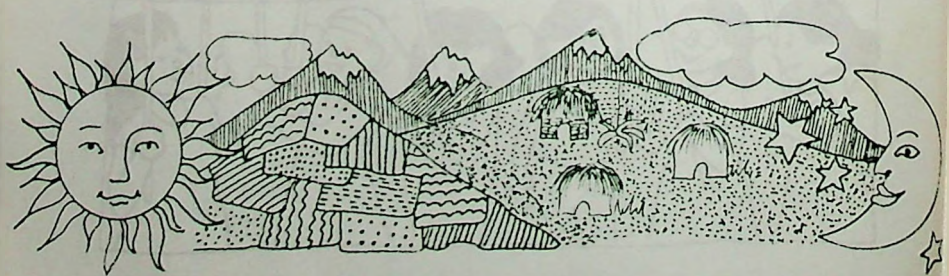
"PIGLAS-DIWA. ISSUES AND TRENDS ABOUT WOMEN OF THE PHILIPPINES". Center for Women's Resources, Quezon City, Philippines, 198[illegible]

Quarterly publication in English of the Center for Women's Resources of the Philippines, that attempts to contribute to the Philippine women's liberation ("Piglas Diwa" is a Philippine term that means a spirit trying to obtain freedom). The journal adresses subjects related to women's conditions: health, education, work, women's centers and organizations, urban poverty, etc.
Requests to: Center for Women's Resources, 2nd floor, Marsantos Building, 43 A Roces Avenue, Quezon City, Philippines.



"HEALTH CENTERS IN NEED OF TREATMENT. A JOINT EVALUATION OF SWEDEN'S SUPPORT TO THE HEALTH SECTOR DEVELOPMENT IN TANZANIA, 1972-1986". SIDA Evaluation Report, Stockholm, Sweden, 1987.

An evaluation of Swedish cooperation in the construction of rural health centers in Tanzania, representing practically half of the entire Swedish governmental cooperation in Tanzania. The document evaluates the role of rural health centers in the implementation of primary health strategies in Tanzania's rural zones. Edited in English.
Request to: SIDA (Swedish International Development Authority), S-10525 Stockholm, Sweden.



NEWSLETTER No. 10
POPULAR EDUCATION AND PRIMARY HEALTH CARE NETWORK

April 1989

Coordinator of the Network: Teresa Marshall

Pérez Valenzuela 1634 Casilla 6257 Santiago 22 Chile
Fono 2235822 Telex CEAAL 240230 BOOTH CL-CHILE

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47/1, (First Floor) St. Marks Road
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Health and Popular Education

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DR. RAVI NARAYAN
COMMUNITY HEALTH CELL
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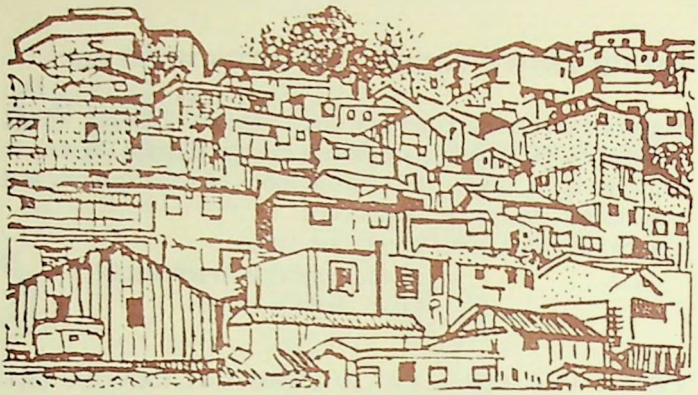


IMPROVING ENVIRONMENT FOR CHILD HEALTH DEVELOPMENT.

Urban Examples, Unicef, March 88.

This issue of "urban examples" presents five case studies. They are all reports on poor urban settlements that seek to face the need for drinking water, sewage and health services (Argentina, Brazil, Sri Lanka, Jordan, Honduras). (English)

It can be requested from: Urban Section - Programme Division
UNICEF HQ Rm H-11-F
3 U.N. Plaza
New York, N.Y. 10017, U.S.A

HEALTHY CITIES

Bulletin produced by Healthy Cities Centre it attempts to support groups involved in public policies promoting health in the cities of the world (english).

Contributions received.

It can be requested from: The Editor Healthy Cities
Normanton Grange, Laughan Avenue
Aigburth, Liverpool 17, ENGLAND

HEALTHY PUBLIC POLICY

Report on the Adelaide Conference.

Report on the Second International Conference on Health Promotion (April 1988, Australia), organized by WHO and the government of Australia. The report gives an account of the principal subjects of the debate: the fairness of health policies and public responsibility regarding them. It also refers to the main subjects of future policies: intersectorial action. the action of the organized community, the training of human resources, action in the environment.

Recognizing in short: "but meeting the goal of an indivisible and global health depends on the political will of countries to orient their own policies and strategies towards the common goal of global health" (english).

It can be requested from: WHO
Health Promotion Unit
8 Scherfigsvej
DK-2100 Copengahen, DENMARK

MARIA, LIBERACION DEL PUEBLO.
(MARIA, LIBERATION OF THE PEOPLE)

This is a monthly publication made by the women of the working class settlements of Cuernavaca (Mexico). It contains information on actual conditions in Central America and particularly in Mexico; and includes a photonovel, educational methodology and advice on health matters. It can be requested from: (in spanish)

Emma Pérez H. Apartado Postal 158-B
62190 Cuernavaca, Mor.- MEXICO

HACIENDO NUESTRAS CONEXIONES.
(MAKING OUR CONNECTIONS)

A handbook for advisers that work with women on mass mental health. It reflects an experience of working with women, and includes exercises, dynamics and theory on metal health and sexuality (in spanish).

It can be obtained from: Casa Sofia c/o Mónica Hingston
Casilla 52414 - Correo Central
Santiago, CHILE

Cost: US$ 9,50 (includes air mail postage)
$ 1.500 chilean pesos

VOICES RISING.

Bulletin of the Women's Program of the International Council of Adult Education. This is a publication on women and Mass Education. It promotes the exchange of, debates on and the propagation of information on subjects that are vital for women and mass education. It is published in spanish, english and french. It contains the practices and the ideas of women in different parts of the world. Including subjects related to Peace, Human Rights, Health, Educational Methodologies, Social and Political Movements.

It can be requested from: ICAE Women's Program c/o PRG
309-229 College Street - Toronto,Ont
CANADA MST 1RY

News

PERU: Friday, 10 June: Thirty people from different health organizations held a workshop in Lima to exchange experiences, share the debate on problems within their spheres and start the establishment of the Peruvian Health and Popular Education Network. The event took place at the Casa ANC (Asociación Nacional de Centros), on the occasion of the conducting of the Peruvian Symposium on Popular Education.

The workshop had been organized by Celats (Marta Escobar) and Cidepsa (Alberto Goyoso), who had previously collected the requirements of the Centres that work in this field and their expectations regarding the idea of setting up a Network. All were in agreement that there was a need to have in Perú a space for meeting and coordination, where debates, exchange and training would be sponsored. The need for permanent collaboration in the carrying out of collective activities (for example, the next Primary Health Care Meeting), and the organization of small events, apprenticeships, visits and research among the Centers was recognized. The urgent need to share the materials produced by each Center, so as to set up a Health Documentation Center was pointed out.

The participation of so many groups.... Flora Tristán, Manuela Ramos, Provida, Perú Mujer, Cesip, Ceplar, Sea, Servicio de la Mujer Minera, Calandria, Edaprospo, Visión Mundial, Alternativa, Prisma, Incafam, Cipa, Cepco, Amauta - (Arequipa), Tipacom, Centro de Medicina Andina (Cuzco), Ces, Celats, Cidepsa. And the enthusiasm shown, enable us to look ahead to the success of this Network. Alberto Gayoso and Mónica Escobar assumed the responsibility for encouraging and coordinating this process.

But, within a perspective of granting more importance to real coordination than to the coordinators and hoping to unleash a process of participation and rotation of those "responsible". Those who may be interested in contacting this initiative, may get in touch with coordinators at: Red Salud - A.N.C.

Pablo Bermudez 234 -Lima 11, PERU

CHILE: TRAINING. the plans for health training and popular education continue.

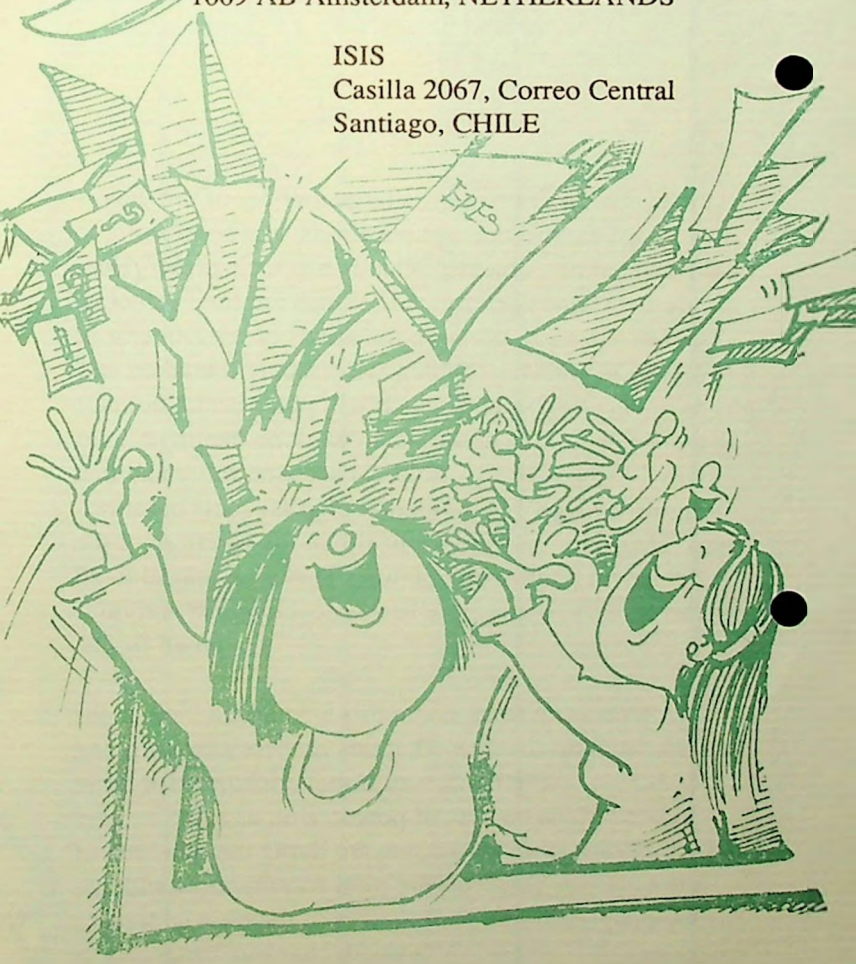
PIIE (Programa Interdisciplinario de Investigación en Educación) is developing a training course in popular education methods for health workers. This course has the support of the Canadian Public Health Association

INTERNATIONAL DAY OF ACTION FOR THE HEALTH OF WOMEN - 28 May 1988.

THE INTERNATIONAL NETWORK OF WOMEN FOR REPRODUCTIVE RIGHTS AND THE HEALTH NETWORK FOR WOMEN OF LATIN AMERICA AND THE CARIBBEAN (ISIS) launched an international campaign with regard to the problem of mortality. Both networks collected and spread information on maternal mortality from a woman's point of view, promoting a campaign that was based on the women's real needs, helping to avoid their deaths, their risks, and improve the life and health of women.

We ask all those interested in learning about this important campaign to see how they can continue collaborating. Please contact: The International Network of Women for Reproductive Rights - P.O. Box 4098
1009 AB Amsterdam, NETHERLANDS

ISIS
Casilla 2067, Correo Central
Santiago, CHILE



CHILE: EPES launches the EPES games.... A few days ago we celebrated the launching of the large folder of EPES games. This is a new edition, corrected and coloured. Now everybody can have them.

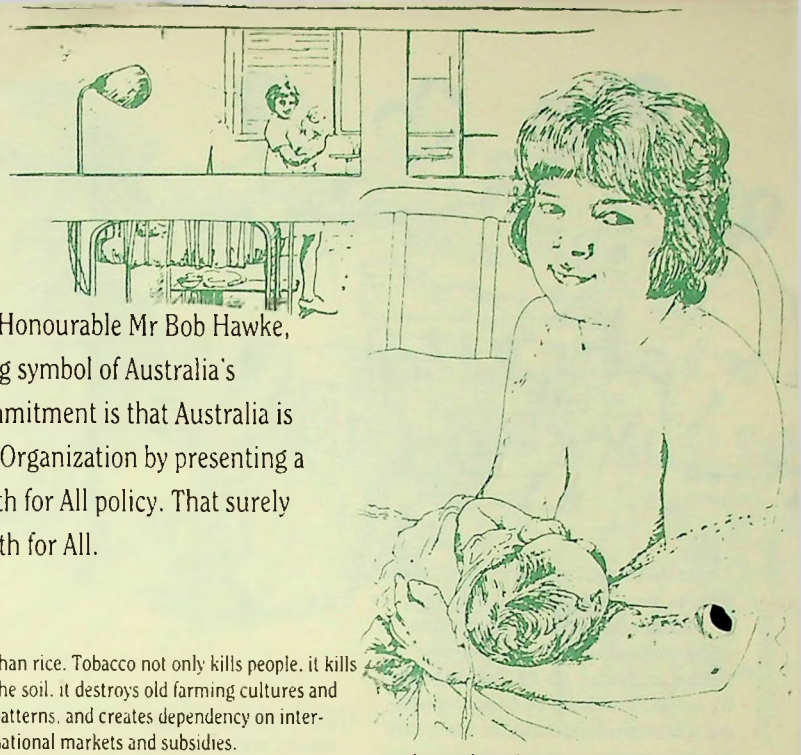
They can be requested at: EPES
Casilla 15167 - Santiago, CHILE

This health letter contains a large number of previews - speeches, experiences, publications, news- referring to health related movements. What is happening now? How are the changes expressed? Which are their principal trends? If we run though the words of the Director of WHD, Dr. Halfdan Mahler, we discover a marked emphasis on those strategies which will place health policies at the forefront. He invites us to work on health policies that express equity, political accountability and that require the active participation of grass roots organizations. He invites us to place health in the forefront of the debate on politics and culture. This is an appeal to all social leaders to promote health development activities on all fronts.

The interesting thing about this is to take a look at our practices and discover in what this process already going ahead. Action on the borders of impoverishment for those located in the centers of power. But, as some authors have already pointed out, we are living the rebellion of the chorus. Today in the rural communities with the native peoples, in the poor sectors of the city, with these spaces health is created, published, changed, produced. A space that never stops creating even when sailing through difficult seas. The experiences and publications described briefly in this letter tell of this permanent itinerary.

Keynote Address

Opening Session – 5 April 1988
Dr Halfdan Mahler, Director-General, World Health Organization



I should first like to express our gratitude to the Prime Minister, the Right Honourable Mr Bob Hawke, for having honoured us by opening this Conference. This is an outstanding symbol of Australia's commitment to health at the highest political level. A further sign of that commitment is that Australia is honouring its bicentennial year and the fortieth birthday of the World Health Organization by presenting a set of health goals and targets based on the World Health Organization's Health for All policy. That surely underlines the tone and aim of our meeting: the focus on action towards Health for All.

A major statement made at the First International Conference on Health Promotion in 1986 in Ottawa was 'health is not divisible'. We are no longer in the period of the 'first fleet', when a country could hope to export its problems to another continent. The world has become too interlinked and interdependent for such actions. The new environmental hazards and chemical threats and the global challenge of AIDS are perhaps the most obvious expressions of this in the health arena.

National boundaries are a geopolitical fact. But just as health is created largely outside the health sector, so it is created largely across these national boundaries. The winds and viruses will not respect them. The international markets have long transcended them. Not only knowledge and technology are exported from the industrialized to the developing countries; tobacco, alcohol, pharmaceuticals, and consumer goods are also exported. To these I would add the export of images, ideas about the world, and lifestyles – all of which can be potentially hazardous. These of course are well-known examples. Less obvious is the impact of the industrialized countries' use of the developing countries' resources. To meet the demands of the rich and generate income for themselves, the developing countries are often forced to deplete their natural and human resources for short-term benefit but long-term loss.

Let me illustrate this with some spotlights on tobacco, since this Thursday will be the first world-wide No-Tobacco Day.

In Bangladesh, one of the poorest countries in the world, the tobacco-growing area has increased rapidly from 47 000 hectares in 1976 to about 55 000 hectares in 1982. Tobacco smoking in that country has doubled in the past two decades. In the poorer parts of the world in general, smoking is increasing faster than is population growth. Governments and international agencies are subsidizing tobacco farming. About 60% of the costs to farmers of growing tobacco in the European Community are met by Common Market funds.

Tobacco requires nutrients, a high input of fertilizer and pesticides. Many tobacco farmers all over the world are poor and take great health risks to grow the product. Landowners are able to earn twice as much on the cost of their labour if they grow tobacco rather than rice. Tobacco not only kills people, it kills the soil, it destroys old farming cultures and patterns, and creates dependency on international markets and subsidies.

It is this type of fact that has led us to select Healthy Public Policy as the theme for this Second International Conference on Health Promotion. We wished to underline the key theme of the Ottawa Charter, that the domain of personal health over which the individual has direct control is very small when compared to the influence of culture, economy, and environment. I could repeat the example I gave above for many other areas and products, which to me illustrate the lack of honesty and transparency in much policy-making. They exemplify a policy choice of placing products and markets over the health of people. It is against such policies that we have set the challenge of Health for All.

With the commitment to Health for All, the World Health Organization and its Member States have recognized the need to give health priority in policy-making. With Health for All, we have moved from public health strategies that were focused only on the health of the nation-state to a world consensus on health development, from which each country can develop its national goals based on a common understanding, not only of what constitutes the world's health problems but – even more importantly – of what constitutes common strategies for solutions.

Healthy Public Policy is one of these strategies, which we propose to develop even further and move from the area of rhetoric to the area of action. At the First International Conference on Health Promotion we discussed the changed meaning of the words 'health' and 'public' in relation to the 'old' and the 'new' public health. In Adelaide we intend to look closely not only at the changes in the content and perception of policy, but also at a new style of policy-making.

Let me quote here the working definition of Healthy Public Policy that the background paper *Healthy Public Policy Issues and Options* offers to the Conference:

Healthy Public Policy is the policy challenge set by a new vision of public health. It refers to policy decisions in any sector or level of government that are characterized by an explicit concern for health and an accountability for health impact. It is expressed through horizontal strategies such as intersectoral cooperation and public participation.

I believe vehemently that health policy action must move closer to people. Rather than controlling people, it must empower and protect them, and it must aim at strengthening international co-operation, equity, and human rights. It must work towards a negotiated consensus, not a grand solution from above. Governments should first be held accountable to their people before they ask their people to be accountable to them.

In the Ottawa Charter we committed ourselves to move towards a new public health. We ...sed the responsibilities of governments to ensure the health of their citizens and we claimed an advocacy role for the health sector. We stressed that Health for All had put policy and related structural change for health back into focus and had retrieved some of the most important roots of public health. I called this the rediscovery of an old, forgotten melody. I would like to urge you not to forget this melody at this Conference. Many of the early public health pioneers were also social reformers, pioneers in the organization of labour, education, housing, and sanitation. Much of this link has been lost in public health development. Social medicine and social policy have taken separate roads. Recent textbooks on public health or epidemiology frighten me by showing how much public health has lost its original link to social justice, social change, and social ...orm, and how it has opted for behavioural victim-blaming instead.

A hundred years ago social reformers in the industrialized countries were abolishing child labour. They were making it possible for children to go to school and get an education. They were developing family policies. They were developing what was then the major institution within the medical care system, the hospital.

Many developing countries still have this strong link between social policy, social justice, and public health.

But many excellent attempts to integrate health improvement strategies are limited by macro influences that are far beyond their control. Take the integrated rural development projects in Latin America and the Caribbean: the drop in infant mortality and the increase in life expectancy at birth in Costa Rica during the 1970s were directly proportional to the coverage and duration of the Rural Health Programme. However, the consequences of the world-wide economic crisis are beginning to reverse this trend. Decreased income, austerity in public health spending, and subsequent higher poverty levels are now causing rising malnutrition, increased morbidity, and a halt in the decline of infant mortality. The direct consequences of macro-economic policy-making are rapid and brutal, and seriously impede national health goals.

But it is not only the economy that can have far-reaching effects on health. The World Health Organization studies undertaken in the context of the United Nations decade for women showed a clear interrelationship between the literacy rate of women, family-planning practices, and the health of women and families. Just a few years after the end of that decade major cultural and religious changes in some countries have brought about a drop in female literacy and a related rise in female poverty and infant mortality.

We all know that 'good public policy' improves security, quality of life, and, we hope, the ability of people to pursue happiness. This has been proved by history, and is shown day by day in each of the World Health Organization's Member States. As public health proponents, we must welcome any such policy. But let us not too readily attribute such developments to a higher value attached to health or to the successful advocacy of public health lobbies. Many policy-makers still see health in purely medical terms, and interpret all health costs as expenditure and not social investment.

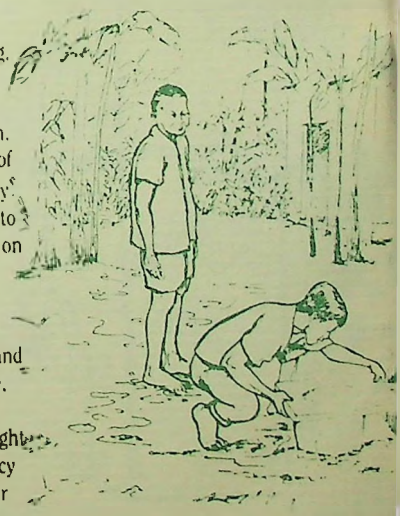
A five-country study on intersectorality commissioned by the World Health Organization, and a number of case studies at this Conference clearly show that intersectoral action for health is still rare. More often than not, other sectors take action for reasons of their own, which then have an impact on health. Health-related components of housing, agriculture, or education policy are seldom made explicit. It is self-defeating to attribute such policies to intersectoral action for health, since that does not give us a realistic picture of how the health sector has fulfilled its advocacy role, or of how far governments are prepared to be accountable for the effects of their actions on the health of the people.

That is why we are suggesting honesty and transparency, or, in more technical language, 'accountability for health'. If societies truly place a high value on health and see it as a right of each citizen, then each governmental policy needs to be assessed in terms of its positive or negative impact on health. But this honesty also implies that we in public health do not simply put the blame on the other sectors for not acting as we think they should, but that we take our role as advocates for the health of the public seriously.

Honesty implies that we critically assess whether we have raised our voice loudly enough and whether we have worked hard enough on developing strategies and mechanisms that reflect the new public health need. Only on such a basis can public health re-establish public confidence and trust. Agenda for such action are outlined in the background paper and are illustrated by the case studies.

But, with all the importance that needs to be attached to responsible governmental action for health, we must not fall into another trap: to think of Health for All as meaning only governmental action for health. I insist that Health for All is a movement. It is an idea, a challenge we have put forward, and it takes many forms. It includes many actors, some of whom are not easily controlled. Of course I attach great importance to the fact that more and more World Health Organization Member States are developing Health for All policies and actions – but I also insist that Health for All is a movement of the people. The *Scope and Purpose* of the Conference states it clearly:

Healthy Public Policy should be:
policy for the people
with the people
by the people.



As the Chinese maxim says:
Go to the people
live with them
learn from them
love them.

The public in its many forms plays a major role in setting agendas and forcing officials to end practices that are harmful to health and have become 'business as usual'. In my opinion this role still needs strengthening all over the world.

More usually, people have to find other ways and means to express themselves and to be heard. Public health is still far from being as open and as public as I would wish it to be – as it would need to be in order to be truly successful.

Many different social movements have been highly relevant to public health development. In the 1970s the social movements in the developed countries were about identity and autonomy and they had a strong influence on how we began to rediscover health. The women's movement is exemplary for drawing our attention to the rights of the people in defining their health and their health needs.

Movements now speak for ecology, peace, and international co-operation. This shift opens the way for a joint public health voice from the developed and the developing world in the context of Health for All: health is indivisible.

I mention these movements because we must be constantly aware that Health for All is not the Scripture written in 1977–78 and never to be touched again. As such it would become rigid and die. Health for All must remain a living thing, taking up the health issues that most trouble people and societies all over the world.

For very different reasons, survival is becoming a key issue in the 1980s in all parts of the world. Public health has the responsibility to respond with global action.

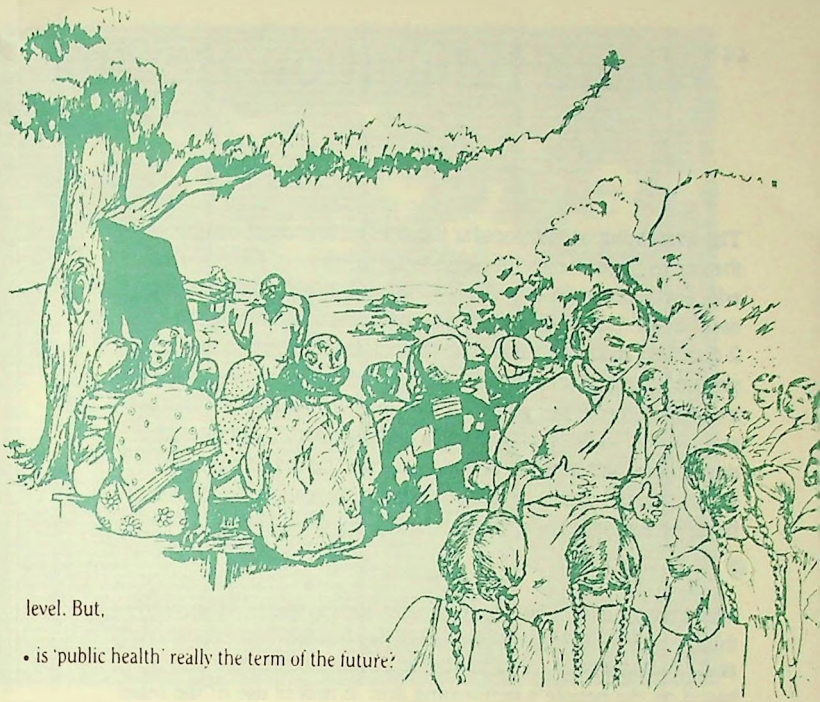
At the Ottawa Conference, our starting-point in health promotion was to achieve a wider understanding of where the health of people is created and to see people as part of a larger ecological system. The individual is not only the body, but also the mind and the spirit. The person is integrated into a physical and socio-economic environment. Health is created by the specific interaction between human biology and personal behaviour within a culture and a biosphere.

It is a very special link between our past and our future that this type of thinking is reflected in those case studies that are concerned with traditional understandings of health, such as the studies on Maori and Aboriginal health. Health is seen by these people as the result of a complex interplay between the individual, his or her territory of conception, and his or her spiritual integrity: the body, the land, the spirit.

Looking into the future I see that, just as the understanding of social health has come to include cultural and spiritual well-being, so will physical well-being come to mean much more than the biology of the human body: it will include a safe environment and the responsibility for our physical surroundings on the planet as a whole.

The key themes of my speech have been the global responsibility of public health and the new content and style of health policy development. At this Conference we should also be aware of the major geopolitical shifts due to take place by the turn of this century.

The reorientation of public health is the challenge set by the World Health Organization as the major public health agency at the global level. But,



- is 'public health' really the term of the future?
- are we not confining ourselves to the health sector at a time when we should be moving radically out of it?
- are we really aware of the high relevance that ecological and environmental questions have to the future of public health? They have recently been outlined in *Our Common Future*, the report of the World Commission on Environment and Development;
- do we really know how much changing values, beliefs, and expectations will influence public health?

Maybe we will be called upon to invent a new type of World Health Organization to respond to the new challenges I have touched upon.

The Health for All movement must continue to be a challenge. In tackling today's environmental and social risks, we must be able to achieve results similar to those achieved by traditional public health. We must confront what now kills people, lets them suffer unbearably, causes pain – in short, gives them no access to health. Healthy Public Policy is one of the main areas for such action. I expect that this Conference will outline the major strategies and ways to approach the main aim of Healthy Public Policy as stated:

Healthy Public Policy aims to create the preconditions for healthy living through:

- *closing the health gap between social groups and between nations;*
- *broadening the health choices of people to make the healthy choice the easier and the possible choice; and*
- *ensuring supportive social environments.*

It has become clear that health is not a private good but a societal, social, and individual resource. We are now learning the same about the environment. At the end of the 1980s we were able to see our planet Earth from space for the first time – and for the first time to grasp it as a vulnerable system, whose ecology we are responsible for.

Let us take up the challenge with this Conference on Healthy Public Policy in order to protect the interests of future generations and the survival of this planet Earth.

I leave you with a quotation paraphrased from George Bernard Shaw:

The problems of the world cannot possibly be solved by sceptics or cynics whose horizons are limited by the obvious realities. We need men and women who can dream of things that never were ... and ask, why not?

"Where Education Begins and Entertainment Continues"

The increasing use of popular theater (rechristened community theater in Sierra Leone in 1986) as an instrument for popular education, community organization, mobiization and development in the 3rd world has spread phenomenally during the last 2 decades. Besides, it has contributed significantly to building people's confidence, participation, self-expression and critical awareness. From the urban squalor of Latin America's favellas and barrios, to the slums of India and Bangladesh and the undeveloped rural areas of Africa, popular/community theater-drama, music, dance, puppetry and poetry - is a spontaneous made of education and grassroots development communication.

Many reasons have been put forward for the use of community theater as a tool for development. It is entertaining, educational and developmental, is culturally relevant, inexpensive and is based on the people's performing arts. It makes use of the other cultural resources and the creativity of the people and expresses popular knowledge and concerns. As a codification of reality, it can be used to raise issues of the moment and to stimulate discussion and dialogue. But all these attributes do not guarantee that theater will be used to serve the interests and aspirations and to satisfy the needs of the people. Theatre should not be looked upon as a tool per se but as an integral part of a socio-educational process which engenders confidence-building, problem identification, data collection and analysis, strategising and organizing for collective action.

COMMUNICATION MODES IN COMMUNITY DEVELOPMENT

The Government of Sierra Leone, people's development organizations (PDOs) national a well as international, have embarked with varying degrees of success on community development programmes and projects aimed at improving the quality of life of the people. Some have exploit the country's rich and exuberant cultural resources and traditions and have used the indigenous performing arts, especially, drama for education and conscientization and for the dissemination of all types of development messages and packages.

The idea of using drama for community education and mobilization is not a new phenomenon. Since the beginning of the UN 2nd Development Decade, it has been realized that most poverty-focussed development programs for the rural have foundered. One reason has been that the programmes are conceptualized in government ministeries in urban and peri-urban areas where armchair and doctrinaire bureaucrats, totally out of touch with the needs, interests and aspirations and ignorant, if not oblivious, of the socio-economic and other realities of the people; prepare their blueprints. The programmes are implemented
by extension agents who traines as "constructed technocrats" are conditioned to analyze problems in a narrowly technical way and to propagate technical solutions which invariably fail to address the socio-economic parameters which created the problems in the first place. Essentially, this is because the traditional communication modes in development and extension work are largely top-down, directive, authoritarian and impersonal. Extension workers assume that the information flow is linear and that development information is the monopoly of "experts". Extension workers usually assume the paternalistic "I - know - what - is -best - for - you " , stance and this has given rise to much, and at times stout opposition in the part of the intended programme beneficiaries.

A usually held belief is that villagers do not like change and they offer resistance to whatever plans are made for their development.

Social Anthropological studies have debunked the myth that villagers are lazy, conservative and bound by traditions and superstitions. Such characterizations continue to be flaunted by those developmentalists who wish to be absolved from responsibilities for project failures. Current trends are that the yawning gap between extension workers as change agents and the

communities with whom, and not for whom, they work must be bridged to promote dialogue and genuine participation and forster better understanding, rapport and mutual confidence.

THEATRE FOR DEVELOPMENT IN SIERRA LEONE.

Theatre for development was introduced in Sierra Leone in the late 1970s. The Planned Parenthood Association and Plan International of Sierra Leone and health educators in provincial hospitals have all experimented with drama and other folk media for community adult education and for the dissemination of their family planning and primary health care messages.

The now-phased out CARE Project LEARN (Local Educational Activities for Rural Networks) used drama to transmit its agricultural, health, nutrition and sanitation messages in the Northern and Southern provinces.

The LEARN experiment used resource kits which contained among others a series of taped dramatised stories featuring the day-to-day experiencies of a typical farm family. The limitation of all the above experiments was that the villagers - the programme beneficiaries - were entirely left out not only in the identification and analysis of their own problems but also in the drama making, and dramatization and thus became passive listeners and mere objects of sloganistic messages.

In recent years a new consciousness has emerged both among social scientists and within groups long used as subjects of social science research. Experts in conventional social science research now concede that qualitative methods can destroy institutions and processes.

In response to the crisis faced by conventional models, various alternatives have emerged among them participatory/action research.

Whatever benefits development has brought to some - the very tiny minority, it has bypassed the very people who are most in need of an improved standard of life - the masses in the rural and periurban areas and the slums of urban areas. Many so-called poverty-focussed projects have not focussed on the key ingredients that would help extricate the poor from the quagmire of their poverty. Rather, very many projects have made life harder for the intended beneficiaries turning them into peasants and tenants rather than helping them to develop as selfsufficient farmers and rural workers. Mathur notes "most studies recently conducted in rural Asia tend to confirm that the standard of living of the absolute poor has declined over time... By and large, the poor have tended to stay poor". It has now increasingly been realised that only rarely have the poor - the real experts on poverty, the people who experience it day after day - been consulted about what they need and want to develop themselves. They have rarely been allowed to participate in decisions which affect their lives in a way that would unleash their creative energies and abilities.

Out of all these failures, a glimmer of light has begun to emerge. This light is marked Participatory Research (PR) predicated on the genuine, effective and optimal participation of

the researched in the development process. "The PR process arose in the context of questioning much basic research issues as the relationship between the purposes and consequences of the means and ends of social research, the implications and results of using the traditional and conventional social science methodologies, the relationship between the researcher and the researched, neutrality, subjectivity and objectivity".

PR has been described as a three-pronged activity : an approach to social investigation with the full and active participation of the community in the entire research process; a means of taking action for development and an educational process of mobilization for development, all of which are closely interwoven with each other. In short, PR consists of three interrelated and interdependent processes :

a) Collective investigation of problems and issues with the active participation of the researched in the entire research process .

b) Collective analysis in which the researched develop a better understanding not only of the problems in hand but also of the underlying structural causes of the problems.

c) Collective action by the community aimed at short-term as well long-term solutions to the problems.

The above three interrelated processes of PR are related to the three functional and existential questions in the process of conscientization.

- "What are the problems in our present situation?"; "Why do the problems exist?" and "How can we rid ourselves of the problems?" The basic objective, them, of PR is progressive social change for the betterment and libertation of the oppressed and marginalised peoples. PR is a tool which the oppressed can use to begin to take control of the economic and political forces that muzzle them.

THE COMMUNITY THEATRE FOR EDUCATION AND DEVELOPMENT:

Since October, 1986, the Institute of Adult Education and Extra-Mural Studies (INSTADEX), Fourah Bay College, University of Sierra Leone, has mounted a series of innovative training and orientation workshops for extension and development workers, theatre practitioners and activists in the Theory and Practice of participatory research community theatre.

The Community Theatre for Development Workshop, from the first stage of establishing rapport, mutual understanding and confidence with the particpating workshop communities to the last stage of discussing for workshop follow-up strategies before the workshops ended, were holisitic learning experiences on the part of the workshops participants (WPs), the resource persons (RPs), the Local Liaison Persons (LLPs), the village participants (VPs) and the communities. Village participants were encouraged to take part in the dramatizations and their improvisations clearly highlighted some of the underlying contradictions, rationalisations promotional and obstructional - the pushing and blocking - factors that undergird village development. Storylines, drama-making, rehearsals, the performances, post
performance and post-"swop" performance discussions resulted in new and valuable perspectives and the plays kept changing as the understanding of the actors and onlookers deepened. The constant interaction and dialogue with and participation of the villagers produced what Kidd has called "transformational drama" which enhanced the process of conscientization rather than villagers merely watching and even discussing ready-made plays produced by interventionists.

The development component is operationalised as workshop follow-ups to concretize the awareness created in the participating communities thanks to the dramatizations and post-performance discussions. One major development strategy has been the launching of the Institute's Programme SWASH (Safe Water and Adequate Sanitation for Health) (with in-built drama components) which comprises community action, health and sanitation projects the construction of a spring box, water wells and pit latrines. Two of the identified, highlighted and dramatized problems in most of the first (November 1986) training workshop's dramatizations were contaminated water and unhealthy sanitation practices. These, no doubt, led to high incidences of water-related diseases like diarrhoea, dysentery and malaria, and also to high rates of morbidity and mortality, especially among infants and children. The launching of programme SWASH was predicated on the firm conviction that improving only water quality or digging latrines will have little or no effect on the incidence of diarrhoeal and malarial diseases. The Institute was convinced that a combination of improved water quality, increased water availability, hygienic as well as community-acceptable latrines and a vigorously sustained, multi-media community educational programme using in particular the folk media, especially drama, can be very effective in changing the health and sanitation practices of individuals, families and communities.

THE DISSEMINATION

INSTADEX has now reached the Dissemination Stage in its Community Theatre for Education and Development programmes. Circular letters were despatched in 1987 to development and adult education agencies in Sierra Leone informing them of the great potentials of participatory research (PR) drama in disseminating all types of development messages and packages. The Institute now collaborates with local and national

agencies in training their social and community development workers in the theory and practice of this new genre of drama. In similar vein it also collaborates with outside agencies like The African Association for Literacy and Adult Education (AALAE), The African Council on Communication Education (ACCE). The African Association for Training and Development (AATD) and The Institute of Child Health in London for a Child-To-Child pprogramme in Sierra Leone.

A NEW FOCUS

It is pertinent to note that all our training and orientation workshops on Community Theatre for Development since 1986 have been unfocussed in the sense that workshop participants (WPs and RPs) have operationalised the workshops with no predetermined focus e.g. health, nutrition and sanitation education. They have worked in seven villages in the Southern province and in the Western area and have produced dramas based squarely on what they and the village participants (VPs) together identified as "solvable" community problems after participatory researches.

For the next three years, INSTADEX will focus its community theatre programmes on sensitizing not only the general public but also development workers and even policy makers all over Sierra Leone about the preventive and promotional measures in regard to the largely preventable yet debilitating,disabling and lethal diseases. To mention some - diarrhoea, malaria, filariasis, schistosomiasis, onchocerciasis and the six childhood killer diseases in the UNICEF sponsored child survival and development programme.

CONCLUSION

'Our experience at INSTADEX is an eloquent testimoy to the fact that the theatre using the people's language, their idiom and their performing arts can be a very efficacious medium and an appropriate technology (AT) for generating community involvent in the process of participatory grassroots development. It can provide, when used as a liberating and not as a domesticating mode, a forum for collective problem identification, data collection and analysis and development-focussed dramatizations, all geared towards the continuing search for a better life for our people. But the theatrical and cultural activities should form an integral part of the community's life and should mirror its aspirations and represent its total psyche.

The final objective of our Community Theatre activities should be to create a people's theatre aimed at using the people's culture to engender the process of change and development. Our ultimate goal-the control of the very medium of drama by the people themselves who will take the initiatives to marry their culture with their development - will have brought our grassroots community education and development programmes full circle.

INSTITUTE OF ADULT EDUCATION
AND EXTRA-MURAL STUDIES
Fourah Bay College
University of Sierra Leone
FREETOWN-SIERRA LEONE

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POPULAR EDUCATION AND PRIMARY HEALTH CARE NETWORK
July 1988

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Draft for trial and comment

CHAINS

A Simulation Game

Devised by

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Introduction

CHAINS is designed to simulate some of the dynamics of relationships in a 'free market' economy. It has been used with a variety of groups in India to encourage some reflection upon society and the economy. In particular, it can be used to raise questions about the ownership of industry, the distribution of wealth, economic structures and power, employment, individualism, and the organisation of the poor and unemployed.

It is a relatively unstructured game, and is simple to prepare and organise. However, it is important that the discussion afterwards should be thorough if the participants' insights are to be shared, if learning is to be maximised, and if feelings and interactions are to be processed and dealt with.

Outline

The game is suitable for a group of 20-40 people. Apart from the organiser, at least three other persons will be needed to help administer the game. The remainder of the group will be the players.

The players are given 'money' roughly according to the distribution of wealth in the population at large. The players are then briefed, and the potential for certain economic activities or industries is described. Various capital assets, together with the raw materials for the industries, are then sold, mainly by auction. Only those players with more money will find themselves able to bid or to set up industries. The remainder will have to seek employment or otherwise remain idle spectators. Every player must contribute some money at intervals to represent his basic consumption of food, etc.

The briefing takes about 20 minutes. Play then proceeds for an hour or more, depending upon the size and the response of the group. It is followed by a discussion for which at least half an hour is required.

Materials

The following materials are required:-

a) for manufacturing paper chains:

1 - 2 pairs of scissors (depending upon the size of the group)

1 - 2 rulers (or measured sticks)

1 - 2 pots of paste (flour-and-water paste is suitable)

b) for making nets:

5 - 10 balls of rough cheap string

1 - 2 pairs of scissors

1 - 2 rulers

c) for blowing balloons:

5 - 10 packets of small balloons, each of 10 balloons. (All the balloons must be the same size)

d) for assembling paper-clips:

5 - 10 Packets of paper-clips, each of 100 clips. (All the clips must be the same size.)

All the above materials will be sold to the players.

...2

e) "Currency":

Chips, counters or other materials to represent money in units of 100 (we have used gherkins called tondlikai); units of 10 (we have used ground-nuts); and units of 1 (we have used Bengal Gram). The distribution of money among the players is shown in the following section. In addition the Purchasing Corporation will require some working capital for payments.

f) Ground-nuts, small sweets or whatever for the 'conversion' of money at the end of the game. A ratio of 1 sweet to 10 units of money is suggested.

g) A ruler for checking the links in the paper-chains; and a cotton tape previously measured off for checking the balloons. (See the following section). These are for the use of the Purchasing Corporation.

h) List of the names of all players, mounted on a clip-board. This is for the Collector.

If refreshments are being served during the game, they should also be incorporated as part of the materials.

Preparation

Apart from the Organiser, three other persons will be needed to take the parts of Purchasing Corporation, Collector and Policeman. If it is a large group, the Organiser may also need an assistant to act as Auctioneer; and the person acting as Purchasing Corporation will also need an assistant Inspector or Buyer. All these people must be briefed before the game starts. (See the following section).

The room where the game is to be played must be considered beforehand. The first stage of the game is to auction off the assets of the room, such as all doors with access to toilets/drinking water/telephone or whatever. Similarly the furniture, especially the chairs, will also be sold. There should be a place to which the unsold furniture can be removed. Some imagination must be used in examining the room beforehand to see what will have value during the game and can be offered for sale.

A door-frame, window-frame or blackboard must be chosen to correspond to the size specified for finished paper-chains. The dimensions of the door-frame should be greater than the reach of a single person's arms. (See following section). Similarly a window-frame not less than 4 ft. X 3 ft. must be chosen to correspond to the size specified for finished nets.

A couple of the balloons must be blown to near-bursting point, and then the distance round their circumference must be marked off on a length of cotton tape. Balloon-blowing is meant to be a risky business, and some of the balloons should burst. So an extra centimeter or two can be added on the tape to the distance measured around their circumference. The tape should be given to the Purchasing Corporation for use when inspecting and purchasing balloons.

A table should be arranged for the Purchasing Corporation near the door-frame mentioned above. It is convenient for the Purchasing Corporation if players can approach the table from one side only, and if there is some storage space behind the table, the raw materials and the finished products can be kept in this space.

....3.

The money must be counted beforehand and wrapped in covers or twists of paper. The distribution of money is as follows:

	1000 units	100 units	10 units
20 - 30 players	1 player	3 players	the remaining players
30 - 50 players	2 players	6 players	" "

(The ratio 'in reality' is 1:6:50, but for the sake of the game's dynamics, the above ratios are recommended.)

Briefing the Assistants

The person taking the part of Purchasing Corporation has the following tasks:-

a) to collect the payments from those players who purchase chairs or other assets in the room:

b) to collect the amounts paid in the sales or bid in the auctions, and to hand over the raw materials and equipment purchased;

c) to receive and inspect all finished products and purchase them for the amount specified if the products are up to standard.

The previously measured tape will be required for checking the balloons. Any paper-chain which is brought for inspection must be held up against all the four corners of the door-frame by the manufacturer and his partners/employees. (This is intended to be a task that cannot be performed by one person alone - hence the importance of the frame's dimensions).

Similarly any net which is brought for inspection must be stretched across the window-frame by the manufecturer and his partners/employees.

The purchasing Corporation should be very strict in applying standards and specified sizes for finished products. (See the following section), and should not hesitate to reject sub-standard products.

The Collector should circulate among the players every 10 or 15 minutes, and collect 5 units from each one. He should have the list of the players and record his collections. Any player who cannot pay must be told to crouch, squat or sit. (See the following section). He should also inform the organiser and the Policeman if anyone is reduced to this situation.

The Policeman is asked to circulate among the players, to enforce the rules, to maintain law and order, and settle disputes. Both the Collector and the Policeman should be ready to help in the removal of unpurchased chairs at the beginning of the game.

Briefing the Players

The introduction should include the persons chosen to assist in the game as Purchasing Corporation, Collector, Policeman etc. This will help to establish them in their particular roles. After the introduction of people, it may be useful to say a few words about simulations in general.

....4.

This particular game can be described as an attempt to focus on some aspects of the industrial economy. Participants can also be told that the game itself will take an hour or so to play, and that there will be a discussion for half-an-hour afterwards. If the group has not had much experience with the games, it may be useful to stress the importance of the discussion.

Coming next to the game itself, players should be told that they will be given something to represent money, but they need not be told that they will be given different amounts of money. The money can be handed out according to the table above; and the values of the 'currency' explained, and written on a blackboard. The players should be told that at the end of the game their money - or, better still, the profits they have made - will be exchanged for some commodity of significant (and edible) worth.

The briefing then continues with the following points: the objectives of all players in the game is to earn money, to survive, and to become rich. There will be various economic activities through which people can earn money, and these will be explained shortly.

Every 15 minutes, every player in the game must contribute 5 units to represent the food he is eating and his basic consumption. The Collector will be circulating among the players and must be given the five units.

Any player who does not have enough to pay these units must, from then on, keep one hand within reach of the floor i.e., he must kneel, crouch or sit. He can crawl or creep about, but he must no longer stand upright. He must continue like this until he has paid the units. Any player who fails to pay the five units for a second time must then sit against the wall without moving or must lie down on the floor. Such unfortunates are then virtually out of the game unless someone else 'feeds' them by paying off their dues.

There are three ways in which players can earn more money. One is through the ownership of assets. The assets of the room in which the game is being played - the doors, the chairs etc., will be sold off after this briefing. Some will be auctioned; and some will be sold at a flat rate. People who buy them can then rent them out, or can charge a toll for their use. Take the door for example: if anyone wants to go out to the toilet for a drink of water, they will have to pass through the door. The owner of the door can then levy a toll on them.

The second way of earning money is to set up an industry. There will be four industries in the game, which will be described in a moment. The raw materials and the equipment needed for these industries will also be sanctioned. All the finished products can then be sold to the Purchasing Corporation. Please note that the Purchasing Corporation has set strict standards and will not purchase anything which is not made according to the standard.

The third way of earning money is to sell your labour to anyone who will give you work.

The first industry is the manufacture of paper-chains. Newspaper must be cut into strips, 1 inch wide and 6 inches long, and pasted into chains. The final length of the chain is to be the outer dimensions of ....(Here indicate the door-frames or whatever which was chosen before the game began.) The chains must be held up around all sides of the .... at the time of sale for the inspection of the Purchasing Corporation.

....5.

A completed paper-chain with links as specified will be purchased by the Corporation for 1000 units.

The second industry is the making of nets. String must be cut into lengths of exactly six inches. These must then be knotted into equilateral triangles, and extended into a net of such triangles. The finished net must be large enough to cover.....(Here indicate the window-frame previously chosen). It must be held up against the frame at the time of sale for the inspection of the Purchasing Corporation. A completed net with triangles as specified will be purchased for 750 units.

The third industry is blowing balloons. Unused balloons will be auctioned in packets of ten. They must be blows to their maximum size, and tied up before they are taken to the Purchasing Corporation. There they will be measured. If they are accepted, the Corporation will pay 50 units for every balloon.

The fourth industry is the assembling of paper-clips. The clips must be assembled in chains of 57, each clip pointing in alternate directions, head to head, tail to tail. Clips will be sold at a fixed rate of 75 units for a packet of 100 clips. For every completed chain, the Purchasing Corporation will pay 100 units.

Starting the Game

When the briefing is finished, the sale of assets can begin. The players should be invited to buy their chairs at a rate of 20 units. They should be told that they will have to stand otherwise. When those who want to buy chairs have said so and paid the Purchasing Corporation, all the other chairs should be removed by the Collector and Policeman. Then the other assets of the room should be sold or auctioned.

When that is done, the raw materials and equipment for the industries can be auctioned, one after another. The auctioneer should accept bids only in ten units, and should make the auction as fast as possible. After one set of the materials and equipment for each industry has been auctioned and sold, it may be advisable to have a break for 15 minutes before another round of sales.

If tea or coffee is being served during the period of the game, this can also be treated as a resource. Cups can be offered for sale to the individuals at some price which prevents the poorest from buying them. Or the whole supply can be auctioned to the highest bidder, who may then retail it to other players at a profit.

After play has been proceeded for some time, and after one or two more auctions have been held, the organiser can informally review the progress of the game with his colleagues. Each of them should also be observing the players, and be taking note of who is engaged in activity, and of what kind, and who is standing idle. Sometimes all the initiatives are taken by the wealthy who may (or may not) employ the poor as labourers or as caretakers of their property. Sometimes the poor will form some sort of association, and will pool their resources and provide themselves with work. Such trends should be observed for feed-back reflection later.

The game can be ended after an hour or so at the discretion of the Organiser and his colleagues. This may be after one or two of the large paper-chains and string nets have been completed. The players should be given warning ten minutes before the end.

Discussion

Even at the discussion, only those who purchased chairs should be allowed to sit on them.

People are first asked to calculate the amount of money with them at the end of the game and thus, together with the amounts they started with, can be written on the blackboard. Then the rewards can be presented to the players, either on the basis of money they have at the end of the game, or on the basis of the profits they have accumulated.

People can then be asked to comment upon their experiences and feelings at different stages in the game, for example, during the sale of assets, during the bidding of raw materials, at any time when they were without money and had to contribute for their food, when they were seeking work, when they were given work, when they could not have tea, and so on.

Any group, partnership, or association should be asked to comment on their experience. In particular, they should ask how their association came to be formed, and on what basis.

Those who set up industries are invited to describe their experience, and to reflect upon the basis of which they recruited people to work with them. What share of the profits was paid out for wages? What share did they retain for themselves? What did their workers experience?

Finally the discussion may turn to reflection upon the relationship between some of the processes within the game, and those in the economy at large. What are the choices before the poor, given the present distribution of wealth? How can the poor obtain a larger share of the total production? Whom does the industry benefit?

1. Relevant Health Education
   Education by Appropriate Analogy (Chapter V)

2. Doctrine of Multiple causality (Appendix D)

3. Notions of Etiology (Appendix. D)

From

A METHODOLOGY GUID- FOR THE COMMUNITY

DIAGNOSIS OF HEALTH

Project Community Diagnosis 1978-79

Mark Nicter, K.H. Bhat, Srinivas Devadiga and

Mini Nichter

Office of Population and Health

USAID

New Delhi

V. Relevant Health Education:
Education by Appropriate Analogy

> One cannot expect positive results from an education or political action program which fails to respect the particular view of the world held by the people... it is not our role to speak to the people about our view of the world, nor to attempt to impose that view on them, but rather to dialogue with the people about their view and ours. We must realize that their view of the world manifested variously in their action reflects their situation in the world. Educational and political action which is not critically aware of this situation runs the risk either of the banking or preaching in the desert.
>
> Pedagogy of the Oppressed,
> Paolo Friere

In the above quote by Paolo Friere, reference is made to the banking mode of education, a mode of education prevalent throughout the developing world. What is implied by the term banking is that information is deposited into a villager's mind verbatim, as if the mind were empty. This mode of education presupposes that once information is deposited it will incur interest over time. The poverty of this type of education is seen in village India today in thedividend it is yielding in the form of inertia and the compartmentalization of new ideas.

What is required is a form of education which engenders synthesis and fosters the organization of new and existing information as opposed to the compartmentalization of information into seperate spheres of reality . The process of education which is advocated evolves out of dialogue and the posing of appropriate questions which reveal and challenge assumptions. Such education necessitates preliminary investigation of the cognitive universe, the phenomenological context in which the villager lives.

One of the purposes of a community diagnosis of health study is the identification of indigenous concepts which may be used in the framing of relevant educational strategies. These strategies, rather than being based on ideas outside the villagers comprehension, are based on what is already known or questioned. In this sense, the mode of education recommended is an extension of classical modes of education which communicated knowledge conceptually through analogies and metaphors poetically orchestrated around immediate experience.

The reasoning behind this mode of education can be illustrated with reference to everyday speech. Theeeveryday speech of villagers is composed of numerous analogies, metaphors, and proverbs. To understand such speech one has to comprehend more than simply the words spoken. What is necessary is an understanding of the relationship between what is spoken about and what is being referred to. Commonly, an idea which is easily understood on one plane is used to describe an idea or istuation on another plane. By explaining something in this manner, one is able to convey knowledge within one's cognitive framework, permitting a minimum number of words to be used to convey a maximum amount of understanding; understanding facilitated by reference to what is already known thus making memory easy.

During the project, core staff experimented with analogical reasoning as means of explaining new health ideas. First, attention was focused on domains of knowledge and experience with which the villager was familiar andwhich were commonly exploited in local proverbs, analogies, etc. Then, such domains of knowledge were considered in relation to priority issues in health education. It is the opinion of the research team that it is possible to explain any common biomedical concept vis a vis indigenous concepts by maximising analogical reasoning. The examples given below may illustrate the strategy used.

.....2.

V. Relevant Health Education:
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.....2.

1. FIELD: BODY

1.1 Nutrition:

For your rice crop, you need cow manure, green leaf, and ash, If you have less manure, your crop will have no heigh, if less gree leaf is put, the crop will be less, if less ash is put the husks will appear but inside there will not be grains. The body is like that. Fish and grain are like manure, green leaf like vegetables, minerals (iron, calcium) like ash. If you want a good crop, you must make correct balance.

1.2 Family Planning - spacing

If you plant too many paddy seedlings very close to each other, what will happen? Do they not interfere with each others growth, do you not get a poor crop? Having children close together is like that - should a mother give breast milk to one child while pregnant with another? (Culturally women(South India) think they should not continue breast feeding, but do because of a lack of availibility of milk, funds to purchase milk or benevolence particularly towards a male child.)

2. WOMAN'S CYCLE: SEASONAL, MOON CYCLE

2.1 Relative fertility in woman's monthly cycle:

If a crop is planted in the wrong season is there any benefit? A woman's cycle is like a seasonal cycle, like the moon cycle.

Menses is like amavase/amavas/ (no moon, an inauspicious time of overheat when no new work is begun)-- as the moon becomes more full toward hunime (full moon- auspicious time which is cool and linked to fertility) the benefit (labha) of acts begun is m more. Hunime in a woman is the period 10-15 days after her menses. If child is desired the seed should be planted in that season. If a child is not wanted the seed should be thrown at another time.

3. COOKING: DIGESTION

3.1 Dehydration

If you are cooking some food and there is not enough water in the pot, what happens? The food becomes dry and burns, the pot burns as well and if not removed from the fire it may become spoiled. Digestion is like cooking. If water is less in the body, the body becomes dry and begins to burn, fever comes as well as weakness. If water is not put in the stomach pot, the heat spoils the blood and a lack of water may cause a person to die.

3.2 Dehyderation and Diarrhoea

Diarrhoea is like a hole in the stomach pot--water keeps coming out and if more is not placed in the pot, the blood burns. Wather must be placed in the pot until the hold can be repaired. Repair requires medicine but even more immediately important than repairing the hold is not spoilling what is in the pot i for that is life blood.

3.3 Dehyderation and Fever

Fever is like a pot boiling without a cover. The liquid evaporates and the food (blood) in the pot burns. To reduce this problem, medicine may be given which acts as a cover for the pot(aspirin) but sometimes the problem is that the fire under the pot is too hot. In such cases, medicine must be given to reduce the fire/fuel (food) and the body must be kept cool. But most important in any kind of fever is that the water in the body be enough to prevent the blood in the stomach pot from burning.

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3.4 Fontanel sinking in baby

When boiling rice, if the water becomes less what happens? Doesn't the rice in the center of the pot sink down? And then if water is added doesn't the depression come back to normal level? So it is with a baby. If the liquid in the body is less the fontanel/ netti depresses. When enough liquid is given the depressed area comes to the normal level.

3.5 Preparing Electrolyte solution

In the cooking pot, water is needed. For the stomach pot, when water is urgently needed, boiled water which contains sweet, salt, and sour is best. Salt is needed for the blood, Kara (piquant) should be reduced as this increases heat. To help digestion some sweet and sour are needed. Therfore, for every glass of water, a pinch of salt, a small amoutn of sour (lemon, local fruits) and sweet (2 sppons of jaggery, sugar, honey), are needed.

Digestion is the center and the most important process in indigenous ideology: connected to most illnesses)

4. House: Body

Insects: Germs

4.1 Many types of insects may enter a house. If one is inexperience and has much work these insects may be idisregarded expecially if the person thinks they are harmless. Then one day the person may feel some irritation, like the trouble given by bedbugs, and wonder what is the causes. By that time, many insects may be in the house and it will be difficult to get rid of them without disrupting the activities of the house. At other times, a person may not know what causes such insects to come in great numbers like oil being left on the floor attracting cockroaches. It is the duty of family andfriends to help inexperienced people learn such things, just as it is the duty of adults to instruct children which plants are foods and medicine and which are poisons.

The body is like a house, Krimi enter because the doors are left open(weakness), because something attracts them, or because the body permits them to enter thinking they are harmless guests or beggars. In the case of insects entering a house, knowledge comes after seeing and experiencing them. In the case of illness entering the body, however, Krimi (use a similar local term) which cause illness are not visible. It is not enought to tell a man that "some Krimi" cause illness," so he should not allow them in his body. The body, however, can be taught a lesson. This the purpose of a vaccination. A vaccination contains harmful Krimi made weak by poison. When these Krimi enter the body, they make trouble--but only a little trouble, not like the trouble which many would cause if they came to the body in number. They body learns how to both recognize these trouble some Krimi and kill them. Side effects, such as fever and chills are not bad; they are good signs that the body is learning to ree congnize and fight Krimi through experience. Yes, the side effects, ~~xxxx xx~~ cause trouble but just as in children, sometimes an important lesson must hurt just a little. In the future, if these Krimi come they can be killed more easily and if a body has learned to recognize them by experience, it will not let them enter in number or willsweep them clear, the way a woman sweeps a house clear when she sees ants coming in number. Like sweeping, this requires a short gap in normal activity, in this cas it may cause small problems like a one day fever or diarrhoea. But better this thana big illness later. A vaccination them is a way of the body gaining Krimi anubhawa (experience)--the more anubhava for such Krimi diseases one has, the less chance of getting an illness. That is why children with less body experience

get

get a Krimi diseases more, and why once a child gets Krimi disease like chickenpox or whooping cough, his chances of getting these diseases again is less than other children. Only some krimi can be swept out of the body house, however, others are so common that the body can not prevent them from entering the house as this would be a full time job and man has other works. In such cases, man must learn what attracts such Krimi, what these Krimi do not like (e.g. smoke for mosquitoes), andhow to keep this doors closed (good hygienic diet).

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1. Krimi is one term used by villagers to describe invisible worms.

*The diseases which should be used here are those which etiology surveys have indicated are associated with external worm/germ type agents. Ayurvedic pandits tell us, for examples, that undigested food or impure blood attracts certain Krimi. It is necessary to make these conditions less and to teach the body who are its friends and who are its enemies.

5.1 Harvest: Deliver

Fertilizer: Feeding of Woman during Pregnancy

Near the time of the harvest, if the crop looks weak 1, is that the time to think of adding manure to the field 2 So it is with pregnancy. A diffic lt delivery is often caused by weakness and lack of blood in the mother as well as the baby, At the time of delivery, it is not possible to increase blood. (unlessbblood is given by transfusion- -for villagers who are aware of what a transfusion is). For this reason, it is necessary for a pregnant mother to eat blood/strength producing foods. Dhatu (a local term which refers to accumulated strength and is associated with diet) requires time to be produced and for this reason blood/strength producing foods must be consumed throughtout pregnancy.

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1 Weakness is emphasized here, not crop size. It is commonpl place throughout India for women to link large babies with difficult delivery (as well as problems during pregnancy). Rather than confront this strong attitude directly, it is better to use a culturally appropriate health education strategy and emphasize 'more blood and more strength.' Big is best is an ethnocentric approach and in any case, the size of a baby is not directly correlated with strength as villagers speak of babies whomlook big but are only full of water, indicating an undersirable state.

2 A local proverb expresses a similar idea: "when a man is thirsty, is that the time to start digging a well?"

The Doctrine of Multiple Causality

Relatively few illnesses in rural South India are associated with only one possible etiological factor. Most illnesses are thought capable of being caused by any one of several factors acting alone or in concert with others. Moreover, once ill, a villager is considered vulnerable to additional etiological factors which may prolong or compound illness making it more complex to manage or cure This is one reason why patients sometimes consult different types of practitioners simultaneously so as to remove/ manage multiple etiologicalfactors or reduce their after effects. Another factor which complicates illness classification and lay medical decision making is the fact that similar symptiom sets may be interpreted differently (as types of one illness or different illnesses) due to the onset or progression of symptoms as well as suspected etiological factors. For this reason, data presented on the etiology of illnesses in this report, although based on considerable survey and case observation research should be considered data on dominant notions of etiology not fixed ideas.

The latter point is important when planning appropriate health education strategies. It is stressed that ideas about etiology are flexible. We found that new ideas can readily be introduced in the context of dialogue when explained in terms of existing etiological concepts or perceived states of the body (based on indigenous notions of physiology) associated with the illness in question As can be seen by the list of etiological factors which follows indigenous concepts can be found for most biomedical concepts. Scope exists to define particular illness episodes in terms of alternative etiological notions (if a prevalent idea is counter-productive to health behaviou) as long as the factor attributed is not antithetical(in qualitative affect)to the type of symptoms manifested.

For examples, most itchy skin rashes among children are ambigiously labelled Kajji: 1 a condition strongly associated with over heat in the body and treated by a restricted dies (less Ushna no nanjufoods) and the application of cooling leaves. A differentiation of Kajji into different types caused by a) worms of external origin eating the skin (scabies, impetigo) and b) overheat (kwashiorkor related sking;esopms /artomlarly on the limbs, phrynoderma, vitamin A deficiency) was conveyed to villagers without much difficulty. This overt differentiation was invluable to us in communicating health education information. We were better able to explain why

1 This term is used in both South and North Kanara Districts.
2 See notes on etiology which follow and a forthcoming report on dietary restrictions during illness.

Scabies treatment required the placing of a poisonous medicinal lotion on the skin for 48 hours and the necessity for boiling one's clothing (to kill minuscule worms and to get rid of worm eggs; worm eggs being a concept known to villagers from their experience with picking lice). It also helped us to convey dietary advice in cases of malnutrition. As opposed to discounting local ideology, we planned a nutrition strategy to confront existing ideology, we about kajji caused by states of malnutrition. When a state of malnutrition. [illegible] manifested in skin lesions with pruritus, cooling foods were suggested, such as green gram and ragi, seasme oil (essential fatty a cids), and vine spinach (vegetable) protein and vitamin A) which were culturally acceptable. Accepting that one form of Kajji was caused by overheat (and designing a nutrition strategy accordingly) while differentiating Kajji into different types increased the compliance rate of those under taking scabies therapy in our makeshift first aid station and more importatnly, the credibility of our education message.

Another point to be appreciated is that what appears to be a symptoms of illness may be interpreted as a sign of some broader problem (dosha, upadra) effecting the one who is afflicted or his family unit 2. Alternative notions of the possible etiology which are dwelled upon may be related to attempts at linking causality to particular social domains (social relationships) where vulnerability or instability exists; or they may be attempts to projected resposibility away from normal interaction spheres (onto wandering spirits, inauspicious celestial effects, etc.) as a means of reducing guilt, etc.3 In other words, suspected etiological factors may be functional expressions of anxiety connected to competition, jealousy or guilt, (in respect to fulfilling obligations, role expectations, or one's duty)

To sum up:

1. Rather than undermining health education efforts, the doctrine of multiple causality accomodates new ideas and facilitates innovative health education.

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1 Sesame oil is considered cooling in South Kanara but heating in parts of Tamil Nad. This is an example of why region-specific planning based on a knowledge of indigenous ideology is importe

2 This is especially the case if the one afflicted is the weakest or most vulnerable family member, i.e. a young child or pregnant woman.

3 For example, evil eye as well as toxic breastmilk may be associated with a case of infant diarrhoea. Obviously notions of evil eye focus.

2. Indigenous concepts of etiology complement biomedical concepts of etiology (if not logically than analogically).

3. New ideas introduced appropriately in terms of concepts which the ~~xxxxxxx xxxxxx xxxxxx~~ villager can relates to, facilitate both understanding and greater scope for their application of these ideas.

4. An entrance into the villager's conceptual universe, as well as personal medical history, can be gained by discussing both the classification of symptoms as partic lar illness categories and the suspected causes of an illness experience.

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3 (cont.) attention away from the mother and feelings of guilt.

Notes on common notions of etiology and associated symptoms in South Kanara District, Karnataka

1. Less food/ Kadime tinas/

Specifically, this refers to eating an insufficient quantity of the staple food one is accustomed to eating (in this case, rice). It is important to keep in mind that the villagers' sense of body cycle normality derives from the maintenance of a routine digestive cycle and body signs associated with this staple specific cycle 'faces consistency and regularity. urine color, timings of hunger, etc.)

2. Improper dies: /apathya/

a. taking meals erratically (among castes maintaining routine commensality patterns)

b. eating foods having properties counter-indicated in particular seasons, ~~xxx xxxxxx xxx~~ to particular age-groups.

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in transition periods, and during illness episodes.

c. commonly, in children, giving chillies and hot curries before the age of 2.

d. commonly, in adults, eating excessively spicy foods /kara/

3. Bad blood /netter hal/

a. bad blood is thought to be caused by overheat /ushna, garam/toxidity /nanju/, loss of slepp. inappropriate eating habits, exposure to extreme weather conditions. hard work, past illnesses and powerful medicines (consumed presently or in the past).

b. Sluggishness and weakness are associated with bad blood interfering with the flow of substance in the body. This is sometimes associated with vata as well (see below).

c. Bad blood in the head and stomach is thought to be pushed out by vomitting while bad blood in the intestines and legs causes sores /pudi/

d. Wounds which become infected are associated with bad blood(an internal factor) more often than lack of external cleanliness

e. During amenorrhoea and pregnancy (a condition described as nanjiin character) impure blood which is normally

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Research in other regions of Karnataka and a knowledge of ethnomedical literature in India, suggests that most of these factors have widespread relevance to rural areas.

expelled from the body is thought to be retained and mixed with good blood (causing bad blood.)

f. Some illnesses are ascribed to bad blood being passed on from mother to fetus or breastfeeding child.

4. Climatic changes /have mana/

Fluctuations in temperature are thought to throw the body off balance. For villagers, the healthiest time of the year is when the temperature is most constant. Climate changes are suspect especially at times of seasonal change. These times are associated with bad winds and the movement of spirits (discribed as gali or sonku)

5. Heat in the body /ushna, garam /

a. A certain amount of controlled heat is required for the maintenance of bodily processes especially the digestive process. Controlled heat is associated with strength (trana, shakti) while an exees of heat may cause and be associated with the following symptoms.

1. burning sensation in stomach.
2. burning sensation in eyes., feet, and hand (anaemia, calcium deficiency)
3. burning sensation during urination
4. Indigestion
5. diarrhoea/ constipation/(especially dry stools)
6. blood in feces
7. redness of the skin/ rashes/ boils
8. dry cough
9. body pain. particularly back ache
10. cracking of soles and palms

11. balding/hairlessness
12. dissolving of bones: bones becoming brittle
13. dhatu loss, mental upset and confusion

b. A state of overheat (ushna) can be passed on from mother to child, through the breastmilk causing the baby to experience indigestion, diarrhoes, boils, or fever.

c. Overheat is the after (end) effect of many other etiological factors (e.g. food climate, evil eye, encounters with a spirit, mental worry). Therefore it is important to ascertain if the term is being used as a general statement or in conjunction with notions revealed by further inquiry. The most common general references to overheat is to refer to the eating foods, the feeling of hunger, or sleeplessness.

6. Excessive Coolness (tampu, tandi)

a. In terms of prevalent health (and for that matter, ritual) ideology, cool /tampuØ is needed to controlheat in the body. Generally, in reference to health, tampu is associated with with weight gain and slower digestion. Too much tampu is thought to manifest the the following symptoms:

1. excess phlegm
2. cold, runny nose, sore throat
3. wet cough
4. indigestion and constipation (fewer bowel movements as opposed to dry feces)
5. complaints that the blood has become thick and doesn't flow properly causing fatigue.
6. headache.

b. Excess cool is thought to be transferred through breatmilk causing baby to experience indigestion. cold and accumulation of hlegm.

7. Toxic substances /nanji/

a. Nanji can result from:

1. the retention of bad blood not emitted by routine body cycles (amenorrhoea and pregnancy seen as the disruption of the menstrual cycle).
2. substances consumed by the body which it cannot digest such as the unctuous juice of brinjal or drumstick (foods classified as nanju.
3. the consumption of too many sweet foods, oils, or impure foods.
4. child receiving impure breastmilk from its mother.

b. Nanji is associated with infection. pus, boils and itchiness. Nanji in the blood is thought to prolong the cure of most illnesses: particularly wounds, skin diseases and intestinal complaints. for this reqon, foods classified as nanju are not eaten during illness episodes.

c. Nanji (toxic) should not be confused with visha (poison). It ia generally believed that nanju foods are the best tasting foods tasting foods and their consumptions is common.

8. An excess of one of the three body humors (tridosha):

a. The principle of body humoreis the basis of ayurveda, the classical

system of Indian medicine. It may first be emphasised that few villagers (as well ad few vaidya , fural herbal practitioners.) know much about the principles of ayurveda. However, ayurvedic terminology and the use of ayurvedic regimens are very much part of folk medical cultures in India. While tridosha, as a principles of body physiology, is not known. the effects of humoral aggravation (the symptoms manifesting) are known andhumoral terminology is used in colloqial languages to describe the'course'of such symptoms Most commonly these 'causes' are associated with the eating of foods clssifed locally as having a quality (guna) which produces these symptoms when consumed in excess or at inappropriate times. 1 As might be imagined, interaction between laymen and learned ayurvedic practitioners 2 has caused a number of ayurvedic terms to to flow into the local vernacular where they are given local meanings. and usuage.

b. Symptoms associated with tridosha terminology:

1. Pitta

   a. nausea
   b. tasting of bitterness in mouth
   c. dizziness
   d. loss of mental equilibrium, mental upset, taking nonsense
   e. yellow urine
   f. heartburn
   g. yellowing of body / jaundice
   h. associated with overheat in the body

2. Kapha

   a. aphlegm laden cough. It may be noted that young children are thought to have a propensity toward kapha disorders and have more kapha in the body. For this reason, respiratory illnesses are often not treated in the early stages. This does not mean, however, that mothers do not try and check the excess of kapha, for a number of curative and preventive home remedies are utilized.

   b. mucus exuding from the nose, eyes, mouth, or anus (foamy stools)

   c. foaming at the mouth particularly after febrile fits among infants is linked to an excess of kapha as well as spirit attack.

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1. The classification of foods with reference to the tridosha is more complex than this (one should consider the ayurvedic concepts of triguna , Viriya, and vipaka but for our purposes this passing reference is sufficient).

2. I will refer to these practitioners as pandits to differentiate them from vaidya practitioners who dispenses herbal medicine but do not follow a system of diagnosis and therapy.

3. Vata:

Vata is the wind (movement, motor function) principle in the body. An excess of vata is thought to cause body pain and when vata is blocked it is thought to cause stiffness in joints. Vata conditions are sometimes linked to less blood. Vata is associated with the effect of sanni planet (Saturn) and excretions from the body which are blackish in color.

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4. Vayu:

Vayu is associated with wind in the form of gaseousness within the body causing:

a. indigestion, flatulence

b. feeling of fullness and being stuffed up

c. feeling of breathlessness

d. fatigue, laziness

CONTAGION FACTORS / antu, pagarana /

9. gali

a. This term literally means wind. It is used to describe a spirit wind (sometimes called sonku), a malevolent wind carrying illness from one village to another, and the wind ensuing from an ill for menstruating person when he/she passes.

b. It may be noted that some illnesses associated with gali such as chickenpox or measles are thought to manifest from the stomach first not the external surface of the body. Pox fall / burundu/ on the body surface from the interior.

c. Gali is thought to cause sudden drametic symptoms usually associated with overheat or cause impurity to the blood resulting in boils, pox coming to surface of the skin etc, Specific reference to sonku is more in Ati month and is associated with sudden fever or pain.

10. breath / svasa / of a person who is ill.

11. crossing / kadapu/

An idea exists that crossing (steppin over, passing through a transition point) associates one with the malevolent qualities of the material / force crossed. Common agents cited are body excrements of the ill (faces, urine, saliva, scabs), shadows or blood of menstruating women, food fouched by the ill etc.

12. Contact with impurity /mailge, basta, made/

a. direct contact with impurities such as saliva /dalle/ or the consumption of impure substances is commonly associated with ifection and the appearance of boils.

b. contact with the pus of one who has a skin disease or diseases in which lesions manifest.

c. contact with the breath of a diseased person in life and the spirit of a diseased person after death /khale/.

d. touching the body of a diseased person or his personal effects (clothes, blankets, etc.)

13. Minuscule worms, germs / krimi, puri / keidi /

Many illnesses are attributed to be caused by worms of internal of external origin. Folk notions of physiology give functional role of worms / five da puri/ in the digestive process. Some illnesscs are spoken of as caused by having more or less of these worms, more active or sleeping worms which for example may cause loss of appetite or improper motion. These worms are particularly suspect when a small child has a loss of appetite, is listless, vomits, is irritable, has diarrhoea, grinds his teeth, or has a bulging stomach, many other diseases, particularly fungal diseases and infected wounds are also attributed to worms. The notions of

....9.

minuscule (invisible) external worms /Krimi pudi/ which enter a body causing illness are similar to biomedical concepts of germ, virus, and are a part of the folk health culture.1 It may be noted however, that the etiological factors are associated with precipitating reasons for these external agents being attrated to particular persons or being able to enter domains (body) domain, house domain, village domain) normally protected (closed to intrusion, disruption) ritually or by substances enhancing one's positive health. This reasoning often focuses attention on states of vulnerability (due to climatic changes, lack of spirit protection, transition in one's life, states of impurity etc.) Here we find the basis for a strong indigenous concept of preventive and promotive (positive) health.

14. Hereditary factors:

This is a complex concept which may refer to:

a. illness being passed on through the bloodline of a lineage (matrilineal, patrilineal reference)

b. an illness which comes as a course or recompense to an individual or family due to non-fulfillment of obligations, sin, papa, karma etc.

c. an illness which another family member experienced in the past associated with either spirit attact by the deceased or a sign from the deceased of its presence.

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1. The concept of external etiological factors (minuscule worms- Krimi, insects - Kita is found within ayurvedic dogma.

15. Spirits:

Each type of spirits is associated with a social domain or state of wildness/uncontrol. Suspicion of a particular type of spirit focuses attention on imbalance or vulnerability in that domain. References to vague stars / spirits of the wild (of the forest, transition points, etc.) focuses attention and responsibility for illness away from social domains / relationships other wise suspect. Examples from South Karnara are:

a. Kule - ancestor spirit. Knowledge about the lineage of Kule effecting the afflicted throw light on friction/ jealousy in that kin group or between the kin group of the afflicted and that which the Kule represents.

b. buta -spirit of a social domain jaga/be it the family domain Kutumba village, kingdom, forest etc. A buta is a manifestation of power which can be either malevolent of benevolent depending on his this personified power is controlled. Suspicion about specific buta usually is associated with instability in domains (commonly, non-fulfillment of obligations fowards the members of that domain (alive and dead) Reference to wild or controllable buta are often associated with responsibility projecting away from the person experiencing problems.

c. naga - a snake deity associated with fertility as well as skin diseases such as leprosy and herpes zoster, eye complaints, menstrual problems, breast pain in a lactating woman and sterility. In this case, folklore has influenced the association certain illnesses with naga.

d. pide - spirit of a deceased child thought to be attracted to other children out of love or envy. The touch of pide is associated with a wide range of childrens illnesses. The pide may be a deceased family member or a roaming spirit.

....8.

e. Mari - (Bhagavti, Amma) Goddesses associated with pox diseases either inflicted out of love or anger. Goddess linked illnesses are often not spoken about as speaking of the goddess and the illness is thought to bring the goddess into presence thus spreading the disease.

Note: illnesses caused by spirit trouble are freferred to NOT as a roga (disease) but as dosha or upadra disturbances/ trouble.

16. Stars:

The illeffect of celestial bodies is commonly referred to as graha chara . The lay public does not know much about astrology. Saturn, Sanni is often associated with vata complaints, no moon with over-heat in the body and full moon with coolness and an increase in kapha. Coughting and fits are thought to increase during the period of no moon and full moon as well as as sankranti (another transitional point) andpatients report this to practitioners to aid dianosis.

17. Fate: multiple notions exist of qualified (transformable) and unqualified fate.

a. hanne baraha - predetermined fate (writing no fore - head). non- negotiable. (at birth, one's destiny is written)

b. adrishta - bad luck

c. Karma - inherited or self made sins or obligations which necessitate and bring recompense.

d. avasu - life expectation, associated with the concept of rebirth.

e. papa - accumulated sins.

18. Evil eye - dristhi/evil eye is associated with visible signs of overheat in the body (sudden appearance of rashes, fever, unconsciousness) especially in children and pregnant women (e.e. those most vulnerable). Dristhi is also related to guilt projection by mother when child falls ill.

19. Witcheraft - associated with competition, jealousv, suppressed anger within andacross linerage and caste lines /mata/

20. Dhatu loss - dhatu is a body substances associated with positive health and vitality. Dhatu is responsible for the control. the control of desire, concentration, virility and the ability to gain weight. Commonly, dhatu is feared to be lost due to masturbation or sexual excess where if leaves the body as semen. Specific foods produce and reduce dhatu. A reducation dhatu makes one vulnerable to illness.

21. Pregnancy desires: unfulfilled desires during preganancy are thought to affect fetus development and are associated with limbs and sense organs, defects, car discharges etc.

Review of etiological factors by broad category (internal), external, moral

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Internal:

1. Food/diet:

a. less of staple food

b. inappropriate food - season - age

c. Impure food. toxic (nanju) food eaten in excess

d. food which aggravates tridosha

e. gaseous (vayu) foods interfering with movement and body cycles

2. Excess of uncontrolled heat in the body or excess cold:

(see additional notes on the hot / cold idiom)

a. loss of feeling of balance in body/mind

b. lack of control over one's supply of vital qualitative energy

c. Interference of physiological processes resulting in blockage of basic life systems --- digestion, defecation movement of blood and energy/trana, shakti/ menstruation etc.

3. Blood becoming:

a. less

b. impure

c. thick/thin

As a result of:

1. less or inappropriate food, poor digestion
2. overheat in the body
3. over work
4. exposure to extreme climatic conditions
5. spirits
6. hereditary factor (related to moral factors -- ancesors. sin, etc.)

4. Aggravation of the tridosha:

Tridosha viewed as substances causing illness when in excess: more than a view of humors playing a necessary role in the physiological process.

a. Vata

b. pitta

c. Kapha

5. Dhatu loss:

1. overheat
2. improper diet
3. sexual excess, deviance, masturbation

6. Aggravation or suppression of intestinal worm activity in the gut, as well as reduction of optimum number of worms necessary for digestion or an increase of worms past the optimum.

7. Impurity (body or blood) due to natural processes (menstruation the blocking of natural processes (amenorrhoea, constipation, or the entrance into a state of body (delivery) or status (birth, death) transition. Associated with states of vulnerability, or states where other etiological factors are attracted.

.....10

8. Non fulfillment of pregnancy desires.

External Factors:

1. bad wind
2. Contact with those who are ill(touch, crossing them or body excretions)
3. contact with impurity
4. minuscule worms or insects
5. negative qualities of seasons, seasonal changes
6. spirit contact; curse, trouble
7. evil eye
8. witchcraft
9. effect of cerestial bodies-- stars, planets, etc.

Moral Factors:

1. notions of fate (ayasu, karma, hane baraha)
2. spirit trouble- failure to upkeep obligations/responsibility in domains of prescribed social interation (family lineage caste, village.)

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1. Relevant Health Education
   Education by Appropriate Analogy(Chapter V)

2. Doctrine of Multiple causality (Appendix D)

3. Notions of Etiology (Appendix. D)

From

A METHODOLOGY GUID FOR THE COMMUNITY

DIAGNOSIS OF HEALTH

Project Community Diagnosis 1978-79

Mark Nicter, K.H. Bhat, Srinivas Devadiga and

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Office of Population and Health

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New Delhi

V. Relevant Health Education:
Education by Appropriate Analogy

> One cannot expect positive results from an education or political action program which fails to respect the particular view of the world held by the people... it is not our role to speak to the people about our view of the world, nor to attempt to impose that view on them, but rather to dialogue with the people about their view and ours. We must realize that their view of the world manifested variously in their action reflects their situation in the world. Educational and political action which is not critically aware of this situation runs the risk either of the banking or preaching in the desert.
>
> Pedagogy of the Oppressed,
> Paolo Friere

In the above quote by Paolo Friere, reference is made to the banking mode of education, a mode of education prevalent throughout the developing world. What is implied by the term banking is that information is deposited into a villager's mind verbatim, as if the mind were empty. This mode of education presupposes that once information is deposited it will incur interest over time. The poverty of this type of education is seen in village India today in thedividend it is yielding in the form of inertia and the compartmentalization of new ideas.

What is required is a form of education which engenders synthesis and fosters the organization of new and existing information as opposed to the compartmentalization of information into seperate spheres of reality . The process of education which is advocated evolves out of dialogue and the posing of appropriate questions which reveal and challenge assumptions. Such education necessitates preliminary investigation of the cognitive universe, the phenomenological context in which the villager lives.

One of the purposes of a community diagnosis of health study is the identification of indigenous concepts which may be used in the framing of relevant educational strategies. These strategies, rather than being based on ideas outside the villagers comprehension, are based on what is already known or questioned. In this sense, the mode of education recommended is an extension of classical modes of education which communicated knowledge conceptually through analogies and metaphors poetically orchestrated around immediate experience.

The reasoning behind this mode of education can be illustrated with reference to everyday speech. Theeeveryday speech of villagers is composed of numerous analogies, metaphors, and proverbs. To understand such speech one has to comprehend more than simply the words spoken. What is necessary is an understanding of the relationship between what is spoken about and what is being referred to. Commonly, an idea which is easily understood on one plane is used to describe an idea or istuation on another plane. By explaining something in this manner, one is able to convey knowledge within one's cognitive framework, permitting a minimum number of words to be used to convey a maximum amount of understanding; understanding facilitated by reference to what is already known thus making memory easy.

During the project, core staff experimented with analogical reasoning as means of explaining new health ideas. First, attention was focused on domains of knowledge and experience with which the villager was familiar andwhich were commonly exploited in local proverbs, analogies, etc. Then, such domains of knowledge were considered in relation to priority issues in health education. It is the opinion of the research team that it is possible to explain any common biomedical concept vis a vis indigenous concepts by maximising analogical reasoning. The examples given below may illustrate the strategy used.

1. FIELD: BODY

1.1 Nutrition:

For your rice crop, you need cow manure, green leaf, and ash, If you have less manure, your crop will have no heigh, if less gree leaf is put, the crop will be less, if less ash is put the husks will appear but inside there will not be grains. The body is like that. Fish and grain are like manure, green leaf like vegetables, minerals (iron, calcium) like ash. If you want a good crop, you must make correct balance.

1.2 Family Planning - spacing

If you plant too many paddy seedlings very close to each other, what will happen? Do they not interfere with each others growth, do you not get a poor crop? Having children close together is like that - should a mother give breast milk to one child while pregnant with another? (Culturally women(South India) think they should not continue breast feeding, but do because of a lack of availibility of milk, funds to purchase milk or benevolence particularly towards a male child.)

2. WOMAN'S CYCLE: SEASONAL, MOON CYCLE

2.1 Relative fertility in woman's monthly cycle:

If a crop is planted in the wrong season is there any benefit? A woman's cycle is like a seasonal cycle, like the moon cycle.

Menses is like amavase/amavas/ (no moon, an inauspicious time of overheat when no new work is begun)-- as the moon becomes more full toward hunime (full moon- auspicious time which is cool and linked to fertility) the benefit (labha) of acts begun is m more. Hunime in a woman is the period 10-15 days after her menses. If child is desired the seed should be planted in that season. If a child is not wanted the seed should be thrown at another time.

3. COOKING: DIGESTION

3.1 Dehydration

If you are cooking some food and there is not enough water in the pot, what happens? The food becomes dry and burns, the pot burns as well and if not removed from the fire it may become spoiled. Digestion is like cooking. If water is less in the body, the body becomes dry and begins to burn, fever comes as well as weakness. If water is not put in the stomach pot, the heat spoils the blood and a lack of water may cause a person to die.

3.2 Dehyderation and Diarrhoea

Diarrhoea is like a hole in the stomach pot--water keeps coming out and if more is not placed in the pot, the blood burns. Wather must be placed in the pot until the hold can be repaired. Repair requires medicine but even more immediately important than repairing the hold is not spoilling what is in the pot for that is life blood.

3.3 Dehyderation and Fever

Fever is like a pot boiling without a cover. The liquid evaporates and the food (blood) in the pot burns. To reduce this problem, medicine may be given which acts as a cover for the pot(aspirin) but sometimes the problem is that the fire under the pot is too hot. In such cases, medicine must be given to reduce the fire/fuel (food) and the body must be kept cool. But most important in any kind of fever is that the water in the body be enough to prevent the blood in the stomach pot from burning.

3.4 Fontanel sinking in baby

When boiling rice, if the water becomes less what happens? Doesn't the rice in the center of the pot sink down? And then if water is added doesn't the depression come back to normal level? So it is with a baby. If the liquid in the body is less the fontanel/ netti depresses. When enough liquid is given the depressed area comes to the normal level.

3.5 Preparing Electrolyte solution

In the cooking pot, water is needed. For the stomach pot, when water is urgently needed, boiled water which contains sweet, salt, and sour is best. Salt is needed for the blood, Kara (piquant) should be reduced as this increases heat. To help digestion some sweet and sour are needed. Therfore, for every glass of water, a pinch of salt, a small amouth of sour (lemon, local fruits) and sweet (2 sppons of jaggery, sugar, honey), are needed.

Digestion is the center and the most important process in indigenous ideology: connected to most illnesses)

4. House: Body

Insects: Germs

4.1 Many types of insects may enter a house. If one is inexperience and has much work these insects may be idisregarded expecially if the person thinks they are harmless. Then one day the person may feel some irritation, like the trouble given by bedbugs, and wonder what is the causes. By that time, many insects may be in the house and it will be difficult to get rid of them without disrupting the activities of the house. At other times, a person may not know what causes such insects to come in great numbers like oil being left on the floor attracting cockroaches. It is the duty of family andfriends to help inexperienced people learn such things, just as it is the duty of adults to instruct children which plants are foods and medicine and which are poisons.

The body is like a house, Krimi enter because the doors are left open(weakness), because something attracts them, or because the body permits them to enter thinking they are harmless guests or beggars. In the case of insects entering a house, knowledge comes after seeing and experiencing them. In the case of illness entering the body, however, Krimi (use a similar local term) which cause illness are not visible. It is not enought to tell a man that "some Krimi" cause illness," so he should not allow them in his body. The body, however, can be taught a lesson. This the purpose of a vaccination. A vaccination contains harmful Krimi made weak by poison. When these Krimi enter the body, they make trouble--but only a little trouble, not like the trouble which many would cause if they came to the body in number. They body learns how to both recognize these trouble some Krimi and kill them. Side effects, such as fever and chills are not bad; they are good signs that the body is learning to ree congnize and fight Krimi through experience. Yes, the side effects, ~~xxxx xx~~ cause trouble but just as in children, sometimes an important lesson must hurt just a little. In the future, if these Krimi come they can be killed more easily and if a body has learned to recognize them by experience, it will not let them enter in number or willsweep them clear, the way a woman sweeps a house clear when she sees ants coming in number. Like sweeping, this requires a short gap in normal activity, in this cas it may cause small problems like a one day fever or diarrhoea. But better this thana big illness later, A vaccination then is a way of the body gaining Krimi anubhawa (experience)--the more anubhava for such Krimi diseases one has, the less chance of getting an illness. That is why children with less body experience

get

get a Krimi diseases more, and why once a child gets Krimi disease like chickenpox or whooping cough, his chances of getting these diseases again is less than other children. Only some krimi can be swept out of the body house, however, others are so common that the body can not prevent them from entering the house as this would be a full time job and man has other works. In such cases, man must learn what attracts such Krimi, what these Krimi do not like (e.g. smoke for mosquitoes), andhow to keep this doors closed (good hygienic diet).

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1. Krimi is one term used by villagers to describe invisible worms.

*The diseases which should be used here are those which etiology surveys have indicated are associated with external worm/germ type agents. Ayurvedic pandits tell us, for examples, that undigested food or impure blood attracts certain Krimi. It is necessary to make these conditions less and to teach the body who are its friends and who are its enemies.

5.1 Harvest: Deliver

Fertilizer: Feeding of Woman during Pregnancy

Near the time of the harvest, if the crop looks weak 1, is that the time to think of adding manure to the field 2 So it is with pregnancy. A diffic lt delivery is often caused by weakness and lack of blood in the mother as well as the baby, At the time of delivery, it is not possible to increase blood. (unlessbblood is given by transfusion- -for villagers who are aware of what a transfusion is). For this reason, it is necessary for a pregnant mother to eat blood/strength producing foods. Dhatu (a local term which refers to accumulated strength and is associated with diet) requires time to be produced and for this reason blood/strength producing foods must be consumed throughtout pregnancy.

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1 Weakness is emphasized here, not crop size. It is common place throughout India for women to link large babies with difficult delivery (as well as problems during pregnancy). Rather than confront this strong attitude directly, it is better to use a culturally appropriate health education strategy and emphasize 'more blood and more strength.' Big is best is an ethnocentric approach and in any case, the size of a baby is not directly correlated with strength as villagers speak of babies whomlook big but are only full of water, indicating an undersirable state.

2 A local proverb expresses a similar idea: "when a man is thirsty, is that the time to start digging a well?"

The Doctrine of Multiple Causality

Relatively few illnesses in rural South India are associated with only one possible etiological factor. Most illnesses are thought capable of being caused by any one of several factors acting alone or in concert with others. Moreover, once ill, a villager is considered vulnerable to additional etiological factors which may prolong or compcund illness making it more complex to manage or cure This is one reason why patients sometimes consult different types of practitioners simultaneously so as to remove/ manage multiple etiologicalfactors or reduce their after effects. Another factor which complicates illness classification and lay medical decision making is the fact that similar symptiom sets may be interpreted differently (as types of one illness or different illnesses) due to the onset or progression of symptoms as well as suspected etiological factors. For this reason, data presented on the etiology of illnesses in this report, although based on considerable survey and case observation research should be considered data on dominant notions of etiology not fixed ideas.

The latter point is important when planning appropriate health education strategies. It is stressed that ideas about etiology are flexible. We found that new ideas can readily be introduced in the context of dialogue when explained in terms of existing etiological concepts or perceived states of the body (based on indigenous notions of physiology) asscciated with the illness in question As can be seen by the list of etiological factors which follows indigenous concepts can be found for most biomedical concepts. Scope exists to define particular illness episodes in terms of alternative etiological notions (if a prevalent idea is counter-productive to health behaviou) as long as the factor attributed is not antithetical(in qualitative affect)to the type of symptoms manifested.

For examples, most itchy skin rashes among children are ambigiously labelled Kajji: 1 a condition strongly associated with over heat in the body and treated by a restricted dies (less Ushna no nanjufoods) and the application of cooling leaves. A differentiation of Kajji into different types caused by a) worms of external origin eating the skin (scabies, impetigo) and b) overheat (kwashiorkor related sking;esopms /artomlarly on the limbs, phrynoderma, vitamin A deficiency) was conveyed to villagers without much difficulty. This overt differentiation was invluable to us in communicating health education information. We were better able to explain why

1 This term is used in both South and North Kanara Districts.
2 See notes on etiology which follow and a forthcoming report on dietary restrictions during illness.

Scabies treatment required the placing of a poisonous medicinal lotion on the skin for 48 hours and the necessity for boiling one's clothing (to kill minuscule worms and to get rid of worm eggs; worm eggs being a concept known to villagers from their experience with picking lice). It also helped us to convey dietary advice in cases of malnutrition. As opposed to discounting local ideology, we planned a nutrition strategy to confront existing ideology, we about kajji caused by states of malnutrition. When a state of malnutrition. ~~When a xxxxx of~~ manifested in skin lesions with pruritus, cooling foods were suggested, such as green gram and ragi, seasme oil (essential fatty a cids), and vine spinach (vegetable) protein and vitamin A) which were culturally acceptable. Accepting that one form of Kajji was caused by overheat (and designing a nutrition strategy accordingly) while differentiating Kajji into different types increased the compliance rate of those under taking scabies therapy in our makeshift first aid station and more importatnly, the credibility of our education message.

Another point to be appreciated is that what appears to be a symptoms of illness may be interpreted as a sign of some broader problem (dosha, upadra) effecting the one who is afflicted or his family unit 2. Alternative notions of the possible etiology which are dwelled upon may be related to attempts at linking causality to particular social domains (social relationships) where vulnerability or instability exists; or they may be attempts to projected resposibility away from normal interaction spheres (onto wandering spirits, inauspicious celestial effects, etc.) as a means of reducing guilt, etc.3 In other words, suspected etiological factors may be functional expressions of anxiety connected to competition, jealousy or guilt, (in respect to fulfilling obligations, role expectations, or one's duty)

To sum up:

1. Rather than underminging health education efforts, the doctrine of multiple causality accomodates new ideas and facilitates innovative health education.

1
Sesame oil is considered cooling in South Kanara but heating in parts of Tamil Nad. This is an example of why region-specific planning based on a knowledge of indigenous ideology is importe

2 This is especially the case if the one afflicted is the weakest or most vulnerable family member, i.e. a young child or pregnant woman.

3
For example, evil eye as well as toxic breastmilk may be associated with a case of infant diarrhoea. Obviously notions of evil eye focus.

2. Indigenous concepts of etiology complement biomedical concepts of etiology (if not logically than analogically).

3. New ideas introduced appropriately in terms of concepts which the ~~personal medical history~~ villager can relates to, facilitate both understanding and greater scope for their application of these ideas.

4. An entrance into the villager's conceptual universe, as well as personal medical history, can be gained by discussing both the classification of symptoms as partic lar illness categories and the suspected causes of an illness experience.

3
(cont.) attention away from the mother and feelings of guilt.

Notes on common notions of etiology and

associated symptoms in South Kanara District, Karnataka

1. Less food/ Kadime tinas/

Specifically, this refers to eating an insufficient quantity of the staple food one is accustomed to eating (in this case, rice). It is important to keep in mind that the villagers' sense of body cycle normality derives from the maintenance of a routine digestive cycle and body signs associated with this staple specific cycle 'faces consistency and regularity. urine color, timings of hunger, etc.)

2. Improper dies: /apathya/

a. taking meals erratically (among castes maintaining routine commensality patterns)

b. eating foods having properties counter-indicated in particular seasons, ~~and during~~ ikk to particular age-groups.

.....3.

in transition periods, and during illness episodes.

c. commonly, in children, giving chillies and hot curries before the age of 2.

d. commonly, in adults, eating excessively spicy foods /kara/

3. Bad blood /netter hal/

a. bad blood is thought to be caused by overheat /ushna, garam/toxidity /nanju/, loss of slepp. inappropriate eating habits, exposure to extreme weather conditions. hard work, past illnesses and powerful medicines 'consumed presently or in the past).

b. Sluggishness and weskness are associated with bad blood interfering with the flow of substance in the body. This is sometimes associated with vata as well (see below).

c. Bad blood in the head and stomach is thought to be pushed out by vomitting while bad blood in the intestines and legs causes sores /pudi/

d. Wounds which become infected are associated with bad blood(an internal factor) more often than lack of external cleanliness

e. During amenorrhoea and pregnancy (a condition described as nanjiin character) impure blood which is normally

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Research in other regions of Karnataka and a knowledge of ethnomedical literature in India, suggests that most of these factors have widespread relevance to rural areas.

expelled from the body is thought to be retained and mixed with good blood (causing bad blood.)

f. Some illnesses are ascribed to bad blood being passed on from mother to fetus or breastfeeding child.

4. Climatic changes /have mana/

Fluctuations in temperature are thought to throw the body off balance. For villagers, the healthiest time of the year is when the temperature is most constant. Climate changes are suspect especially at times of seasonal change. These times are associated with bad winds and the movement of spirits (discribed as gali or sonku)

5. Heat in the body /ushna, garam /

a. A certain amount of controlled heat is required for the maintenance of bodily processes especially the digestive process. Controlled heat is associated with strength (trana, shakti) while an exces of heat may cause and be associated with the following symptoms.

1. burning sensation in stomach.
2. burning sensation in eyes., feet, and hand (anaemia, calcium deficiency)
3. burning sensation during urination
4. Indigestion
5. diarrhoea/ constipation/(especially dry stools)
6. blood in feces
7. redness of the skin/ rashes/ boils
8. dry cough
9. body pain. particularly back ache
10. cracking of soles and palms

11. balding/hairlessness
12. dissolving of bones: bones becoming brittle
13. dhatu loss, mental upset and confusion

b. A state of overheat (ushna) can be passed on from mother to child, through the breastmilk causing the baby to experience indigestion, diarrhoes, boils, or fever.

c. Overheat is the after (end) effect of many other etiological factors (e.g. food climate, evil eye, encounters with a spirit, mental worry). Therefore it is important to ascertain if the term is being used as a general statement or in conjunction with notions revealed by further inquiry. The most common general references to overheat is to refer to the eating foods, the feeling of hunger, or sleeplessness.

6. Excessive Coolness (tampu, tandi)

a. In terms of prevalent health (and for that matter, ritual) ideology, cool /tampuØ is needed to controlheat in the body. Generally, in reference to health, tampu is associated with with weight gain and slower digestion. Too much tampu is thought to manifest the the following symptoms:

1. excess phlegm
2. cold, runny nose, sore throat
3. wet cough
4. indigestion and constipation (fewer bowel movements as opposed to dry feces)
5. complaints that the blood has become thick and doesn't flow properly causing fatigue.
6. headache.

b. Excess cool is thought to be transferred through breatmilk causing baby to experience indigestion. cold and accumulation of hlegm.

7. Toxic substances /nanji/

a. Nanji can result from:

1. the retention of bad blood not emitted by routine body cycles (amenorrhoea and pregnancy seen as the disruption of the menstrugl cycle).
2. substances consumed by the body which it cannot digest such as the unctuous juice of brinjal or drumstick (foods classified as nanju.
3. the consumption of too many sweet foods, oils, or impure foods.
4. child receiving impure breastmilk from its mother.

b. Nanji is associated with infection. pus, boils and itchiness. Nanji in the blood is thought to prolong the cure of most illnesses: particularly wounds, skin diseases and intestinal complaints for this reqon, foods classified as nanju are not eaten during illness episodes.

c. Nanji (toxic) should not be confused with visha (poison). It ia generally believed that nanju foods are the best tasting foods tasting foods and their consumptions is common.

8. An excess of one of the three body humors (tridosha):

a. The principle of body humoreis the basis of ayurveda, the classical

system of Indian medicine. It may first be emphasised that few villagers (as well ad few vaidya , fural herbal practitioners.) know much about the principles of ayurveda. However, ayurvedic terminology and the use of ayurvedic regimens are very much part of folk medical cultures in India. While tridosha, as a principles of body physiology, is not known. the effects of humoral aggravation (the symptoms manifesting) are known andhumoral terminology is used in colloqial languages to describe the'course'of such symptoms Most commonly these 'causes' are associated with the eating of foods clssifed locally as having a quality (guna) which produces these symptoms when consumed in excess or at inappropriate times. 1 As might be imagined, interaction between laymen and learned ayurvedic practitioners 2 has caused a number of ayurvedic terms to to flow into the local vernacular where they are given local meanings. and usuage.

b. Symptoms associated with tridosha terminology:

1. Pitta

a. nausea

b. tasting of bitterness in mouth

c. dizziness

d. loss of mental equilibrium, mental upset, taking nonsense

e. yellow urine

f. heartburn

g. yellowing of body / jaundice

h. associated with overheat in the body

2. Kapha

a. aphlegm laden cough. It may be noted that young children are thought to have a propensity toward kapha disorders and have more kapha in the body. For this reason, respiratory illnesses are often not treated in the early stages. This does not mean, however, that mothers do not try and check the excess of kapha, for a number of curative and preventive home remedies are utilized.

b. mucus exuding from the nose, eyes, mouth, or anus (foamy stools)

c. foaming at the mouth particularly after febrile fits among infants is linked to an excess of kapha as well as spirit attack.

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1. The classification of foods with reference to the tridosha is more complex than this (one should consider the ayurvedic concepts of triguna , Viriya, and vipaka but for our purposes this passing reference is sufficient).

2. I will refer to these practitioners as pandits to differentiate them from vaidya practitioners who dispenses herbal medicine but do not follow a system of diagnosis and therapy.

3. Vata:

Vata is the wind (movement, motor function) principle in the body. An excess of vata is thought to cause body pain and when vata is blocked it is thought to cause stiffness in joints. Vata conditions are sometimes linked to less blood. Vata is associated with the effect of sanni planet (Saturn) and excretions from the body which are blackish in color.

...6

4. Vayu:

Vayu is associated with wind in the form of gaseousness within the body causing:

a. indigestion, flatulence

b. feeling of fullness and being stuffed up

c. feeling of breathlessness

d. fatigue, laziness

CONTAGION FACTORS / antu, pagarana /

9. gali

a. This term literally means wind. It is used to describe a spirit wind (sometimes called sonku), a malevolent wind carrying illness from one village to another, and the wind ensuing from an ill for menstruating person when he/she passes.

b. It may be noted that some illnesses associated with gali such as chickenpox or measles are thought to manifest from the stomach first not the external surface of the body. Pox fall / burundu/ on the body surface from the interior.

c. Gali is thought to cause sudden dramatic symptoms usually associated with overheat or cause impurity to theblood resulting in boils, pox coming to surface of the skin etc. Specific reference to sonku is more in Ati month and is associated with sudden fever or pain.

10. breath / svasa / of a person who is ill.

11. crossing / kadapu/

An idea exists that crossing (steppin over, passing through a transition point) associates one with the malevolent qualities of the material / force crossed. Common agents cited are body excrements of the ill (faces, urine, saliva, scabs), shadows or blood of menstruating women, food fouched by the ill etc.

12. Contact with impurity /mailge, basta, made/

a. direct contact with impurities such as saliva /dalle/ or the consumption of impure substances is commonly associated with ifection and the appearance of boils.

b. contact with the pus of one who has a skin disease or diseases in which lesions manifest.

c. contact with the breath of a diseased person in life and the spirit of a diseased person after death /khale/.

d. touching the body of a diseased person or his personal effects (clothes, blankets, etc.)

13. Minuscule worms, germs / krimi, puri / keidi /

Many illnesses are attributed to be caused by worms of internal of external origin. Folk notions of physiology give functional role of worms / five da puri/ in the digestive process. Some illnesscs are spoken of as caused by having more or less of these worms, more active or sleeping worms which for example may cause loss of appetite or improper motion. These worms are particularly suspect when a small child has a loss of appetite, is listless, vomits, is irritable, has diarrhoea, grinds his teeth, or has a bulging stomach, many other diseases, particularly fungal diseases and infected wounds are also attributed to worms. The notions of

minuscule (invisible) external worms /Krimi pudi/ which enter a body causing illness are similar to biomedical concepts of germ, virus, and are a part of the folk health culture.1 It may be noted however, that the etiological factors are associated with precipitating reasons for these external agents being attracted to particular persons or being able to enter domains (body) domain, house domain, village domain) normally protected (closed to intrusion, disruption) ritually or by substances enhancing one's positive health. This reasoning often focuses attention on states of vulnerability (due to climatic changes, lack of spirit protection, transition in one's life, states of impurity etc.) Here we find the basis for a strong indigenous concept of preventive and promotive (positive) health.

14. Hereditary factors:

This is a complex concept which may refer to:

a. illness being passed on through the bloodline of a lineage (matrilineal, patrilineal reference)

b. an illness which comes as a course or recompense to an individual or family due to non-fulfillment of obligations, sin, papa, karma etc.

c. an illness which another family member experienced in the past associated with either spirit attact by the deceased or a sign from the deceased of its presence.

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1. The concept of external etiological factors (minuscule worms- Krimi, insects - Kita is found within ayurvedic dogma.

15. Spirits:

Each type of spirits is associated with a social domain or state of ~~xk;kxxss~~ wildness/uncontrol. Suspicion of a particular type of spirit focuses attention on imbalance or vulnerability in that domain. References to vague stars / spirits of the wild (of the forest, transition points, etc.) focuses attention and responsibility for illness away from social domains / relationships other wise suspect. Examples from South Karnara are:

a. Kule - ancestor spirit. Knowledge about the lineage of Kule effecting the afflicted throw light on friction/ jealousy in that kin group or between the kin group of the afflicted and that which the Kule represents.

b. buta -spirit of a social domain jaga/be it the family domain Kutumba village, kingdom, forest etc. A buta is a manifestation of power which can be either malevolent of benevolent depending on his this personified power is controlled. Suspicion about specific buta usually is associated with instability in domains (commonly, non-fulfillment of obligations fowards the members of that domain (alive and dead) ~~xkkk~~ Reference to wild or controllable buta are often associated with responsibility projecting away from the person experiencing problems.

c. naga - a snake deity associated with fertility as well as skin diseases such as leprosy and herpes zoster, eye complaints, menstrual problems, breast pain in a lactating woman and sterility. In this case, folklore has influenced the association certain illnesses with naga.

d. pide - spirit of a deceased child thought to be attracted to other children out of love or envy. The touch of pide is associated with a wide range of childrens illnesses. The pide may be a deceased family member or a roaming spirit.

e. Mari - (Bhagavti, Amma) Goddesses associated with pox diseases either inflicted out of love or anger. Goddess linked illnesses are often not spoken about as speaking of the goddess and the illness is thought to bring the goddess into presence thus spreading the disease.

Note: illnesses caused by spirit trouble are freferred to NOT as a roga (disease) but as dosha or upadra disturbances/ trouble.

16. Stars:

The illeffect of celestial bodies is commonly referred to as graha chara . The lay public does not know much about astrology. Saturn, Sanni is often associated with vata complaints, no moon with over-heat in the body and full moon with coolness and an increase in kapha. Coughting and fits are thought to increase during the period of no moon and full moon as well as as sankranti (another transitional point) andpatients report this to practitioners to aid dianosis.

17. Fate: multiple notions exist of qualified (transformable) and unqualified fate.

a. hanne baraha - predetermined fate (writing no fore - head). non- negotiable. (at birth, one's destiny is written)

b. adrishta - bad luck

c. Karma - inherited or self made sins or obligations which necessitate and bring recompense.

d. ayasu - life expectation, associated with the concept of rebirth.

e. papa - accumulated sins.

18. Evil eye - dristhi/evil eye is associated with visible signs of overheat in the body (sudden appearance of rashes, fever, unconsciousness) especially in children and pregnant women (e.e. those most vulnerable). Dristhi is also related to guilt projedtion by mother when child falls ill.

19. Witcheraft - associated with competition, jealousv, suppressed anger within andacross linerage and caste lines /mata/

20. Dhatu loss - dhatu is a body substances associated with positive health and vitality. Dhatu is responsible for the control. the control of desire, concentration, virility and the ability to gain weight. Commonly, dhatu is feared to be lost due to masturbation or sexual excess where if leaves the body as semen. Specific foods produce and reduce dhatu. A reducation dhatu makes one vulnerable to illness.

21. Pregnancy desires: unfulfilled desires during preganancy are thought to affect fetus development and are associated with limbs and sense organs, defects, car discharges etc.

Review of etiological factors by broad category (internal), external, moral

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Internal:

1. Food/diet:

a. less of staple food

b. inappropriate food - season - age

c. Impure food. toxic (nanju) food eaten in excess

d. food which aggravates tridosha

e. gaseous (vayu) foods interfering with movement and body cycles

2. Excess of uncontrolled heat in the body or excess cold:

(see additional notes on the hot / cold idiom)

a. loss of feeling of balance in body/mind

b. lack of control over one's supply of vital qualitative energy

c. Interference of physiological processes resulting in blockage of basic life systems --- digestion, defecation movement of blood and energy/trana, shakti/ menstruation etc.

3. Blood becoming:

a. less

b. impure

c. thick/thin

As a result of:

1. less or inappropriate food, poor digestion
2. overheat in the body
3. over work
4. exposure to extreme climatic conditions
5. spirits
6. hereditary factor (related to moral factors -- ancesors. sin, etc.)

4. Aggravation of the tridosha:

Tridosha viewed as substances causing illness when in excess: more than a view of humors playing a necessary role in the physiological process.

a. Vata

b. pitta

c. Kapha

5. Dhatu loss:

1. overheat
2. improper diet
3. sexual excess, deviance, masturbation

6. Aggravation or suppression of intestinal worm activity in the gut, as well as reduction of optimum number of worms necessary for digestion or an increase of worms past the optimum.

7. Impurity (body or blood) due to natural processes (menstruation the blocking of natural processes (amenorrhoea, constipation, or the entrance into a state of body (delivery) or status (birth, death) transition. Associated with states of vulnerability, or states where other etiological factors are attracted.

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8. Non fulfillment of pregnancy desires.

External Factors:

1. bad wind
2. Contact with those who are ill(touch, crossing them or body excretions)
3. contact with impurity
4. minuscule worms or insects
5. negative qualities of seasons, seasonal changes
6. spirit contact; curse, trouble
7. evil eye
8. witchcraft
9. effect of~~x~~ cerestial bodies-- stars, planets, etc.

Moral Factors:

1. notions of fate (ayasu, karma, hane baraha)
2. spirit trouble- failure to upkeep obligations/responsibility in domains of prescribed social interation (family lineage caste, village.)