# PEOPLE'S HEALTH ASSEMBLY

information brochure no 2

# Invitation

## TO PARTICIPATE IN PRE-ASSEMBLY ACTIVITIES...

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*Coordinating Group:* Asian Community Health Action Network (ACHAN) ◆ Consumers International (CI) ◆ Dag Hammarskjöld Foundation (DHF) ◆ Gonoshasthaya Kendra (GK) ◆ Health Action International (HAI) ◆ International People's Health Council (IPHC) ◆ Third World Network (TWN) ◆ Women's Global Network for Reproductive Rights (WGNRR)

# Introduction

**The People's Health Assembly** is a broad, new initiative that seeks to involve a large number of people in formulating their own health agenda and setting their own priorities. People's rich experiences will be presented, discussed and translated into clear, practical and democratic policy guidelines. Efforts will be made to regain the imperative that health, and health for all, is one of the most important goals for everyone to strive for and a process that everyone must be a part of. Health and equitable development will be put forward as top priorities in local, national and international policy-making.

The PHA project is a long-term process, which is organised in a way that seeks to involve as many people as possible from all corners of the world and from all kinds of communities and backgrounds. The PHA process will have three over-lapping and interlinked phases:

- Pre-Assembly Activities which include analytical work, local/national/regional meetings and the collection of stories and case-studies;
- The Assembly Event which will be held in Gonoshasthaya Kendra, Savar, Bangladesh between 4-8 December 2000 immediately followed by a follow-up Forum;
- Post-Assembly Activities which involves continued advocacy and follow-up meetings.

At this point of the PHA process, we wish to encourage you to get involved in the **Pre-Assembly activities**. Pre-Assembly activities are ways that people can actively participate and input into a people's agenda for health. So join us now in this challenge to put together a collective agenda for health and have our voices heard in a worldwide effort to improve the current health situation as well as point the direction for strategic and concrete action plans.

You can do this by organising meetings, producing stories and case studies and contributing to the analytical work and the formulation of the *People's Charter for Health*.

# Some Guidelines

If you and/or your organisation,network, institution, etc. are interested in participating in the pre-Assembly activities, below are **some guiding principles**:

- Through the various PHA activities people are encouraged to increase their understanding of how their own situation at the grassroots level relates to structures, decisions and thinking at other levels-i.e. linking the micro and macro perspectives. Activities could, for example, deal with how people's particular health-related problems are caused and exacerbated by the present overarching model of development and globalisation.
- It will be particularly valuable if activities could highlight the intersectoral dimensions of health care and development. The rising incidence of health problems and even death linked to, among others, environmental degradation, poverty, massive migrations, discriminatory practices in terms of gender, class, caste, race-ethnicity, sexual preference, violence and armed conflict, etc.
- Activities should ideally lead to the identification of strategies and solutions to the health-related problems dealt with. Where possible, these activities should bring out the richness and diversity of shared, community, indigenous knowledge and practices in contesting the problems.
- The strengthening of links and cooperation between groups and individuals is encouraged. The pre-assembly activities are also an opportunity for groups and individuals to network and work together towards change.

## WHO CAN PARTICIPATE

**Everyone!** Priorities, however, will be given to individuals, organisations, networks who are already involved and working on these health and health-related issues at the local, national and regional levels.

## HOW YOU CAN PARTICIPATE

As mentioned above, you can participate by:

- organising local/country/regional meetings,
- facilitating the collection of stories and case-studies,
- contributing to the analytical process and formulation of the People's Charter for Health.

The guidelines for participation for the different activities are enclosed. Enclosed you will also find some guidelines on how to obtain funds for the activities that you plan to organise.

For further information, please contact your **regional coordinators**. You are encouraged to work closely with the regional coordinators so that the links in the PHA work and process are continually strengthened. So, please keep us informed of the activities that you are planning to organise.

# Organising

## LOCAL/NATIONAL/ REGIONAL MEETINGS

By organising these **Pre-Assembly meetings**, a large number of people can come together to learn and draw from each others' experiences; increase their understanding of the underlying causes of health problems; and work towards concrete solutions to the problems they face. (see box 2 for examples of themes) These meetings will provide people with an opportunity to relate with other people involved in the PHA as well as contribute to the formulation of a ***People's Charter for Health.***


We invite you and all interested groups to **organise PHA-related meetings.** You may build and expand on an already planned meeting or organise a separate one.

With hundreds of meetings taking place all over the world, these PHA-related meetings have the potential to make a strong impact on health and development, moving towards a people's agenda for health.

## WHAT CAN THE MEETINGS LOOK LIKE?

**Meetings** can have a rich diversity in content, size, length, participation and focus. Some suggestions on various approaches are:

- *Building on already planned meetings on specific issues*. Planned meetings may be linked to the PHA process with the purpose of feeding the results of discussions into the analytical process leading to a People's Charter for Health.
- *Holding discussions based on background material from the PHA secretariat*. Analytical documents on various health-related issues, draft versions of the Charter and selected people's stories and case studies will be made available as background discussion material that can be used when organising PHA-related meetings. See **Contact addresses** below on how to request for these discussion documents.
- *Producing stories and case studies*. Another possible theme for a meeting may be the identification, analysis and formulation of stories or case studies. For further information on producing and submitting stories and case studies, please see the section `Contributing stories and case studies' .
- *Using discussion questions provided in these guidelines* (see box 1 for examples). Outcomes of such discussions should ideally be submitted to the Analytical Group Coordinator (see address below).

### Box 1 Examples of questions that can be discussed during meetings

1. What are the most important health problems in your country? Identify the top three.
2. What are the most important factors giving rise to these problems?
3. **Are there any innovative and (preferably) sustainable responses to any of these (or other) health problems?**

**If so,**
**What are the positive features of these responses? Refer specifically to both formal health sector activities as well as community/ civil society activities?**
Consider whether such positive features can be replicated to address other problems

If no,

What are the obstacles to innovation?

Are there any innovative projects which can address some of these obstacles?

## MEETINGS AT DIFFERENT LEVELS

**PHA-related meetings** may take place at different levels:

- at the local level, e.g. community groups gathering to discuss their particular problems, health workers meeting at the workplace, gatherings in schools and universities, etc;
- at the national level, in conjunction with (piggy-backing on/holding back-to-back meetings with) existing meetings or as PHA-specific events;
- at the regional or sub-regional level, with the opportunity to share experiences, problems, situations in the different countries as well as strategies and/or plans of action.

Meetings can range from a few hours in conjunction with other occasions to full-fledged meetings covering several days.

## WHO CAN PARTICIPATE IN A

Meetings may include a **range of participants** such as members of NGOs working in different areas, activists, community groups, health workers, researchers, invited decision-makers and others.

## HOW WILL THE MEETINGS RELATE TO

Key points or summaries of discussions stemming from the meetings should be communicated to the regional PHA coordinator or his/her sub-regional or national collaborators (see contact addresses). These materials will be shared with other PHA-related meetings and fed into the process of drafting a People's Charter for Health. The information will furthermore be made available at the PHA website for all those interested in the PHA process.

Furthermore, meetings can be used to generate resources which directly input into the PHA event in Bangladesh in the form of e.g. exhibitions, presentation and cultural performances. The formulation of statements, action points and policy recommendations is encouraged as input into the People's Charter for Health as well as possible presentation/ sharing during the Assembly Event in December 2000.

## HOW TO GO ABOUT ORGANISING

**Registration:** Please register with the regional coordinator any PHA-related meetings you are planning to/would like to organise, either on the enclosed form or at the web address: www.pha2000.org or www-sph.health.latrobe.edu/pha

**Support:** The regional coordinators of the PHA are ready to help advice in the planning and execution of meetings. However, funding possibilities from the PHA-secretariat to facilitate the organising of meetings are limited. Thus, fund-raising for local, national, regional meetings will need to take place in a decentralised manner. Regional coordinators may be able to provide support in identifying possible funding sources. See the section on **Funding and Support** enclosed.

**Background material:** Background discussion documents, and at a later stage draft versions of the People's Charter for Health, will be made available for use in meetings. In addition, general PHA-related information, templates and printed material can be requested from either the regional coordinators or the main PHA secretariat.

If you have any queries, pls contact the regional coordinator of your region.

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# PEOPLE'S HEALTH ASSEMBLY 2000

## Local/National/Regional Meetings

## Registration Form

Name of meeting: _____

Objective of meeting:

_____

_____

_____

Type of meeting:

❒ Focus Group Discussion ❒ Conference

❒ Workshop ❒ Others: _____

❒ Seminar

Levels:

❒ Community ❒ Sub-regional

❒ Local ❒ Regional

❒ National ❒ Others: _____

Organisers: _____

Time: _____

Venue: _____

Preliminary Programme (attach programme if necessary):

_____

_____

_____

Expected number of participants: _____

Composition of participants (i.e. community workers, health activists, women activists, human rights activists, academics, policy-makers, etc.):

_____

_____

Other relevant information:

_____

_____

Needs/requests from Regional Coordinators:

_____

_____

Contact person: _____

Address: _____

_____

_____

tel: _____ fax: _____

email: _____

website: _____

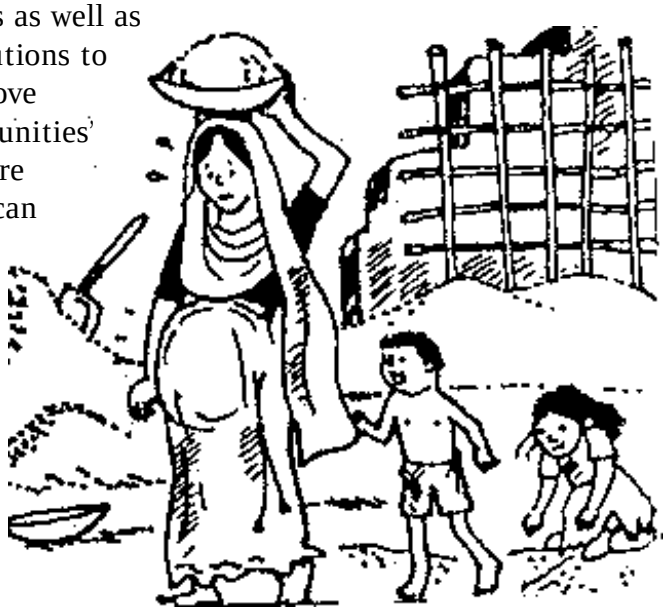
Please return form to the regional coordinator of your region.

# Contributing

# STORIES AND CASE STUDIES

## PEOPLE'S STORIES AND TESTIMONIES

**One of the main inputs** for the PHA will be the specific stories of people's real experiences with health related problems in their communities. We would like to gather stories from all over the world, both those that illustrate current problems as well as innovative, successful solutions to people's struggles to improve their own and their communities' health. In particular, we are interested in stories that can demonstrate how common or important problems at the micro/ local level are in part influenced or determined by policies or decisions made at the macro/ global level.



The stories and testimonies will play an **essential role** in the overall PHA process. They will be used as a major input in the analytical work aimed at producing a People's Charter for Health. They will also serve as a basis for discussion in the local, national and regional meetings that will be organised around the world.

Through these stories, links between the everyday realities of people, and policy-making and global politics can be made to further strengthen policy intervention at the local, national, regional and global levels.

## CASE STUDIES OF INNOVATIVE RESPONSES TO PROBLEMS

In addition to people's stories and testimonies, we are interested in examples which illustrate **innovative and sustainable responses** to health problems. The Primary Health Care approach has a comprehensive character in that it recognises the contribution of communities and other sectors as well as health services. Too often responses have been narrowed down to medical, technical activities, often centrally planned and "delivered" from above. There is, however, a rich experience of projects and programmes internationally which demonstrate innovative, comprehensive and sustainable responses to common health problems. These may originate within the health sector but may also commence as responses to challenges in other areas which impact on health: for example, there are many integrated development projects which may not explicitly address health issues but nevertheless contribute significantly to people's health and well-being.

We are interested in gathering examples -"**case studies**"- which illustrate a variety of experiences involving health and health-related sectors. These may include innovative, community-based health care initiatives; intersectoral responses to environmental problems; and organised actions or movements to address major economic or social threats to health. We are particularly interested in successful case-studies which demonstrate aspects which could be replicated in other settings, but also recognise that failures or negative experiences can be instructive.

## WHAT CAN THE STORIES LOOK LIKE?

Stories can take a **wide range of forms** and we encourage alternative and popular (cultural) means of conveying the message/story. Written case studies, theatre, films/videos, documentaries, slideshows, exhibitions, oral stories, stories inscribed in material culture of the community i.e. art, quilts, baskets, rugs, blowpipes,etc. - all forms are welcome in all languages.

We recommend that written stories be 2-5 pages long and encourage the inclusion of illustrations (photographs, drawings, maps, etc.).

If you are producing a story in non-written form, it is particularly important that a written summary explaining the story accompanies the registration form.

We would encourage you to use the collection of these stories as an opportunity for discussion and joint analysis, involving many people in the activity. Where possible, stories should make links between the family/household and individual events and these global issues. (see box 2 for examples of themes)

## WHO CAN SUBMIT A STORY?

In order to organise a truly people-centred PHA, we want to provide an opportunity for everyone to share their health-related experiences with the rest of the world. Thus **everybody**-individuals, groups and organisations-is welcome to submit their stories.

## WHAT WILL HAPPEN WITH THE STORY?

**The myriad of stories** will input into the PHA process in different ways. Some of these stories will be presented at the PHA Main Event, others will contribute to the People's Charter for Health and some will be used as discussion material for PHA-related national/ regional meetings. While the stories will effectively provide the foundation for the PHA process, they will also be made available on the PHA website and other publications. For these purposes, the stories may undergo some editorial changes.

In the People's Health Assembly Event in Dhaka, December 2000, a selection of stories will be presented and discussed. There will also be opportunities to present stories at the Follow-up Forum, immediately after the PHA Event.

## HOW DOES ONE SUBMIT A STORY/CASE-STUDY TO THE PHA?

We welcome your support in identifying suitable stories and case-studies and encouraging people to write about them or present them in the various forms. When the story/case study is ready for submission, please send it to your regional coordinator together with the enclosed registration form.

In order to use these experiences actively in the analytical work as well as in local, national and regional meetings, the earlier they can be submitted the better. You are encouraged to submit stories/case-studies before **31 March 2000** and no later than 30 June 2000. Preference will be given to stories/case-studies received earlier.

If you have any queries, please contact the regional coordinator of your region.

# examples of stories

## STORY 1: STORY OF WHITE DEATH

(*Adapted by David Werner from a story developed with village women in Sierra Leon*)

This story is intended for use as a group activity to help participants analyse the root causes of common health problems. The group can form a "chain of causes" linking events at the community level to policies and decisions at the national and global level. (An explanation of this learning method is included at the end of the story.)

Fatu lived with her 7 children and sometimes her husband in a small village 70 miles from Freetown in Sierra Leon, Africa. She was 34 years old but looked older.

She worked hard growing vegetables in the tiny garden outside the family hut. She also had a few chickens. But for all her efforts, often there wasn't enough food. Fatu, as mothers do, always gave the best food to her husband and then to her children.

Her husband, Allah bless him, was not much help. It was hard to find work. Sometimes he did odd jobs for the a rich landholder, for very little pay. And sometimes he went for weeks or months to Freetown-looking for employment, he said. But he usually came back with no money. Not being able to support his family adequately made him moody, and as times he drank more than he should. If Fatu complained, he beat her. She didn't complain often.

Life used to be easier. Fatu's husband used to go into the jungle to hunt for wild game. She had picked native fruits and nuts there. And in small openings in the forest she had planted cassava and bananas. In those times they usually had enough to eat. And they were healthier.

But things had changed. Three years ago a rich businessman from the city had come and cut-down the forests with huge machines. On the barren ground where the jungle had been he planted cocoa trees. He put up signs that said: No Trespassing.

Now Fatu no longer had forest land to plant or gather in. And her husband brought home much less wild game. With the best forest land destroyed and posted, the few woodlands that were left were so over-hunted by hungry families that game was now scarce. Some of the bigger game birds and animals had already disappeared. Perhaps forever.

The radio said that turning forests into cocoa farms was part of a government agreement with a thing called the "World Bank." (It was part of a "Production for Export" policy imposed by the Bank to make sure Sierra Leone earned enough money to keep making payments on its big foreign debt.)

Fatu knew what debt was! She owed a lot to the village clinic pharmacy. A few years ago, medicine had been free. The government used to say that health care was a basic human right. But not any more! To encourage "community participation" and "self-reliance," the authorities told the people, now they must pay for their medicines.

That was easier said than done. Poor people, especially women, often had no money at all. At first Fatu had asked for credit to buy medicines. But now she owed so much that the pharmacist refused to give her medicine when she or her children got sick. "First pay your debt," said the pharmacist. But she didn't even have enough money for food. And for some reason both she and her children seemed to be getting sick more often.

For the last year or so Fatu's health had been poor. She always felt tired. Her skin had lost its shine and the palms of her hands and her tongue were pale and yellowish. The clinic nurse said she her blood was weak, something she called "anemia." She said it was because Fatu's food did not have enough iron in it to replace the blood she lost each month when she saw the moon. And because of the "big bleed" every time she had a baby.

The nurse told Fatu to "Eat lots of red meat, cow's liver, and the like."

"Yes, Ma'am," Fatu smiled and nodded. But where on earth, she wondered, was she to get the money

for such costly luxuries?

Years ago Fatu had learned during her traditional initiation (puberty rites) that cassava eaves and potato leaves help strengthen the blood. So she began to eat more of these. But she cooked them for a long time in a lot of water, and threw out the iron-rich water. Such was the custom.

Fatu kept getting weaker, her hands and gums more pale. She craved meat so much that sometimes she would nibble on chunks of red earth. But she did not eat the chickens she raised because she needed their eggs. When her children had diarrhea and colds, she would sell the eggs to buy packets of Oral Rehydration Salts (ORS), cough syrups, and other modern medicine.

In the past, when her children had diarrhea she had always given them rice porridge, and had made herbal teas for their coughs and colds. Often these home remedies had worked well.

But one day a traveling drug salesman named "Doctor" told Fatu she was irresponsible and backward. He said it was the children's repeated infections that made them so thin. And lack of good treatment.

"If you want to keep her children alive and healthy," he said, "you must give them good medicines. Real medicines, like these."

So Fatu sold her eggs and bought cough syrups and ORS. Her children got better for a while. But they became thinner. And as they got thinner they got sick more often, especially with diarrhea. Fatu didn't have enough eggs to pay for all the ORS packets she needed. So she also began selling the beans from the family garden. This meant that there was little else to eat than rice, with a few overcooked greens.

Another problem that plagued Fatu was malaria. It too, she knew, weakened her blood. She had suffered attacks of malaria for as long as she could remember. But now they were much worse and lasted longer. This was partly because she no longer had her traditional medicine.

Treatment of malaria varied with gender. While men often bought chloroquine tablets to treat their fevers, women rarely had money to buy them. And the men usually didn't offer to help. This meant that when the clinic pharmacy began to charge "user fees" for medicine, fewer cases of malaria were treated. And less treatment meant that the mosquito-carried illness spread more rapidly. More people died, especially women and children.

In the past Fatu and the other women had always treated their malaria with a bitter wild herb. The herb had only grown in the dense forest near the river. But now that the forest had been destroyed to plant cocoa, the bitter herb was gone, too. The woman tried using other herbs, but they didn't help much.

Fatu certainly didn't have the money to buy Chloroquine tablets, even at the so-called "low price" in the clinic pharmacy. So she suffered her fevers in silence.

Then Fatu got pregnant again. As soon she realized this, she went to get to get iron pills at the clinic, as she had always done with earlier pregnancies. For pregnant women, iron pills had always been free. But now, at the new "Bamako Clinic Pharmacy" which had replaced the old Health Post, she was told she had to pay. (This is part of UNICEF and World Bank's new cost-recovery scheme). She told the dispenser that she had no money. But he told her she wasn't "indigent" enough (whatever that meant) to qualify for free iron pills, since her husband sometimes had a job. And since she already owed a lot of money for ORS and cough syrups, he couldn't give her any more credit. She went home and asked her husband for money.

He said he didn't have any. Even when he had a job, he never had much money because a lot of what he earned he spent on alcohol and cigarettes. (There seemed to be a lot more advertising for liquor and tobacco than there used to be, and a lot more people were drinking and smoking. Even children.)

Her husband still liked to hunt. Although the best forest land had been turned into private cocoa plantations, occasionally he still managed to bring home some quail and other small game.

But with so many hungry mouths, the meat never went very far. A digba (traditional healer) had told the woman that the vital organs of animals and birds-the liver, the heart, the lungs-were extra good for strengthening the blood. Fatu hungered for these vital foods. But she didn't dare ask her husband to let her have them. According to local custom, the man had the right to such delicacies. She was afraid to ask him.

Fatu had become pregnant again when her youngest child was only eight months old. She had wanted to wait longer, but had little choice. She still felt weak and tired from the last time. When she had given light to her previous baby, she had lost more blood than usual. The palms of her hands were still very pale. Frequent attacks of malaria made her still weaker. Now when she worked in the garden, she quickly lost her breath.

Fatu had heard about 'the pill,' or an injection, to prevent pregnancy. But the man at the Mosque said they were the work of the Devil. Fatu had also heard about condoms, but she was afraid to ask her husband to use one.

So here she was, pregnant again, severely anemic, without iron tablets, and without adequate food. During her pregnancy, she became weaker and paler. By the ninth month the palms of her hands were sickly white. Her feet were more swollen than usual. She felt increasingly exhausted. After only a little exercise she had to stop to catch her breath.

When her time came to give birth, she went to a trained birth attendant (TBA). With one look at Fatu's inner eye-lids and tongue, the TBA saw Fatu was dangerously anemic. '"You must go to the hospital at once," she said.

"But how?" asked Fatu. The hospital was far away. And her pains were already frequent. The government had promised to provide for an ambulance for such emergencies. But the plans had been canceled due to budget cut-backs (which was part of the World Bank's "Structural Adjustment Program").

To pay a private driver was out of the question. So the TBA had no choice but to deliver the baby herself, though she recognized the high risk. The birth took longer than usual. Fatu didn't have enough strength to push hard. But at last the baby came out, small and thin and without a whimper. He died two days later.

After the delivery Fatu bled and bled. Her blood was so thin you could see through it. It was too thin to clot well. The TBA gave Fatu special medicines to control the bleeding. Free of charge!

At last the bleeding slowed down and stopped. But Fatu was drained. Three days later she was still too weak to walk home, and had to be carried. A kindly neighbor woman helped take care of her. And amazingly, so did her husband, who for the first time seemed truly concerned. He found some spare cash and went to the pharmacy to buy iron pills. Better late than never.

But as the days went by, Fatu did not get much stronger. The dispenser said the iron pills would take months to strengthen her blood again.

Then-a month after Fatu gave birth-the chills and fever of malaria struck again. Her worried husband went to the clinic pharmacy. Rumor had it that Chloroquine no longer worked against malaria. So he asked for the new wonder drug advertized on the radio. But the pharmacist said that, effective or not, Chloroquine was still the only anti-malarial on the Bamako Essential Drug List. (He explained that the new medicine was covered by international patent laws, and was therefore prohibitively expensive.)

But who knows, said the pharmacist, Chloroquine would probably be better than nothing. Fatu's husband bought some with his last money, hoping it would help.

But it didn't help. Each day the fevers and chills got worse. Fatu looked like a ghost. Her children clung around her sleeping mat fearing she would die, like the woman next door. Completely still, she breathed as heavily as she used to when she carried a big load of firewood up a steep hill. She had stopped eating food. She was only hungry for air.

One night when her husband and children were sleeping, Fatu quietly died. Some people said she had been hexed. But the village wise woman called it the White Death. She said: In the old days before the white man came, when the dark forest cared for the people and the people cared for the forest and each other, their dances and their harmony kept the White Death away.

**The "But why?" game - for the Story of White Death**

To play this game the facilitator leads the participants through a series of questions to trace the many inter-connected causes that led to Fatu's death.

In preparation for this activity, the facilitator should read "The Story of Luis" and the "But why?" game in Helping Health Workers Learn, and spend some time formulating the series of questions she/he will ask. It is important that the facilitator consider each of the participants answers and construct the next question accordingly. For example:

> "BUT WHY, if Fatu had chickens, didn't she eat them to get the iron she needed?"
> "Because she wanted them to lay eggs?"
>
> "BUT WHY, then, didn't she eat the eggs?"
> "Because she sold them to buy ORS and cough syrup for her children's ailments."
>
> "BUT WHY didn't she give her children home remedies, which would have worked as well?"

"Because a traveling drugs salesman shamed her into buying costly commercial medicines."

"BUT WHY haven't nurses, health workers, and pharmacist explained to people that for common diarrhea and colds, home remedies work as well as modern medicines, and leave the family with more money to buy food?"

"Because the health workers have been taught to use modern medicines only, and be contemptuous of old traditions."

Encourage participants to give answers based not just on the events in the story, but also on their own situation and experience (as in the last answer above).

As questions that lead from one to another, so that participants construct a whole chain of causes. There may be several connected chains. When one branch of a chain of causes is exhausted, the facilitator can think of a new leading question to introduce another branch of the chain. For example, a question to follow the last answer above might be:

"BUT WHY, if Fatu raised beans as well as chickens, didn't she at least eat beans?"
"Because, as her children got thinner and sick more often, she sold the beans, too, for (unnecessary) medicines."

After a few more questions, the theme may need to be shifted again. Perhaps:

"BUT WHY was Fatu paler and weaker than two years before?"
"Because her chills and fevers from malaria were worse now than they used to be, and weakened her blood more."

"BUT WHY did her malaria weaken her more than it used to?"
"Because she could no longer find the herbs she used to treat it with."

"BUT WHY not?"
"Because the forest where they grew had been cut down to plant cocoa."

"BUT WHY?"

"Because the World Bank demanded that ... " etc.

If one or two participants tend to dominate the discussion, encourage answers from those who say least.

*Chain of causes*

After the "But why?" game, in order to reinforce and analyze the key causes contributing to Fatu's death, and how they interconnect, the group can construct a "chain of causes" using cardboard links. They progressively build a chain from a cardboard figure of Fatu to her (cardboard) grave. This methodology is also explained following the "Story of Luis" in Helping Health Workers Learn. Depending on time available, the participants can use pre-made cardboard figures of the woman, her grave, and the links ... or they can make their own.

Experimentation is needed to see whether it works better to use similar links for all causes, or to color and illustrate links differently for physical, biological, cultural, economic, and political causes. (Depending on the audience, it may be better to speak in terms of causes related to non-living things, living things (germs, worms, etc.), beliefs and customs, money, and power). Both ways should perhaps be tried with local groups, to learn which way they feel makes things clearer and more interesting, or opens the way to more perceptive analysis and action.

After the chain has been completed (stretching from the cardboard figure of the woman to her grave), the facilitator asks the participants which links of the chain they might best be able to break. Which links (or causes) might a woman like Fatu be able to do something about by herself? Which causes might be dealt with collectively at family level? At community level? At national level? Through international solidarity?

If all works well, perhaps this process will lead to plans of action. The more the participants themselves take the lead, the better. They may come up with ideas and solutions the facilitator never dreamed of.

## STORY 2: THE STORY OF SAM

Sam was dead. He had one bullet wound to his head. A discharged gun lay by his side. His doctor wrote "suicide" on the death certificate.

Sam had been the Director of Pharmacy at a major metropolitan teaching hospital in a wealthy western country. Six years before his death a Conservative State government came to power, elected by a huge mandate. They had campaigned to reduce State debt, lower taxes and increase efficiency and stimulate overseas investments.

They proceeded to slash public spending and privatise public services. Hospitals were merged into regional networks. Network administrators were employed on short-term contracts, paid huge salaries and offered large performance bonuses for carrying out the government's agenda. Staff were exhorted to "do more with less." Across the State, hospitals were closed and 3000 nurses and ancillary staff, including pharmacists, were sacked. But Sam survived, depressed and overworked.

However the Network Administration believed that many more savings could be made in pharmacy. He ordered that free supplies of drugs to out-patients must cease. Co-payments (patient charges) were put in place. Only two days supply of medication was allowed to be dispensed, patients were then expected to see a private doctor for further prescriptions. But still the savings were insufficient to meet government targets.

It was decided to put the hospital pharmacy service out to tender for privatised operation. Sam organised the hospital pharmacy staff to submit an internal tender to complete with private companies.

Two external bids were received from private health care organisations. None produced the savings the Network Administrator wanted. All were rejected, including the internal staff proposal, despite the huge time and effort involved in their preparation.

Sam was then called to the office of the Network Administrator and ordered to reduce his pharmacy budget by 20%. He protested that patient services had already been reduced and a further reduction of this magnitude would severely impact on patient's health care. His staff agreed. They consulted their Union. They threatened industrial action. They leaked the story to the press.

Two days later, Sam and his Deputy were called to separate offices in the personnel department. Each was summarily dismissed. They were ordered to leave the hospital immediately, escorted by hospital security guards.

Sam has served the hospital loyally for over 20 years, was highly regarded by his colleagues and widely respected foe his dedication, knowledge and skill. He was dismissed ignominiously regardless.

That evening, when his wife and children returned home, they found him dead.

What caused Sam's death?

Suicide? But why?
To easy access to guns? But why?
Untreated depression? But why?
Lack of termination counselling by Personnel? But why?
Insensitive Network Administrators? But why?
Impotent Unions? But why?
Public apathy? But why?
State government policy? But why?
Neo-liberal health economists? But why?
Global private health industry interests? But why?

This is a true story with only some details changed.

## STORY 3: GUATEMALAN HEALTH PROMOTERS AND HEALTH CARE REFORM

For over thirty years the community based health worker or health promoter has been an important figure in the provision of primary health care throughout the highlands of Guatemala. Community health promoters were involved in health programs sponsored by the Catholic and Protestant churches in the indigenous communities in the late 60´s and early 70´s. NGO´s developed many other programs after the devastating earthquake of 1976.

In many communities the health promoters were the only health care providers, given that the governmental health personnel were concentrated in secondary and tertiary health facilities in the capital and the larger cities of the republic. Private practitioners rarely found their way to the Indian communities in a country where the indigenous were regarded as third class citizens and were among the poorest of the poor. There were virtually no indigenous allopathic medical personnel until the 80´s, although there was a strong, deeply -rooted tradition of indigenous medicine. The sajurín, the Mayan priests, and the comadrona, or midwife were regarded as the principal actors in the traditional health practice deeply engrained in the native cosmovision.

After the earthquake the programs for community health and health promotion flourished. An Association of Community Health Services was established with membership from programs throughout the country. One of the struggles of the association was to obtain official recognition of the health promoters by the Ministry of Health and the provision of a carnet or identity card. However, there was critical opposition from the established medical professionals to the recognition of health promotors. They were regarded as either competition for the doctors, or quacks.

Official recognition of health promoters became even more important during the period of violence in the 80s. Heath promoters were often identified as subversives in the increasingly repressive atmosphere of the country. Many health promoters were assassinated or disappeared during this period, especially those from communities that were in areas of conflict between the Army and the insurgency.

In the meantime the quantity and quality of health promoter programs improved with support from the Association, the donor agencies, and international solidarity. Many programs became full-fledged development programs with integral community health goals.

After the culmination of the peace process and the signing of the peace accords in 1996, the role of the community health worker became more apparent. By this time, however, the modernization of the health sector and health care reforms defined by the World Bank were in full swing, with the intention to decentralize the health system and to privatize health care.

In certain areas of the country the Ministry of Health proposed the contracting of health services to organizations based in the exterior. The communities to be served reacted by stating they wanted their own programs, and their indigenous health promoters to be the service providers, not foreign organizations with little sensibility to the culture and no knowledge of the language and culture of the communities.

Interestingly enough, some Ministry officials felt that the health promoter programs could be a low cost alternative, and they proposed that the promoters work as volunteers in the local systems. So, the alternative would be high cost contracted services, or low cost volunteer services. What about justice and equity?

Representatives of the church-based programs and the other health promoter programs began to meet and design their strategy to deal with health care reform. They have been able to open up dialogue and debate with the Ministry of Health, in spite of the resistance of many officials.

By no means is the situation resolved. There are many variables in the equation, and regional, ethnic, and cultural differences abound. However, it is clear that at last the Ministry will have to take the community health promotion movement seriously.

*What are the lessons learned from the Guatemalan experience?*

# PEOPLE'S HEALTH ASSEMBLY ..... 2000

## Collecting Stories/Case-Studies Submission Form

Name of story/case-study: _____

Short description of key words(in about 50 words):

_____

_____

_____

_____

Type:

- ❒ Written stories
- ❒ Video/film/documentary
- ❒ Picture story/collage
- ❒ Songs/Folk song
- ❒ Poetry
- ❒ Others: _____

Name of author(s): _____

Country: _____

Organisation/institution (if applicable):

_____

Address:

_____

_____

_____

tel: _____ fax: _____

email: _____

website: _____

# Contributing to the ANALYTICAL PROCESS

You are also welcome to contribute to the analytical process in several direct ways.

## PROVIDE FEEDBACK ON DRAFT CHARTER AND ANALYTICAL BACKGROUND PAPERS

**Individuals and groups** are invited to comment on and provide feedback to the analytical material that is being produced through the PHA process. Please indicate on the attached registration form your topics of interest (see box 2 for example of themes) as well as information on how we contact you for further communication. Your comments and feed-back will be channelled directly to the PHA analytical working group.

## SUBMISSION OF PAPERS, REPORTS AND STATEMENTS

We warmly encourage you to submit academic/research papers, reports, statements and other forms of analytical material that you find is exceptional in quality and relevant to the PHA process. This material should be sent to the coordinator of the analytical working group. See information on the attached registration form.

## FUNCTION AS AN EXPERT/RESOURCE PERSON

If you have particular expertise in any of the relevant areas and would like to contribute with input, reflections and writings, we invite you to register as a resource person for the analytical process.

**Box 2** Some examples of themes for analysis, discussions, meetings, and the collection of people's stories and case studies

- Globalisation and Health (structural adjustment programmes, trade, foreign investments, liberalisation etc.)
- Basic Needs, Land and Food Security
- Women and Health
- Health and the Environment (Occupational, local, national and global problems)
- Emerging and Re-emerging Diseases
- War, Violence and Human Rights
- Alternative and Indigenous Health Knowledge Systems
- Lifestyles, Cultures and Health
- The Media and Consumption Patterns
- TNCs and Health
- International Institutions and Health/Role of UN bodies
- Health care reform
- Health Agencies and Health Financing
- Health Personnel Training and Education
- Technology and its impact on health (New Technologies/ Appropriate technologies)
- Modern medicines and its limits
- Pharmaceutical drugs
- Overview of the Health situation locally, nationally and regionally

For more information please contact:
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# Funding AND Support

## HOW TO APPLY...

The activities related to the PHA process might require funds from sources outside of your own organization. The first requests for funding should be made to your present donors, assuming you have such funding.

If there are social organizations or foundations in your country that provide small grants, you might request a donation for your PHA related activities.

Additionally, you might look to international non-governmental organizations that have been supportive of primary health care and have shown a long term commitment to Health for All. Some of these organizations have national and/or regional offices where you might request funds for local events. Suggestions include: the OXFAM family - OXFAM UK, OXFAM Canada, NOVIB, OXFAM Belgium, etc., Christian Aid, Medicus Mundi, Save the Children Fund, Bread for the World, CAFOD, CARITAS International, Lutheran World Relief, and others.

The types of donor or funding agencies and their representation varies considerably over the world. To get help with funding, always begin at the local and national levels.

The PHA secretariat and Organizing Group are making contacts with donor agencies and church based agencies in Europe and North America. We are informing them of our PHA process and are requesting that they support local counterparts initiatives in the countries where they are active.

A good funding proposal should include the following information:

1. Name, address and legal status of your organization
2. Structure of the organization
3. Objectives of the project
4. Location of the project
5. Activities proposed
6. Expected results
7. Target group
8. Financial resources already available, including local contributions. Remember to value all your time and effort and that of other participants in your activities.
9. Budget requirements