International People's Health University

Short Course in Porto Alegre – 8th – 18th September 2008

Narrative report

Preparations

The preparations for the Porto Alegre IPHU started in November 2007, during the IPHU short course in Savar, Bangladesh. First arrangements were made concerning dates and course duration. In Brazil, some support was obtained from the School of Public Health of Rio Grande do Sul. From them on, the Porto Alegre team, together with the IPHU Coordination, worked intensively on the arrangements were made for venue, translation, transportation, field visits, applications and selection of participants, choosing faculty and finalizing the programme.

Arrivals

Participants and facilitators arrived at the Vila Betania venue in Porto Alegre between 6th and 8th September. This course of the IPHU counted on the presence of 53 persons coming from many different countries: Brazil, Argentina, Uruguay, Paraguay, Ecuador, Colombia, Bolivia, Guatemala, Nicaragua, El Salvador, Mexico, Australia, South Africa and Germany. See (**http://tinyurl.com/iphu-poa08**) for photos of the whole group.

Opening, welcomes and orientation

The course coordinator David Legge welcomed participants and spoke about IPHU. Not a traditional academic course. Focused on the barriers to health, both access and the conditions which shape people's health. Sharing experiences and building a people's health movement. This IPHU course is different from most university public health courses. At its core the difference is between a professional vocation and a political commitment.

This course has several elements. One of them is knowledge, including technical knowledge about the health system; health sector reform; the social, the environmental determinants or health; the use of information technology. We also need to learn how to improve our own practice: our political analysis and strategy; how we work with communities and with activists in other sectors. We need to create space in our lives for reflecting together on our practice; learning from each other; learning from our experience.

We need to think about what it means to build PHM in our countries and regions. What are the priorities for building PHM. We can work locally, with countries in Latin America and globally. For example: the challenges of the privatization of water, biopiracy, patents, the use of grains to make energy.

One other element of this course is the Panel Discussions. These are moments of debate for important issues and difficult questions; questions that may bring controversies. This should help us in developing our listening and critical thinking.

About PHM and IPHU

PHM is an organisation, a network of networks, a global social movement. It is a vision and a project; building a global social movement. Based almost entirely on volunteers. Overall it is important to think of PHM in terms of the link between the global and the local.

PHM was established at Savar in 2000. IPHU was created as a project to support the building of PHM. The 1st IPHU was in 2005 in Cuenca. This was followed by courses in Bhopal, Vancouver, Atlanta, Savar, Jaipur, Cairo, and now Porto Alegre.

Some of the key documents for PHM are:
1 - People's Charter for Health (2000)
2 - Mumbai Declaraion (2004)
3 - Cuenca Declaration - (2005)

PHM is above all a movement that is fighting for peoples' health. It is working on creating a shared vision among local groups around local issues and making the links with the global factors. The PHM deals with global issues, social determinants, environmental, engagement with the movements, with communities, gender and race, ethnicity.

These are theories which are useful in thinking about PHM's work:

- Governance theory
- Historical, political theories of social change
- Globalisation theory
- Social movement theory
- Legitimation theory and Ideology
- PHC and community mobilisation.

Getting started

Once the course started, a coordination committee was formed with volunteer participants and facilitators, in order to share discussions and tasks around the evolution of the course. During the first days, the group defined some goals for the course:

- Find the balance between being flexible without losing control of the time
- Find the balance to respect the different rhythms of people in the class
- This course as an opportunity to prepare materials to the 2010 People's Health Assembly.
- Develop the ability to share tasks. As soon as the course starts, everyone is welcome in participating of its organisation, volunteering in different tasks.
- Activities should be very interactive, attracting everyone's participation.
- Reports from practice should bring the stories of each one for the group to anlyse and think collectively and systematically how to rethink our own practices critically.

Topics

Brazil Health System

This first talk, given by Juvenal Dias da Costa, was an introduction to the Brazilian National Health System, its roots in groups of intellectuals and popular movements after a big meningitis epidemics that affected the middle class with great letality. Its organisation is based on the principles of access, efficacy and equity. Tudor Hart's inverse care law was evoked, to say that many health systems or health policies exclude to the most needed. Before the National Health System, or the *Sistema Único de Saúde* (SUS), the system was based on contributions, excluding all those who didn't have a formal job. The SUS was created in the 1988 Constitution, after the 1986 National Health Conference, that had brought up the objectives and principles of the SUS. Other important features of the SUS are descentralisation of management in three spheres and social participation (social control) through the health councils.

Brazilian Health System 2

This discussion was led by Armando de Negri Filho.

The basic principles of the Brazilian health system are unity, universality, comprehensiveness and equity.

What is wealth? Is it only the economy, ie the per capita income? Are health policies directed to the right to health of individuals or to the market?
"A democracy without social justice is a mere formality" (Boaventura de Sousa Santos).

The struggle for health is not a class struggle, but it is a struggle for democracy by social rights for public health. The politicizing the fight for health arises from key issues such as the tax system. Tax reform to achieve justice is essential.

We have to fight for causes we believe. We have to take political positions. What gives us strength in this struggle is the struggle for rights. We have to hit what is radically human and socially right.

Talking about a universal health system already is subversive by itself, that is, forces us to think of a way completely. How must we prioritize? But is prioritizing universal? A benefit is not a right. It is said that we are growing rapidly, that we do not have enough to distribute and we must prioritise. This is neoliberal logic.

The training of health workers must be addressed. First there needs to be political transformation and to the extent that the market structure is targeted, the training will follow to meet the market.

Brazil lives a contradiction between policies that intend to be socialising and a political and economic structure that is based on the laws of the market.

The social movements in Brazil are operating within a formal structure, for example, the Health Councils get absorbed by administrative duties. They hardly achieve to have their own agenda.

Some of the big challenges of the Brazilian Health System (SUS)

- Health beyond health services – this is not in the agenda.
- Financing: are there enough resources to achieve health for all? How much is needed to guarantee the right to health? This is the question that is never answered. A health system that is constantly managing scarcity lives in constant crisis.

Further reading on Brazil health system

The Struggle for Health

In this talk, David Legge evoked that health activists in the PHM do not stop at the technical dimensions of health care and prevention. They also worry about the political dynamics and about the kind of political movements which might create a healthier world.

Among the actions that we take to move towards a better world is to work with the communities whose health is damaged or vulnerable because of those wider political factors. The logic of comprehensive primary health care is to work with communities to address the bigger factors, not instead of but as part of addressing the immediate health issues they face.

These are issues on which we don't have easy answers. Indeed the answers are going to depend on the specifics of where we stand and when.

Further reading on 'the struggle for health'

Health Sector Reform in Latin America

This topic was led by Eduardo Espinoza from El Salvador.
See presentation

Eduardo spoke about widening inequalities in Latin America and the implications for exposure to health hazards and access to health care. Widening income inequalities associated with privatisation of health care had combined to create high barriers to access.

He spoke about the origins and logic of the neoliberal model associated with the World Bank and about the impact of privatization of health care in El Salvador.

He spoke about the continuing pressure to delegitimise government involvement in health care and to promote a view of health care as a commodity which is best accessed through market relations. He talked about two opposed logics: neoliberal (distributive policy, access to health services, selective primary care) and community-based (redistributive policy, access to health, comprehensive primary health care, health as a fundamental right).

With the logic of privatisation comes a logic of stratification of health care with inadequate 'safety nets' for the poor and high quality care for the rich. The concept of privatisation opposes the logic of health as a human right.

He argued that health activists in Latin America should oppose all forms of privatization and promote the idea that health care is a public good, not a commodity.

Further reading on health sector reform

Social Determinants of Health

This topic was presented by Stela Meneghel. She reviewed the work of the Brazilian Commission on Social Determinants of Health and reflected on its implications for Latin America.

“Medicine is a social science, and politics is nothing but medicine in a large scale”
Rudolf Virchow.

The social determinants established by the WHO included:

Early childhood development
Globalisation
Health systems
Urban settings
Employment conditions
Women and gender equity
Measurement and evidence
Social exclusion

More on social determinants

Environmental Determinants

This topic was presented by Nicolas Campoverde. He talked about the concept of environment and about health as a primary term. Mining is one of the most contaminating activities in the planet. Nature is ready to dialogue with us as long as we want to do so. He gave an example of malefic human action: bacterial resistance.

Further reading on environmental determinants

Working with Communities

This topic was presented by Humberto Scorza. He shared his experience as a health counsellor for 2 decades. In working with communities, the principle, above all others, is respect. It`s about learning to listen and not to impose.

Further reading on working with communities

Globalisation

The first presentation for this topic was presented by David Legge.

This term globalisation is used in several different ways:
1. global village: communications, information, transport
2. pattern of global economic activity
3. political system of governance

The elements of governance include: International institutions (UN, WTO, ONE, WHO, IMF, WB, WTO), Nations (especially the 'great' powers), Forums (eg the World Economic Forum in Davos), and **Social movements: this is where we understand the role of PHM.**

He explained the origins of `The Debt Trap`, going back to the most important economic theories of micro and macro economy. He went through the 'long boom' after the second world war, 'Fordism' (wages feed sales), Keynesian policies, the post-Fordist pattern, monetarism and the global recession in the 1980s.

The dominant principles of global economic management - *structural adjustment* (driven by the IMF and the World Bank) and *'free' trade* (driven through the WTO) - make sense, at least from the point of view of transnational corporations and the rich countries.

Structural adjustment describes a range of policies imposed on highly indebted developing countries to enable them to repay their debts, but often at great cost, including to population health and health services. Structural adjustment policies include: reduced social expenditure, reduced tariffs, export orientation, devaluation, etc. By the early 1990s there was widespread rejection of the brutality of structural adjustment as imposed by the IMF and the World Bank became more involved in framing structural adjustment policies (now reframed as 'poverty reduction' strategies).

Meanwhile the pressures on developing countries to open their markets to rich world manufactures were growing through the WTO (which opened for business in 1995).

Under the slogan of 'free' trade, a fundamentally unfair global trading regime has been crafted. There are many dimensions to this unfairness but the differences in its treatment of agriculture, manufacturing, services and intellectual property are key elements.

The thirld world debt is only one of several channels of mobilising debt to support consumption.

The global financial crisis of 2008 was inevitable because this debt-fueled consumption was fundamentally unsustainable. The emerging global recession has been precipitated by the sub-prime mortgage crisis but caused by the global crisis of over-production. The present policies of massive spending are not addressing that crisis; rather they represent a new phase of tax funded consumption to make up for the collapse of debt funded consumption. Equally unsustainable.

In the light of the theory of a crisis of over-production the policy strategies to move the global economy to a more sustainable basis are clear. They include regulation of the global finance industry and the reform of global trade (to allow a framework of graded protectionism). On top of these imperatives comes the environmental crisis and the need for major structural changes in the global economy to reduce greenhouse gas production and other forms of environmental despoliation.

The implications of this analysis of globalisation for population health and for health services are easy to see. Likewise this analysis provides new insights into some of the dominant themes of health policy globally, such as the privatisation and safety net policies of the World Bank.

This analysis also highlights the significance of ideology in sustaining this regime. It thus also highlights the significance of delegitimation as a strategy of the people's health movement. The power of this strategy has been seen in a number of key engagements.

Further reading on globalisation

Globalisation Part II

The second presentation on globalisation was presented by Armando de Negri Filho.

Neoliberalism is an ideology and an economic doctrine. He described the origins of the neoliberal hegemony from the second world war to the present, including the development of the IMF, WB and WTO.

He reviewed the unfolding history of this regime in relation to Chile (1973), Bolivia (1980), Collor elected in Brazil (1989), Fujimoro in Peru (1989), Mexico (1994) and the WSF of 2001.

The “neoliberal diversity” creates a perverse fragmentation of social movements. It ends by stealing society`s political spirit. The current neoliberal doctrine is not sustainable.

Spirituality and Meaning and Health Activism

David Legge provided a brief introduction to the Spirit and Meaning Exercise.

The meaning of life is a determinant of health. This was reflected in the Second World Health Assembly of Peoples, developed in Cuenca, in July 2005. Against this background, the working groups developed the following questions:

1. What keeps me engaged in the fight? How do I maintain my commitment and energy despite the disappointments?
2. How can we deal with the materialism, selfishness, individualism and consumerism which destroys the environment, drives conflict and prevents the building of social solidarity?

The groups` answers addressed the following issues, among others:
- Meeting with other people who share the same dream.
- Keeping the joy in the struggle.
- Taking time to listen to oneself and others (evaluation).
- Awareness of the injustices we see, indignation and anger with the abuse of power.
- Feeling part of the problems of the planet, conviction og being part of a whole: ancestry and descent.
- Believing in the cause (belief, conviction) and keeping hope.
- Systematic exposure to other experiences and cultures, and making links between peoples. Experimenting and respecting differences.
- Communicate and disseminate our experiences
- Spirituality gives sustenance to life.
- Having clear goals.
- Conviction and political commitment.

- Good examples of leaders, models we admire.
- Rely on the family.
- Learn new experiences.
- Ties of friendship with the group we work with, empathy.
- Keeping inspiration, searching for new sources.
- Remember our history.
- Optimism with the successes and achievements.
- Harmony with the ecosystem.
- Practicing solidarity and compassion.

Research in Primary Care

This topic was presented by Erno Harzheim. He mentioned important references such as B Starfield, L Green, C. Hames, D Mant. He talked about types of research: basic, clinical, health services, health systems.

There was vigorous discussion after the presentation. Some of the topics discussed were: medical hegemony, the role of quantitative and qualitative research, and the importance of acknowledging the principles of community mobilization in researching Primary Health Care and action on the social and political determinants of health.

Trade Regulation and Access to Essential Medicines

This topic was presented by Ricardo Kuchenbecker.

He gave an overview of the development of international agreements and laws governing intellectual property, since the Paris Convention in 1883.

Key question is whether health should be regarded as a "commodity" or a "public good"; something that can be traded or which should be treated as a public good. He talked about the TRIPS Agreement, patents and Compulsory Licence.

Further reading:
PAHO Report CD48/18 on Public health, innovation and intellectual property submitted to 48th Directing Council 29 Sept - 3 Ooct 2008: in English; in Spanish.
PAHO Resolution CD48.R15 on Public health, innovation and intellectual property: in English; in Spanish.

More on: trade and health.
More on TRIPS and big pharma.

Global Health Policies

This topic presented and facilitated by David Sanders. He presented some global indicators that illustrate inequities between and within countries. Primary health care International Conference (Alma-Ata, 1978) set up the principles of Primary health care: Universal access, Community and individual health, Participation and social control, Addressing the social determinants as well as health care.

After the conference in Alma-Ata, the selective approach to primary health care has dominated global health policy over the last 20 years, prioritizing focussed 'cost effective' interventions.

He spoke about new global partnerships for health development and addressed the problem of human resources. There`s a need to change the training of health workers.

He emphasized the power of community-based actions and gave examples such as the Mitanin Program, in India. Community health workers can improve access, but need to be carefully selected and be given adequate training, supervision and logistic support.

The presentation was followed by active discussion.

Further reading on health systems policies

The Right to Health

This topic presented by Fernando Borgia. He defined the right to health approach and proposed a group work. Groups gave examples of violations to the right to health and of how to implement a rights-based approach.

Further reading

The Right to Health

Volunteered Topics

Participant from Porto Alegre made a presentation on permanent education on public health.

Participant from Porto Alegre shared the Brazilian policy of humanization.

Sharing experiences - learning from experiences

One of the main objectives of the IPHU is to offer and opportunity of sharing experiences of health activism to strengthen the struggles around the world. This is one of the reasons IPHU participants stay together on the same venue, sharing course activities, meals, social moments and informal everyday life talks. In Porto Alegre, a great number of extremely rich experiences were shared.

Reports from Practice

The participant from Rosario, Argentina, shared his experience in creating a new course in medical school: Socio-enviromental Health, since 2004. This course was brought up as a students` demand. The course is based on theory, group work and field practice. It`s an elective course for 3rd year medical school students, and students from other courses. Among all the students who have taken this course, 25-30% continue with a practical project on environmental health.

Participant from Porto Alegre, Brazil, spoke about GAPA (Group of Support and Prevention of AIDS). GAPA was founded in 1985, coming along with the Brazilian Health Reform. GAPA RS, in Porto Alegre, opened in 1989. Today there are 11 GAPAs in the country, forming a network for the prevention of HIV infection and for the support of people living with HIV/AIDS.

The group learned from the experience of the Guarjila Community in El Salvador by watching a video directed by Eduardo Espinoza. This is one example of how community organisation can combat neoliberal forces and be effective in improving people`s health with its own resources.

Participant from Belem, Brazil, who is a nurse working in a mental health service, shared the experience of building a quilt with the use of art and poetry to express people`s feelings in relation to the problems that caused damage to health. She also talked about the feminization of AIDS and explained in a poem how to use the female condom. Talked about legalising the right to abortion and about the invisibility of lesbians.

Facilitator from Florencio Varela, Argentina, shared the experience of implementing primary health care strategies in Florencio Varela, a city 23km far from Buenos Aires. She emphasized community participation in identifying health needs, and respect for local culture. Example of how the health management team can work together with the city`s population.

Full report of Florencio Varela project

Participants from Medellin, Colombia, shared their experience in the struggle for health in their country. They are part of the National Health and Social Security Movement and were organisers of a Right to Health Camp, where written testimonies of right to health violations embased the thinking of new actions.

Participant from San Martin, Argentina, shared her experience of working with Red Jarilla, a Community-based association working with traditional health practices, especially plants and herbs. They work with diffusion of these traditional values and training of community members.

Participant from Porto Alegre, Brazil, shared her experience working with Medecins du Monde in the rural zone of Angola. She talked about working with communities and together with the local health system. Contradictions about development assistance were addressed, especially the potential risk of vertical actions in fragmenting the local health system. Questions about sustainability of external aid were raised.

Participants from Uruguay presented the projects of ALAMES (Social Medicine Latin American Association) in Uruguay, with special attention to the National Health Forum.

Participant from Colombia shared the experience of working with the Cauca Indian Community through the Regional Cauca Indian Council.

Participant from Argentina spoke about her experience of living and working for many years as a doctor in Mozambique.

Participants from Argentina shared their experience with the Evita Movement in First Aid Training Programme and oral health promotion.

Participant from Bolivia shared her life experience working with the rights of indigenous women, how they struggled to defend their ancestral culture.

Field Visits and External Activities

Participants went on field visits to health services, social initiatives and training programmes during the morning. These were reported by each group in the afternoon.

Reports from Field Visits

Presidente Vargas Hospital: focussed on mother-child care, is a reference in the city for cases of sexual abuse and violence. The group noted that opening hours are limited (service not available during the night), and that only the women are approached. The group also raised questions about the health workers' status, which differed according to the nature of the contract (municipal or state).

Relief Hospital: emergency care, state reference for any kind of trauma. Ambulances service (SAMU) with mobile teams very overcharged. The group realised that there was imbalance between supply and demand for services.

Guarani indigenous community: currently there are only 4 thousand Guaranis in Brazil. This community is formed by 20 families (~150 people), living from agriculture and handicrafts. They have a school where they learn Portuguese and Guarani language. They have a health team, but the people seek traditional healers first, then the "official" health team. The group noted that the two kinds of approaches are not coordinated, although there was respect towards traditional healing. The group claimed that this community is living in a land that served as a dump not long ago, this should be denounced.

Santa Maria Health Centre: works with a Family Health Strategy team. The team is responsible for the care of 600 families living in the catchment area. Team is formed by: 1 doctor, 1 nurse, 2 nurse technicians and 2 community health workers. The group outlined that the region is of high unemployment and that one of the main problems is drug dealing. The group also reported the little community involvement in the area.

Esperança Cordeiro Health Centre: works with a Family Health Strategy team. The group brought up that there were striking differences between the salaries of different categories of health workers and that there was privatisation of staff management. The group saw the unexpected visit of the city's secretary of health. The group noted that this team was following the principles of humanized assistance and providing comprehensive care. Lack of community participation was an important issue reported.

School of Public Health and San Pedro home: The school has permanent education programmes in the health field and a multiprofessional residency programme. It's managed under the State Health Department (under the state government) and it's mission is to train professionals that are oriented to the Brazilian National Health System's public policies. The group also visited the São Pedro Residential Facility, which is aimed at the social reintegration of people suffering from mental health disorders. This is one of the devices included in the national Psychiatric Reform.

Sanatorio Partenon: HIV/AIDS, TB, hanseniasis, and hepatitis care with an interdisciplinary team. The group noted that there is a nursery for the staff's children.

Psycho-social care centre: device included in the national Psychiatric Reform, aimed at providing ambulatory and community support for people suffering from mental health

disorders. Works with an interdisciplinary team connected to other sectors. The group noted that the staff was overcharged and that their working contracts were precarious.

Quilombola – Black remanescents community (28 families), live in precarious situation, without school or health service. There is a health programme being implemented by technicians, who lack understanding of the meanings of the quilombolas. The group noted that this programme seems to be an external one, poorly adapted to the quilombola's specificities. The group expressed it's worry about the expropriation of the traditional culture of the community.

Conceição Community Health Service: this was one of the pioneers of community health programmes of assistance and training in Brazil. The group was impressed with the visit to the Jardim Itu unit, where community participation was very strong and the staff was very committed.

Pro-Jovem Youth Programme: social programme for reintegration of young people through work. The group noted that there's lack of a consistent work on prevention.

Visit to the Municipal Health Council

The Council invited IPHU for a special meeting for remembering the 20 years of occupation of one the cities most important health facilities. The occupation is a successful example of popular mobilisation. IPHU participants had the opportunity to know more about the Council and social participation in Brazil.

Street Demonstration with the Municipal Health Coucil

The IPHU joined the Health Council on a Demonstration demanding improvements in health care in Porto Alegre. There was a call for citizens to fight for the right to health, that is being disrespected by the current local government.

Panel Discussions

Panel discussions intend to talk about and debate around difficult questions. Experts are invited to the panel and a facilitator moderates the interaction with the participants.

The first Panel Discussion was about tobacco use, alcohol and violence.

Another Panel discussion was made after the visit to the Municipal Health Council. The debrief discussion was led by SILVIA (health council member) and CLARETE (health council expert). The debate was very interactive, there were many questions about how the Health Council was constituted, how does it work, what is its real influence over the *decisions on health.* Oscar, the Vice President of the Municipal Health Council of Porto Alegre, talked about further issues and answered many questions.*The Council is constituted by users (50%), health providers (25%), and health managers (25%). It is* connected to the Municipal Secretary of Health, but works independently. It has 80 members in Porto Alegre.

A last one was about working with communities and intersectoral work. The facilitators simulated a TV programme with invited experts on the theme and active participation of the public.

Group Work

Objectives of Working in Country and Thematic Groups

- Country Groups: how to build PHM in our own country, making the links between our problems; building solidarity; working together on the common factors globally.
- Thematic Groups: working on issues that we share in common across countries, such as trade reform and the health of the 3rd world peoples. What should we do in relation to the reform of intellectual property or the food crisis. The goal is to create a plan for a project, possible to implement in practice, and implement across several countries.

Starting the Group Work with the People's Charter for Health

Critical reading and discussion about the Charter, based on the following questions:
Where could it be strengthened?
What needs to be changed?
What could be added?

The Country Groups were formed as follows for this first group discussion:

- Colombia, Bolivia, Ecuador, Nicaragua, Guatemala, Mexico (Centro-America-Andina)
- Argentina, Uruguay, Paraguay, Australia (Conosur)
- Brazil

Group discussions were a theoretical exercise for reflection. There was debate around the Charter as the basis for reaching out to other networks in building the people's health movement. Reopening of the Charter for amendments could only occur at the next Assembly in 2010.

After the initial discussion around the Charter, during the following days, groups were asked to think about projects and initiatives in their countries and regions which would build PHM locally and would strengthen the regional PHM network.

BRAZIL
The following topics were discussed: Social Control (community participation); food safety; violence (mobilization in association with the various bodies involved but with added training for social movements); patriarchy (including women (gender), equity between genders and sexual rights); environmental determinants (including environmental racism); precarious labour relations; racism; logistics (publicity, campaigns, structure); professional education.

URUGUAY
Discussed the following: Environmental issues (plantations, environmental racism); reform of the health system (including privatisation and commodification); citizen`s participation and defence to the right to health.

ARGENTINA - PARAGUAY - AUSTRALIA
Health and political construction; Training in Health: Promoters, Leaders, Students;

Ecosystem and health; Determinants of health; Reflection and Promotion of the Right to health.

CENTRAL AMERICA ANDEAN REGION - (Colombia, Guatemala, Mexico, Peru)
The right to health and its vulnerability to Neoliberalism (including the privatization of water); Depredation of the environment; Economic globalization (including 'free trade agreements'); Migration and "brain drain". Violence, conflict and narcotraffic; Transversal Topic: Gender, Racial and Ethnic, Social Class.

The group proposed the following strategies:
1. Build popular organizations - community autonomy, construction of identity
2. Strategic development of communication - create programs for television, radio, internet to disseminate successful strategies
3. Create cohesion in politics, with popular power criteria. Prevent the dispersion in both the macro and the micro. Promote consensus of agendas.
4. Strategic comprehensive teaching and curriculum in the training of environmentalists, community, health professionals.

Interim Reports of Country and Regional Groups

1. Brazil

   - Promote the PHM in Brazil, diffuse and enhance partnerships. Think of good communication strategies for advertising and for communication between PHM members in Brazil.

   - Participate in the WSF 2009 in Belem, as an important step in building and strengthening the PHM in Brazil.

   - Organise the launching of the Global Health Watch 2.

   - Strengthen partnership with Health Coucils.

   - Develop appropriate strategies for fund raising.

   - Learning other languages to enable global communication.

2. Uruguay

   - The National Social Forums on Health have been enhancing the discussion about the right to health, with increasing popular participation.
   - Officially associate the PHM to the Health Forum.
   - Disseminate the discussion around the basic principles of PHM.
   - Organise the launching of the Global Health Watch 2.

3. Southern Cone

   - Building the PHM in each country will require good communication.
   - Develop the Blog and use it for exchange of information (experiences, documents, photos).
   - Have coordinated translations to different languages.

- Organise an IPHU short course in Rosario, Argentina, in 2009.
- Develop appropriate strategies for fund raising.

Country Group Works – final reports

Final country reports presentation

Thematic Groups

Drug Trafficking, Migration and Violence Group Final Narco Violence Migration project presentation

Communications Group Report Report presentation here

Popular Education Report here

Working on Information and Communications Technology (ICT) for Health Activism

The facilitator gave a general introduction to ICT, which was very interactive.
Importance of open access applications were outlined.
Blogging was introduced with an activity for each of the country and regional groups to create a blog and keep on feeding the daily experiences of this course.

These were the blogs created by the groups:
CentroAmericaAndina Blogspot
MSP ConoSur Blogspot
IPHU Brasil Blogspot

Further session presented and facilitated by Virgilio.
www.iphuportoalegre.blogspot.com
www.opps-ues.blogspot.com
www.skype.com
www.scribd.com

Socialising

Dinner in the Churrascaria with Health Council leaders: typical churrasco gaucho and regional dances.

Excursion to Porto Alegre Articrafts Fair, Central Park and Regional Gaucho Event.

Closure

Evaluation and Strategy Discussion for the Future of IPHU

Participants filled in an evaluation form and the Porto Alegre IPHU organisers shared the experience of organising an IPHU Course.

Closing Ceremony – Certificates and Cultural moment

After the IPHU, during the XVIII World Congress of Epidemiology

Launching of PHM Brazil in the end of the Primary Health Care Symposium

The following entities are now part of PHM – Brazil Circle, officially launched on this date.

CES-the State Council of Health;
GAPA / RS - Support Group for the Prevention of AIDS
CEDEMPA - Center for the Study and Protection of Black People
IACOREQ - Office of the European Advisory Board Remnants of Quilombos;
Maria Mulher- Organization of Black Women;
Brazilian Feminist Network of Health;
Nzinga MBANDI;
National Black Women's Forum;
MST - Movement of Landless Rural Workers;
Casa Laudelina - Organization of Black Women;
Candaces - National Collective of Autonomic Black Lesbian Feminists
Forum of Black Women of the Amazon;
Feminist Health Network from Pará;
ABRASBUCO - Brazilian Association of Collective Oral Health;
ESP / RS - School of Public Health / RS;
Movement for Eradication of viral hepatitis (MOVHE)

Perspectives

Future IPHU courses: see http://www.phmovement.org/iphu/

Community Action for Health Project

The idea of this IPHU Research Project was born in Porto Alegre. This project proposal aims to promote wider appreciation that support for popular mobilisation around the right to health care and action on the social determinants of health are core principles of PHC and to document contemporary episodes of community action for health and reflect upon the principles which might guide PHC agencies and practitioners in supporting it.