THE CONSTRUCTION OF CRITICAL KNOWLEDGE FOR THE DEVELOPMENT OF HUMAN HEALTH.

An evaluation of a health promotion intervention in a rural community in Mexico, 1997-1999.

THESIS SUBMITTED FOR THE DEGREE
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I declare that the work presented in this thesis titled: *'THE CONSTRUCTION OF CRITICAL KNOWLEDGE FOR THE DEVELOPMENT OF HUMAN HEALTH. An evaluation of a health promotion intervention in a rural community in Mexico, 1997-1999'* is my own.

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ABSTRACT

This study is about the power dimensions of health promotion seen from the perspective of a rural community in Mexico. Drawing upon the conception of health promotion proposed in the Ottawa Charter 1986, health promotion is examined here as a device of hegemonic power and also as a possibility to subvert domination. The assumptions underpinning this thesis are based in the works of Antonio Gramsci, Pierre Bourdieu and Paulo Freire. The work of Michel Foucault also helped in the development of particular concepts of health and health promotion. It is argued in this thesis that the control of power is achieved by controlling meaning in social networks and that, because of the unique capacity of health to involve the objective and subjective dimensions of the human person, the discourse and practice of health promotion are outstanding means for the control of meaning. This thesis has three main components: the analysis of power and knowledge and of the official discourse and practice of health promotion; the design of a pedagogic intervention aiming to achieve changes in adult learners subordination patterns and the description and evaluation of that intervention. The pedagogic intervention focused on processes rather than on contents and brought problems of students' reality to deconstruction through dialogue. This study has a qualitative methodological approach and is presented as a case study. The empirical data were collected through fieldwork observations during the implementation of the intervention. It is proposed in this study that dialogue can be a means to triangulate data. The analysis of data is done here with the aid of process and outcome indicators capable of monitoring changes in the students' position in the face of power. This thesis showed that there was a possibility to achieve changes in students' patterns of subordination through pedagogic practices where they constructed knowledge embedded in their values and meanings to face their health problems.

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CHAPTER 1
INTRODUCTION

This thesis is about a perceived knowledge gap in the health conception underlying health promotion discourses and practices where the role of individual and collective capacity and power for the promotion of health is not fully addressed.

A departure point for this research is the examination of institutional health discourses, policies and practices in a rural community in Mexico. This examination shows that the definition of health behind official health discourses focuses on disease rather than on health and that official health promotion discourse is mainly rhetoric. After the continuous and systematic use of official health discourses, scientific or other knowledge constructed around health has prioritised disease over health, thus developing a perceived meaning of health as always disease-oriented and giving great power to medical technology and scientific medical knowledge and practices. This examination also shows that official definitions and discourses about health promotion open the way to health practices that often benefit the institutions more than their supposed beneficiaries. This unveils an insufficiently explored dimension of health practice: the uses of knowledge from a position of power, through health promotion. This points to the existence of gaps in scientific research, discussion and knowledge about the conception and practice of health. With this research study I intend to address some of those gaps. This thesis also addresses methodological and evaluation gaps found in health promotion research.

This study focuses on the exploration of a definition of health that can be meaningful for people with restricted access to power and where the individual person's material body and subjectivity are regarded as one whole . This exploration is done from the understanding of how the meanings, values and knowledge about health are constructed amongst the poor[1] and the repercussions of institutional health practices over them. It also explores what practices can derive from that understanding.

[1] The terms 'marginal' and 'poor' are used here to make reference to individuals or groups of population -large or small- with restricted access to services, infrastructure, knowledge, employment, income, voice, formal education, etc.

This research study uses this understanding in the design of a pedagogic intervention aiming to promote the health of specific people in a rural area in Mexico. Also in the light of this new understanding, this research evaluates the process and outcome of this pedagogic intervention.

ANTECEDENTS AND INITIAL ARGUMENTS

As part of my work I have been involved in setting up primary health care services in Mexico and in training medical students who for some of their academic career must work in marginal communities. For many years my academic work within the medical training programme in the Universidad Autónoma Metropolitana – Xochimilco (UAM-X) was related to this compulsory social service in Mexican rural areas[2]. Through teaching I became aware of a gap between the medical syllabus based on the scientific bio-medical model of disease and the reality it is meant to transform. This is particularly noticeable in medical students, who demonstrate a lack of understanding and training in health promotion.

I also developed links with popular health movements[3] that constructed and developed health promotion ideas and practices incorporating popular education[4]. I got an insight into the health problems of people who have not been able to have access to health services and found that, by collective reflection about their problems, they develop a set of useful tools to better understand their situation and to take decisions to improve their living conditions.

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[2] For a better understanding of UAM-X and the academic and pedagogic context of compulsory social service refer to Arbesú and Berruecos 1996; UAM-X 1994, 1992, 1991; Arenas and Serrano 1981; UAMX-DCBS 1975. In México by law, all pre-graduate students should attend social service for over six months. UAM medical curricula incorporated social service as part of its programmes, with marks and academic credits.

[3] Examples are the Catholic 'Christian Grassroots Communities' followers of the Liberation Theology and some co-operative and health promoters unions in Southeast México.

[4] A discussion about popular education is presented in chapter four (p86) within this thesis.

Through observations and reflection done during those experiences, I have noticed that pedagogic relations between the official staff and the population are central to the delivery of health services and for the construction of health knowledge. I have also noticed that scientific health knowledge is scarce within the observed population and that young generations hold and use very little local traditional health knowledge[5] to deal with their problems of health. Thus, lack of access to health knowledge is compounded by the disappearance of alternative, popular knowledge. Incorporating empirical experiences and theoretical reflections I constructed a set of initial assumptions underpining this work that I present here and develop in this thesis.

Underpining the argument of this thesis is the idea that the individual person has interlocked objective and subjective dimensions. Also the individual person is only possible in a context constructed by the interrelations of the material and symbolic worlds. The wholeness of the objective and subjective individual existing in the material and the symbolic worlds constitutes the human subject.

In the Ottawa Charter for Health Promotion -conceived during the First International Conference in Health Promotion in 1986- is also present the consideration of the objective and subjective characteristics of human subjects. The Ottawa Conference on Health Promotion agreed that:

> 'Health Promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, *an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment.* Health is, therefore, seen as *a resource for everyday life, not the objective of living.*" (Added emphasis) (Ottawa Charter for Health Promotion 1986:4)

According to the Ottawa Charter's definition of health promotion, health does not refer to disease only but to a number of the objective and subjective dimensions of the individual subjects and their context that enable them to take decisions and realise their aspirations. Thus, to refer to a healthy individual and to act towards the development of health, it is necessary to identify and develop the characteristics of the human subjects that enable them to take decisions and realise their aspirations. In this context, the aims

[5] Traditional health knowledge and practices are defined here as knowledge and practices that have been created locally and transmitted in informal ways from generation to generation. Before the spread of scientific health knowledge and practices, the health care of people rested upon traditional knowledge.

of any project for the development of health should include aspects capable of meeting the necessities of the understanding, development and exertion of those characteristics.

However, there are many obstacles to achieving the inclusion of such aims in health projects. From the conceptions that all social relations are power relations (Bourdieu and Wacquant 1992); that power is something that only exists if acted (Foucault 1979,1973) and that power is not given or distributed, but taken and retained (Gramsci 1975b)[6]; to include aims seeking to meet the necessities of decision-taking human subjects, threatens the power of other groups or individuals. In this way, it can be said that all the obstacles to achieving the inclusion of such aims in health projects are generated because of the dynamics of power.

The effects of power over health projects and the effect of health projects over disenfranchised individuals can be seen in all groups in society. However, the effects of sharing one of the thinnest slices of power or no power at all are visible at first sight in subjects without access to overall wealth whose health is officialy cared for by institutions.

The effects of power are visible even in projects that claim to be liberating and critical. In the last four decades, emancipation, critical or liberation theories have expanded through the world. One educator leading those theories and translating them into practice and method was the Brazilean Paulo Freire. The philosophy proclaimed by Freire has become known as the 'pedagogy of liberation' (Freire 1989). However, critical health promotion projects often show contradictions between philosophy, aims, and practices. The method proposed that through the triggering of reflection and the unveiling of knowledge the individuals can't identify because of their oppressed condition, liberation could be achieved. However, in my empirical experience, I had noticed that most projects aiming for liberation are led by individuals, groups or institutions that are recognised locally as some kind of authority: intellectual, religious, economic, political or other. This perceived authority reduces the possibilities to

[6] The scientific analysis of power relations is an object of study of the social sciences and specifically of the sociology of power. Different authors have explored different aspects of power since many centuries ago (see for example Machiavelli 1958). Particularly relevant in are the works of Marx (1974), Althusser (1970), Gramsci (1975a, 1962) and Foucault (1984, 1979)

trigger local issues, selected or thought by local people. Even more, authorities always have their own pedagogic agenda from which they trigger their actions. Therefore, to develop a more genuine liberating health pedagogy it is necessary to address the power dimensions embedded in every pedagogic action.

These considerations led to the construction of a central argument to develop in this thesis: The practices and discourses about health generated by authorities -whatever their kind- are uneven practices of power. To achieve changes in health it is necessary to address and develop the subjects' power. In this thesis I will develop this argument and will test it through the analysis and evaluation of the implementation of a pedagogic intervention.

To develop and test this argument I considered three research aims. First, to investigate the processes, role and impact of official pedagogic practices -emphasising the role of health promotion programmes and practices over the power dynamics and health situation of poor people. Second, to evaluate the extent to which a health-teaching programme carried out between August 1997 and March 1999 was able to change the patterns of power dynamics and the health situation of people belonging to a rural community. And finally, to provide information and analysis about the design, implementation and evaluation of health promotion projects to social organisations looking for the development of the health of poor people.

Having presented the main argument to be developed in this thesis and the aims of this research work, I will present below the research questions and problems.

RESEARCH QUESTIONS AND PROBLEMS

Previous observations and arguments led me to raise two main questions for this research: What are the characteristics of the dynamics of power underlying relationships between health services and individual subjects who have restricted access to power and overall wealth? Is it possible to modify the health and disease situation of those subjects through changes in the dynamics of power resulting from a planned pedagogic intervention?

These two questions complement each other. Question one is asking for understanding about power dynamics in the context of health. That understanding is the starting point to answer the second question. Also, in answering question two, I intend to generate new understandings about question one. To answer those questions, I identified five problems behind them as follows:

One. As it will be examined later on in this thesis, the official health discourses in Mexico claim a right to health for all the population. However, these have been shown to be mere rhetoric when compared with official health practices or with the insignificant changes in health and disease patterns attributable to official health practices. Even more, the official[7] health system in Mexico tends to exclude what we can call local[8] health knowledge, the processes of communicating such knowledge and the decisions and practices based on that knowledge. This situation is probably reinforced by the official education system that has failed to open access to 'scientific'[9] or other health knowledge to marginal populations. A first problem for this research is to examine how the inconsistencies of the official health discourses and practices are achieved and maintained.

Two. However incoherent, there are in fact official practices and official discourses present in poor communities. Here, local people find it difficult to raise their voices, use their local knowledge or make their local values 'valuable' for the institutions, when confronting official health programmes or personnel. In this way it is hard for local people to make effective claims for quality official health services and to understand and decide upon medical and other practices that affect their bodies, culture and resources. A second problem for this research is to document and examine those pedagogic relationships in an attempt to find out why and how they endure this situation and what are their characteristics and processes, paying special attention to existing knowledge dynamics.

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[7] By 'official health system' it will be understood in this thesis the health system run by governmental or governmental-sponsored institutions to differentiate it from local or private health systems present in the communities.

[8] To refer to people, events, or other issues appertaining to specific communities, with its own processes, values and meanings it will be used here the term 'local' to differentiate them from official and more general regional or national ones.

[9] By 'scientific' health knowledge or practices it will be understood in this work the knowledge or practices developed by science and medical technology and spread or practised by health institutions to differentiate them from other health knowledge locally created, transmitted and used.

Three. The problems raised from critical health promotion inconsistency between philosophy/aims/implementation referred to in previous paragraphs, revealed practical gaps in the evaluation of the consistency between specific project goals and correspondent actions. This leads to a third research problem: to find out and test alternative ways in which such programmes can be designed and implemented in a way that dominant authority practices can be under the surveillance and control of the population it claims to serve.

Four. Most budget administrators and financial agencies tend to ask for objective measurable aims and results –often asking for quantitative evaluations- to support a project, whatever its nature. This can be true for international or national agencies as well as for NGOs or individuals working for health promotion. Also, there is a necessity to find ways to show them how changes in the social environment and in the knowledge construction processes can affect the individual's subjectivity and how the individual's subjectivity is expressed in changes in the individual's physical bodies. Health promotion results are not easily transformed into quantitative meassurements neither are they visible in the short term. A fourth problem for this research is to find objective outcome and process parameters to evaluate health promotion in a way that the health promotion peculiar timing and agendas can be preserved.

Five. Finally, the main concepts involved in this research –poverty, disease, health, health promotion, education- and the policies and actions derived from those concepts, have been in continuous debate in the last three decades. A fifth problem for this research is to explore those concepts, to propose alternatives and to test them through the conception, implementation and evaluation of a pedagogic model developed from such alternative concepts.

In box 1.1 I present a summary of the aims, underlying assumptions, main questions and problems for this research. I will present this research's methodological approach in the following paragraphs.

BOX 1.1. AIMS, ASSUMPTIONS, QUESTIONS AND PROBLEMS FOR THIS RESEARCH

MAIN ARGUMENT The practices and discourses about health generated by authorities -whatever their kind- are uneven practices of power. To achieve changes in health it is necessary to address and develop the subject's power.			
AIMS	UNDERLYING ASSUMPTIONS	QUESTIONS	PROBLEMS
-To investigate the processes, role and impact of official pedagogic practices – emphasising the role of health promotion programmes and practices- over the power dynamics and health situation of poor people. - To evaluate the extent into which a health-teaching programme carried out between August 1997 and March 1999 was able to change the patterns of power dynamics and health situation of people belonging to a rural community. -To provide information and analysis about the design, implementation and evaluation of health promotion projects to social organisations looking for the development of the health of poor people.	-The wholeness of the objective and subjective individual existing in the material and the symbolic worlds constitutes a human subject. -Health does not refer to disease only but to a number of the objective and subjective dimensions of the individual subjects and their context that enable the first to take decisions and realise their aspirations. -Obstacles to achieve the inclusion of such aims in health projects or for the commitment to them are generated because of the dynamics of power. -The effects of sharing one of the thinnest slices of power or no power at all are visible at first sight in subjects without access to overall wealth whose health is officially cared for by institutions. -The effects of power are visible even in projects that claim to be liberating and critical.	What are the characteristics of the dynamics of power underlying relationships between health services and individual subjects that have restricted access to power and overall wealth? Is it possible to modify the health and disease situation of those subjects through changes in the dynamics of power resulting from a planned pedagogic intervention?	-To examine how contradictions between official discourses and actions are achieved and maintained. -To document and examine institution/public pedagogic relationships in an attempt to find out why and how they endure and what are their characteristics and processes, paying special attention to existing knowledge dynamics. -To find out and test alternative ways in which such programmes can be designed and implemented in a way that dominant authority practices can be under the surveillance and control of the population they claim to serve. -To find objective outcome and process parameters to convince the administrators and financial agencies to support projects aiming to develop capacities to take decisions and realise aspirations taking into account the times and agendas of health promotion. -To explore the concepts of poverty, disease, health, health promotion and education to propose and test conceptual alternatives.

METHODOLOGICAL APPROACH

To develop the argument of this thesis and achieve the research aims, I will look at the power dynamics in which local people are involved and at the impact of the processes of power in the health knowledge, values, meanings and practices of specific people in a rural community in Mexico. The research interest in knowledge is focused in the following areas: knowledge, power, pedagogic relations, social structures, critical

teaching alternatives, health promotion, health enhancement, health knowledge and practices, the body and social structures.

To develop the arguments for this research I am looking at processes and outcomes from particular definitions of poverty, disease, health, health promotion and education, as it will be seen throughout the development of this thesis. Different ways in which dominant power is constructed and reflected in individual and social perceptions of health and disease will be studied and analysed in public and private health practices; in access to health services and knowledge and in patterns of health and disease amongst marginal people. How change in the patterns of domination can emerge from a pedagogic intervention will also be studied.

I decided to examine power and change by using theory already constructed around it in the understanding of fieldwork observations of life in a marginal community and of the development, implementation and evaluation of a teaching programme that aimed to produce change in the patterns of the students' relation with power. To do that, I selected a qualitative methodological approach that could help to look closely at subjective and objective aspects of the power relations of specific people. Therefore I chose a naturalistic interpretative approach for a descriptive and explanatory case study.

This research intervention was conceived and designed before the case was selected, assuming a 'theoretical reality' that I considered could fit in Mexico's marginal society empirical reality. The community of Mino[10] was identified as a marginal rural community in Mexico and selected for this study. This pedagogic intervention was developed and adapted to the concrete context and necessities of Mino.

ABOUT THE STRUCTURE OF THIS THESIS

This research was composed of three stages: the development of understanding about health/ power/ knowledge relationships; the translation of that understanding into a pedagogic intervention; and the implementation, analysis and evaluation of that

[10] 'Mino' is not the real name of this community, I will use this name throughout this thesis to conceal its real name for ethical reasons.

intervention. Chapters two and three are the result of the first stage. Chapter four is the result of the second stage. Chapter five is the methodological chapter and chapters six to nine are the result of the third stage.

Chapter two explores theories of power, social structures and knowledge which underpin the arguments of this thesis. It will be argued in this chapter, that knowledge is the vehicle for the exertion of dominant power. Because of the importance of knowledge for the exertion of power, I considered it necessary to develop a practical tool that could help to assess how power is embedded in specific knowledge. This practical tool is a taxonomy of knowledge that considers different ways in which knowledge is produced, transmitted and used. It will be argued that a power rationale embedded in this taxonomy can open alternative ways of looking at knowledge about health and disease and a more conscious way of using it.

Chapter three explores the concepts of poverty, disease, health and health promotion. In this chapter I present the concepts about health and health promotion that will be used in this thesis and develop an idea of what should be the characteristics of a 'healthy subject' to pursue through an alternative conception and practice of health promotion. With the support of Gramsci's concepts of hegemony and Bourdieu's concepts of social reproduction, in this chapter I analyse the social construction of disease, poverty and subordinated health. It will be argued that in the production of most poverty and disease are entangled uneven power relations. After arguing that institutional practices of health often increase poverty and disease I focus here on one specific health practice: health promotion.

Chapter four presents the design of the pedagogic research intervention. It starts with an account of key elements to consider for a critical pedagogy, identified through the understanding of health, power and knowledge developed in chapters two and three. Those elements are presented as a set of questions and answers about what to change, what to include and what to observe for the development of this research intervention. After the analysis and identification of the necessary profiles of teachers and students for this intervention, I proceed to identify practical ways to implement a health teaching programme capable of meeting the key elements identified through the answers referred to above. At this point I develop and introduce the concept of the pedagogy

that will sustain the pedagogic research intervention as well as the pedagogic model and will call the intervention CHTP (critical health teaching programme).

In chapter five I present the research methodology. This chapter starts to establish the links between this methodology and the research questions and arguments. Then follows a description of how the research was carried out and the rationale of the selection of a qualitative approach for it. Here I propose that dialogue can be used as a way to triangulate data and explain how I used dialogue as a way of triangulation in this research. Next comes a description of the data collection and about the precautions taken to guarantee the research subjects' anonymity, confidentiality and informed consent. Then, I present a set of indicators that helped in the analysis of the intervention processes and outcomes. Those indicators were constructed as another product of the analysis of health, power and knowledge in previous chapters.

Chapters six to nine are descriptive and analytical. In these chapters I describe the context and implementation of CHTP intervention and analyse and evaluate this in the light of the concepts and theory developed in previous chapters and through the analysis and evaluation of process and outcome indicators. I present the conclusions of the research in chapter ten.

ABOUT THE RESEARCH SITE

The research intervention was implemented in a rural community in Mexico. To give the reader a taste of the site that can help in the understanding of the context of the research, I present here a brief profile of the selected community: the community of Mino.

Mino is a small peasant village located in a semi-arid valley about two hours drive from Mexico City. As will be described and analysed in chapters six and seven within this thesis, Mino has a population of eight hundred habitants living in dispersed houses with unreliable public services. Until two generations ago, the prevailing language in this community was *Hñahñú*, an indigenous language. Now, people in Mino speak Spanish. Overall attendance in formal education goes no higher than secondary school and most

adults have not even completed elementary school. Minoans are in continuous migration searching for jobs in large Mexican cities. Minoan's diseases correspond to what have been called 'the diseases of poverty' (Laurell 1981) and health care is scarce and of low quality.

FURTHER REMARKS

Further remarks are necessary to facilitate understanding of this work. Mino and the health policies are the teaching programme contexts. CHTP (critical health teaching programme) is the teaching programme under examination. It is a collective programme undertaken by Mino students. Two medical students in their last year of medical training perform as CHTP teachers and I as participant researcher in the role of project co-ordinator and CHTP auxiliary teacher. All Mino people attending CHTP are called 'students'. Students remaining until the third CHTP period are called *cuidadores* (carers). '*Cuidadores*' is the name they choose to call themselves considering the practice they were doing. When necessary, I also refer to the *cuidadores* by their changed names that I used to replace their real names to preserve their anonymity: Elvira, Olga, Mundo, Luz, Elena, Teo, Guillermo, Alicia, Esther, Roberto and Goyo. That will be fully explained in chapter eight. The word 'teacher' is reserved for the medical university students performing as CHTP teachers. Their changed names are Pablo and Manuela.

I will use *italics* for the non-English words: *cuidadores, cuidados, doxa* and *heterodoxa* only in this introductory chapter. Finally I find it important to say that CHTP work is continuing and this case study refers to the period between August 1997 and March 1999.

CHAPTER 2
THEORETICAL FRAMEWORK
POWER AND KNOWLEDGE

As discussed in the introduction, this research was composed of three stages: the development of understanding about health/ power/ knowledge relationships; the translation of that understanding into a pedagogic intervention; and the implementation and evaluation of that intervention. This and next chapter result from stage one.

This chapter outlines the theories of power and knowledge used in this thesis. It will be argued here that it is possible to control all aspects of human life through the control of knowledge. The chapter will provide the basis for an understanding of the power dimensions of knowledge necessary to conceive a pedagogic practice capable of reverting dominance.

The chapter has three purposes: first, to develop understanding of the dynamics and processes of power in society; second, to identify and analyse the role of knowledge in social relationships controlled by dominant power; and third, to develop a way to look at knowledge through which its power dimensions can be elicited.

This chapter starts with a brief review of the concept of hegemony underpinning this research. Through that concept, Gramsci explains existing relations between dominant and dominated groups in society. This is followed by a review of Bourdieu's concepts of difference, doxa, capital, fields and habitus that will be used to explore the power dimensions of health throughout this thesis.

Next in this chapter I develop general concepts about knowledge to discover some of its dimensions relating to the possibility of using knowledge to control power. This chapter ends with the development of a taxonomy of knowledge that incorporates power dimensions.

THE RELATIONS OF KNOWLEDGE AND POWER

Even though the interest in developing knowledge about power has been present in most periods in history[11], the changes that occurred in social relations after the French and the Industrial revolutions, pointed to the importance of systematically studying it. The interest to systematically study power/society intensified in the Nineteen Century. The work of Marx, Marxists and the post-marxists has been basic for the understanding of unequal relations of power.

Most relevant for the study of the knowledge relations between power, the health authority and the body, is the work of the French philosopher Michel Foucault. In this thesis, his reflections, ideas and concepts will be used to develop specific arguments about disease, the body and the subject from the perspective of power. However, because of the interest I had in translating my learnings about power/knowledge/health into a pedagogic model capable of giving solid grounds to the research intervention, I decided to use in this work –for the conception and design of a pedagogic intervention- the theoretical propositions of a political activist (the Italian Antonio Gramsci), a sociologist (the French Pierre Bourdieu) and a pedagogue (the Brazilean Paulo Freire) rather than the concepts of a philosopher.

From their first writings, the theories of Gramsci and Bourdieu generated political and academic debate. However, in this thesis I draw on their conceptions to explore a specific field of health practice: the field of health promotion. Those concepts were selected because I see them as complementing each other in the explanation of how dominant power is achieved and maintained through pedagogic action. They were also selected because they can be related with other theories of power, such as Marx's and Foucault's and can be translated into practical tools to examine power in action. Gramsci's concept of hegemony is introduced below.

[11] Examples of that interest are the works of Socrates and Aristotle (Wood 1978).

Gramsci's concepts of hegemony

Hegemony is a concept originally developed by the Marxist Antonio Gramsci (1891-1937) following Benedetto Croce (Buci-Glucksmann 1988, Showstack 1988, Portelli 1987, Sacristán 1980). Gramsci considers hegemony as the cultural, ethical and political direction of society flowing into economic direction (Gramsci 1981, 1975, 1967, 1962). Gramsci's concept of hegemony derives from a class-based analysis of society whereby hegemony can be considered as a 'social condition in which all aspects of social reality are dominated by or supportive of a single class' (Livingstone 1976:235 cited in Mayo 1999:35). Immersed in the concept of hegemony is the concept of subordination. Subordination is defined as the individual or group state of acceptance of hegemonic direction. I will expland this here.

Gramsci considers, from a basic assumption of social classes, a division of society participants as belonging to the 'civic' or the 'political' society where the civic society is the social system's moral and intellectual guide. The political society is the coercive State apparatus where the State is the interplay of civic and political society. The political society, when autonomous from civic society, is recognised by Gramsci as a dictatorship and when dependant of the civic society, as a democracy. It is within the civic society that social structures to resist dominant power can emerge. The development of a solid civic society can prevent State dictatorship.

Hegemonic relations between the subordinated and the hegemonic social groups are carried out as power relations insofar as they are there to gain and retain power; the hegemonic social class needs to set up alliances with the subordinated groups. The power in play in such relations is power that hegemony takes from the subordinated and exerts over them to extend and maintain subordination. Thus, hegemony depends on the existence of a social base: the subordinated groups.

The overall objective of dominance is to take and hold as much power as possible, always pursuing a power monopoly. According to Gramsci, power can only be taken and retained either by coercion or by consensus. Power monopoly mechanisms, coercion and consensus, constitute complementary forms of violence against the subordinated. An explanation of coercion and consensus follows.

Cultural, ethical and political direction of society by a single class is possible because of the imposition of values, knowledge and practices through cultural action reinforced and/or backed by coercive action. Gramsci calls 'cultural action' the use of symbolic violence to impose values, knowledge and practices leading to subordination. Those values, knowledge and practices are selected by a single class (hegemonic groups) and imposed upon the other social classes (subordinated groups) to the extent that the subordinated support and reinforce the hegemonic power (Ashley 1989). The acceptance of those values, knowledge and social practices by the subordinated constitute what Gramsci calls 'consensus'. Consensus then is a state of accepted dominance of subordinated groups in society. People's thoughts for change or emancipation are controlled through consensus; hence dissent with hegemony is prevented. Through consensus it is possible for hegemony to establish alliances with the subordinated groups.

Coercion is a way of domination achieved by physical exertion of power through the use of physical violence. Through coercion people's actions for change and emancipation are limited. Coercion prevents and corrects action for change or emancipation once consensus has failed to do so and alliances between the hegemony and the subordinated can't be achieved or maintained. Examples of coercion are police, army, paramilitary or similar action. Coercion can be also exerted through an ever-present menace of potential physical violence. This form of coercion is more widely exerted than actual physical violence.

Both, coercion and consensus are ways to control the subordinated classes' dissent, to set up hegemony/subordination alliances and to take and hold the power at stake in society. Through coercion and consensus, hegemonic power can mould groups in society - such as workers, peasants or other- and achieve 'social conforming' by imposing amongst them, selected differential values, knowledge and practices and assigning to them different social roles functional for the control of power.

However, hegemony is not an ever-lasting social establishment. On the contrary, as a result of the characteristics and processes of dominance/subordination, hegemony

changes in form and practice according to the historic characteristics of the time and place it has developed.

Hegemonic processes take part within what Gramsci calls the 'historic block'. A historic block is the overall society organisation and its relations occurring at specific points in history. Historic blocks can present different realities to different groups in society according to the place each group has within a specific historic block, and to the perception they have of it. Through the cultural action and social conformity explained in former paragraphs, hegemony inculcates in the subordinated a way of looking at reality. When the historic block presents a reality that moves away from the view of the reality inculcated from the hegemony, a contradiction appears for the subordinated groups making them question the hegemonic truth. Contradictions can also appear within the dominant class emerging from their internal power struggles. When contradictions appear, the historic block 'opens' giving way to a possibility to subvert dominance and to change. The historic block opens by itself from time to time, however it is possible to force it to open by creating the conditions in which contradictions can be seen. Organised, conscious and collective subversion from dominance within a historic block is called 'counter-hegemony'.

Gramsci gives great relevance to action within cultural spaces to push the historic block open and change on behalf of subordinated groups. The 'organic intellectual' can take part in counter-hegemony through cultural action. Intellectuals are specific social groups or persons whose role is to give direction to society's organisation within specific historic blocks. A counter-hegemonic organic intellectual is a conscious-of-reality person or group of persons performing counter-hegemonic cultural action to make the rest become conscious of reality and in this way to elicit contradictions in specific historic blocks. Counter-hegemonic organic intellectual work is carried out through study groups (study circles) where 'study' stands for producing knowledge about how society and domination have been constructed through history and then to contrast that knowledge with ongoing contradictory reality. It includes reflection about strategic action to revert dominance.

As it can be seen, the concept of hegemony is an open-ended explanation of power. Within it are inbuilt dynamic and practical aspects that provide explanations of

hegemonic weaknesses. Also in the conceptions of hegemony can be found answers to revert hegemony. Now I will present some concepts of Bourdieu that can help us to better understand those dynamic and practical aspects of hegemony.

Bourdieu's concepts of difference, doxa, capital, fields and habitus

The concepts of the sociologist Pierre Bourdieu about difference, doxa, capital, fields and habitus can complement Gramsci's understanding of dominant power and subordination. A brief presentation of those concepts follows.

Bourdieu argues that social reality is the relations occurring between and within individual persons or groups of individuals independently of their individual consciousness and will (Bourdieu and Wacquant 1992). The way of living for every person and group in society reflects their classifications and representations of the world. It is through classifications and representations that meaning is possible. Thus for hegemonic power, meaning becomes the most valuable aspect of human life to control. Power struggles are struggles to classify, represent and give meaning to the world. Bourdieu proposes that from basic material structures -the material world-, the human being constructs a symbolic and a social world. The material and the symbolic worlds, are inter-related and inter-dependent. The struggles for meaning occur in the symbolic, subjective world and express through practices in the practical, material world (Bourdieu 1990). Similar to the aims of cultural action described by Gramsci, the aim of those struggles is to inculcate a specific set of classifications, representations and meanings in specific groups of the population to control the symbolic and practical worlds from inside each individual and social group (Bourdieu 1998, 1990, 1984).

Bourdieu's concepts develop from the conception of men and women in society as 'agents' or 'elements of a structure which exist in and through signifying practices' (Fowler 1997:2). Signifying practices are practices in the material world embedded with symbolic value from which the material and symbolic worlds take meanings. It is from signifying practices that social representations evolve for particular individuals (agents) and groups in society (agencies) thus giving them existence. Through signifying practices agents and agencies develop relations as power struggles to give

meanings in and to the symbolic and material worlds. Those relations and signifying practices are carried out without agent's awareness of their symbolic content and value.

From every day social practices, particular individuals construct knowledge with a greater or lesser degree of consciousness. Some of this knowledge is constructed as 'visible' conventions -or orthodoxa- from where the individual relates to society. The individual also interiorises as knowledge a set of assumptions embedded as taken-for-granted and hidden from his/her consciousness coded as doxatic knowledge or doxa (Hodder 1998). Doxa is then a set of classifications, representations and meanings that are not questioned or thought, becoming invisible for the agents even when they express in and rule their practice. To control the construction of doxa in the subordinated population is then a means to control social practice, hence a means to maintain hegemonic power.

To count as doxa, knowledge most not be thought, seen or questioned. When questioned or named, doxa becomes orthodoxa or objective, visible knowledge, subjected to scrutiny and confrontation. As visible, objective, conscious knowledge, orthodoxa can be controlled, transformed and used in conscious practices and to support the emergence of alternative and critical thinking (heterodoxa). However, when the individual's doxa is questioned it may come into consciousness and thus be transformed into orthodoxa. This may lead to an understanding vacuum, expressed in the individual as uncertainty and fear, which in turn may lead to sublimination and thus a return to doxa and stability.

Bourdieu explains how pedagogic work to inculcate doxa is carried out through the concepts of distinction, fields and habitus, which are explained below.

What makes one social group distinct from another is the bonded symbolic value they give to meanings and practices. For particular agents, existential human fear is abrogated or superseded by the acquisition of feelings of identity, belonging and security arising from those bonded values, meanings and practices that make them recognise themselves as members of a specific social network insofar as they are different from another.

Classifications, representations and meanings create 'distinction' -difference, limits- between one person and another and between one group in society and another. Distinction is achieved through the acquisition, construction and use of 'capital' in accordance with specific values, meanings and practices of particular social groups. An explanation of the meaning of 'capital' follows.

Capital is material and symbolic cultural products that can be accumulated and exchanged in the practical world according with the value agents give to it, as they are principles of distinction (Beasley-Murray 2000). Capital takes its value from agents' subjective appreciations when exchanged in the symbolic or practical worlds. The capital is produced and circulated in the symbolic and material worlds as cultural products. Once in circulation, social groups can adopt capital in accordance with their particular principles of distinction. Social practices in the practical world are performed as capital exchanges where the total symbolic and material capital volume and the way in which capital is exchanged account for social position and the construction of social classes. Even when distinction is achieved by the construction of bonded values, meanings and practices between some agents, it is also a means to separation, to exclude and include other agents and to perceive exclusion and inclusion. By excluding and including an agent or agency can concentrate symbolic and material capital to better control it (Bourdieu 1998, 1984).

The symbolic capital of dominant power is exchanged with agents in society on an unequal basis due to differences in capital volume and the use of symbolic violence[12] in capital exchanges. Symbolic violence -probably as the 'social conform' proposed by Gramsci- secures the boundaries, the separation, the gap existing between different spaces and positions in social reality making possible their control. Distinction is possible because of the construction of what Bourdieu calls 'habitus'. I will explain this below.

Society agents and agencies construct social relations from and as schemes of perception, thinking and realization internalised in the individual through experience

[12] Bourdieu defines symbolic violence as '...the violence which extorts submission, which is not perceived as such, based on 'collective expectations' or 'socially inculcated beliefs'' (Bourdieu 1998:103).

(Bourdieu and Wacquant 1998, Bourdieu and Passeron 1990). Bourdieu calls these perception, thinking and realisation schemes 'habitus'. Agents' life experiences take part in a context where power agencies carry out systematic simultaneous padagogic work to shape habitus through the inculcation of doxatic knowledge. Habitus is a result, a finished work inside the individual. It enables the social agent to cope with every situation in the practical and symbolic worlds, including unforeseen and ever-changing situations. The processes of habitus construction include socially established rules of social practice but also particular ways in which each individual confronts problems of reality. Habitus is nourished in agents' relations in the practical world but is also reinforced by their previously constructed habitus (Bourdieu 1977). In this way, an already existing agent's habitus functions as a 'structuring structure'. From those structures, agents can perceive and obey without consciousness the demands made by power.

Bourdieu explains how habitus is achieved, how is it generated, what are the processes involved in its construction through the concept of 'field' as explained here (Grenfell and Davis 1998, Bourdieu 1990, 1977). Individual social agents express habitus in and through social relations in the practical world. Those relations take part within specific capital exchange networks bonded by rules, objectives, meanings and historical relations. Bourdieu calls 'fields' those capital exchanage networks. For example, a family can be analysed as a field since it exists according to particular rules, objectives, meanings and historical relations which define the way in which the individuals belonging to that specific family exchange feelings, affection, money, knowledge, material belongings or other symbolic or material capital. Other examples of fields are: women, academics, peasants, a social organisation, the media, etc. Bourdieu proposes the existence of fields inserted in larger fields (networks containing smaller networks) such as a family field inserted in a neighbourhood field or a national education system field inserted in a world education field. Agents can participate in different fields holding different positions in each while their habitus remains the same, since it is transpositionable. But, how large, comprehensive and powerful can a field be?

Bourdieu conceives the idea of a 'meta-field of power', or in other ways, a field that contains most fields however large or small. Bourdieu argues that present society market relations can be seen as a meta-field of power. Contained in this meta-field are

two hyper-fields: the field of production and the field of culture. Power is exerted by controlling the agencies in the cultural field to impose upon other agents in society selected arbitrary contents favourable to production ends. With the intermediation of power agents and agencies, that arbitrary content will flow from larger fields to smaller fields like a cascade, until they become individual person's doxa and habitus.

However, a field is not static. An agent can choose different ways of capital exchange to maintain or modify field characteristics. It is because the variety of agents' habitus and the individual choices within the field that it can change its exchange rules, objectives, values and limits. Implicit in fields' dynamics is the possibility of active resistance against dominant power. Bourdieu considers that '... belonging to a field means by definition that one is capable of producing effects in it...' (Bourdieu and Wacquant 1992:80). Changes in fields' rules, objectives, values and limits can be achieved through changes in individual habitus and choices arising from doxa unveiling the construction of critical knowledge alternative to doxa: heterodoxa.

Agents' awareness of habitus can modify their signifying practices by the construction of alternative classifications, representations, meanings, capital value and different bonding for 'distinction'. In this situation agents can seek 'distinction' with different objectives, rules and bondings conforming alternative capital exchange networks where opinion plays a part as valuable capital thus constructing fields of opinion. The agents of fields of opinion also move in other fields where they can influence change through their already modified habitus and the choices they take in the fields.

Very much like Gramsci envisioned the historic block opening as a subversion opportunity, Bourdieu proposes that from unfitness between the practical and the symbolic worlds rise opportunities to unveil doxa and to construct heterodoxa and fields of opinion capable of generating change. In this way, Bourdieu's conceptual propositions are also dynamic and open-ended, giving way to alternatives to subvert hegemony.

Gramsci's concepts can be used to examine overall hegemonic action over health. Bourdieu's theories can be used to explore the processes in which health hegemony and subordination occur. I propose that the understanding of the hegemony/subordination

processes in health can illuminate strategic action to subvert dominance in specific contexts thus to improve people's capacities to 'identify and realise their aspirations'.

POWER CONTENTS OF KNOWLEDGE

For the control of doxa and distinction and thus habitus and fields, hegemony requires the control of meanings and values immersed in knowledge. It is important then, for the purposes of this research, to develop a conception and taxonomy of knowledge that can respond to the complexities of power and where power can be visible. I considered it worth testing this taxonomy to see the extent to which it is capable of opening alternative ways of looking at and using knowledge in a more conscious way. For the development of that conception I will start by arguing that knowledge is capital with symbolic and material value in the networks of social relations as follows.

Knowledge is a psychological process ocurring in the individual human mind as well as a collective, social product shared by many individuals (Villoro 1994). It is a phenomenon of human consciousness (Hessen 1999). As such, knowledge is a concept describing abstractions, an output of pedagogic experience where reality[13] is represented with some degree of organisation. Knowledge is more than opinion but less than truth. The Blackwell Dictionary of Sociology defines knowledge as "what we perceive to be real and true" (Johnston, 1995:150). Robberechts (1968:11), in his presentation of Husserl's thought argues:

> *This reminds us of a general law of our knowledge: the impossibility to see things as should be per se, as they should be if I wasn't looking at them... we see things and others through our eyes, our nervous system and an avalanche of habits and presupositions of all kinds.*

To define knowledge is also an abstraction: what is real, what is truth? It is in the interaction with reality that the individual person or the collective subject constructs knowledge. Through knowledge, the subject captures the object's properties. Within knowledge the human subject recognises him/herself and finds an identity. As subjectivity, knowledge can change or adapt in accordance with subject's reality perception and representation of self and collective identity. Knowledge is then the

[13] Berger and Luckmann (1991:13) defined reality as "a quality appertaining to phenomena that we recognise as having a being independent of our own volition (we cannot 'wish them away')".

abstract relation between the object and the subject occurring in the material and the symbolic worlds as individual and collective human product with recognised value (Fisher 1999, Villoro 1994, Piaget 1981, Hessen 1999). Therefore knowledge is capital with the potential capacity to be exchanged in the networks of social relations.

The transactions in the social networks are individual practices constructed from prevailing collective reality representations and conceptual conventions (Rosenau 1992). The individual knowing subject organises those conventions and representations as his/her particular knowledge (Berger and Luckmann 1991). For these reasons, knowledge construction processes are individual, mediated by exchanges in the social networks of capital exchange. Hence it could be said that there is no possibility of asserting a specific knowledge as identical to another even if it has been constructed through transactions in common social realities.

However, Thomas Kühn (1971) proposes that knowledge is collectively organised and recognised in the form of knowledge paradigms. Knowledge paradigms conduct the way in which reality is collectively seen (see for example: Dubet 1989). Insofar as knowledge paradigms are collectively constructed; they are a result of the selection and organisation of knowledge at stake expressed in specific fields as texts and discourses. Texts and discourses are constituted by verbal or written language and other symbolic practices with meaning and value content. In this way, no knowledge or discourse is 'the first' but a result of individual and collective perception of reality and reorganisation of previous knowledge in conformity with specific ongoing knowledge paradigms. It is in this sense, that knowledge is inter-textual and dependent on social relations (García 1985, Foucault 1973).

Inter-textual and social-dependent knowledge can lack dynamism, as it can be 'caught in a cycle' when the specific conditions of a social group do not change. However, Bachelart (1980) claims that it is through "the breaking of paradigms" -to see reality from points of view that question and confront prevailing paradigms- that different reality explanations containing different knowledge and knowledge organisation emerge. Knowledge breaks are produced at different levels: micro and macro; individual and collective; particular and general. All these have the potential of gearing up to major collective transcendental paradigm breaks conformed as epistemological

breaks. The breaking of paradigms can be a way of unveiling doxa with the potential of constructing fields of opinion as new paradigms.

I will present below some characteristics of knowledge from a point of view where its power dimensions can be made visible.

Knowledge characteristics

Knowledge has subjective and objective dynamic dimensions in so far as it is a subjective representation of an objective reality and the means for further interaction with reality. Knowledge gives meaning to the objective and subjective worlds and is also a source of meaning construction for the human subject. Hence knowledge is only practical and perspectival (Usher 1997 a, 1997b).

Knowledge has practical and linguistic representational content. As such, knowledge generation is a practice of 'languaging' (Usher 1997 b). It includes rules of representation (such as those embedded in language) and evocations of practice 'through the networking, interconnection and mutual implication of the material and non-material' (Hodder 1998b: 118). Through a languaging practice, the subjects interact with reality making use of explicit, conscious and implicit, taken-for-granted knowledge. Languaging practices are ways of exchanging capital in the fields.

Knowledge has biological, psychological, social and historical dimensions. Knowledge development depends upon the quality and integrity of material or subjective structures, apparatus and tools to construct and deconstruct knowledge, which appertain to biological, psychological, social and historical dimensions. The construction of knowledge takes place in basic psycho-neurological processes studied by Piaget (1990,1989), Vigotzky (1988) and other authors, as well as in intricate social relation networks and individual perceptual differences (Merleau-Ponti 2000, Vigotsky 1988, Habermas 1984, Husserl 1962, Heidegger 1962). Knowledge construction is an act and effect of present time and the continuous signification and re-signification of individual and collective history. As a social construct, the theory of knowledge is a dimension of social and political theory (Bourdieu 1977).

A knowledge dimension proposed by Husserl (1962) considers a perceptual and representational difference between "*noema*" and "*noesis*". From a consideration that all knowledge is only possible because of an initial human perception of reality, Husserl makes a distinction between knowledge that is elaborated and constructed by the knowing subject as representations -*noesis*- and knowledge that is perceptual – *noema*. *Noema* refers to descriptive knowledge reproduced or constructed by a knowing subject that reflects more the perceived material characteristics of the object than the particular conceptual constructs of the subject. Then, *noema* relates more to -though not the same as - "information". *Noesis* refers to deep knowledge constructed through the knowing subject's particular understandings developed by linking a specific object of reality with previous knowledge and representations. *Noesis* is subject's active presence in the elaboration of a perception and in the constitution of a meaning (Merleau-Ponti 1999, Robberechts 1968). According to Husserl, *Noesis* refers more to the knowing subject's conceptual constructs than to the object. *Noesis* is more related to 'wisdom' than *noema* (Grenfell 1998). *Noema* and *noesis* are intrinsically related: "*noema* is the object or sense constituted, considered in its essential dependence to *Noesis*" (Robberechts 1968:83).

It is said here that *noema* is less embedded with the subject's meaning and value than *noesis* and that doxatic knowledge is interiorised from *noematic* knowledge presented to individual subjects by agents and agencies in the capital interchange networks described in previous sections within this chaper. Doxatic knowledge can take the values and meanings presented as *noematic* knowledge when the subjects are passive in the construction of their overall knowledge capital.

When knowledge is context extrapolated -as a result of struggles for knowledge control- it can retain its descriptive value but changes its deep meaning and value losing its original nature and transforming into another kind of the same knowledge or a different knowledge. Context-extrapolated knowledge changes the original way in which the subject captured the object thus referring to a different reality even when the material or subjective object remains the same. It is considered here that knowledge without reference to its original context is more *noema* than *noesis*. Extrapolated knowledge, to recover its *noesis* dimension, needs to adapt to the new cultural context into which it has been imported.

The construction of *noema* or *noesis* is also dependent on the interests that the knowing subjects have as explained below.

Knowledge, human interests and culture

Knowledge, as principal ingredient of human perception, thinking and action, is the precursor but also an effect of cultural reproduction. Individual and collective representations are embedded in culture insofar as culture is only existent if given objective practical or symbolic meaning (Thompson 1993, Thurn 1976, Giménez s/f b, Gramsci 1975 b). As cultural product, knowledge has in its core human characteristics. Habermas (1987) argues that knowledge is a result of technical, practical and emancipation human interests as follows:

> *...from an understanding of humans as both tool-making and language-using animals: they must produce from nature what is needed for material existence [technical interests]... interest in the creation of knowledge which would enable it to control objectified processes and to maintain communication [practical interests] ... a third interest: an interest in the reflective appropriation of human life [emancipatory interests].* (Held, 1997:255. Brackets content added).

Technical, practical and emancipatory human interests in knowledge develop individually from basic human desire and need and collectively from capital exchanges in society where values and meanings are constructed. The characteristics of human interests in knowledge are not the same for all individuals or groups in society. Some of those different charactersitics are contradictory, opposed or restricting the realisation of other subjects' particular interests. Those differences burst forth in struggles for knowledge control thus culture control. What knowledge is constructed within a specific context in history and specific groups in society depends upon the characteristics of their struggles to control knowledge.

It is said here that knowledge is constructed within specific historical and social contexts with particular meanings, values and representations consistent with particular characteristics of corresponding struggles for knowledge control. In the present context of a society that has been increasingly more regulated by market interests, the development of technical and practical interests in knowledge and the increasingly lack

of presence of emancipatory interests, are particularly relevant to achieve hegemony. This will be explained next.

Knowledge, technology and market

Technological knowledge is a cultural product that takes more the *noematic* than the *noesis* form. Technology advancement has changed the relation of human subjects with knowledge as this quote from Held (1997:254) illustrates:

> *... the increasing tendency to define practical problems as technical issues threatens an essential aspect of human life; for technocratic consciousness not only justifies a particular class interest in domination, but also affects the very structure of human interests.*

The value of knowledge in technology products is hardly recognised. That is the case with computers which most people are eager to buy and use but don't see or question the very knowledge, as *noesis*, sustaining them. Technological knowledge has been useful to market interests insofar as applied technological knowledge feeds the market with trading alternatives such as publicity and commodities and provides efficient ways to conform public opinion, values and knowledge.

Market interests have changed the meaning of knowledge by its context extrapolation. An example of that is the recognition and uses the international agencies make of knowledge implicit in documents such as the World Bank's (1998) "Knowledge for development". In this document, knowledge is only regarded as such if practical (ready-to-be-used for technology production), neglecting most social sciences, humanities and arts, popular and other knowledge. In that document a priority is set to 'bring knowledge to the underdeveloped' meaning by that to open and expand the cybernetic and technology market.

Technology goods production goes hand in hand with the construction of expanding markets. The modern subject has been seriously threatened and transformed with the replacement of knowledge by technology and goods and the progressive abandonment of emancipatory interests in knowledge (Chapela et al 2001). As its market-dependence increases, the subject becomes a 'client' and develops more and more external subjection finding bondings and distinction in market regulated values and meanings. In this context, knowledge becomes another product for trading. Through change in

meanings and values, a culture of the market has emerged where the 'thing' defines the person, where 'you are what you can expend in the market' and 'you are part of 'us' as far as you expend as we do'.

Insofar as knowledge is the relation a subject establishes with the objects of reality – from where the subjects recognise themelves, achieve an identity and give meaning to life and reality- struggles for knowledge control are struggles to subordinate subjects' representations of reality. Through knowledge control, hegemonic agencies can inculcate in the subordinated doxatic representations of themselves and the world that fortify hegemonic power. Contemporary hegemony has blinded the subject's emancipatory interests in knowledge by creating a culture of clients, who are valuable when acquiring goods in the market. The analysis of knowledge in a specific social group can provide valuable information for the understanding of the subject's processes of subordination and therefore for the understanding of health.

Taking into consideration the power dimensions of knowledge found here, I constructed a taxonomy that could help in that analysis. This will be discussed and presented next.

A TAXONOMY OF KNOWLEDGE

To analyse knowledge from a power perspective, I developed a taxonomy that considers knowledge value, validity and validation as explained below.

A distinction between knowledge validity, value and validation will be done taking into consideration from whom, where and how knowledge takes meaning, thus addressing the struggle for meaning in the fields (see box 2.1 below to follow the argument in the next paragraphs).

BOX 2.1. KNOWLEDGE VALIDITY, VALUE AND VALIDATION

	VALIDITY	VALUE	VALIDATION
DEFINITION	internal and external logic and coherence of knowledge	collective and individual appreciation of specific knowledge as means of practice	arbitrary assessment of knowledge
ORIGIN	confrontation with reality and other explanations	efficiency to explain problems of reality	imposed through symbolic violence
WHO DEFINE MEANING	experts and lay people	individuals or collectivities	power agents and agencies
ICONS AND RITUALS MEDIATION?	No	No	Yes

Validity deals with the internal and external logic of knowledge. Internal as how knowledge is linked from within and how accurate, complete and integral it is to respond to the questions that it is trying to answer. External as how it is linked with other knowledge and how well it gives account of reality problems. Knowledge validity is proved in judging how it explains a problem of reality when compared with other explanations. These judgements are often made by experts but can also be made by people needing to understand a problem of reality. Icons do not mediate validity since it relates with efficient construction and not with collective recognition of knowledge. Knowledge with a strong internal logic and coherence can be weak in external coherence thus with low validity. An example follows. Strong internal coherent economic knowledge explaining macro economic problems, such as emerging market theories, rapidly weakens as it is confronted and contrasted with regional or local knowledge constructed through the economic lived-reality of marginal groups of population, showing little or null external coherence. Then, the knowledge dimension is less exposed to the exercise of hegemonic power.

Value is related to collective and individual appreciation of specific knowledge as a means for practice. An example: expert medical knowledge expressed in an expensive prescription that a person can't afford can be highly valued by doctors as high quality professional knowledge but it is possible that that person will value it less since that medical knowledge can't solve his/her suffering. Knowledge value depends upon individual and social capacities to perceive it, to think in, with and from it and to transform knowledge into action. Knowledge value does not depend on icons, awards or rituals. However, the value given to a specific knowledge depends upon the rules and objectives of specific fields, thus liable to be modified by hegemonic power.

Imposed by the use of symbolic violence, validation is a concrete and arbitrary assessment of knowledge. It has to do with the way in which knowledge is certified from agencies as pertaining accountability. Validation depends upon who speaks in the name of truth and on specific interests of specific social agents. Validation often comes from people or agencies with socially recognised prestige and power. Icons such as certificates, diplomas, awards and so on, mediate validation. Rituals (such as meetings, conferences, use of tools, practices, spaces, etc.,) are also validation means. This dimension of knowledge is '*per se*' controlled from hegemonic power.

Validated knowledge can have weak validity or value, yet prevail upon valid and valued knowledge. That is true when people find it low in internal and external coherence and value but can't express it because of the supression of individual or collective voice through symbolic violence. Knowledge validation often becomes a barrier between people's valid and valued knowledge and the knowledge they actually use to understand and solve their problems.

To analyse knowledge validity, value and validation is to inquire about knowledge coherence and also about the social relations from which knowledge emerges. The knowledge taxonomy presented here takes into account questions of knowledge validity, value and validation linking knowledge with the contextual power practices from which it has been created. This taxonomy will help to further analyse hegemony/subordination processes and characteristics through the understanding of local knowledge.

Common sense, popular, expert, institutionalised and 'fake' knowledge

As a principle of human representation and action, I propose in this work that knowledge can be classified in accordance to its value, validity and validation. To assess value and validity I make the following questions: Who holds a particular knowledge and who is represented in it? How is it constructed and transmitted? What kind of problems and whose reality does it relate to? What is its degree of specialisation and organisation? Does it keep its original nature or has it been extrapolated? And what is its practical use? A direct question about validation: who validates a particular knowledge? and the answers obtained for value and validity examination will help to

assess validation. A five-category taxonomy of knowledge constructed from those questions is proposed in box 2.2 and explained in the following paragraphs.

BOX 2.2 A TAXONOMY OF KNOWLEDGE

	COMMON SENSE	POPULAR	EXPERT	INSTITUTIONALISED	FAKE
WHO HOLDS IT	Every person	Any person within a specific social group	Selected people from inside or outside a specific social group	Institutional agents and agencies	Individual persons
WHO IS REPRESENTED IN IT	The individual person	The person and the person's social group	The person's own and other social groups	Institution	Nobody
RELATION WITH WHO'S REALITY	Personal	Personal, collective	Groups or persons in a social group	Institution	His own
RELATION WITH WHAT PROBLEMS	Unexpected unknown	Existential, daily life	Specific, specialised individual or collective	Institutional	Personal
HOW IS IT TRANSMITTED	As intuition	Informal transmission from generation to generation	More structured pedagogies. Initiation rituals guided by teachers or people of knowledge	Rituals, norms, rules, regulations, sanctions, codes under institution supervision and control	Veiled in deceiving practices
DEGREE OF SPECIALISATION	None	Low	High	High	Low or none
DEREE OF ORGANISATION	Minimal, can show organisation through action	Medium	High	Highly organised, sharp boundaries	Minimal, can show through action
KNOWLEDGE NATURE	Keeps its original nature	Keeps its original nature	Keeps its original nature, can be extrapolated	Extrapolated expert or popular knowledge losing its original identity and nature	No internal or external coherence, false knowledge
PRACTICAL USE	To cope with the unexpected and the unknown	Collective values representation. Identity and belonging. To solve problems of every day life	To understand and solve specific problems	Institutional power	Holder's opportunism
VALIDATION	Personal through immediate efficacy	Collective with a historical dimension	Peer social groups, social groups of practice in relation with how it gives account of reality	Institutional	Self, clients

This taxonomy sees knowledge as *noema* and *noesis* constructed and held by individuals as doxa, orthodoxa or heterodoxa. It considers its hegemony/subordination, relational-social, individual and collective, representational, material and symbolic characteristics and the human interests and cultural aspects of knowledge production and uses. The five knowledge categories present in this taxonomy: common sense, popular, expert, intitutionalised and fake knowledge, are explained below.

Common sense

Common sense is constituted as non-conscious spontaneous reactions of thought requiring elemental experiences as antecedent. Common sense includes deep representations of symbolic value. It can be seen as the most basic survival equipment

that permits the individual to cope with unknown or unexpected life situations (Holton 2000). Common sense is defined from specific non-explicit basic simple rules shared by specific social groups. Those can account as very elemental knowledge. Knowledge consciously constructed at specific time and context can derive into common sense as it is incorporated as intuition in every day practice. I found that common sense could be a triggering knowledge to confront hegemony since it can elicit imposed knowledge and representations as reality contradictions emerge.

While common sense is non-conscious and permits the individual to cope with the unexpected, it is not the same as doxa. While common sense requires of elemental experiences as antecedents, doxa is the result of systematic pedagogic work and has the capacity to construct structuring structures. Another difference is that common sense is more superficial than doxa; therefore it can be more easily unveiled and questioned without threatening the individual's stability.

Popular knowledge

Popular knowledge is defined here as organised endurable knowledge with a basic degree of specialisation, collected and transmitted in various informal ways within a specific social group in order to understand and act upon specific realities. Popular knowledge is conscious knowledge transmitted from generation to generation. It is validated as far as it gives account of values and practices that contain the means of understanding and coping with known life events. It has a strong historic content and value since it incorporates reality representations that give identity and sense to the collective social group. Popular knowledge is accessible to every member of the same social group since it derives from collective experiences (see for example: Menéndez 1992, Canclini 1984). Popular knowledge value and validity develop from its repeated efficacy. This kind of knowledge has a basic level of specialisation since it is related to specific every day life-problems or events such as disease, marriage and death. Underlying popular knowledge there are existential assumptions that transcend into the way knowledge is coded and signified.

Popular knowledge circulation, construction and deconstruction depend upon the social group's structures, systems, apparatus and tools, strength, quality and integrity. It

constructs local social identity (See for example Giménez 1996, Rowe and Schelling 1993, Canclini 1984). Rich popular knowledge can construct strong identities. When social integrity is broken, identity is threatened. Popular knowledge can transcend in the creation of new identities. Resistance towards cultural invasion or imposition is often based on common sense and popular knowledge.

Expert knowledge

Expert knowledge is considered in this taxonomy as specialised knowledge held by specific persons or group of persons within a social group in a systematic order to respond to specific aspects of life problems. This knowledge is at the basis of specialised skills, techniques, practices, rituals and tools. It is constructed within a frame of representation coming from the social group within which it is constructed as well as from other social groups concerned with producing knowledge of the same kind. An example follows. Village midwives' knowledge, as expert knowledge, takes the representations from the social group they belong to and also those from other midwives or similar practitioners (See for example: Aguirre 1992, Luengas 1992, Maclean 1974). In this way, expert knowledge can be interchanged, confronted and developed.

Expert knowledge is transmitted and acquired through more or less sophisticated rituals. It is not accessible to every person in the social group but only to those selected and trained through different ritual procedures within which knowledge is transmitted, acquired and validated. Ritual procedures include specific language, practices, tools, techniques, settings, believes and representations with strong symbolic value. Those rituals maintain a strong link with the knowledge's nature and the purposes it is to be used for. This knowledge validation relies upon collective and peer recognition of its efficacy. A validating community can be the receptors of expert knowledge practice as well as other experts holding knowledge of the same kind. Examples of expert knowledge can be taken from "story tellers", healers and farmers to philosophers, doctors and agronomists (see for example Silgado, 1980).

Expert knowledge value is seen in close relation with the accuracy in the understanding of the reality it originally confronted. Relationships between this knowledge and reality

are not mediated by structures other than those posed by the problems it claims to understand. Non-experts or lay people have access to experts in order to expose their problems and obtain specific expert advice. Expert knowledge is highly organised and specialised. It constructs its own limits and boundaries to be recognised as a domain of expertise. Boundary flexibility depends upon the degree of knowledge specialisation and variety of existent experts. In a social group with few experts, outsiders' expert knowledge is required to explain and solve problems of diverse nature. Expert knowledge has logic and methods, which can be used in conjunction with common sense and popular knowledge to give an account of unexpected events. An example is the local shaman who must give an account of how to understand and what to do when a "development project" (such as the construction of a high-way to better exploit natural resources) is about to destroy their village. It is then not surprising to find experts as leaders in social movements and social change.

Because of its capacity to help in the understanding and changing of problems of reality and its closeness to them, expert knowledge can also be used as micro scale dominating power that can be "hired" or perpetuated for macro scale domination purposes. If not systematically organised, used, constructed and reconstructed this knowledge tends to deteriorate as fake expert or non-truthful knowledge that will be explained in following paragraphs (p48).

Local and non-local expert knowledge, popular knowledge and common sense can be pooled for the generation of counter-hegemonic power. An example of this is the use of knowledge that indigenous organisations do in the Southeast of México to resist an ongoing low and medium intensity war with the Mexican government[14].

Institutionalised knowledge

Institutionalised knowledge is context extrapolated expert knowledge held, framed, conformed and used in accordance with institutional values, objectives, structures, hierarchies and norms. As such it is reconstructed and organised from institutional logic

[14] Michel (1998), Le Bot (1997), Lenkersdorf (1996) and other authors describe the way in which those social groups and organisations collectively explore and give solution to their every day life and war problems showing the convergence of common sense, popular and expert knowledge.

and rationale. Institutionalised knowledge is used for social control (Berger and Luckman 1991). It is regarded as the institution's property and accounts for institutional representations that can only change with overall institutional change.

Institutionalised knowledge has very sharp boundaries and powerful systems of inclusion and exclusion of other knowledge (for example popular knowledge). It does not refer in the first instance to the problems of reality it claims to address, but to the problems it solves for the institution. In this sense, institutionalised knowledge is de-naturalised knowledge where selected expert knowledge meaning is filled with institutional meaning. Thus, it gives more account of the institution's reality than of the problems of other reality that institution is meant to be meeting. As such, the institution defines reality.

As institutions do not exist without persons, institutionalised knowledge is a result of perception, thoughts and actions of institutionalised people. Therefore, institutionalised knowledge is constructed in a circular way: institutionalised people construct the institution that institutionalises them (see for example Lourau 1977). Lay people or experts outside institutions will have contact with institutionalised knowledge through institutional discourses, norms and regulations. Institutionalised knowledge is transmitted through institutions systems and apparatus of control including aspirants and admission regulations, models of knowledge acquisition, teachers and evaluation practices. Often this knowledge is constructed without any sense of the outside world and as such contributes to the institution's self-recreation.

Institutionalised knowledge has a highly mythical value coming from the institution's position amongst other institutions within an overall society. That value is often viewed in terms of prestige and power. Its efficacy is considered mainly in terms of the efficiency it has in the provision of more power and prestige. As such it is knowledge immersed in and used for domination. Domination through institutionalised knowledge is exerted as cultural symbolic domination in the generation of social subordination through symbolic violence or social control through physical violence.

Common sense, popular knowledge and a wide range of expert knowledge are neglected as real knowledge by institutions. Nevertheless, for the construction of

institutionalised knowledge institutions often search within what they regard as 'popular beliefs'. They take and elaborate popular knowledge and common sense through the intricate melting pot of institutional structures until it is ready to be presented and claimed as new, original knowledge and used for new power transactions. In this way, some popular knowledge is 'upgraded' and valued as 'proper' knowledge insofar as validating institutions appropriate it. This knowledge is wrapped in sophisticated language and used in internal institutional rituals and transactions or as unreachable magic or mystic expressions to deploy in practice when dealing with lay people. Institutional health knowledge can be just pleasing to institutional knowledge holders immersed in expensive rituals. An institution's directives, boards, policies, rules, rituals and links with other institutions or groups in society are determining factors in how and what knowledge is constructed and validated as well as how power and prestige are used.

Fake knowledge

For the purposes of this discussion and taxonomy, I identify and define a fifth kind of knowledge: fake knowledge. Examples of this kind of knowledge will be provided in chapter seven (p174). Fake knowledge is knowledge lacking internal and external coherence. It is distorted expert and popular knowledge. It is presented as expert or institutionalised knowledge when it is neither of them. Fake knowledge is more what Hessen (1999) has call 'irony' or 'illusion' about reality than knowledge. Fake knowledge is used with opportunistic purposes and individual benefit. Fake knowledge holders use fake knowledge to ensure the efficacy of action guided by hidden purposes and aims. Fake knowledge loses its original organisation and specialisation until the only recognisable knowledge is that used by fake knowledge holders to achieve their aims and to cover their backs while occupying the place of truth experts.

Fake knowledge holders are pervasive when there is a lack of experts and knowledge access, which is a characteristic of poverty. They find their opportunity within social groups that have lost their own expert knowledge; when existent knowledge can not give explanations to emerging problems and when there is restricted access to other expert knowledge. Fake knowledge holders, are frequently found within institutions in charge of the implementation of hidden agendas. That is the case of some health

teaching programmes and medical services in Mexico. Often fake knowledge and institutionalised knowledge mix. Hence fake expert knowledge and domination are frequently found together.

Knowledge accessibility and linkage to local problems is different for common sense, popular, expert and institutionalised knowledge. It is said here that the knowledge that is more accessible and more linked with local problems is likely to be more meaningful for the knowing subjects in poor communities.

This taxonomy will be used to analyse and evaluate the power contents of the knowledge at stake in the researched site and also to identify what kind of knowledge is likely to help for the development of health through a pedagogic intervention.

CONCLUSIONS

The central argument in this chapter is that it is possible to control all aspects of human life through the control of knowledge. In it I have shown that in each society, all aspects of social reality are ruled by a single class constituted as hegemonic power. This dominance is possible because of the support of the other social classes that have been cuturally and ethically shaped through the domination of all aspects of culture. By controlling culture, the dominant power achieves social consensus and subordination. The control of culture in society and the achievement of consensus renders an economic direction to social practice.

Since subordination is achieved by the imposition of a dominant truth, the control of meaning is the most valuable aspect for hegemony. Meaning can be controlled through pedagogic practices of systematic inculcation of knowledge that is invisible, unquestioned, unthinkable and taken-for-granted ('doxa'). It is from doxa that the individual persons ('agents') develop perceptual, thinking and realisation and deep structures ('habitus') from where they confront the problems of every-day-life and give meaning to existence. To control the construction of doxa is a means to control social practice in the practical world, hence a means to maintain hegemony. From the

revelation of doxa emerges a possibility to construct new conscious knowledge and to develop opinion about dominant impositions.

It has been argued in this chapter that the study of the dynamics of power in each society and the pedagogic action directed to elicit contradictions between the dominant truth and reality can subvert subordination.

Since hegemony is possible because of the control of knowledge, I analysed in this chapter different characteristics of knowledge that can be controlled by power, to find ways to use the development of knowledge as counter-hegemonic action in a planned pedagogic intervention.

In the next chapter I will continue exploring the uses of knowledge and meaning in the struggles of hegemony. In the light of the understanding about power and knowledge developed in this chapter, I will examine the uses of health and health promotion in the hegemonic struggle for meaning in the arena of health.

CHAPTER 3
HEALTH PROMOTION

In the previous chapter I analysed the power contents of knowledge and argued that the hegemonic agencies achieve subordination and enhance hegemonic power by controlling knowledge and meaning in society. In this chapter, the understanding derived from that analysis will help in the examination of the struggles for meaning in the health arena and in the conception of particular definitions of health and health promotion necessary to meet the changes aimed for in this research intervention.

It will be argued in this chapter that the health promotion initiative launched in the Ottawa Charter 1986 is an advanced and critical discourse about health that has been used rhetorically. It will also be argued that the discourse of health promotion is powerful for the construction of meanings and values since it basically refers to a pedagogic practice. Thus, it can be used as a device for hegemony or to counteract hegemony.

This chapter has two purposes: to analyse the hegemonic discourse of health and health promotion and to conceptualise health and health promotion in a way that can be useful for the design of this research intervention.

First in this chapter I explore how the human body is a place of power exertion and how poverty and marginality are constructed as a result of market impositions. I continue exploring existing health/market relationships. Following the concepts developed in the previous chapter, I will argue that health discourses and practices controlled by market hegemony are constructing doxatic knowledge and subordination. Then I analyse the World Health Organisation's definition of health that has sustained the health discourse and practices since the 1940s. This analysis is followed by an examination of the origins, development and discourse of health promotion. That examination will show that health promotion became an arena for struggles for meaning and that health promotion is not a politically 'neutral' practice. Then I will

show how the international discourse about health and health promotion are expressed in the particular case of Mexico.

Finally in this chapter and drawing from the Ottawa Charter's definition of health promotion, I develop particular concepts of health and health promotion that I consider could meet the necessities of this research intervention. These definitions will result in a conception of a 'healthy subject' to pursue in this research intervention.

THE STRUGGLE FOR MEANING IN THE HEALTH MARKET HEGEMONY

Insofar as the body is the material vehicle to produce and circulate capital in the fields[15], it has potential value for capital accumulation. As such, the physical human body is invested with relations of power and domination, becoming a force useful for hegemony only if productive and subjected (Brenkman 1987). Then, for hegemonic purposes, it is necessary to break human persons' subjective/material integrity to control their body and to subject the otherwise free subject (Lingis 1994, Foucault 1984, 1979).

Subjection of the subject is not only achieved through visible violence, it may be calculated, organised, technically thought out, subtly achieved through symbolic violence and what might be called the political technology of the body (Foucault 1999). Foucault (ibid: 259) argues:

> *Historians long ago began to write the history of the body. They have studied the body in the field of historical demography or pathology; they have considered it as the seat of needs and appetites, as the locus of physiological processes and metabolisms, as a target for the attacks of germs or viruses... But the body is also directly involved in a political field; power relations have an immediate hold upon it; they invest it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs.*

In this way, the material human body becomes the objective place of hegemonic power exertion. Here I will discuss some of the macro-processes of hegemony for the construction of subordination and how they are expressed in poverty and disease.

[15] For an explanation of the concepts of fields, coercion, consensus, historic block, cultural action, hegemony, subordination, the meta-field of power, symbolic and material world, difference, habitus and doxa refer to previous chapter.

Hegemony in present historic block

The present historic block is characterised amongst other, by advances in war and communication technologies and by the emergence of the power meta-field of the market. By the use of these advances, hegemonic cultural action to produce subordination through the control of the human body is achieved all-at-once in simultaneous pedagogic work facilitating coercion and consensus. An example of coercion in the present historic block is the military, high, medium and low intensity, war carried out at strategic points of the planet affecting directly the bodies of millions of persons (Chomsky 1999, Klare and Kornbluth 1992, Vergara et al 1988). An example of cultural action and subordination through consensus is the imposition of the concepts of 'globalisation' and 'terrorism' as an explanation of present social reality. These conceptions have been criticised by various authors and groups in society arguing that terrorism is a justification for war and globalisation is a veiled form of barbaric capitalism realised through planetary war and market and a changed world geography (Freedman et al 2002, Gupta 2002, Burbules and Torres 2000, Kurnitzky 2000, Luke and Luke 2000, Petras 1999, Chomsky 1999, Hasmondhalgh 1998, Kiely and Marfleet 1998, Landa 1997, Hoovelt 1997, Chomsky and Dietrich 1995, Vilas 1995).

The world's geography has changed in the present historic block due to technological innovations in communication, which have shrunk the world in time and space and created virtual spaces where social relations can take place (Luke 1999, Shapiro 1999, Rosenau 1992). The market emergence creates new ways for hegemony where ownership and access to commodities are restricted to specific social groups. The market emergence also creates a new social subject: the client. Lefebvre (1991) explains market-client relations suggesting that:

> *The commodity world brings in its wake certain attitudes towards space, certain actions upon space, even a certain concept of space. Indeed, all the commodity chains, circulatory systems and networks, connected on high by Gold, the god of exchange, do have a distinct homogeneity. Yet each location, each link in a chain of commodities, is occupied by a thing. (Ibid: 341)*

Those changes represented a new way of social disparity since not everybody has access to the cybernetic high ways. In the new geography the concept of territory expands to the virtual world where merchandise of different kinds are realised, creating new hegemonic needs and social order as explained by Hoogvelt (1997:118)[16]:

> *...symbolic orderings of space and time provide a framework for experience through which we learn who and what we are in society ... the organisation of space defines social relations ... holds the key to power. Today, the freedom to more capital-owning for international bourgeoisie is a decisive advantage over the mass of workers who are restricted in their movements and migrations by the passports they carry.*

The subordinated groups remain marginal in this new geography resenting its struggles and exploitation. At the end of the XX and the beginning of the XXI centuries, hegemony changed meanings and spaces controlling the world's wealth through the mediation of governments, leading private entrepreneurs and international agencies as the new political society (Chomsky and Dietrich 1995, Day & Klein 1991). That mediation has made possible the regulation of national and international decisions through market oriented values, priorities and agendas where people as 'clients' are valued according with market interests. Examples of those agencies are the World Bank, the International Monetary Fund, the United Nations World Health Organisation and the United Nations Educational Scientific and Cultural Organisation.

The agendas controlled by the market, differentially open or restrict access to different groups of the population to material and symbolic wealth,[17] securing the boundaries between different fields with the consequent generation of poverty and a deteriorated human biological context (Biggs 1998). Then, poverty can be seen as a condition of restricted access to overall wealth (Boltvinik 2000, 1996, 1995[a], 1995b, 1990, Giovanella and Fleur 1995, Boltvinik and Hernández 1999). The effects of market-oriented policies upon the construction of poverty have only recently been recognised by international hegemonic agencies as a factor limiting market expansion (See for example World Bank 2001, G8 Genoa Summit 2001, Gwatkin and Gillot 2000).

Differences in access to overall wealth are expressed in different groups of society as different ways of becoming ill, of seeking healing and understanding, and of dying

[16] See also Harvey 1996 and Dear and Flusty 1999

[17] Overall wealth: such as food, work, employment, income, services, material infrastructure; values and knowledge; history, voice, rights and power; social infrastructure, belonging, care, or other.

(Larkin 1998, Roemer 1996, Menéndez 1992, Laurell 1990) reflecting those groups' habitus and the values, knowledge and meanings in play in their subordinated fields[18]. In the 1990s Evans (1996) demonstrated differences in disease patterns in a population with access to all services (sewage, food, health care, schooling, etc,) but occupying different places in the social hierarchy thus with differential access to other resources such as voice and decisions (See also Corin 1996, Marmot and Mustard 1996 and Hertzman et al 1996). Differences in access are written through life on the body showing the effects of hegemony/subordination relations expressed, amongst others, in the disease pattern of specific social groups, as will be analysed in the case of the rural community of Mino in chapter seven (p154).

Following previous arguments, in this thesis I consider poverty and marginality a condition of restricted access to overall material and symbolic wealth resulting from hegemony/subordination processes and disease as poverty written in individual and collective physical bodies. I will discuss below the participation of the hegemonic health agencies in the construction of poverty and disease.

Health agencies in the construction of subordination

A principal agency in carrying out hegemonic cultural action is the medical institution dominating the health field. This dominance is possible since the medical practices directly involve the individual's physical body and subjectivity. The hegemonic medical discourse is constructed by doxatic medical conceptions, representations, meanings and values where health is conceived and practised as always-disease-related. Hegemonic medical doxa include an overwhelming representation of health coming from a biological medical paradigm where problems and solutions are seen as individual, objective, rational, practical and exclusive to the medical institution. That conception of health organises the arbitrary contents inculcated in the population as health and health care doxa at the expense of other knowledge, meanings, values and practices about health, hence promoting subordination. This will be expanded below.

[18] Timio (1979) does a historical account about differences in the way in which people die according to their social class.

Particularly during the second part of the XX century, the individualistic and disease-related approach to health, transformed health knowledge and practices into goods for market realisation where patients became clients and disease a condition to convert into goods (Naidoo & Wills 2000, Eibenschutz 1996, Laurell 1994, Brudon 1987, Navarro 1983). Hegemonic medical health and disease doxa are expressed in the way institutions define health needs, health priorities, indicators and policies; and in how resources are allocated (Foucault 1997, Eduardo Menéndez 1992, 1990, 1985, 1979, Yocelewsky 1996, Laurell 1996, Módena 1990, Navarro 1986).

Consistent with its role as a power agency inculcating market arbitrary doxatic contents in the institutions and in the public to achieve market objectives[19], the World Bank recommends governmenets in the so called 'Third World Countries' to reduce primary health services to inexpensive practices (Eibenschutz 1996, Blanco and Rivera 1994, Laurell 1994, López 1994). The World Bank recommendations are backed by simultaneous and systematic pedagogic work of the World Health Organisation. To explain how those recommendations have been set in action, a panorama of WHO health discourse and health policies follow.

The hegemonic health discourse

The World Health Organisation (WHO) produced a health definition in the nineteen forties, which has been used unquestioningly in most medical or governmental directed programmes in the last four decades: 'a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity' (WHO 1946). In this definition health is considered as a 'state', becoming a static condition an individual either has or does not have. A static condition opposes the very biological, symbolic, historical and social relational dynamic human nature. That definition does not make explicit who will set the 'wellbeing' and 'completeness' parameters thus leaving these judgements to power decisions, which in present day society are dominated by medical agencies. Finally, that definition can only be discursive and not practical since no

[19] See examples of how the international organisations relate poverty and disease with limitations to expand the market in the following already referred papers: World Bank 2001, G8 Genoa Summit 2001, Gwatkin and Gilliot 2000

human force can account for 'completeness' as has been discussed after some decades by the U.K. National Health Service (1979) (See for example: Williams 1995).

This definition remained more or less unquestioned until the contradictions between the hegemonic health doxa and the social and material conditions of health in the 1960s and 1970s[20] gave way to a questioning of doxa and to the emergence of human, body, social relations, culture and other health paradigms alternative to the hegemonic from where different health concepts and practices developed (see for example: Mckeown 1982, Inglis 1981, Ehrenreich 1978, Illich 1976, Dubos 1975, Canguilhem 1971, Boston's Women 1978)[21]. Health collective critical ways of looking at health and disease emerged from Latin America and Italy (see for example Timio 1979) constructing heterodoxatic ways of looking at health. An example of this is the Marxist approach of Laurell that conceptualises health as a health/disease process vinculating it with capitalist production processes (Laurell 1981). Other examples of that heterodoxa are present in the works of Aggleton (1990), Turner (1987), Navarro (1983) and Terris (1980) amongst others.

Even when the WHO definition of health was confirmed in the 1970s during the Alma Ata Conference on Primary Health Care[22] (PHC) more attention was paid to the role of the population in the delivery of services at low costs. In this conference PHC was understood as the strategy to achieve the policy 'Health for all by the year 2000' (WHO 1979). From the WHO health definition and after the Alma Ata Conference recommendations, the health open agenda switched towards PHC while developing a market oriented hidden agenda that neglected attention to populations of little worth as

[20] Mc Keown (1982) -through the analysis of medical practices and innovations such as vaccination and antibiotics- showed that worlds' increasing life expectancy was a product of improved human environment and not of medical intervention.

[21] Official recognition of disease components other than the biologic can be traced in public health concepts and practices emerged in late nineteenth century as product of industrial development necessities and workers' political struggles (Rosen 1985, Mendes 1984, Navarro 1984, González-Casanova 1984). In the 1940s the medical historian Henry Sigerist called for medical professionals' attention to the complex human dimensions to which medicine needed to respond (Terris 1980) and proposed health promotion as one of the four big tasks of medicine (Sigerist 1946, 1941). Until the 1960s, public health focused in sanitation and epidemiological control carried out by extensive one-disease-focused campaigns such as vaccination or anti-malaria. Control practices were maintained through medical institutions giving way to the 'sanitary officer', the 'sanitary inspector', 'sanitary regulator' or other.

[22] PHC. Primary Health Care, the first level of medical care: the second being the small referral hospitals and clinics and the third specialised services (WHO 1978,1979)

money producers. (See for example: Lerner 1996, Tamez 1996, Possas 1996, Laurell 1994, Brudon 1987, Navarro 1983, Chossudovsky 1983). An example of the results of the hidden agenda is presented in box 3.1 showing more per capita health expenditure in countries with lower perinatal deaths[23] (see also World Bank 1993).

BOX 3.1. RESOURCES DISTRIBUTION IN COUNTRIES WITH CONSOLIDATED ECONOMY AND IN LATIN AMERICA AND THE CARIBBEAN COMPARED WITH THEIR TRANSMITTABLE FATAL DISEASES AND PERINATAL DEATHS. 1993.

REGION	PER CAPITA HEALTH EXPENDITURE (DOLLARS)	HEALTH EXPENDITURE AS PBN%	TRANSMITTABLE AND PERINATAL DEATHS AS % OF TOTAL DEATHS
CONSOLIDATED ECONOMIES	1 860	9.2	6.2
LATINAMERICA AND THE CARIBBEAN	105	4.2	32.3*

Source: World Bank (1993a and 1993b)

* Data for countries with a high population with restricted access to wealth should be considered with under and mis-registration as has been analysed and discussed since the classic article of Escudero (1981).

Whilst advocating for grassroots people's participation and health promotion - as one component of PHC-, disease and health controlling medical practices were maintained. Sanitary policies and mass sanitary practices for the poor continued. Two decades later, disease in the world had not diminished (See for example López 1994; Laurell 1994, 1991) and the aims of 'Health for all by the year 2000' were revealed to policy makers as unachievable and with little possibilities to be extended and achieved in the first decades of the new century.

Meanwhile, a world's grassroots health movement in the late 1960s, the 1970s and the 1980s was promoting empowering skills to control disease and to meet health problems (see for example: Newell 1988, Rifkin 1980, Nierere 1968a, Nierere 1968b). Professionals from different areas -other than the medical- started to get involved in the understanding of health. In countries with access to wealth, the national health systems -such as the British (Royal Commission on the National Health Service 1979)- were also proving inefficient in dealing with disease and were recognising that the

[23] Perinatal death is a leading indicator of countries' health.

boundaries between disease and the individual's or group's social conditions and life were difficult to establish (Henderson and Cohen 1985). This, and the deteriorating economic and social conditions prevailing in Asia, Africa and Latin America that contradicted the hegemonic market doxa, forced the hegemonic agencies to rethink the role of community in the delivery of services and to think of the benefits of the institutionalisation of health promotion. I will discuss in the next paragraphs the development of the official discourse of health promotion.

Origins, development and discourse of health promotion

In the 1986 Ottawa Conference on Health Promotion supported by WHO, health promotion was officially institutionalised[24]. The Ottawa Conference summoned health workers coming from different medical and non-medical related professions. This Conference discussed the necessity of changing health policies[25], from 'disease care' to promoting health.

The Ottawa Charter declaration (1986:4) defines health promotion as follows:

> Health Promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, *an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment.* Health is, therefore, seen as *a resource for everyday life, not the objective of living.* (Added emphasis)

The Ottawa Charter's concept of health promotion does not make explicit changes in the official WHO health definition discussed above. It is more an extension than a change of the WHO definition. Nevertheless, in my interpretation of the Ottawa Charter's definition of Health Promotion, some changes can be perceived. In the Ottawa Charter's definition of health, health is conceived as a resource, an individual and collective capacity opposed to WHO static 'state' definition. This capacity is seen as an individual and collective responsibility to control present life, and government and other social institutions' responsibility towards health lay in ensuring basic

[24] Whilst health promotion can be analysed as a historic human practice present in all societies, I will refer here to health promotion prevailing in the late twentieth century as governmental and non-governmental discourse and practice. The health promotion concept incorporated to official national and international health discourses, agendas and policies in the 1980s.

[25] In that Conference health policy change was exemplified by the Canadian experience (Lalonde 1996, Canadian Government 1974).

conditions to make possible the development of the individual and collective health capacity. Control of present life has sense in terms of an individually or collectively designed future revealing the dynamic nature of health. Learmonth and Cheung (1996) argue that the introduction of the words 'enabling', 'process' and 'control' in the Ottawa Charter, the health definition is reflecting the social context of health. In this definition, health is not a condition or a state but a human capacity detached from disease, transforming disease as one of the multiple factors that might hinder the development of the human health capacity. As such, this definition entangles objective and subjective aspects of the human subject.

The Ottawa Charter identifies five areas for health promotion action: Participation, training, service reorganisation, inter-institutional and inter-governmental action and policy reform. From the Ottawa Charter's perspective, action in these areas is expected to yield better environments, which will constitute the starting point to realise and develop the health capacity. The overall Ottawa Charter's perspective of health promotion action has been officially maintained at successive health promotion international conferences: Adelaide (WHO 1988), Sundsvall, Jakarta, Puerto Rico (International Conferences on Health Promotion and Education 1991, 1997, 1998), Mexico (WHO 2000) and Paris (International Union of Health Promotion and Education 2001).

The Ottawa Charter's underlying conceptions of health and health promotion have had multiple interpretations representing different health values, meanings and practices. However, a mutual determination between health and development has been accepted by most health promotion discourses (Barreto, 1996). From the Ottawa Conference followed the 'Healthy Cities' movement. Healthy cities were considered as cities equipped with basic conditions to develop health (Werner et al 1998, Cerqueira 1997, International Conference on Health Promotion and Education 1991, Ashton 1987). In Latin America the healthy cities approach to health promotion developed as 'healthy municipalities' (Castro 1998, Cerqueira 1998, González 1998, Barreto 1996, OPS 1992, OPS/OMS 1992).

The Jakarta Conference on Health Promotion and Education (1997) identified six priorities for health promotion where national agendas and local interests were present:

strengthening the evidence base for health promotion; increasing investment for health promotion development; promoting social responsibility for health; increasing community capacities; empowering individuals and communities and securing an infrastructure for health promotion from the reorientation of health systems and services with health promotion criteria. Those priorities were also discussed and accepted in the Fifth Global Conference on Health Promotion (2000). (See also Byrne 2000 and World Health Assembly 1998).

The Jakarta Conference emphasis in the socio-economic determinants of health stressed the political character of health promotion and the necessity to commit resources for health actions (See for example Bertinato 1999). Advocacy and the development of alliances and partnerships were recognised as strategic areas for health promotion (Wise 2001, Westphal et al 2000, Rice 1999).

Rice (1999) argues that advocacy is one aspect of health promotion essential to develop effective policies and programmes. Advocacy target audiences are decision makers, policy makers and programme managers. Wise (2001) claims that advocacy sets the agenda, shapes the debate and advances policy. Wise addresses my definition of advocacy used in the UAM Health Promotion Diploma (Chapela 1994):

> *To advocate means to defend, speak in favour of someone or something, sustain a cause against outside interests, defend an idea. An advocate is someone who performs activities or negotiations aiming to achieve something for someone, to exert power of doing something on behalf of someone, groups, communities or society as a whole.*

Wise (2001), as other authors, sustains the necessity to gather evidence for political negotiation to support health promotion actions (Lethbridge 2001, International Poverty and Health Network 2001, People's Health Assembly 2000, Holland and Blackburn 1998, Ziglio 1991). Evidence of health promotion effectiveness can enforce governments or other agencies to rethink financing priorities, to pay attention to specific problematic health areas, to make necessary legal and regulatory changes, etc. To gather and communicate evidence is a strategy for advocacy.

In Ottawa and in Sundsvall (1991), healthy environments were recognised as a necessary condition from which the social groups or the individuals can design possible

futures and perform actions to achieve them. In Sunsvall, by 'supportive environment' was understood the physical and the social aspects of people's surroundings. Underlying the spirit of Ottawa, the Sundsvall and Jakarta conferences are conceptions of empowerment as key elements to promote health (Wallernstein and Freudenberg 1998, Wallernstein 1992). From that spirit, empowerment has been seen as power devolution to the individual and the social groups; as development of values, knowledge and skills useful for the achievement of projected futures; and as development of inclusive governmental and policy systems (Wallernstein 1992).

Since the necessary changes in health services threaten the position of the health agencies in the health and other fields, it is unlikely that those will be done by the power agencies. However, some national and international projects sustained for several years, which incorporate health education contents and meet agencies' demands can be useful as an 'umbrella' to develop empowering health promotion. That is the case of the Child-to-child program (Aarons et al 1979, Pridmore and Stephens 2000).

As a relative new discipline, and because of the potential weight it has as a heterodoxatic practice, health promotion is facing power struggles to define its character, specificity and discourse. Most scientific and institutional literature and documents about health promotion focus on programmes and actions thus making of health promotion an instrumental tool and neglecting conceptual discussions of health and health promotion We can find health promotion conceptions and discussions already linked to market discourses (See for example World Bank 2001, G8 Genoa Summit 2001, Gwatkin and Gilliot 2000, Prince of Wales Business Leaders Forum 2000, World Conference in Health Promotion 2000 and International Conference in Health Promotion and Education 1997). At the same time discussions relative to health promotion have taken the issues of restricted access to wealth and the right to health to international forums (See for example People's Health Assembly 2000, Cerqueira 2000, Werner et al 1998, WHO Working Group on Health Promotion in Developing Countries 1991). These discourses are apparently unified in meaning. Nevertheless, health promotion practice reveals important differences in conceptions, meanings, beneficiaries and ends showing power struggles to gain capital in the emergent field of health promotion. The health promotion struggles for meaning can be illustrated by conflicts between health promotion and health education explained below.

Health education and health promotion

Throughout history, popular knowledge and experts in society have related education with ways of improving life. Foster's (1839) work *An essay of the evils of popular ignorance* is one example of that. Since the 1880's health education has been incorporated into different governments' responsibility to achieve industrial success. Illustrative of that is Twining's work (1882) *Science in popular education: as means of promoting health, well being and industrial success.* In the early 1900s health education became part of school practices mainly stressing hygiene. Examples of that are Montellano's (1919): *School hygiene, a new way to teach an elementary hygiene*, and The Open Air School Movement (Crowley 1909).

Since the 40's, health education had been incorporated as one sanitary action amongst others. The health education practice was mainly to provide information about specific diseases, vaccines and nutrition controlled by sanitary and epidemiology specialised medical doctors (Oyarbide 1996, Loewe 1985). With changing health paradigms in the 1970s a different approach to health education appeared parallel to traditional approaches.

At present time much health education keeps hygiene oriented contents. Some institutionalised health education used, and still uses, a technological approach to achieve 'changes in habits', 'well-being life style', 'healthier life' and other designations stressing the condition of the physical body. Often the health education agenda is not defined at local level and knowledge is selected to achieve external institutional goals. Over the years, informative education has been seen as a health panacea and remains like that for some health education practitioners. The technological approach to education and the demands imposed by national and international agencies -anticipated projects, fixed goals, efficiency assessed through quantity- hindered critical education projects (Jarillo 1999).

Health promotion, which incorporated sociologists, anthropologists, economists and other professionals coming from the social sciences, exposed the problems of traditional health education and incorporated health education as one of its tools. Some

health educators joined the health promotion approach to improving health; some others considered health promotion as a present modality of health education and others maintained traditional health education conceptions and practices (Chapela 2001 a). A dispute between health education and health promotion supporters appeared as conceptual and practical differences that I interpret as political struggles to control the up-to-now medical territory. That dispute has not finished.

Different uses of the concept of 'health promotion'

The term 'health promotion' has been used indistinctly to name different disease oriented practices with underlying different concepts sustained by different knowledge. Examples of those practices are preventive medicine, health education, sanitation, and community medicine. Other examples are esoteric, naturistic and religious-linked healing or preventive practices. Most of those practices are also linked to the use of goods that openup the way to the health market expansion (Chapela, 2001b).

In the academic world as well, health promotion has different interpretations. Some of those are presented here. Ecological definitions and practices of health promotion refer to a balance between the physical body and the environment (See for example Rootman and Raeburn1994, Morris 1969, Ratcliffe 1968, Audy 1967, Sargent 1965, Dubos 1961). Conservative Social Medicine concepts and consequent health promotion actions, regard health as no-disease and the distribution of disease dependent on social structures and environmental infrastructure such as sewage, income, schooling and other, but they hardly adress the causes of power and poverty (See for example: McKeown 1982, Linton et al 1967, Johnson 1948, Smith and Evans 1944 and Winslow 1920). Alternative Social Medicine developed from Marxist conceptions of society in Mexico, Latin America, Italy and Spain and proposed that health is related to the production systems. A first proposition of alternative Social Medicine was that there is not such a thing as health, but a health-disease process (Laurell 1981). Based on that conceptualisation of health, alternative Social Medicine also perpetuated the understanding of health from its relation with disease, thus health promotion practices, while looking at disease from the perspective of the subordinated classes and class struggles, were seen from a disease perspective.

Differences in meaning of health promotion are also visible between health promotion in practice and health promotion on 'paper'. This becomes evident when comparing institutional health promotion projects and their correspondent practice and also when comparing grassroots health promotion with health promotion designed by experts.

Cardacci (1998) argues that health promotion action is mainly done in paternalistic/assistencial or romantic/idealistic ways and warns about how disempowering actions carried out as empowering can be. Cowley (1986) noticed that when health promotion projects work, there is reaction from different power agencies against such projects. That was discussed during the Puerto Rico (1998) and the Paris (2001) Conferences on Health Promotion where the presentation of the case of Mexican indigenous health promoters -under continuous harassment by the army, white patrols and government-, unveiled symbolic and/or practical harassment of health promoters not only in Mexico but also in other parts of the world.

Since health promotion is always carried out in the cultural field, it is not politically 'neutral'(see also Leichter 1991). Most hegemonic health definitions and health promotion actions are intrinsically related to disease consistent with biologist hegemonic medical paradigms where the human body is seen fragmented, apart and different from the human person and detached from a relational social reality. It is argued here that the practice of health promotion is pedagogic work implemented by pedagogic authorities who inculcate selected arbitrary contents through pedagogic action in health to achieve subordination. As it can be seen, the practice of health promotion has a double value for power since it addresses subjects' material body and subjects' subjectivity.

However, because of its heterodoxatic roots, I see in health promotion a potential tool to reverse hegemony. Before exploring how health promotion could be used to counter-act hegemony, I will present below some characteristics of health and health promotion in Mexico.

Health policies and health promotion in Mexico

During the 80s and 90s in Mexico and Latin America the public health sector was unattended and dismantled until it was under-equipped and the quality dropped (Laurell 1997, 1994; López 1994, Possas 1995). As a consequence of that dismantling, a study carried out in 1993-1994 by FUNSALUD[26] 'demonstrated' that public health services were bad, people wanted private services and that they could pay for them (CONAPO 1995). That report remarked: '...nearly half of the interviewed adults considered that private general practices are the best in their community' (Zurita 1997:241) and '...it is fundamental to take advantage of services users' disposition to pay to improve services quality' (Knaul 1997:190). These report contents were in contradiction with other studies showing the need of public health services and how the privatisation agendas did not take into account that need (Lopez-Arellano and Blanco 2001, Laurell and Lopez-Arellano 1996, Whitehead 1992, Cohn 1991, Donahue 1991, Unger 1988, Gish 1982). The 'demonstration' of the FUNSALUD report supported policy changes towards services' privatisation and the tendency to abandon public services in Mexico. In 2000 the FUNSALUD chief director was appointed by the Mexican president to lead the Health Ministry. In the 2001-2006 National Health Programme (Secretaría de Salud 2001) those arguments are used to support the necessity to open up the health market to the private sector.

In 1995, after de FUNSALUD report, a 'basic health package' policy reduced public medical services to the free provision of thirteen practices, of which none have resolute character (Secretaría de Salud 1997 a, 1997b, Sistema Nacional de Salud 1997, Secretaría de Salud 1996)[27]. The basic health package has shown its incapacity to face the local health and disease problems as it will be exemplified in page 165 (See also Laurell 1994a, 1994b, Lopez 1994). Within the basic health package, valuable disciplines or sets of practices such as health education, preventive medicine or sanitation are offered as cheap replacements for efficient and high quality basic curative and disease preventive services.

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[26] FUNSALUD a non-governmental institution in México, supported by the World Bank, which research products are used to support governmental policies.

[27] These practices will be analysed in chapter seven (p154).

From market hegemony, economic parameters to give 'value' to human life had been used to define countries' and institutions' policies, budgets and programmes[28]. Through these, hegemonic medicine strengthened and established difference in human values, social belonging and access to health knowledge and services amongst different groups in society. The basic health package in Mexico is one expression of the value poor people have in the fields of culture and production and of how the imposition of doxatic contents from hegemony expresses in health practices and in the construction of subordination and consequent disease and poverty.

The policies to train health personnel in Mexico also show how difference is constructed through the assignation of different profiles, contents, awards, etc., to different programmes according to the services they are expected to provide within private and institutional practices. Difference is also constructed through the differential value given to costumers. In box 3.2, I exemplify this by providing information about official training programmes for the development of health personnel in Mexico. This box illustrates differential characteristics of health training programmes that correspond to differentially served populations. Whilst it has been recognised in discourse the importance of primary health care for the improvement of the disease pattern, most training resources and quality are alloted to health care in second and third levels. Also, the schemes of health resources training privilege services for people living in the cities, where second and third levels of health care are available, over services for people living in the rural areas. This differential training results not only in differences in the quality of the delivery of services but also in arbitrary contents targetted at different groups in society in the search of social conforming, resulting in consolidation of difference.

[28] As argued in previous paragraphs the body is only useful to hegemony if productive and subjected. An example of economic parameters valuing human life is the AVAD: *Años de vida ajustados por discapacidad.* (Life years adjusted for discapacity) (Blanco y Rivera 1994; López 1994. See also: Williams 1999, Murray 1994,).

BOX 3.2. SOME CHARACTERISTICS OF OFFICIAL TEACHING PROGRAMMES FOR THE DEVELOPMENT OF HEALTH PERSONNEL IN MEXICO

	RECRUITS	AIM AND PRACTICES	LENGTH	TEACHERS	CERTIFI CATION
HEALTH PROMOTER	-Non or basic formal studies -coming from the social group they will serve.,mainly poor communities -on voluntary or paid basis low relatively to student's needs	-Small villages or groups of poor population -to diminish PHC costs -limited preventive and placebo actions reported regionally to health authority	Days to weeks	Health.promoter, health.auxiliary, technician or medical not specialist	-None -Health Ministry or other govern mental institution
HEALTH AID	-Basic formal studies -coming from or close to the social group they will serve., mainly poor communities -on free hosted or paid basis	-Small villages or towns -local support to political or governmental campaigns; to diminish costs -some preventive curative and rehabilitation action; restricted prescription, reported and supervised locally by the medical authority	Weeks	Technician or medical not specialist	-Health Ministry or other govern mental institution
TECHNICIANS	-Primary or secondary school -mainly coming from low middle class searching employment qualification -free or fees payment	-Towns and cities -ancillary in the support to medical action -selected disease prevention and rehabilitation practice; basic prescription supervised in hospitals	Months to 1-3 years	Technician or medical, seldom specialist.	-Private registered -Health Ministry or other governmental
MEDICAL OR ALLIED	-Pre-university studies -mainly middle and upper class -free or fees payment	-Towns and cities - labor force to accomplish PHC targets - curative; basic preventive diagnosis and prescription; health services officials with scarce supervision	4 or 5 years plus one more of social service	General medical, specialist, occasionally posgraduate	-Private or public university -Education Ministry
SPECIALIST OR POSGRADUATED	-Medical degree or equivalent -middle upper class -free, fees payment or paid with minimum wages	Cities' public and private hospitals, universities -secondary and third level health care, services administration and policy making -curative and rehabilitation; health services authorities peer and institutional supervision and control	One to five years	-Specialists -occasionally posgraduate	-Public or private university -Health Ministry -Education Ministry

Adapted from: Chapela 1993

Governmental health promotion in Mexico has been presented as specific Health Ministry's programmes mostly directed to accident prevention, screening for specific diseases such as cardio-vascular, cancer and diabetes, as well as nutrition, addiction,

sex education and the promotion of physical education. Health promotion governmental programmes are very much like in the rest of the world: Family Health, Healthy Schools, Health Programme for the Adolescents, Health in Settings and Promotion of Physical Education. The Mexican government also provides support to NGOs' health education programmes directed to prevent accidents, violence, sexual diseases and obesity (Cardacci 2000).

The Mexican government has used the term 'health promotion' instead of health education or other supportive discourse to replace medical services for cheap specific preventive measures as can be seen through the1995 Presidents' Annual Health Report (Poder Ejecutivo Federal, 1995:79, 85):

> *...it was sought to strengthen programs that could help to spread basic services coverage to population living in places with greatest marginality, with emphasis in vaccines, nutrition and reproductive health campaigns and programs ... Health promotion is a high priority topic for the [Mexican] Republic government and is a health sector's program fundamental axis...Public health personnel participation to fight together several medical-social problems is supported by 34 active health committees.*

Governmental action in health promotion is assessed in terms of chats, reproductive health, number of health committees, and other measures related to the basic health package presented in previous paragraphs (See also: Sistema Nacional de Salud, 1997, Secretaría de Salud 2001).

Thus, the WHO definition of health and other official discurses and open agendas are shown to be mere rhetoric when compared with practice. In the next section I will develop definitions of health and health promotion that consider the aspects of health promotion proposed in the Ottawa Charter that can help in the development of the health of people marginal to the market.

A HEALTH DEFINITION FOR EMANCIPATORY HEALTH PROMOTION

Because of the conditions in which it developed, the evaluation and research of health promotion has been limited by the needs of financial agencies (Chalmers 1997, Catford 1993, Brown 1983). These needs are prescriptive and founded in evidence and effectiveness linked to market necessities. This has neglected basic epistemological and

methodological problems of health promotion. Thus, I considered it necessary to draw on and reconceptualise the Ottawa Charter's definition of health promotion in a way that could reflect its multiple dimensions and could direct this research pedagogic intervention.

As mentioned before, health promotion was defined in the Ottawa Charter as:

> ...the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, *an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment.* Health is, therefore, seen as *a resource for everyday life, not the objective of living.* [Added emphasis] (WHO 1986).

One important input of this definition to alternative ways to look at health, which consider the power of the individual person, is the recognition of the capacity of human beings to identify and realise their individual and collective aspirations.

For this research's purposes and considering the Ottawa Charter's definition of health promotion, I defined health as an embodied human capacity to decide and construct transcendental feasible futures and achieve them. This definition is explained below.

The physical individual body can be regarded as the material expression of the human individual's subjectivity. It is by and through the body that the individual and the social group can interact with the environment to achieve their projected futures. The body can be seen as the limits of 'the external' and the 'internal', the public and the private (García 1999, Foucault 1997, Kristeva 1995, Lash 1991, Turner 1991, Frank 1991, Robberechts 1968). To understand health it is necessary to understand the body as constitutive of the human subject, the place of subjective inscription and the objective place of power exertion as explained next.

The conception of body is present particularly in sociological and philosophical discussions (see for example Merlau-Ponti 2000, 1981, Foucault 1997, 1984, 1979, Boyne 1991, Kristeva 1984, Lacan 1971, Husserl 1962). The paradoxical absence of the subject's body from hegemonic discussions in medical discourses is another expression of its biologic-curative-technical approach. Neglect of body discussions are seen here as a way to achieve for society *iatrocentrism* -centred in doctors or medicine-

where the use of the body can be controlled by medical prescriptions. In this way, there is hardly a social space where medical arbitrariness -preferably as doxa- is absent: sexuality, reproduction, marriage, work, eating and leisure activities, school, family, mental sanity, good or bad. However, hegemonic medical knowledge hardly takes into account discussions of the philosophical or the social body. Thus the importance of including a particular perception of body for a health definition that seeks to reverse dominance.

I argue here that the consideration of health as 'an embodied human capacity to decide and construct transcendental feasible futures and achieve them' can help to identify links between the material and symbolic worlds and between the subject's body and their subjectivity, to identify from where dominance hinders health; to better understand the mechanisms of power imposition and to find ways to devolve and develop human capacities capable of improving individual and collective living conditions, access to wealth and, in return also the characteristics of subjects' body inscriptions (see box 3.3).

BOX 3.3. APPLICATION OF A PARTICULAR DEFINITION OF HEALTH IN THIS RESEARCH

CONCEPT	APPLICATION
SUBJECT EMBODIMENT	To identify links between the material and symbolic worlds.
HUMAN CAPACITY	To identify from where dominance hinders health.
DECIDE AND CONSTRUCT TRANSCENDENTAL FEASIBLE FUTURES	To better understand the mechanisms of power imposition.
CONSTRUCT AND ACHIEVE TRANSCENDENTAL FEASIBLE FUTURES	To find ways to devolve and develop human capacities capable of improving individual and collective living conditions, access to wealth and body inscriptions.

In this definition there is a historical dimension of health under consideration that states that, in order to anticipate the future it is necessary to understand present individual and collective reality in the light of the past. A social dimension since all past and present reality understanding and action is realised in the network of social relations where the body is the place and means of power exertion. A philosophical dimension since it considers human wholeness as the transcendental being capable of responsibility,

freedom and dignity considering that the human subject is an ethical subject (Coveney 1998). It regards human beings as an extension of nature and all human action an action of nature. This definition considers that each human being is the constructor of their transcendental future, the re-constructor of the past, and the present organiser, thus involving aesthetic and other values such as pleasure and happiness. A psycho-biological dimension since it considers the body as the means of subject's expression (Husserl 1999 a, 1999 b, Holenstein 1999) for desire satisfaction, communication and performance in the practical world requiring creativity, rationality, emotions and skills. A political dimension insofar as a continuous construction of individual and collective alternatives, choices and actions is necesary to decide, construct and achieve feasible futures. Finally this health definition comprises an economic dimension as any feasible health action implies resources utilisation and action organisation (see box 3.4).

BOX 3.4. SIX DIMENSIONS OF A DEFINITION FOR HEALTH

	AN EMBODIED HUMAN CAPACITY TO DECIDE AND CONSTRUCT TRANSCENDENTAL FEASIBLE FUTURES AND ACHIEVE THEM
HISTORICAL	To anticipate future it is necessary to understand present individual and collective reality in the light of the past.
SOCIAL	All past and present reality understanding and action is realised in the network of social relations. The body is the place of power exertion.
PHILOSOPHICAL	The human subject is: nature's extension and an ethical subject; The constructor of its transcendental future, past reconstructor and present organiser.
PSYCHO-BIOLOGICAL	The body is for the subject: means for expression, desire satisfaction, communication and performance; creativity, rationality, emotions and skills.
POLITICAL	The construction of individual and collective alternatives, choices and actions is necessary to decide and construct feasible futures.
ECONOMIC	Any feasible action implies resources utilisation and action organisation.

According to this definition of health, health does not only refer to individuals' material body integrity (vis a vis disease) but to the capacity that integral subjects have to decide and realise their aspirations. The concept of 'integrity' may vary in accordance with the subject's projected future and present reality. Physical body failure can be a health facilitator or a health obstacle according to the context and value it gets from the individual and the social group. At an individual level, this possibility of physical body failure to become a positive health factor can be illustrated by known cases of heart failure that make the sick persons and their families rethink their values, future and present practices. Quite the opposite, a person with high physical integrity might have low health development. That can be the case with a champion gymnast who has

trained since they were very young without having had a chance to decide about her/his life. The hegemonic medical disregard of subjects' integrity has been geared to an indiscriminate use of technological products whilst ignoring the intrinsic body/subject relation. On the other hand, individual or collective lack of technological goods or access to them may neglect the necessities of the biological body.

Health problems are complex problems and as such they require new research and inquiring questions and different knowledge organisation and utilisation (Bojalil and Chapela 1999). Health promotion is a crossroads for different disciplines and sciences as it constructs diverse study objects (see for example the essays compiled by Macdonald and Bunton 1992). Health and health promotion problems are related to biological, social, ethic, cultural, psychological, political, economic, historical, aesthetic and affective factors underpinned by values and knowledge. Individual or collective understanding of disease as an expression of the overall human condition, can be one of many other departure points to make significant improvements in the promotion of health. The concept of health presented here led me to an alternative way of looking at health promotion. This is presented in next section.

Emancipatory health promotion

The redefinition of health presented here leads to a reconceptualisation and redefinition of health promotion. The health definition presented above refers to integral subjects. According to that definition, to promote health means to promote subjects' embodied capacity to decide and construct transcendental feasible futures and achieve them. Considering that most people in the present time and world have been subjected to market hegemony and therefore are 'broken subjects' with a decreased capacity to decide, the aim of health promotion could be to develop subjects' integrity through emancipatory practices.

Following these arguments, I define emancipatory health promotion as the practices leading to the achievement of subject's integrity.

Emancipatory health promotion is different from empowering health promotion insofar as emancipatory health promotion considers the subjects' emancipation a first priority

and the improvement of disease and poverty a result of emancipation, whilst empowering health promotion considers disease a first priority where empowerment is a practical tool used to prevent disease.

A second difference between emancipatory health promotion and empowerment health promotion is the difference in their aims. Emancipatory health promotion regards human beings as ethical subjects capable of constructing knowledge independently from experts or institutions and, based on that knowledge, give meaning and value to their world and practice. Differently from emancipatory health promotion, empowering health promotion provides a form of ethics 'by providing means by which subjects assess their own desires, attitudes and conducts in relation to those set out by health promotion expertise' (Coveney 1998:461). (See Box 3.5.).

BOX 3.5. EMPOWERING AND EMANCIPATORY HEALTH PROMOTION

	EMPOWERING	EMANCIPATORY
WHAT IS DISEASE?	The focus.	A result.
WHAT IS THE PRIORITY?	Disease.	Subjects' emancipation.
WHAT IS THE AIM?	Make people to understand selected knowledge constructed by experts.	Knowing subjects' autonomy to construct knowledge.
WHAT ARE THE MEANS?	Reflection about problems set, shaped or directed from expert knowledge that have to do with subjects' reality. Provision of selected knowledge about those problems.	Reflection about problems of subjects' reality shaped by themselves. Free access to all kinds of knowledge necessary to study and solve those problems. Access to tools to construct new autonomous knowledge.

It is said here that the five health promotion actions defined in the Ottawa Charter and presented in previous sections in this chapter (p60), can be interpreted from an emancipatory perspective, as directed to develop human capacities to construct futures and achieve them by opening up the possibility to question doxa and to the development of new fields of opinion for lay populations. Emancipatory health promotion actions interpreted in this way are presented in box 3.6.

BOX 3.6. EMANCIPATORY HEALTH PROMOTION ACTIONS

ACTIONS PROPOSED IN THE OTTAWA CHARTER	INTERPRETATION FROM AN EMANCIPATORY PERSPECTIVE
PARTICIPATION	Effective political intervention by individuals and social groups.
TRAINING	Development of values, knowledge and skills for: information and voice access; advocacy and lobbying; decision making and planning; defining and understanding problems; making feasible projects for the future and to create, define and perform actions geared towards achieving that future.
SERVICES REORGANISATION	Structural change from individual action to overall services, to meet needs defined from lay people exercise of reflection and decision.
INTER-SECTORIAL ACTION	Multifocal approach to new and more complex problems as well as change in individual, collective and governmental resources allocation rationale.
POLICY REFORM	Development of necessary policy grids to make health promotion actions feasible, organised, legal and accountable.

Emancipatory health promotion actions require the development of individual and collective values, knowledge and skills to achieve effective communication, advocacy and lobbying to access the political field. It also requires skills and knowledge to look for information and develop understandings of individual and collective problems to make effective decisions and interventions guided by feasible projects within different subordinated fields. To efficiently develop individual and collective skills and knowledge it is necessary that the health services turn to a multifocal approach to face new and more complex problems; a structural change -from individual action to overall services- to meet new defined needs; the development of necessary policy grids to make health promotion actions feasible, organised, legal and accountable and change in individual, collective and governmental resources allocation rationale.

The definition of health and emancipatory health promotion presented here helped me to conceive an idea of the characteristics of integral subjects to pursue through a pedagogic intervention that aims to achieve changes in the patterns of hegemony/subordination of those subjects. I will call those integral subjects 'healthy subjects' as will be explained and discussed in the next section.

AN IDEA OF A 'HEALTHY SUBJECT' FOR THIS RESEARCH INTERVENTION

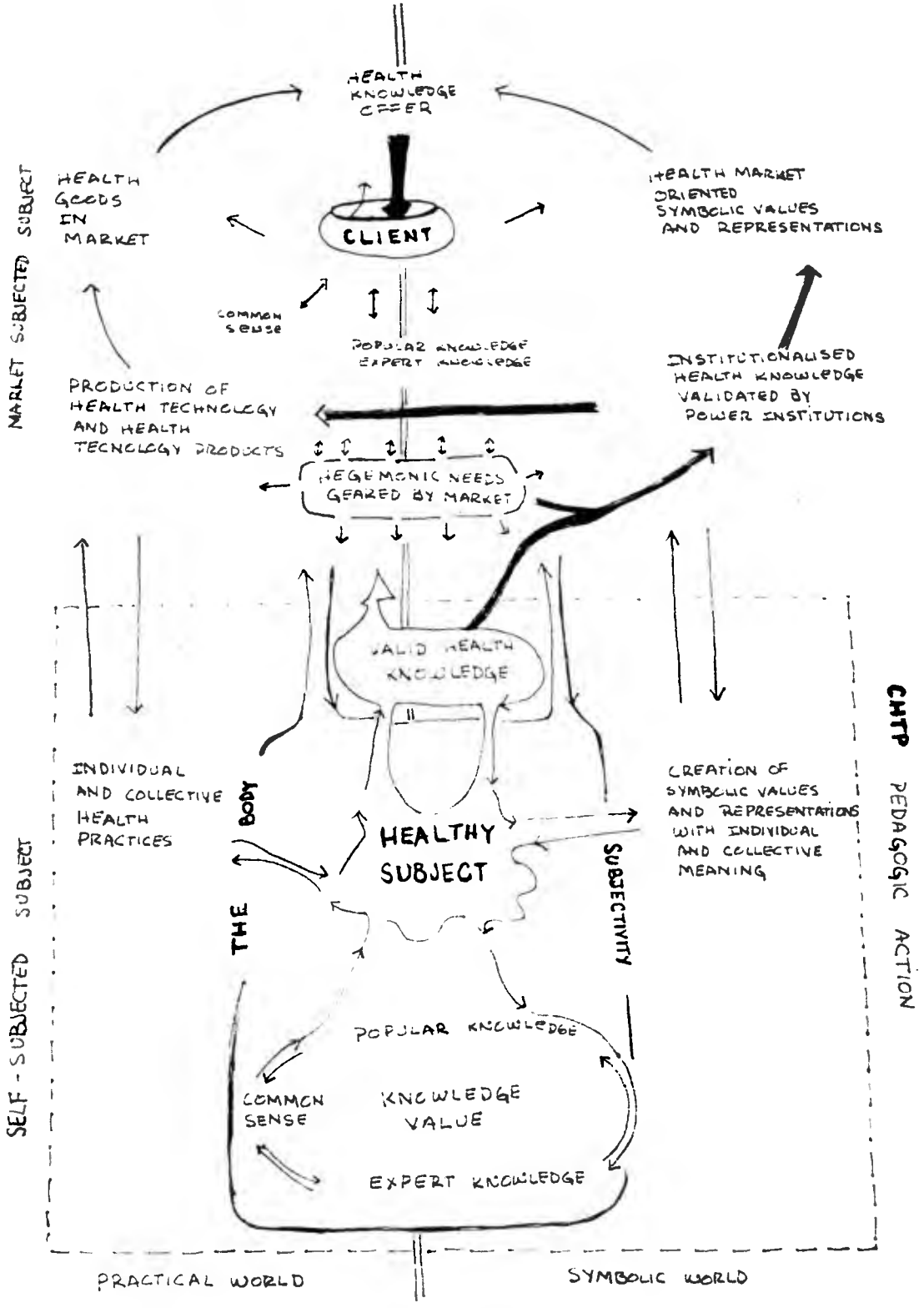
For the purposes of this research intervention, it is considered here that a 'healthy subject' is a self-subjected subject capable of developing health. This 'healthy subject' conception brings together ontological, epistemological, pedagogical and biological

considerations about a subject capable of developing health meanings, knowledge, values and practices as explained in next paragraphs.

The idea of the subject has been discussed by Adorno 2000, Morales 1997, Dor 1986, Braunstein 1980, Foucault 1997, Lacan 1971, 1953 and other authors. For the purposes of this argument, the subject will be considered as the being constructing knowledge, meaning, representations and identity when in relation with objects of reality. Subjects can relate with objects through the mediation of values and meanings imposed through symbolic or material violence, thus confronting reality from 'outside' themselves. In these circumstances, the subjects are 'subjected from outside'. Yet, when the subjects relate with the objects of reality through the exercise of their human capacities and because of emancipatory interests, they become self-subjected subjects. Immerse in the health market[29], the subjects take representations and meanings from market impositions where they become 'clients', losing self-subjection. (To follow this discussion refer to diagram 3.1).

[29] As discussed before, hegemony in health during the last decades opened a market with high monetary and power revenues (Navarro 1983, Laurell 1994, 1981, 1979, Brudon 1987, Silverman and Lee 1983, Waitzkin 1981).

DIAGRAM 3.1
CONCEPTION OF HEALTHY SUBJECT



A 'client' is a subject that is subjected from outside, passive and with very limited influences over the practical and symbolic worlds, thus with limited possibilities to confront hegemonic impositions. In constructing clients, the market ensures consumerism. For clients, the practical and symbolic worlds are regulated by market needs. As clients, market-subjected subjects will take most knowledge from knowledge offered in the market. Client exchanges with common sense, popular knowledge and expert knowledge will be subordinated to market objectives, rules and values. This research's intervention pursues the devolution and strengthening of self-subjection to market-medical clients as a practice of emancipatory health promotion.

A healthy subject is a self-subjected subject actively influencing and creating the practical and symbolic worlds, thus with possibilities to create heterodoxa and fields of opinion. Contrasting with clients, healthy subjects are immersed in a practical world regulated by the market yet, they are capable of constructing their own individual and collective symbolic world. Healthy subjects can influence and modify the practical world to make of it an expression of their symbolic world. For healthy subjects the symbolic and practical worlds are not separated, but immersed in a single reality. Healthy subjects understand reality through individual and collective continuous comparison and contrast of knowledge, meanings, values and practices at stake in their every-day life from where they construct and de-construct valid and valuable knowledge about their symbolic and practical worlds. In doing so, healthy subjects are building and rebuilding knowledge from popular and expert knowledge utilising common sense.

The healthy subjects can better understand and construct their social and material, subjective and practical worlds in a way that permits them take autonomous transcendental symbolic and practical decisions, through the construction of meanings and knowledge. The healthy subject combines emancipation, technical and practical human interests to construct knowledge as *noema* and *noesis*. Healthy subjects' perceptions, thoughts and practices of emancipation can lead to changes in the value of the capital they have to interchange in their fields; in the characteristics of distinction; in the construction of new capital and in the ways in which they play their capital in the fields. The healthy subjects would then be in a position of selecting and constructing

capital exchange networks where they can define the values, rules, bonds and objectives. Healthy subjects can also play more efficiently in fields that they do not control. With this equipment, healthy subjects can confront uncertain reality and project and perform necessary changes in accordance with their decisions. As a result, it could be expected that the healthy subject's body would show inscriptions telling a story of emancipation practices and the way in which they perceive and have access to wealth. I present a comparison between clents and healthy subjects in box 3.7.

BOX 3.7. CLIENT AND HEALTHY SUBJECT CONCEPTIONS FOR THIS RESEARCH INTERVENTION

	CLIENTS	HEALTHY SUBJECTS
ONTOLOGY	Materialistic, temporal.	Subjectivist, transcendental.
EPISTEMOLOGY	Technical and practical interests in knowledge prevail over emancipatory interests. Knowledge is more *noema* than *noesis*. Comon sense, popular and expert knowledge are subordinated to institutionalised knowledge. Fake knowledge strengthening.	Combines emancipation, technical and practical human interests in constructing knowledge as *noema* and *noesis*. Prevailing knowledges are common sense, popular and expert knowledge.
BODY USE	To conform with market necessities	To conform with self-subjection necessities
BODY INSCRIPTIONS	Of subordination practices	Of emancipatory practices

Healthy subjects and clients have the same potential capacities for constructing, deconstructing and reconstructing knowledge, thus both are considered here as persons capable of joining this research's intervention. To oppose the market-constructed client, this research intervention should pursue the emergence of healthy subjects.

CONCLUSIONS

Contemporary hegemony casts into the shadows the subject's emancipatory interests in knowledge by creating a culture of clients, who are valuable when acquiring goods in the market. This market culture permeates most aspects of individual and collective life, as is the case of medical services and health practices. Cultural action carried out in the name of health constitutes a privileged space for the imposition of arbitrariness and the generation of consensus. The control of meanings, values and knowledge through health discourses and practices has the capacity to break the subject's integrity

thus jeopardising the capacity of the individual and collective subjects to take decisions and achieve their aspirations.

A pro-positive new health promotion discourse was launched in the Ottawa Charter. Underlying this discourse is the recognition of individuals' capacity to imagine their futures and achieve them. Whilst the pedagogic practices involved in health promotion can inculcate knowledge and values necessary to maintain hegemony, they also have the potential to develop heterodoxatic knowledge and fields of opinion.

I have shown in this chapter that health and health promotion have multiple interpretations and argued that it was necessary for this research to define health in a useful way for the conception of this research intervention. I proposed in this chapter that health is 'an embodied human capacity to decide and construct transcendental feasible futures and achieve them'. This definition considers the capacities of the subject's material body and subjectivities as one whole. I also proposed that emancipatory health promotion is 'the practices leading to the achievement of the subject's integrity' considering that health is dependent on the subject's integrity. Emancipatory health promotion necessarily links with the hegemonic capital interchange networks but seeks the construction of heterodoxa and fields of opinion as counter-hegemonic action.

Finally, I proposed in this chapter that an emancipatory project should aim for the development of healthy subjects. I defined a healthy subject as 'a self-subjected subject capable of developing health'. Healthy subjects are free beings and ethical subjects possibly only because of the relations they establish with a world made out of social relations from where they take and give meaning to time and space. The healthy subjects' subjective and material environment and their subjective world are inscribed on their individual and collective material bodies. They can develop knowledge useful for understanding the relational way in which knowledge is constructed and used for hegemony and to find ways to counteract hegemony.

In the next chapter I will develop a pedagogic model that I thought could constitute an emancipatory health promotion intervention aiming at the development of healthy subjects, to be tested by this research.

CHAPTER 4
THE PEDAGOGIC INTERVENTION: CRITICAL HEALTH TEACHING PROGRAMME (CHTP)

In previous chapters I presented the results of the first phase of this research where I developed a framework of concepts and theories about the power implications in health practices, focusing on the practice of health promotion. These concepts and theories were used in the conception of a healthy subject to pursue through emancipatory health promotion. In this chapter I translate those into a pedagogy capable of developing healthy subjects which underpins the pedagogic intervention designed for this research.

The purpose of this chapter is to set out the second phase of the research, developing an emancipatory pedagogic model supported by previous discussions. I start this chapter with the presentation of the development of liberating education in Latinamerica giving special attention to the concepts of the Brazilian pedagogue Paulo Freire. I will complement this with a brief presentation of a movement of empowering health promotion in Mexico.

In the second part of this chapter I present an extract of considerations regarding what are necessary changes to modify the present power/knowledge/health situation, what to include in a planned pedagogical intervention aiming at the development of healthy subjects capable of counteracting hegemony and what to observe in order to evaluate the capacity of that intervention to achieve its aims. These considerations are the result of the theoretical arguments and the analysis of the politics of health promotion developed in chapter three. Those answers are a first step for the conception and design of the pedagogic research intervention.

Next, Gramsci, Bourdieu and Freire's conceptions of the teacher and teaching are incorporated in the development of a particular pedagogy to counteract hegemony in a poor rural community in Mexico. After developing a supporting concept of education, I will explain that particular pedagogy and call it 'self-growing pedagogy'. This chapter

ends with the presentation of the critical health-teaching programme (CHTP) that is the practical application of a self-growing pedagogy in this research intervention[30].

EMPOWERING EDUCATION AND EMANCIPATORY HEALTH PROMOTION

Present market hegemony has subordinated the human emancipatory interests in knowledge to technical and practical interests with consequent disempowering effects. From subordination, an empowering counter-hegemonic pedagogy rose particularly in the 1970s in Latin America and in Mexico. Empowering health promotion benefited from that empowering pedagogy. Empowering health promotion, while not exclusively, relates to pedagogic practices where adults are involved. Empowering health promotion in Mexico is strongly linked with Latin American adult education. It also benefits from critical theories coming mainly from Europe as the following historic review illustrates.

Adult education in Mexico and Latin America

Brandao (1985) argues that adult education in Latin America is not innovative but consolidating previous educational and pedagogic traditions developed marginal to governmental action. In Latin America, adult education used as a domination tool can be traced as far back as the beginning of the Hispanic Colony in 1521 (Batalla 1989). Examples of how adult education helped Spanish domination of indigenous social groups in Mexico can be found in the work of the Catholic missionaries (See for example Moreno-Toscano 1977, Gibson 1975).

Latin American adult education has a strong Marxist tradition inscribed during the early XX century with Anibal Ponce's positivist ideology (Puiggrós 1988). In the twenties, dogmatism coming from the III International Socialist Convention explicitly excluded the indigenous population from revolutionary action because of their 'incapacity' for transformative action (Puiggrós 1983). Official discourses and actions in Mexico maintained that conception about indigenous populations more or less unquestioned (Bonfil-Batalla 1994, Aguirre-Beltrán 1967, Gamio 1960) until the 1994

[30] In this chapter I will use the concepts and terminology examined in previous chapters.

neo-zapatist movement for Indian rights recognition (Le Bot 1997, Mundos 1994 a, 1994b, 1994c.).

In the first decades of the twentieth-century different political activists such as Farabundo Martí in El Salvador confronted prevailing adult education ideas with the necessities of a pedagogy for subversion. It was a political Peruvian activist and pedagogy professional, José Carlos Mariátegui, who proposed a national, popular and Latin American pedagogy with a Marxist framework, linking national and popular will to class struggles (Puiggrós 1983, Miroshevski 1980). Those and other nationalist and popular ideas were taken as examples during the 1930s and 1940s Cardenism in Mexico by the Cultural Brigades; in the 1950s the Catholic Church radiophone schools; and indeed by literacy projects linked with political action (Aguilar 1985).

Since the 1940s, adult education in Latin America has been closely linked with economic and socio-politic processes oriented by international agencies as UNESCO (Pieck 1996, Barquera 1985). Leftist Latin American pedagogy -strongly influenced by the work of Paulo Freire in the 1970s- evolved through popular education discourses linked to struggles fighting oppressive governments, Central America liberation processes and revolutionary Christianity. Examples of these can be found in Cárdenas y García (1998), Jara (1994), Núñez (1992), Hernández (1985) and La Belle (1980) amongst others. (Latin American popular education has been also studied by Gómez and Puiggrós 1986, Fals Borda 1985, Picón 1983 and others). Yet, during the 1970s arose a technological approach to education where teaching programming and aids were the focus (Jarillo 1999) influencing also critical liberating education and even sometimes undermining its critical nature. An example of this is the uses of Bloom´s (1956) educational objectives taxonomy in the elaboration of fixed contents teaching programmes (Comisión de Nuevos Métodos de Enseñanza 1975, Popham and Baker 1970). During the 1980s and 1990s, a market rise impacted adult education. The actual institutional Mexican adult education panorama is characterised by a technique–market–oriented rationale that has also partially filtered non-governmental controlled adult education.

Adult education in Mexico also benefited from critical theory (Bernstein 1996, Held 1990, Apple 1986, 1985, 1979; Giroux 1983,1981, Popewitz 1982). Paulo Freire's

pedagogy comprehends a critical-emancipatory philosophy, concepts and methodology. A brief description of Paulo Freire's pedagogy follows.

Paulo Freire and adult education pedagogy

Paulo Freire's liberating pedagogy provides helpful knowledge for understanding how to implement counter-hegemonic strategies through pedagogic practices. The Brazilean pedagogue Paulo Freire was a leading educator for Latin America and for the rest of the world (Mayo 1999). With the profound political and philosophical implications of his theory, Paulo Freire's work was always studied in education. From his first book 'Pedagogy of the Oppressed' (Freire 1972) to his last 'Pedagogy of Hope' (Freire 1998 a) he was consistent in the way he looked at how oppression could be converted into hope, the hope of liberation. His ontological conception of the human being as a free subject realised through practice, is coherent with his epistemology of 'subjugated knowledge' and critical consciousness and his dialogic and construction of a language of critique and possibility methodology.

Freire argues that oppressed human beings have fear of freedom and do not recognise their own knowledge since the oppressor has subjugated it. In this way, the free human person is 'domesticated'. Yet, oppressors -in the very act of oppressing- find their own oppression. The oppressive educator considers the educated as empty of knowledge, as 'being there' to be filled with knowledge convenient to maintain his oppression ('banking' education). The oppressed educator becomes an oppressor with or without knowing it, and the conscious educator becomes a means for liberation. From Freire's perspective education is far from being a neutral practice. Freire argues that to liberate, it is necessary 'to come into consciousness' - to relieve knowledge from subjugation and to loose the fear of freedom- and to practice freedom through the development of a 'language of critique and possibility'. In that language the free subjects express their values, expectations and knowledge and confront the oppressor. The development of a language of possibility will enable the oppressed to communicate in their exercise of freedom thus developing 'critical consciousness'.

Critical consciousness is constructed in *praxis* by liberating knowledge through dialogic relations in the search for the discovery and construction of collective

knowledge. In dialogue, the words of 'dialogants' are not competing, but looking for the construction of new words thus developing the 'language of critique and possibilities'. A truthful dialogue requires fulfilling three conditions: faith, hope and humility. Faith since dialogants must believe that liberation is possible and also that other dialogants are engaged in the same liberation enterprise. Hope in the possibility of life without oppression. Humility to bring into dialogues all that the dialogants know and don't know and the willingness to perceive and listen to what other dialogants know and don't know. The practice of freedom is a practice of love. A dialogue is unique, impossible to repeat when in search of freedom: 'the only thing you can do to repeat me is create me; you should reinvent me' (Freire quoted in Aguilar and Barquera 1985:66). To use Freire's tools and concepts does not necessarily automatically imply a Freirean rationale: 'Freire himself stopped using the term *conscientisation* since it had been stripped of its original meaning' (Mayo 1999:63). Popular education teaching methods employ dynamic techniques and activities from which dialogue can start.

Freire's critical pedagogy searches to bring the oppressor into consciousness. To liberate the oppressor is seen as a means to freedom for both the oppressor and the oppressed. Freire's model does not include an approach and follow up of liberating *praxis*. He relies on automatic transformation and action know-how once oppression recognition is done (Aguilar 1985).

Freire's contributions to local and informal education extend to educational philosophy and methodology (Freire 1998 a, 1998b, 1997 a, 1987b). Some isolated attempts have been made to apply Freire's philosophy and method to health care (see for example: Wallernstein 1992, Minkler and Cox 1980). However, Freire's contributions to popular education impacted non-governmental health promotion in Mexico as explained below.

Popular education and empowering health promotion in Mexico

Freires'concepts and methods were followed in Mexico during the 1980s by about a hundred organisations working in local health through popular education[31]. These groups started a particular tradition of health promoters: they were grassroots people with capacity to make some diagnosis and prescribe locally available curing and preventive measures. As in other countries (e.g. Guatemala, El Salvador, Thailand, India), health promoters constituted the only health resource in rural and urban areas where people were excluded from health services. During the 1980s official bodies in Mexico took over the notion of health promoter and also the tools to train them. Yet, their curricula -mainly attending institutional needs- was centrally designed and implemented in all rural Mexico disregarding local conditions and characteristics[3233].

Despite positive results of critical and popular education in health promotion projects, health promoters developed restricted health knowledge. Most health promoters likely to intervene in effective community change were designated to participate in popular education health projects by well-organised communities. Empowerment through popular education for health development occurred mostly within local organisations, but often it did not transcend local boundaries[34].

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[31] One NGO organizing those health promoters' organisations in the 1980s was PRODUSSEP (Popular Health Services and Education Promotion) an organisation that had three areas: clinic, research and training.

[32] An example of this is the IMSS-COPLAMAR programme, an extension of governmental health services to the marginal communities in México.

[33] It is interesting to notice how in the up-rise of the Indians in Southeast México, 1994, the only effective health resource in the area was the grid of health promoters. They were prosecuted immediately since they were well known as linking and organising persons in the area (Tello 1995). They had been trained and training other people through popular education and critical education philosophies and methodologies. Medical doctors trained in the Universidad Autónoma Metropolitana-Xichimilco are responsible of health promoters training in that area since the early 1980s.

[34] From a survey of selected health projects in México (Chapela 1991) involving training of health personnel with popular education perspective and ran during the 1980s and early 1990s, it seemed that much emphasis had been set either in popular education tools or in communicating specific knowledge. Also that survey revealed that in those projects most information and planning came from the respective NGO which personnel did not receive specific planning, teaching or research training; that there was scarce research to organise experiences and that NGOs worked with little peer or other external assessment and communication. After a decade of NGO work, there was not very much change in project contents or methodology. Finally financement issues (either by presence or absence) deteriorated NGO's internal dynamics. Haro and de Keijzer (1998) produced a compilation of community participation in health experiences and evaluation. Chapela (1998) presents a review of civil organisations, rural development and participation in México.

Why and how had popular education for health failed to expand and yield more empowerment for local people is a whole field for research. Some explanations are that hegemony directly or indirectly imposed obstacles to projects' success and that NGO's lacked understanding of local societies and their relations with external societies. Other explanations are that NGO personnel worked from the medical habitus they acquired through the institutions; that Freire's pedagogy was not fully understood and that NGOs performed their work mostly in an intuitive way.

As mentioned in the introductory chapter (p16), this research project aims to provide information to empowering health projects that can be used for their evaluation and change. In the following section I will discuss and present a pedagogic model that expresses the learning of the previous discussions of power, knowledge, social structures and education.

THEORY TRANSLATED INTO A PEDAGOGIC MODEL

For the conception of a pedagogic model and an CHTP capable of counteracting hegemony, I considered the analysis of hegemony, social reproduction, knowledge, health and health promotion as presented in chapters two and three. That analysis provided understanding about what are necessary changes to modify the present power/knowledge/health situation, what to include in a planned pedagogic intervention aiming at the development of healthy subjects capable of counteracting hegemony and what to observe to evaluate the capacity of that intervention to achieve its aims. In box 4.1 can be found a summary of those elements[35].

[35] For an understanding of box 4.1, refer to chapters two and three within this thesis since it is a result of the theoretical discussions presented there.

BOX 4.1. WHAT TO CHANGE, WHAT TO INCLUDE AND WHAT TO OBSERVE FOR A PEDAGOGY FOR EMANCIPATION

?	ABOUT POWER	ABOUT KNOWLEDGE AND HEALTH KNOWLEDGE	ABOUT THE PROMOTION OF HEALTH
WHAT TO CHANGE?	Restricted access to overall wealth. Poverty inscriptions on the body. Subordination to medical hegemony and hegemony intellectuals. Doctor/patient symbolic violence. Silenced and excluded discourses. Reproduction of medical-hegemonic discourses. 'Difference' focus. Unconscious and disorganised resistance. Students' position and position-taking within their community. Strategies to face poverty.	Subjugated knowledge. The health market-subjection of clients. Health knowledge value, validity and validation. CHTP participants' *noematic* and *noetic* health knowledge. CHTP participants' human interests in health knowledge. Meaning of health knowledge and practices. The practice of subjects participating in CHTP.	Fear of freedom. Subjugated health. Subjects' client self-perception. Health capital. Hegemonic adult education conceptions and practices. Teacher, student and teaching conceptions and practices. Health and disease conceptions. Health teaching programmes. Hegemonic health promotion conceptions and practices. Body inscriptions of poverty.
WHAT TO INCLUDE?	Awareness and identification of disparities and unfitness in the symbolic/material worlds. Doxa disclosing. Awareness of symbolic violence. Symbolic and material capital consciously valued. Students' discourse. Awareness and conscious construction of 'Difference'. Orthodoxa and heterodoxa Awareness and conscious construction of fields of opinion. Awareness and analysis of the historic block. Understanding of the boundaries, objectives, rules and capital of dominant fields. Students' strategies to face poverty inscriptions on the body.	Students' representations and knowledge. Common sense, popular, expert, institutionalised and fake knowledge. Knowledge and skills to develop the knowing capacities of subjects. Knowledge and skills to recognise subject-subjection and subjection origins. Knowledge and skills to recognise health knowledge value, validity and validation. Knowledge and skills to identify, discriminate, select, construct, reconstruct and use health knowledge. Pedagogic practices that include CHTP participants' lives, meanings, values and representations present in the symbolic and practical worlds from where participants can find identity. Health knowledge circulation within CHTP and in CHTP context.	Development of healthy subjects. Loss of fear of freedom. Language of critique and possibility. Awareness of emancipatory health. Emancipatory health promotion conceptions and practices. Meaningful health problems of reality. Knowledge about body inscriptions of poverty. Focus in process, relations and links not in contents Effective political intervention by CHTP participants
WHAT TO OBSERVE?	Habitus and doxa expressions. Bonding capital to construct difference. What happens when the symbolic and practical worlds don't fit? Construction of fields of opinion when solving health problems. CHTP field capital and dynamic. CHTP participants' practice outside CHTP. Development of students and teachers' own discourse. Development of teachers and students' organic intellectual role. Strategies to face the inscriptions of poverty in the body. Strengthening of civic society.	Processes of health knowledge construction, reconstruction and uses. *Noesis* development. Development of human interests in health knowledge. Relations and development of common sense, popular and expert health knowledge. Relations and awareness of fake and institutionalised health knowledge. Development of awareness about health knowledge relations with health market. Development of health capital exchange networks. Development of healthy subjects.	The development of healthy subjects. Development of emancipation. Development of language of critique and possibility. Health development. CHTP teachers and students practice. CHTP environment. CHTP model program implementation. Body inscriptions of change.

From the analysis and evaluation of the elements necessary to be changed for the modification of the present power/knowledge/health situation, the elements to include for a planned pedagogic intervention aiming at the development of healthy subjects capable of counteracting hegemony and the elements to observe for the evaluation of

the capacity of that intervention to achieve its aims, I identified some necessities to confront with this pedagogic intervention. Those elements are summarised below in box 4.2.

BOX 4.2. NECESSITIES OF A PEDAGOGY FOR EMANCIPATION

CONCEPT	CONSIDERATIONS FOR CHTP DESIGN AND EVALUATION
HEGEMONY	
Subordination and cultural action	-to develop awareness of subordination, coercion and consensus
Historic block	-analysis of the historic block where a specific social group is inserted
Political and civic society	-strengthening of civic society
Organic intellectual	-counter-hegemonic organic intellectual role of teachers
Market hegemony and restricted access to wealth	-to provide elements for further understanding of poverty construction and its repercussions for health and disease
Disease	-to improve local strategies to face disease problems
Discourse	-to recognise the existence of different truths in relation to the same condition of health reality -to develop skills to analyse and produce discourses
SOCIAL STRUCTURES	
Habitus	-to examine the conditions in which a specific habitus are constructed, giving special attention to medical symbolic violence -to dislocate habitus, giving special attention to 'patient' habitus -to develop new bonds for distinction
Fields	- to analyse market-medical-hegemony from a macro and micro field perspectives -consider local social structures to develop orthodoxa, heterodoxa and fields of opinion
Capital	-to re-evaluate health capital from heterodoxatic perspectives.
Doxa	-to consider local collective representations as useful knowledge for health development -to depart from local health meanings and knowledge and develop them -to prevent teachers' representations interference with the development of students' representations.
KNOWLEDGE	
Knowledge value, validity and validation	-to consider that medical validation of health knowledge represents an obstacle between local knowledge value and validity
Common sense	-to consider common sense as the departing point for CHTP
Popular knowledge	-to consider popular knowledge a source of knowledge to identify and face local health problems
Expert knowledge	-to include local and outside available expert knowledge as part of CHTP -to aim expert knowledge as the kind of knowledge likely to be constructed through CHTP -to aim that expert knowledge should circulate and become accessible for all local people needing it
Institutionalised knowledge	-to include necessary institutionalised knowledge, to understand it and how it is used and constructed
Fake knowledge	-to develop discrimination skills to identify fake health knowledge
Human interests in knowledge	-to develop emancipatory interests in knowledge and reassess technical and practical interests
Noema and *noesis*	-to pursue the development of *noesis* from *noematic* knowledge.

Once the main aspects to consider for a pedagogy for emancipation were elicited, a comparison and relation between Gramsci, Freire and Bourdieu's concepts presented in

chapter two and three helped to find an idea of 'teacher' to accomplish with the search for a pedagogy for the development of emancipation (refer to box 4.3 to follow bellow this comparison).

BOX 4.3. AN APPROXIMATED RELATION OF GRAMSCI, BOURDIEU AND FREIRE'S CONCEPTS

	GRAMSCI	BOURDIEU	FREIRE
TRADITION	Political	Sociological	Educational
AUTHOR'S WORK	Political and ideological	Academic research	Pedagogic
SOCIETY CLASSIFICATION	Social classes Civic/political society	Fields and agents	Oppressors/ Oppressed
POWER IMPOSITION	Hegemony	Power Arbitrariness	Domination
EXPRESSION OF POWER IMPOSITION	Social conformity	Habitus sustained by doxa	Domestication
RESULT OF POWER IMPOSTION	Subordination	Pedagogic action	Oppression
POWER IMPOSITION PROCESS	Coercion and consensus	Habitus inculcation	Knowledge domestication
CHANGE CONCEPTION	Counter hegemony	Dispositions and position taking change	Transformative action for liberation
CHANGE OPPORTUNITY	Contradiction/opening of historic block	Doxa/ reality Un-fittness	Critical view of reality
CHANGE LOCUS	Consensus	The doxatic	Fear of freedom
COUNTER DOMINANCE ACTION	Insubordination Making the historic block to open. Positions war Cultural action	Construction of heterodoxa and Fields of opinion	Freedom exertion/ development of a language of critique and possibility

Gramsci, Freire and Bourdieu belong to different traditions and their work focused on different aspects of reality processes. As such, their conceptions need to be understood independently. However, some relationships can be found between their concepts and theories. These three authors consider society as constructed with the mediation of impositions to maintain power and society control where domination is expressed by dominated passiveness yielding more power for dominance. Gramsci, Bourdieu and Freire recognise dominance and overall pedagogic work as the products of dominant action and describe how that pedagogic work is done through subordination practices, habitus inculcation or knowledge subjugation. They look for opportunities and ways to change domination. Gramsci, Freire and Bourdieu find a *locus* of change and claim for social counter dominance actions such as insubordination, the constructions of fields of

opinion, the exercise of freedom through dialogic relations and the development of a language of critique and possibility.

When translating Freire, Gramsci and Bourdieu 's concepts into a practical pedagogic model, I continuously found myself facing teachers' crucial role in the development of emancipation. An identification of 'teacher' was done with Gramsci's organic intellectual, Freire's dialogue participant as well as with Bourdieu's power agent (cultural arbitrary). In box 4.4 is presented my interpretation of Gramsci, Freire and Bourdieu's conceptions of teachers and teaching aims, roles and pedagogy. The comparison and contrast of those characteristics in the light of my practical health promotion empirical experiences lead to conceptions of the emancipatory teacher and teaching.

BOX 4.4. LOOKING FOR AN IDEA OF 'TEACHER' IN GRAMSCI, FREIRE AND BOURDIEU

	GRAMSCI	FREIRE	BOURDIEU
'TEACHER'	ORGANIC INTELLECTUAL	DIALOGUE PARTICIPANT	CULTURAL ARBITRARY/ PEDAGOGIC AUTHORITY
DESCRIPTION	An activist with deep understanding of reality, sharing social problems with a specific group in society.	Person with hope, faith and humility capable of sharing and learn through dialogue.	Dominant power agency for values, practices, meanings and knowledge arbitrary inculcation.
ROLE	Rise of social and political reality awareness. To fight hegemony. Knowledge interpreter.	Self-concientisation to liberate self, group and the oppressor.	Chain for the imposition of hegemonic meanings.
AIM	Action for political change.	Action for human Change.	Inculcation of perception, thought, and practice scheme.
PEDAGOGY	Discussion and study groups.	Dialogic, Power-sharing.	Symbolic violence.

While Freire and Gramsci are making counter-hegemonic action propositions, Bourdieu provides elements to understand where hegemonic action is taking place and how it is occurring. Gramsci and Freire propose a figure to induce change to oppose the pedagogic authority described by Bourdieu. Bourdieu provides elements to enlighten specific field features that are to be changed to construct fields of opinion. Gramsci's and Freire's 'teacher' disclose processes resulting from pedagogic work and pedagogic action. While organic intellectuals and dialogue participants aim for changes in power,

social structure and overall human liberation, cultural arbitrary teachers inculcate values, knowledge and practices to maintain supporting dominant power structures.

Organic intellectuals and dialogue participants are independent relevant social figures who learn from experience when working with people, thus confronting circumstances requiring diverse, critical, creative and collective action. They are aware of their action transcendence and their human responsibility. Cultural arbitrary teachers often are non-conscious passive transmitters of others' impositions, power dependent and links with dominant powers. Cultural arbitrary teachers hold a stake in power enough to exert symbolic violence as pedagogic authorities. Organic intellectuals and dialogue participants aim to oppose cultural arbitrary teachers' work and action. On the reverse, cultural arbitrary teachers' task is alienation and to watch and punish liberating actions with symbolic violence. Bourdieu proposes the creation of 'fields of opinion' where heterodoxa can be constructed and opposed to arbitrariness. That construction requires pedagogic work carried out in the Gramscian and Freirean traditions with pedagogic work awareness.

From Gramsci, Freire and Bourdieu's 'teacher' idea, I constructed emancipatory teacher and students models for this pedagogic research intervention. These models are presented below.

Emancipatory teachers are subjects with hope, faith and humility, capable of sharing and learning through dialogue; merging features of activists with deep understanding of the historic block sharing problems with the group they are working with. Those persons learn to discuss and study through dialogic processes. Emancipatory teachers are concerned with power, culture and values and also have power, culture and values dynamics understanding. If consciousness is a key for liberation and political action against social conformity, conscious emancipatory teachers are capable of recognising their fatal arbitrary role to counter this cultural arbitrary fate.

Emancipatory teachers are considered here as persons triggering and conducting planned pedagogic processes until those processes can be continued and conducted by other person or persons. In doing so, emancipatory teachers are knowledge interpreters and mirrors where the group can recognise their knowledge, values, skills and problems

and from there, reconstruct an identity. Emancipatory teachers are groups' companions and possible groups' advisors and find pleasure while performing their tasks, constructing knowledge and monitoring processes and change.

Emancipatory teachers do not need to belong to the same social group as the one they are working with. These teachers may share or not students' goals yet teachers and students share and learn from each other to build common objectives as the emancipatory learning process advances. Teachers and students might have interchangeable roles. Teachers are to 'obey' students' commandments; they are responsible for completing assigned tasks in such a way that the specific necessity that is going to be solved through a specific teaching program is efficiently completed. Emancipatory teachers are capable of pooling their own knowledge with students' knowledge from which students will identify and select what is necessary to describe and solve specific problems[36].

The emancipatory teachers' role is to interpret and help in the interpretation of knowledge, values, other realities, contexts, rules and other necessary elements, to unveil doxa and other restricted and hidden knowledge and values relevant to understand and cope with specific problems of reality. In so doing, emancipatory teachers reveal their aim to counteract arbitrariness, pedagogic action and pedagogic work while accompanying students in the processes of personal or collective change. While traditional teacher's habitus permeates emancipatory teachers, symbolic violence can be difficult to eradicate but can weaken through dialogue encompassing reflection, study and action, disclosing the meaning of symbolic violence and monitoring it. Emancipatory teachers aim to dislocate habitus by the construction of fields of opinion through dialogue and reflective study. They also aim to become unnecessary as a result of the pedagogic process. That is, once the students develop awareness, skills and knowledge about pedagogic processes organisation and conduction, the emancipatory teacher can retire; become a group companion, member or advisor in the same or

[36] Examples of pooling knowledge are found in Chapela and Lara 1996, Lara et al 1996, Haro and de Keijzer 1998, García and Cárdenas 2000, 1998, 1992.

another group. The emancipatory teacher is aware of not generating long term students - teacher or teacher - students dependence.

Emancipatory teachers counterpart are 'emancipatory students': a person or persons in a group with collective purposes, missions or goals that see the pedagogic act as a means to achieve change in their personal, familiar and collective life. Emancipatory students' knowledge is mainly common sense and popular knowledge and they use it to solve every day personal, familiar or collective problems. Emancipatory students have a collective mission addressing collective problems and the emancipatory teacher's role is to trigger and conduct pedagogic processes to help emancipatory students complete their mission. (See box 4.5 for a summary of emancipatory teachers' and students' profile).

BOX 4.5. EMANCIPATORY TEACHERS AND STUDENTS FOR THIS PEDAGOGIC INTERVENTION

	TEACHERS	STUDENTS
TRADITION	Political, educational, cultural.	Collective problems solution.
KNOWLEDGE	Common sense, expert, popular and institutionalized.	Common sense, popular some expert.
WORK	Political , ideological, pedagogic.	Pragmatic, reflective, collective.
CHARACTERISTICS	-Person with hope, faith and humility with understanding of historic block. -Performing group commanded tasks.	-Person with hope, faith and humility approved by a specific social group sharing a collective mission with other students. -Thinks in terms of collective benefit.
ROLE	-Interchangeable with students. -A mirror and interpreter that triggers processes and conducts them. -Is a group companion and an advisor when required.	-Interchangeable. -To identify what is needed. -To feed knowledge to the pedagogic environment.
AIM	To raise insubordination. To oppose arbitrariness, pedagogic action and pedagogic work and raise fields of opinion. To develop a language of critique and possibility.	Change in personal, familiar or collective every - day- live infrastructure.
PEDAGOGY	Problem identification, inquiring, action and knowledge circulation through dialogic processes of discussion and study about problems of student's reality.	Active reflection, study and action upon problems of student's reality.

Once I had a profile of teachers and students for a health teaching programme capable of developing emancipation to counteract hegemony, I proceeded to find ways to modify the syllabus of traditional health promotion medical-oriented teaching

programmes in a way that could fit with the profile of emancipatory teachers and students as shown in box 4.6. To identify the authority contents of traditional programmes, I did an analysis and evaluation of curricular characteristics of three medical oriented programmes[37] in the light of Basil Bernstein's (1996, 1990, 1974) concepts of codes and framing that give account of power and control in pedagogy. According to these concepts, a syllabus with restricted codes and framing tends to be more controlled by authority. The evaluation of the curricular characteristics of medical oriented programmes, showed that medical programmes are run with restricted curricular codes and framing. To those characteristics I proposed possible changes to open codes and framing compatible with an emancipatory syllabus as presented in box 4.6.

[37] This analysis was done for one private, three public medical schools and a governmental health promotion programme: La Salle (n/d), Universidad Nacional Autonoma de Mexico Main and Zaragoza campus (UNAM Facultad de Medicina n/d, UNAM Facultad de Medicina 1993, ENEP Zaragoza 1988, Morales and Cortes s/d) ; Universidad Autonoma Metropolitana (UAM-DCBS 1975) and a governmental programme to train health promoters (Chapela 1993). The statements of the Consejo Mexicano de Medicina General, A.C. (1996) recommend close codes and framing medical teaching programmes.

BOX 4.6. TRADITIONAL AND EMANCIPATORY SYLLABUS

INSTANCE	TRADITIONAL	EMANCIPATORY
STUDENTS	Selected through fixed tests on a 'funnel' basis where more students are excluded than included.	Basic reading and writing skills, attending on a voluntary basis with a collective responsibility
TEACHING PERSONNEL	Experts with medical specialised knowledge acquainted with institution representations and context.	Experts with general medical, planning, communication and research skills and knowledge. Acquainted with local context.
SETTING	Institution's.	Student's
CONTEXT	Individual. Institutional	Collective. Non-institutional.
KNOWLEDGE EMPHASIS	Acquiring and reproducing specific contents	Tools to translate and construct meaningful knowledge
SOURCE OF KNOWLEDGE	Scientific, technical restricted to fixed medical contents. Expert and institutionalised.	Common sense, popular, expert and institutionalised knowledge
USES OF KNOWLEDGE	Accumulation, institution accountability, prestige, as merchandise.	To solve problems, to critically analyse subjective and objective world. Change
FOCUS	Contents.	Problems
AIM	Set by the institution.	Set by teachers and students
SYLLABUS	Medical knowledge through fixed syllabus used in most health personnel training courses.	Contents should be decided as demanded by problem understanding. A basic set of contents used as tools.
POSED PROBLEMS	Fixed, based on general decisions (national, international), disease and technology oriented, not differentiated with other programmes.	Exclusive. Local, with consideration of local, regional and national context. Looked as a fraction of complex problems of collective relevance.
METHOD	Memorisation.	Identifying/enquiring/practice/circulation
LEARNING PROCESS	Learning by rote.	Reflection, contrasting.
LEARNING *LOCUS*	Individual	Collective
COGNITIVE PROCESS	Knowledge compartments, no linking with complex reality. Collection.	Linking, categorising, accommodation.
VALIDATION	Expert examination.	Contrasting with reality, collective and peer recognition.
CERTIFICATION	Award, icon.	Collective recognition
SYMBOLIC VALUE	Prestige, power	Individual and collective satisfaction
MATERIAL VALUE	Economic	Tool to ease collective problems.

Other practical elements to consider in the conception of this research intervention derived from the analysis of health using Bourdieus' cultural capital, cultural arbitrariness, habitus and fields concepts as shown in box 4.7.

BOX 4.7. CHTP PRACTICES AIMING TO DISLOCATE HABITUS

CATEGORY	RATIONALE	CHTP PRACTICES
CULTURAL CAPITAL (CC)	-Health knowledge and practices in a local space include knowledge and practices coming from local and outside spaces. -CC value is given in accordance to how this knowledge is capable of solving posed problems. -Health problems merge with power relations, which at local level restrict access to wider CC.	-Develop an account of local CC by pooling knowledge recreated to solve specific problems and make it ready to be used and further developed by the social group it refers to. -Identify 'outside' CC useful to help in problem solution and add it to CHTP knowledge pool identifying its original source. -Identify, find value and validate common sense, popular and expert knowledge through the identification and solving of reality problems.
CULTURAL ARBITRARINESS	-Health local CC is devaluated in comparison of reified external capital, particularly that coming through school, media and regional private and medical services. -Local truth about health has been replaced by a fragmented medical truth.	-Reveal the 'un-natural of the natural'. -Identify symbolic violence in doctor/patient and teacher/student relations. -Systematically develop awareness about what kind of CC is being used to solve problems. -Identify procedures of knowledge construction and validation. -Identify truthfulness and source of CC. -Systematically test CC against efficiency in problem solving. -Continuously make a revision of 'catalogued' knowledge to delete non-validated knowledge and incorporate self constructed validated knowledge.
HABITUS	Perceptions, way of thinking and consequent actions upon body or individual/collective health, develop from inculcated structures which can be modified by the individual or the group as far as these structures are revealed and understood by them.	-Systematic self and collective reflective work about habitus, medical habitus, health and medical discourse and texts and how a person can turn into arbitrariness agency. -Continuous work framing and contrasting with local reality and original purpose. -Systematic identification of the possible and the feasible. -Circulation of findings and knowledge.
FIELDS	Within the medical field there is no homogeneity in the distribution and access to knowledge and practices, yet the values permeate through the medical school and are present in medical actions. These are reinforced by the medical field constructed 'patient culture'. Thus the pedagogic work necessary to maintain a 'patient culture' and a 'medicalised life culture' can be performed. Besides the medical field there are other fields that interfere in habitus construction expressed through health actions. To identify those intervening fields, its values and purposes can modify the pedagogic action.	-Identification of the medical field. -Identification, comparing and contrasting of health institutions and media-transmitted health-related texts and discourses. -Identification and analysis of local health practitioner's discourses and texts and local health practices. -Taking and analysing testimonies. -Identifying the different health facades present in different fields. -Analysing 'others' attitude when faced with an 'inpatient patient'. -Identification of the 'culture of the patient'.

I synthesised previous analyses in the conception and practice of a self-growing pedagogy explained below.

SELF-GROWING PEDAGOGY

Previous discussions situate the contemporary subject and the health panorama in a world where the environment is uncertain, unstable, within an incredulity mood where knowledge is valued through a production-consumption rationale (Usher et al 1997). Uncertainty and unstability 'requires us to change our conception of education' (Burbles 1995 cited in Usher 1997:25). To look for an education meaning capable of

coping with present health reality and with the demands of our pedagogic intervention, I 'deconstructed'[38] the term 'education'.

Education has been present in each singular social representation throughout human history. Education, very much as health, overlaps epistemological, ethical, aesthetic, sociological, political, psychological and historical -amongst others- interpretations. 'Education', seen from it's Latin root '*educare*': to cultivate (Real Academia Española, 1970) and also 'pedagogy' seen from it's Greek root '*to conduct the child*' (Ibid), stands for cultivation, that is, to care and provide for growing (or walking). Building from those meanings I considered that the act of growing is independent from the cultivator and the way of growing is a result of growing/cultivator relationships. In those relationships the way of growing depends as much upon intrinsic qualities of 'the growing' as upon the 'growing environment'. The growing subjects are exposed to objects, ideas, values and knowledge at stake in the external environment as well as feelings, values and knowledge already existing within themselves. For the growing subject, the cultivator is part of the growing environment. The act of cultivation is what has been considered education.

Education has been seen as formal socialisation (Bernstein 1996, Baudelot and Establet 1976, Berger and Luckmann 1966). Socialisation ensures that new social members of specific social groups know how to participate in social life. Interpreted from a theory of fields, socialisation is relationships carried out within a field (capital exchange networks) enabling participants to 'play' in the field (family, neighbourhood, gender, school, work, 'global village' or other). Market-hegemonic socialisation is carried out within power relationships where dominant power, to maintain hegemony, needs to ensure that the 'growing' remains a growing object of the cultivator (the power agency) as manipulatable 'clients'. Power agencies aim to monopolise socialisation, to watch and punish to achieve social control (Foucault 1997, 1984, 1980, 1979) and to establish monopolistic relations by the manipulation of the growing as growing object of the

[38] '[Derrida's] deconstruction is the reading of texts in terms of their marks, traces, or indecidable features, in terms of their margins, limits, or frameworks, and in terms of their self-circumscriptions or self-delimitations as texts' (Silverman 1989:4).

cultivator probably as proposed by Freire (1989, 1981 a, 1981 b, 1972) in his banking education concept (see also Illich 1973).

In this research I consider education the relationships the growing subject establishes with the growing environment. Those relationships manifest in the practical world when the subject appropriates, explores, transforms and constructs knowledge. Education then is a practice linking the objective and the subjective subject's worlds, knowledge and practice, theory and method. It is said here that when subjects taking the responsibility of the cultivator and the cultivated carry out that practice, it becomes a 'self-growing practice' sustained in a 'self-growing pedagogy' (see below and box 4.8).

BOX 4.8. SELF-GROWING PEDAGOGY

SELF-GROWING	The act of subject's growing mediated by relationships with the growing environment where the subject is enacting his/her own growing as cultivator and cultivated.
PARTICIPANTS	Individual and collective subjects: -growing as self-growing subjects; -taking knowledge at stake and constructing their own to face and solve problems of their reality; -creating their own definitions about reality and problems; -creating necessary 'distinction' qualities to consciously analyse and redefine their fields' characteristics thus breaking social conformity.
SELF-GROWING ENVIRONMENT	Subject's growing environment facilitating the self-growing subject: -to establish relationships with other growing subjects and problems of reality and with individuals, groups and realities related to growing subject's problems; -access to voice, opinion and decisions; -free access to necessary knowledge to understand and solve problems of reality defined by the self-growing subject; -development of perception, inquiring, linking, analysis, communication and action skills.
SELF-GROWING ENVIRONMENT CHARACTERISTICS	In a self-growing environment there are: -active self-growing participants with individual and collective certainty of knowledge worthiness, emotion and motivation when discovering knowledge and satisfaction when using newly acquired or constructed knowledge; -recognised aims and tasks linked with problems of growing subjects' realities, identified and discussed by growing subjects; -necessary knowledge and information at stake to be used freely by the students to understand, confront and solve problems of their reality; -individual and collective multi-focal approaches; -recognition of multiple individualities; -peer non-sanctioning interlocutors and interlocution.

Because through a self-growing pedagogy the subjects appropriate, explore, transform and construct knowledge linking their objective and subjective worlds, this is the adequate pedagogy for the development of the healthy subjects described in previous chapter (p75). Hence, this pedagogic intervention seeks to construct environments from

where the subjects can take basic elements for reflection[39] to trigger the development of knowledge relevant to their own growing in an uncertain world. In this way, contradictions between cultivators' needs and growing subjects' wants can be diminished, reducing doxatic impositions. Box 4.9 shows the characteristics of self-growing teaching and environment.

BOX 4.9. SELF-GROWING TEACHING AND ENVIRONMENT CHARACTERISTICS

SELF-GROWING KEY ASPECTS	SELF-GROWING TEACHING AND ENVIRONMENT CHARACTERISTICS
SUBJECTIVE ASPECTS OF INDIVIDUAL SELF-GROWING	A recognised finality set by the student. Certainty of knowledge worthiness. Emotion and motivation when discovering knowledge. Satisfaction when using newly acquired or constructed knowledge to understand or solve a specific individual or collective problem.
TEACHING ASPECTS FOR SELF-GROWING PEDAGOGY	Dialogue between participants. Reflective confrontation with health problems and decision taking. A collective approach. Adapting of teaching and students roles to self-growing education. Teaching pace according to student's and group characteristics and needs. Existence of peer, non-sanctioning interlocutor. Avoidance or awareness of symbolic violence.
KNOWLEDGE INPUT IN A SELF-GROWING ENVIRONMENT	Health problems brought and shaped by students. Knowledge available and accessible for free students' use. Identification, understanding and giving practical response to body inscriptions of restricted wealth access.

This research intervention is a health self-growing pedagogy teaching program where adults are considered self-growing subjects growing in a self-growing environment where already existing and newly constructed knowledge and information is at stake to be used as participants need and want. This intervention's growing environment has to be constructed from relationships between intervention participants and the local population mediated by the delimitation, understanding and changing of their reality problems. It needs to create new 'distinction' qualities amongst participants to redefine renovated or new participant's fields values, bonds and rules thus to break social conformity. Inbuilt in a self-growing pedagogy are changing participants' roles, where participants become an environment component when in the role of knowledge source and growing subjects when developing knowledge.

[39] In his *Meno*, Plato (1966) refers to these elements 'foot-notes' (Plato 1966).

Self-growing environments and teaching characteristics refer to subjective aspects of individual self-growing, self-growing teaching and knowledge input. Individual subjective aspects are: recognised finalities set by students; certainty of knowledge worthiness; emotion and motivation when discovering knowledge and satisfaction when using newly acquired or constructed knowledge to understand or solve specific individual or collective problems. Self-growing teaching environment aspects are: the promotion of dialogue; reflective confrontation with health problems and decision taking; a collective approach; students and teachers adaptation to a self-growing pedagogy; teaching pace according to students and group needs; presence of peer, non-sanctioning interlocutors and the avoidance or awareness of symbolic violence. Knowledge input aspects of a self-growing pedagogy are: the existence of knowledge available to be used freely by students and teachers and the existence of problems brought and shaped by students.

Teacher's characteristics for a self-growing pedagogy have been defined in a previous analysis and are shown in box 4.10.

BOX 4.10. TEACHERS' CHARACTERISTICS FOR A SELF-GROWING PEDAGOGY

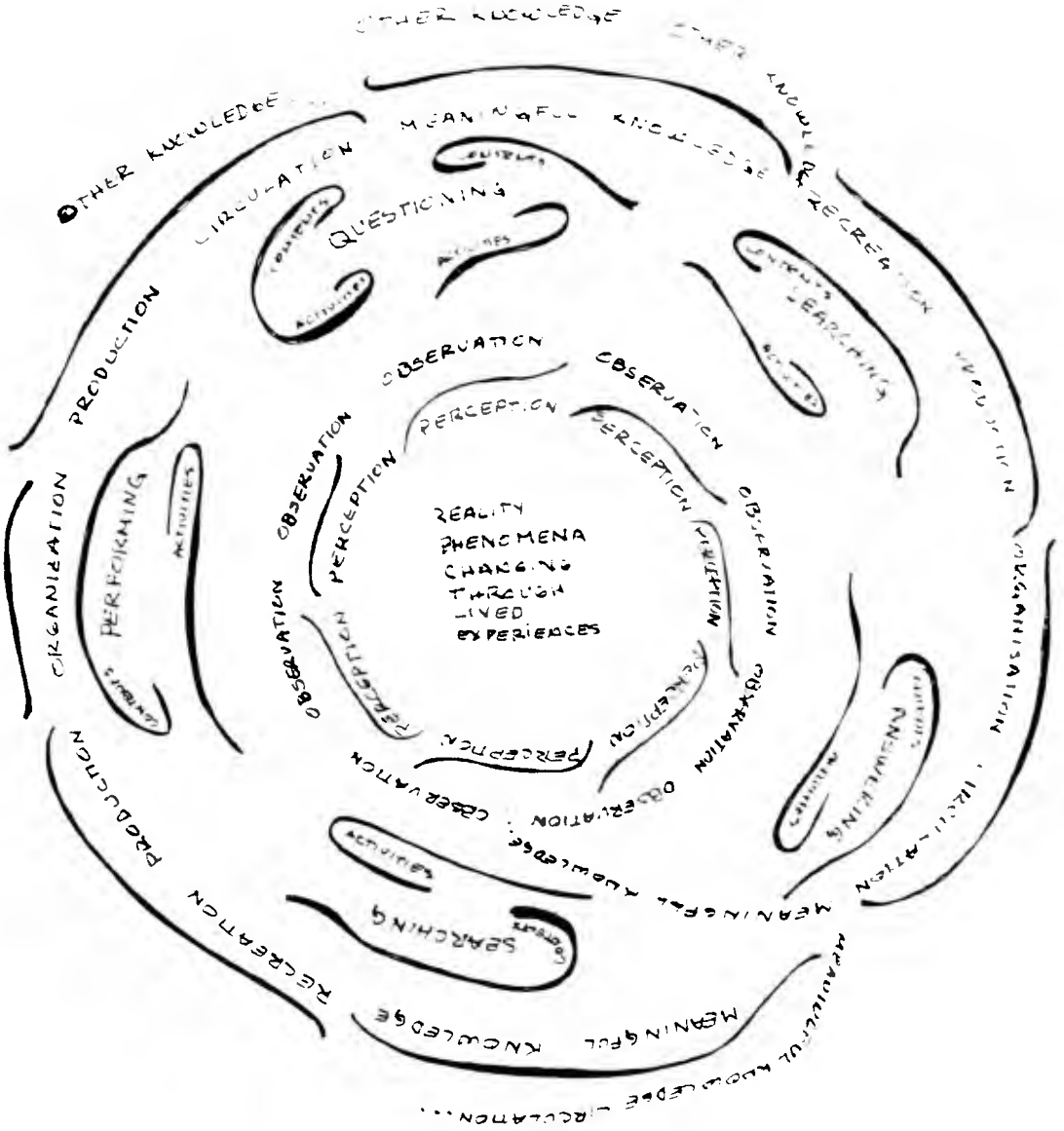
CHARACTERISTIC	THIS CHARACTERISTIC IS NECESSARY TO:
Self-growing subject	Participate and understand CHTP process
Person with hope, faith and humility performing group commanded tasks	Develop dialogic relations Organise and make knowledge accessible for free students' use
Understanding of role tasks.	Organise and make knowledge accessible for free students' use
Interchangeable role with students	Construct his/her own knowledge and understanding
Mirror and interpreter role	Develop dialogic relations Organise and make knowledge accessible for free students' use
Group companion and advisor when required.	Make knowledge accessible for free students' use
Triggers processes and conducts them.	Develop dialogic relations
Creatively identifies necessary knowledge contents to approach problems of specific health reality and designs self-growing activities and teaching aids.	Organise and make knowledge accessible for free students' use
Seeks problem identification, inquiring and action over problems of reality and knowledge circulation through dialogic processes of discussion and study.	Organise and make knowledge accessible for free students' use

CHTP: THIS RESEARCH'S PEDAGOGIC INTERVENTION

Self-growing teaching actions are organised in a critical health-teaching programme (CHTP) aiming at the development of healthy subjects as presented below.

As shown in diagram 4.1, CHTP has at its core the continuous observation of health reality as perceived uncertain and changing phenomena of a specific community's every day life. That reality is at the time affected and constructed by performance and perception. Different ways of observing, searching, answering and proposing, change reality perception. What we can observe is always only a fraction of what is perceived. However, the perception and observation of reality and awareness of observation incompleteness will define CHTP questions and searching, answering, proposing and acting processes related to observed reality.

DIAGRAM 4.1.
CONCEPTION OF CHTP PEDAGOGIC MODEL



Within CHTP, knowledge is in continuous construction, organisation and circulation. Constructed or reconstructed knowledge will feed all pedagogic practices and processes. In this way, syllabus contents and activities will be defined as the learning/teaching process advances. Since this model focus is learning about and through processes, contents become an aid or vehicle to develop learning and change processes. In this way, to learn about a specific content can take all the time and space it needs to generate in the students satisfaction, content understanding and processes appropriation. As students develop processes knowledge and skills, content learning will increasingly take less time and space to be appropriated by students.

Knowledge constructed in this way will become meaningful for students as it represents themselves, is useful to perceive and understand their context, and helps students decide what to change in their perceived reality and how to make defined changes. Also knowledge constructed in this way will generate integrated knowledge in students enabling them to face complex knowledge problems. Within this pedagogic model, meaningful knowledge production and organisation is in continuous circulation establishing relations between perceived reality and learning processes. Meaningful knowledge has exchanges with other knowledge existent in and outside a specific field. Students can take from the knowledge environment what they need to construct and recreate new meaningful knowledge using searching and discrimination abilities developed through the construction of meaningful knowledge.

Results of the implementation of this pedagogic model are continuously evaluated through the value and validity the students confer to knowledge. Through this pedagogic model implementation there is implicit a possibility to overcome barriers to knowledge access.

The CHTP proposal includes: critical adult education teaching practices; reflective practice about problems of reality; discussion and study groups about meaningful problems of reality; knowledge from where students' can take footnotes pooled by teachers and students allowing the group free access to it; dialogue and shared power. It adapts the teaching environment and teachers and students' roles to self-growing pedagogy. CHTP recognises and avoids symbolic violence. CHTP practice confronts

uncertainty by focusing on processes rather than on contents. It develops skills and knowledge to build options and to take decisions.

CONCLUSIONS

In this chapter I explained that this pedagogic intervention was designed as a critical health-teaching programme (CHTP) that follows a 'self-growing' conception and practice of education that I supposed could help in the development of healthy subjects. Healthy subjects have been defined in a previous chapter (p75) as 'free beings and ethical subjects possible only because of the relations they establish with a world made out of social relations from where they take and give meaning to time and space'. In this chapter it has been argued that healthy subjects can construct meaningful knowledge through a self-growing pedagogy that permits them to look for contradictions emerging in *praxis* and elicit knowledge by questioning the unquestionable and thinking the unthinkable to modify reality.

The self-growing pedagogy presented here requires pedagogic characteristics found in previous analyses of health, power and knowledge. This pedagogy considers building up growing environments where the self-educating participants can produce counter-hegemonic 'difference'. The comparison of Gramsci, Freire and Bourdieu's concepts made in this chapter, helped to identify the characteristics of CHTP teachers, teaching, students and teaching environment.

Practical aspects of a self-growing pedagogy are: To focus on processes rather than on contents, to open free access to knowledge, to perform every learning experience through dialogue and to develop skills and knowledge to build options and to take decisions.

Other practical aspects of a self-growing pedagogy are: to find a starting point to trigger learning processes; to conduct learning processes guided by the examination, study and understanding of health problems presented and delimited by students; to let those processes point to contents, learning experiences and teaching aids; and to evaluate students' advances through their practical use of knowledge.

In this chapter I set out the second phase of this research. In the next chapter I will present the methodology used for the evaluation of the third phase of this research: the implementation and evaluation of the research intervention (HCTP).

CHAPTER 5
METHODOLOGY

The implementation, analysis and evaluation of the pedagogic intervention (CHTP) designed in phase two and presented in the previous chapter, constitutes the third and last phase of this research. The purpose of this chapter is to present the methodology deployed for the implementation, analysis and evaluation of that intervention and its context.

First in this chapter I give a summary of the research problems and questions, describe how was this research was carried out, explain why I chose this methodological approach and present the criteria for the selection of the research site. Next in this chapter I present a panorama of the four stages in which CHTP was implemented. I will present the aims of each stage and will set up process and outcome questions that we need to answer for the CHTP evaluation. This chapter continues with the description of how I collected the information, how I recorded it and how I converted it into data. Here I will provide some remarks about anonymity, confidentiality and informed consent. Finally in this chapter I describe how I analysed and evaluated the data.

METHODOLOGICAL APPROACH

This research starts with two interrelated questions: What are the characteristics of the dynamics of power underlying the relationships taking part between health services and individual people that have limited access to wealth? Is it possible to modify their health and disease situation through changes in the dynamics of power resulting from a planned pedagogic intervention?

Question one is asking for information about the present situation of power dynamics at a specific site and within specific people. Question two asks for information and

evaluation about changes in that situation occurring as a result of a planned pedagogic intervention.

The main problem for this research is to find out some understanding of the roles of individual and collective power in health promotion. Four allied problems were detected: to examine how inconsistencies found in the analysis of health promotion discourses and practice are maintained; to examine why and how uneven pedagogic relations taking part between health personnel and local people can endure; to find out pedagogic alternatives in a way that authority can be under surveillance and controlled by local people and finally, to find evaluation parameters for health promotion projects.

In box 5.1 I present these problems and questions.

BOX 5.1. MAIN QUESTIONS AND PROBLEMS FOR THIS RESEARCH

QUESTIONS	PROBLEMS
What are the characteristics of the dynamics of power underlying relationships between health services and individual subjects that have restricted access to power and overall wealth?	-To examine how contradictions between official discourses and actions are achieved and maintained. -To document and examine those pedagogic relationships in an attempt to find out why and how they endure and what are their characteristics and processes, paying special attention to existing knowledge dynamics.
Is it possible to modify the health and disease situation of those subjects through changes in the dynamics of power resulting from a planned pedagogic intervention?	-To find out and test alternative ways in which such programmes can be designed and implemented in a way that authority dominant practices can be under surveillance and control. -To find objective outcome and process parameters to convince the administrators and financial agencies to support projects aiming to develop capacities to take decisions and realise aspirations.

The research questions and problems inquire into power processes occurring in a specific space and time. The inquiry focus was set on processes and change in knowledge, meanings and values and on objective and subjective aspects of human reality. This focus required very close observation of specific people, their circumstances, history, perceptions, feelings, context and processes. As such, I intended to explore deeply into individual and collective processes of change. Also, the planned intervention required the development of confidence and accountability amongst the people involved in the implementation of the intervention. Therefore, to answer the

research questions I selected a qualitative methodology: an exploratory case study of a single case.

Criteria for the assessment of this research

The selection of a qualitative methodology for this research was not unproblematic. Qualitative methods in general and case studies in particular had been widely studied and described by different authors showing its advantages to achieve deep insight into social research problems but also its problems to achieve validity, reliability and generalisability (see for example: Martinez Salgado 1999, Atheleide and Johnston 1998, Denzin 1998, Guba and Lyncoln 1998, Usher 1997, Hammersley 1992, McNiff 1992, Rosenav 1992, Burgess 1990, Grenfell 1998, Hitchcock and Huges 1995 and 1989, Yin 1994, Hawkesworth 1989, Foot Whyte 1969 and others). Claims about the lack of validity, reliability and generalisability of qualitative methodologies have made some health promotion researchers select quantitative methodologies. This will be explained below.

Most current research in health promotion shares the disease-oriented approach resulting from the medical market hegemony discussed in chapter three (p55). This approach is expressed in the demand for quantitative approaches to health promotion research (Latter 2000, Green and Raeburn 1988, Tannahill 1985). From medical positivism, health promotion research is required to prove reliability, validity and generalisability as if the social subjects were malleable objects under scrutiny (Hawe 2000, Tones 1997, Saan 1997). Experimental, random controlled trial and other quantitative methodologies are better accepted as valid health research than qualitative, retrospective, non-randomised and low control methodologies (Wimbush and Watson 2000, Peersman et al 1999, Chalmers et all 1997, Ziglio 1996, Catford 1993). However, there are some authors that have shown the benefits of using qualitative or combined methodologies to research into health promotion (see for example: Warwik 2002, Aggleton 1999, Warwick 1998, Peersman et al 1999, Wallernstein and Freudenberg 1998, Tones 1997).

Outside the main stream of health promotion research, I needed to look for assessment criteria for this particular research. Bryman (1992) proposes four approaches to

diminish the belief that findings may be idiosyncratic: a) to study more than one case, b) to examine a number of cases by team field research, c) to seek a case which is 'typical' of a certain cluster of characteristics and d) to look for 'deviant' cases. This research complies with three of those characteristics by including different points of view and interpretation of the same phenomena, by analysing and evaluating a case which is typical of people without access to wealth and by examining the case with my research team. I also considered Bourdieu's (Bourdieu and Wacquant 1992) proposals of reflexive methodology by the use of dialogue (see below p115) in the search for objectiveness. Finally, I considered Hammersley's assessment criteria as shown in box 5.2.

BOX 5.2. ASSESSMENT CRITERIA FOR SOCIAL SCIENCES RESEARCH ACCORDING TO HAMMERSLEY* AND THIS RESEARCH

NATURAL SCIENCES	SOCIAL SCIENCES	CRITERIA APPLICATION	THIS RESEARCH
Truth value	Concern with credibility	People studied find the account true	The account was reviewed by CHTP teachers who found it true
Aplicability	Transferability	What is seen in one study can be seen in another	The selected case shares characteristics of other people with restricted access to wealth (see next section in this chapter)
Consistency	Concern with dependability	To be able to distinguish effects of the research over reality from reality phenomena	I made change analysis and evaluation from a basis of the analysis and evaluation of the initial conditions of power dynamics and processes, social structures, knowledge, subordination and health
Neutrality	Confirmability	Grounded in data	The interpretations, analysis and evaluation of this research are grounded in data

*Hammersley (1992:63)

I will explain below how I selected the site for this case study.

Criteria for the selection of the researched site

To select this research site I sought three basic conditions. First, even when the results of this research are not attempting generalisation, because of the questions it intends to answer and the selected methodology, evidence should refer to people with restricted access to health services and knowledge, hence a first requirement for the site was that it was a community of marginal people. I decided to do this empirical work in the

context of a rural community in Mexico. This decision was taken because in rural areas most inequalities flow together, including inequalities in health and in access to power as has been studied by Boltvinik (2000, 1996, 1995b, 1990), Boltvinik and Hernandez (1999), Evans (1996), Corin (1996), Marmot and Mustard (1996) and Hertzman et al (1996).

Second, this intervention required candidates with no more than basic formal education, representative of the majority of their social group and willing to join the programme[40]. Therefore a second condition to select this site was that it had people with those characteristics.

A third condition to select the site was that it ensured conditions of autonomy from institutions to be able to get testimonies and other observations without institutional pressures and also to develop the teaching programme without the restrictions of institutional programmes and rules[41].

A complementary characteristic for this site was that it had Spanish as a first language since I am a Spanish speaker and the pedagogic intervention required language understanding and also because the necessary observations to accomplish the research requirements meant avoiding language obstacles.

A final characteristic was that it was located at no more than two hours drive from Mexico City, my place of residence, to diminish transport and transport time and other administrative problems.

Having defined the research site's required characteristics, I contacted previously known NGO's people working in the area and explained this to them. They introduced me to Mino and its people. Mino met the characteristics of a site for this research as shown in box 5.3.

[40] In chapter four pp 94-96 I presented those requirements.
[41] The Health Ministry left the *pasanates* under university supervision.

BOX 5.3 NECESSARY CHARACTERISTICS FOR THIS RESEARCH'S SITE AND THE COMMUNITY OF MINO

NECESSARY CHARACTERISTICS	MINO
A community mainly composed by poor people in Mexico	A rural community with indigenous background. Its economy depending on agriculture and labour in the cities. Located in a semiarid zone with scarce resources for agriculture. With restricted access to health and disease care, school and communication resources and services.
People with no more than basic formal education willing to join the programme	Most people living in Mino have completed no more than secondary school. Because of the scarce educational offer, there are people willing to join educational offers.
Providing the conditions to be autonomous from institutions.	Institutional presence in Mino is scarce. This makes possible the development of the teaching programme with minimal institutional influence.
Spanish is its first language	Even when the old people in Mino speak Hñahñú[42], most people speak Spanish as first language.
Located at no more than two hours drive from Mexico City	It is about two hours drive from Mexico City.

OVERALL PANORAMA OF THE CHTP IMPLEMENTATION

This research intervention (a CHTP) was implemented in the community of Mino from August 1997 to March 1999. From August 1997 to January 1998, I visited Mino on five occasions to recognise and characterise the site and make preparatory arrangements with the Mino people and authorities for the implementation of the CHTP as explained further on in chapter eight. Here follows an overall view of this research intervention.

The CHTP's students were eleven local people who continued their regular activities while attending the CHTP. Pablo and Manuela were medical students in their last training year, appointed by the Health Ministry as medical *pasantes*[43], living in Mino. They were also CHTP teachers. During the CHTP implementation I had four roles: Pablo and Manuela's CHTP teaching aid, a CHTP participant observer, a research coordinator and responsible for Manuela's and Pablo's ongoing training as CHTP teachers as will be further explained in chapter eight (p184).

[42] Hñahñú is the language that Minoans spoke until two generations ago.
[43] *Pasante* is a student in his/her last year of professional training accomplishing law-statutory compulsive social service must times in rural areas in Mexico. Medical *pasantes* in some universities need to cover academic credits during their *pasante* social service year when they are authorised to attend the local medical consultancy and other medical services.

The CHTP was implemented in three physical spaces: the CHTP room; the health clinic; and students' houses, neighbourhoods and work-sites. Manuela, Pablo and the students held regular Saturday and Sunday sessions in the CHTP room. Those sessions lasted four to five hours each. I attended those sessions at least every two weeks. During the week the students had shifts to attend the health clinic medical consultation with Pablo and Manuela. The CHTP's week's work included students' attention to some families, neighbours and students' work-site health problems. Students mainly attended this work accompanied by Manuela or Pablo when required. More information about this will be provided in chapter eight (p181).

The CHTP's implementation had four overlapping stages: the CHTP start up and establishment (August 1997 to January 1998); first CHTP teaching period (February 1998 to April 1998); the second CHTP teaching period (April 1998 to October 1998); and the third CHTP teaching period (October 1998 to March 1999). Each stage corresponded to specific aims to achieve and questions to answer for the analysis and evaluation of the CHTP's processes and outcome. Since I needed to be sure that the CHTP was implemented as intended - thus keeping the flexible characteristics of a self-growing pedagogy-, I looked for aims to achieve and questions to answer at each stage to evaluate and make the necessary changes to the CHTP process. Those aims and questions are presented in box 5.4.

BOX 5.4. CHTP IMPLEMENTATION STAGES, AIMS AND QUESTIONS FOR PROCESS AND OUTCOME EVALUATION

STAGE	AIMS	QUESTIONS
STAGE 1 Aug 1997-Jan 1998 CHTP START UP AND ESTABLISHMENT	-To recognise the site. -To establish links with Minoans. -To achieve first agreements. -To find departure points for the CHTP. -To recruit students.	PROCESS 1.Were we on track? 2. Were there any problems that needed special attention? 3. What action did we take to improve the CHTP performance?
STAGE 2 Feb 1998-Apr 1998 FIRST CHTP PERIOD	-To develop a self-growing environment. -To develop communication, dialogue, perception, observation, enquiring and study skills. -To find out student's conceptions about health, disease, teaching and learning. -To define the CHTP problems through observation of students' perception of their reality.	PROCESS 1.Was the CHTP implemented as intended? 2. In which aspect were the greatest process benefits and costs? 3. How did this intervention proceed to stage three?
STAGE 3 Apr 1998-Oct 1998 SECOND CHTP PERIOD	-To develop and consolidate a self-growing environment. -To approach problems raised by students. -To develop and exercise already developed communication, dialogue, perception, observation, inquiring and study skills. -To identify students' developing identity. -To develop planning and performance skills.	PROCESS 1.Was the CHTP implemented as intended? 2. In which aspect were the greatest process benefits and costs? 3. How did this intervention proceed to stage four?
STAGE 4 Oct 1998-March 1999 THIRD CHTP PERIOD	-To strengthen a self-growing environment and self-growing skills and knowledge already developed. -To develop students' autonomy and self-reliance. -To face community demand's to students.	PROCESS 1.Was the CHTP implemented as intended? 2. In which aspect were the greatest process benefits and costs? OUTCOME 1.To what extent was the CHTP's intended outcome achieved? 2. In which aspects are the greatest changes shown through the CHTP's implementation? 3. What were the costs of the CHTP? implementation for the CHTP's participants? 4. How did CHTP influence or did not influence knowledge and subordination/hegemony change?

Stage one's aims were defined before approaching this research site. Stage two's (the first CHTP period) aims were mainly defined before approaching Mino, however they were adapted to observations derived from first contacts with the site and with Mino's Assembly which acted as gate-keeper. The aims for the third and four stages (the second and third CHTP periods) were progressively defined with students. The questions presented for each stage provided process and outcome evaluation guidelines.

As it has been explained and discussed in chapter four (p97), the self-growing pedagogy proposed that by deconstructing the problems brought by the students to the CHTP as problems of their reality, they will be producing knowledge embedded in their values and meanings and also proposed that problem deconstruction could be done through the practice of dialogue. Here I provide a definition of dialogue.

Dialogue

The notion of dialogue can be traced back to ancient Greece. Dialogue can be considered as the process of building and sharing meaning if we retain its Greek roots: *dia* (through) and *logos* (meaning). However, some other interpretations of dialogue consider it a mode of being with others, a method, technique or procedure, a way of living with an 'other' (Abma 2001, Green 2001, Karlsson 2001, Schwandt 2001, Widdershoven 2001, Bohm 1996, Bubber 1970 and1961). Since the nineteen seventies, Paulo Freire launched the term 'dialogue', a dialogue methodology and an epistemology of dialogue, into popular and adult education. A common place to all dialogue understanding is its interactive nature and its aim to develop meanings and values. Vanderplaat (1995) proposes that understanding emerging from different perspectives and interpretations can be seen as 'illuminative evaluation'. A characteristic of dialogue is to see, record and interpret reality from different points of view.

For the purposes of this research I defined dialogue as: the practice and process of building individual and collective meanings, values and knowledge where two or more individuals share their own meanings values and knowledge aiming to interpret and understand reality from different points of view and in a better way if compared with individual isolated understanding. As has been explained in chapter four (pp 84, 92, 100), dialogue is a basic tool for the development of the CHTP's self-growing pedagogy. Therefore, for the analysis and evaluation of the CHTP's implementation, most research evidence was constructed and collected through and from the practice of dialogue.

DATA COLLECTION

Case context

The case context, the community of Mino, was analysed from previous local or regional studies and from fieldwork information collected during the four phases of this

research presented in previous paragraphs. Fieldwork information included oral, written or other semantic manifestations of human action in Mino. Thus the informants were multiple including all ages, men and women, Minoans and visitors to Mino, merchants or politicians visiting Mino and others. Box 5.5. shows the places where the information for the development of the case context was collected and the kind of information obtained in those places. Observe and recording information were continuous activities carried out by Manuela, Pablo and myself. The information collected for the case context was recorded in fieldwork notes (Fwon), Manuela's, Pablo's and my diaries (Md, Pd, Cd) or tape- recorded (Tr). A description of those registers is made in further paragraphs (pp 118-122).

BOX 5.5. PLACES WHERE THE INFORMATION TO EXAMINE THE CASE CONTEXT WAS COLLECTED

	School	Houses	Parties	Festivities	Living in Mino	Assembly	Church	Health clinic	Medical visits to houses	Library	Literary resources	CHTP
HISTORY	X	X			X				X		X	X
GENERAL CHARACTERISTICS	X				X		X				X	
ORGANISATION		X	X	X	X	X				X		X
FAMILY	X	X	X	X	X			X	X	X		X
SEXUALITY AND GENDER	X	X	X	X	X	X	X	X	X	X		X
KNOWLEDGE	X	X	X	X	X	X	X	X	X	X	X	X
HEALTH PRACTICES	X	X	X	X	X			X	X	X		X
INSTITUTIONS	X	X	X	X	X	X	X	X	X	X		X

For this case study, to transform specific information into valid and reliable data, which is often problematic in qualitative methodologies, I made sure that it had been registered in the same way in at least three records or three different times or from three similar testimonies as means of triangulation[44].

[44] Cohen and Manion (1997), Kemms (2001), Mcdonald (2000), Murphy (1998), Tones (1999), Janesik (1998), Vanderplaat (1995) and other authors propose that qualitative methodology rigour can be achieved by looking at the same object of reality from different perspectives to look for coincidences and differences, thus by means of 'triangulating' information. Triangulation can be done by triangulating data, authors, theory, methodology or disciplines. Brombley (1986) proposes that the collective interpretation of the best available evidence can stand as another way of triangulation.

The CHTP

The research intervention (the CHTP) was analysed and evaluated from information collected in classroom and other CHTP activities, evaluations with teachers and with students, from external observers and during other CHTP activities. The observers, regularity of the observations, the records and kind of information collected for the CHTP's process and outcome evaluation is shown below in box 5.6.

BOX 5.6. CHTP OBSERVATION AND REGISTERS

OBSERVATION	OBSERVERS	REGULARITY	INSTRUMENTS	KIND OF INFORMATION
CLASSROOM AND OTHER CHTP ACTIVITIES	Teachers and I	During weekend sessions	Classrroom observation notes (Cron), flipcharts (Fc), tape recording (Tr), fieldwork observation notes (Fwon).	-Students and teacher's habitus. -'Self' and 'other' recognition. -Emotions and reflexiveness. -Fields dynamics (positioning and position taking). -Symbolic violence. -Students and teachers' knowledge and knowledge development. -Application of knowledge to detect, analyse, evaluate and confront problems of reality. -Teaching environment.
EVALUATION WITH TEACHERS	Teachers and I	Twice a month	Pablo, Martha and my diaries (Pd, Md, Cd), tape recording (Tr), my notes (Etn).	-Knowledge and habitus. -Individual and collective satisfaction and perception of change. -Field dynamics and links with collective problems in Mino. -Students, teachers and group progress, problems and necessities. -Teaching methods, aids, programming, etc., -Closeness to the CHTP's self-growing pedagogy.
EVALUATION WITH STUDENTS	Teachers and I	When community, group or student's problems needed to be analysed. At the beginning and end of each session.	Pablo, Martha and my diaries (Pd, Md, Cd), tape recording (Tr), my notes (Esn).	-Individual and group satisfaction. -Individual and collective perception of skills and knowledge development. -Identity. -Links of their new expertise with collective problems. -Individual and group problems generated from the CHTP. -The CHTP contents, logistic and teaching.
THE CHTP'S CLASSROOM OBSERVATION MADE BY OUTSIDE OBSERVERS	Outside observers	Programmed visits to CHTP	Verbal or written reports, notes, tape recording (On)	-What they could perceive from teacher/student relationships and the CHTP's teaching environment and contents
THE CHTP'S CONTEXT	Teachers and I	Every day	Pablo, Martha and my diaries (Pd, Md, Cd), tape recording (Tr), fieldwork observation notes (Fwon).	-What they could perceive from teacher/student relationships and the CHTP's teaching environment and contents

We held two to three evaluation sessions with teachers at least every two weeks. In those sessions we organised contents and strategies for the following sessions. These evaluations helped us to observe, analyse, evaluate and define necessary changes to the CHTP's development; to assess our learning and performance and to evaluate this research action. The information produced in those sessions was recorded either in my notes and our diaries or tape- recorded.

Following the same pattern as the evaluation with teachers, Manuela and Pablo carried out most evaluations with students. These evaluations were not regular since they were done when problems appeared, when they needed to move from one topic to another, or in response to other circumstances requiring evaluation. In every session with students we had an evaluation summary of the previous session and at the end of each day we closed with another evaluation summary where students were asked to elicit observations and make criticisms and proposals. The main issues raised in these evaluations were recorded on flip charts, in written notes or tape-recorded.

At the beginning and at the end of the second CHTP stage and during the fourth CHTP stage I invited people -that showed an interest in the project and who had the time and disposition to visit us in Mino- to observe and provide us with feedback information about what they observed. I called those visitors 'outside observers'. Before their visit I explained them the rationale, objectives and practice of the CHTP and asked them to be as objective, critical and accurate as possible for their observations, since we needed that to improve our collective work. Observers included a lady with no university studies, five university students -two medical, one communication, one agronomy and one veterinary- and two young men with previous experience in rural adult education. After each visit to the CHTP sessions I asked external observers for feedback and took notes. The medical students did a written report of their observations.

Observation records

The information obtained as described above, was recorded in Pablo's, Manuela's and my diaries (Pd, Md, Cd), classroom observation notes (Cron), tape recording (Tr), flipcharts (Fc) and my notes about classroom observation by outside observers (On).

I registered most classroom observation (Cron) during my weekend sessions in Mino. I also used flipcharts and tape-recorded specific sessions.

Tape recording (Tr) was done when we identified discussion richness that could not be registered with classroom observation notes only. Every time we required tape-recording, Pablo, Manuela and I asked for students' authorisation. Sometimes, the

students themselves asked us to record what they were saying. Manuela, Pablo and I heard the tapes on two occasions during the CHTP and three more after the fourth CHTP stage and together decided what parts of the tapes were more representative of what was happening in and through the CHTP. Those were edited and typed for further analysis and evaluation.

Pablo, Manuela and I kept a diary each (Pd, Md, Cd). The diaries had two sides: on the right-hand page we wrote our objective observations and comments, on the left-hand page we wrote our subjective perceptions about what we had registered on the other side of the diary. The left-hand side also included feelings or other subjective comments about the whole work in Mino.

The CHTP teachers and students used flipcharts as teaching aids, replacing the blackboard. I kept flipchart (Fc) samples for the research analysis and evaluation. I also took written notes on classroom observations and notes of evaluations and other fieldwork notes. Finally, I considered the reports of outside CHTP observers and my notes about their observations, (On) another observation record.

Ethical issues: Confidentiality, anonymity and informed consent

To implement this research in line with current ethical standards, I considered informants' anonymity, confidentiality and informed consent as explained below.

Confidentiality

Because of the characteristics of this intervention, the students wanted to share their problems, information, feelings and opinions with us and each other. Sometimes, they shared these with me in private and later on they wanted to talk about these with other students or teachers. Since the beginning of the CHTP we discussed with the students that Manuela, Pablo and I would use private information only for the CHTP activities and purposes when it had been opened to the CHTP group. In this way, this information was under the students' control.

Anonymity

To achieve anonymity, I have changed the names of teachers and students in this work. Also, I don't provide or otherwise change the names of other informants whose testimonies will be presented in the next chapters. I also concealed the geographical location of the research site.

Informed consent

As will be described in chapter eight, we presented this project for discussion and acceptance to the local Assembly that is the main authority in Mino. In appendix three can be found the written proposal for the Assembly that specifically indicated that this was a research project. This was also repeated and confirmed every time we attended the Assembly to give reports or to ask for authorisation about different issues raised during the CHTP implementation. Finally, during the CHTP sessions the issue of the research was often elicited as part of other discussions.

What counted as 'data' for the research analysis and evaluation

To pursue research reliability and validity, I considered data for the analysis and evaluation of the CHTP: First, information that had been registered in the same way in at least three records or at three different times or from three similar testimonies, as a means of triangulation[45]. Second, information produced through dialogue as explained below.

As presented in the previous section (p115), for the purposes of this research I defined dialogue as: 'the practice and process of building individual and collective meanings, values and knowledge where two or more individuals share their own meanings, values and knowledge aiming to interpret and understand reality from different points of view and in a better way when compared with individual isolated understanding'. According to this definition, in dialogue, the same object of reality is seen from different points of view and, to see reality from different points of view is a means of triangulation. In this

[45] See previous foot note in p 116.

way I considered as data the information about a specific situation, emotion or object of reality that had been expressed in dialogue between at least two CHTP participants in the same way or the new information resulting from the practice of dialogue between at least three participants and expressing the points of view of all people participating in the dialogue. The information product of dialogue was recorded as explained in previous paragraphs.

DATA ANALYSIS

This research was guided by the two main questions presented in box 5.1 (p108). Question one asks for information about the present situation of the power dynamics in a specific site and of specific people. Question two asks for information and evaluation about changes in that situation occurring as the result of a planned pedagogic intervention.

Question one requires a descriptive response, to answer it I first described the site and the situation of the people living at the site using the data collected as referred to before. Then I interpreted it in the light of the concepts of hegemony, fields, doxa and habitus, knowledge, health and healthy subjects as presented in chapters two and three.

Question two calls for an evaluative response. To answer question two, I organised and analysed data with the aid of process and outcome indicators. These process and outcome indicators derived from the theory supporting the self-growing pedagogic model (p103) and the model of a healthy subject (p77), therefore before the implementation of CHTP. I followed the steps presented below for the construction and use of those indicators in the evaluation of the pedagogic intervention.

Step 1. To find out what to include as observable process information about the CHTP

In chapter four (p97) I presented the characteristics of a self-growing pedagogy and the practices to dislocate habitus, necessary for a pedagogy of emancipation. These were summarised in boxes 4.6 (p96) 'Traditional and emancipatory syllabus', 4.9 (p100) 'Self-growing teaching and environment characteristics' and 4.10 (p101) 'Teachers characteristics for a self-growing pedagogy and 4.7 (p97) 'CHTP practices aiming to

dislocate habitus'. Those characteristics are the observable information to assess the closeness of the CHTP's practice with the planned CHTP.

Step 2. To define indicators of self-growing pedagogy

Boxes 4.6 (p96), 4.9 (p100) and 4.10 (p101) contained the characteristics of a self-growing pedagogy, which was the chosen pedagogy for the CHTP. I considered that the presence or absence of these characteristics in the CHTP's development should show if the CHTP had been developed as required for a self-growing pedagogy. In this way, a first process indicator was the degree to which the CHTP syllabus had the emancipatory characteristics shown in box 4.6 (p96). A second process indicator was the degree to which CHTP teachers had the self-growing characteristics shown in box 4.10 (p101). And a third process indicator was the degree to which the CHTP teaching and environment had the self-growing teaching and environment characteristics shown in box 4.9 (p100).

Step 3. To define process indicators of habitus dislocation

In box 4.7 (p97) 'HCTP practices aiming to dislocate habitus' are the necessary practices to dislocate habitus for the purposes of this pedagogic intervention. Those practices are related with: 1) cultural capital, 2) cultural arbitrariness, 3) the processes of habitus construction and 4) the conformation and functioning of the medical field. From these I constructed process indicators four to seven that should show the degree to which those practices aiming to dislocate habitus were present in the CHTP.

The seven process indicators are shown in box 5.9 (p126).

Step 4. To find out what to change through a pedagogy of emancipation

Taking as starting point the questions and answers raised in box 4.1 (p88) 'What to change, what to include and what to observe for a pedagogy of emancipation' I constructed the list of answers presented in box 5.7.

BOX 5.7. ANSWERS REFERRING TO OUTCOME

WHAT TO CHANGE?	WHAT TO OBSERVE?
1. Subordination to medical hegemony. 2. Mino's health capital. 3. Doctor/patient symbolic violence. 4. Difference focus. 5. Students position and position-taking within their community. 6. Restricted access to overall wealth. 7. Health and disease patterns. 8. The health market-subjected subject (client). 9. The practice of subjects participating in the CHTP. 10. Health knowledge value, validity and validation. 11. The CHTP participants' *noematic* and *noetic* health knowledge. 12. The CHTP participants' human interest in health knowledge. 13. Health knowledge and practices meaning. 14. Hegemonic health promotion conceptions and practices. 15. Hegemonic adult education conceptions and practices. 16. Teacher, student and teaching conceptions and practices. 17. Health teaching programmes. 18. Fear of freedom. 19. Subjugated knowledge. 20. Restricted health teaching programmes codes and frames. 21. Restricted access to voice. 22. Body inscriptions. 23. Subjugated health.	1. CHTP participants practice in their respective fields and in the CHTP field. 2. Construction of fields of opinion when solving health problems. 3. *Noesis* development. 4. Human interests in health knowledge. 5. Relations and development of common sense, popular and expert health knowledge. 6. Relations and awareness of fake and institutionalised health knowledge. 7. Health knowledge relations with health market. 8. Processes of health knowledge construction and reconstruction. 9. Developing of knowing health subjects. 10. Developing of health capital exchange networks. 11. Empowerment through CHTP practices. 12. Voice development. 13. Body inscriptions change. 14. Health development.

Step 5. To organise answers about outcome

After examining the twenty- three answers related to the CHTP's outcomes in list 'what to change' and the fourteen in list what to observe? I identified four broad answers containing the others as shown in box 5.8.

BOX 5.8. OUTCOME ANSWERS

	ANSWERS IN LIST A	ANSWERS IN LIST B
SUBORDINATION (1)	3, 8, 14, 15, 17, 19, 20,21, 22,23	2, 3, 4, 6, 7, 9, 11, 12, 14
DIFFERENCE (4)	9, 5, 12, 13, 15, 16, 17, 20	1, 2, 3, 5, 6, 7, 8, 9, 10, 11
SUBJUGATED KNOWLEDGE (19)	2, 5, 6, 9, 10, 11, 16, 17, 18, 20, 21, 23	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14
BODY INSCRIPTIONS (22)	7	5, 13

Step 6. To define outcome indicators

From step five I did a broad classification of outcome indicators as they referred to subordination, difference, subjugated knowledge and body inscriptions. Then I examined each set of answers to find out what elements they had in common. I found that those answers could be organised in fifteen groups as follows: five referred to subordination change, four to difference change, five to subjugated knowledge change and one to body inscriptions change. I considered each group as an outcome indicator. These indicators are shown in box 5.9 below.

BOX 5.9. CHTP PROCESS AND OUTCOME INDICATORS[46]

PROCESS INDICATORS		OUTCOME INDICATORS	
IMPLEMENTATION ASPECTS	INDICATORS	ASPECTS TO CHANGE	INDICATORS
FOLLOWING A SELF- GROWING PEDAGOGY	1.Emancipatory CHTP syllabus. 2. Ideal CHTP teachers' characteristics. 3. Self-growing teaching and environment characteristics.	SUBORDINATION	1.Recognition of subordination. 2. Habitus awareness. 3. Construction of fields of opinion 4. Human interests in health knowledge. 5. Development of voice.
DEVELOPING PROCESS TO DISLOCATE HABITUS	4. Self-growing practices related to cultural capital building, aiming to dislocate habitus. 5. Self-growing practices related to cultural arbitrariness aiming to dislocate habitus. 6. Self-growing practices related to habitus building processes, aiming to dislocate habitus. 7. Self-growing practices related to medical field conformation and functioning, aiming to dislocate habitus.	DIFFERENCE	6. 'Self' and 'other' awareness through the CHTP's practices. 7. CHTP participants' practice in their respective fields and in CHTP field. 8. Development of health capital exchange networks. 9. Construction of specific students' meanings and values.
		SUBJUGATED KNOWLEDGE	10. *Noesis* development. 11. Knowledge value and validity conferred by students. 12. Awareness and identification of fake and institutionalised knowledge and their relations with the health market. 13. CHTP participants' awareness of their knowing capacity. 14. Developing and use of common sense, popular and expert knowledge to solve problems of reality.
		BODY INSCRIPTIONS	15. Change in body inscriptions.

[46] As argued in page 122, these indicators were conceived before the implementation of CHTP.

Step 7. Method for the analysis of process indicators

To analyse process indicators, I triangulated information to construct each utterance of a 'vivid description' of the CHTP which will be presented in chapter eight thus, each utterance counted as triangulated data.

I selected the triangulated data for the construction of 'the vivid description' with two guidlines. A first guidline was the indicators that I constructed to evaluate the CHTP's processes and desired outcomes. A second guidline was that the description reflected as complete as possible what happened in the CHTP.

In box 5.10 I give examples of progressive numbering of the utterances in the CHTP's 'vivid' description. The 'vivid description' is presented in chapter eight and -separated in utterances and numbered- in appendice five at the end of this thesis.

BOX 5.10. EXAMPLES OF NUMBERED UTTERANCES

(226) An example of that is a testimony of an encounter of Elvira with a hospital medical doctor. Elvira's father is being attended for heart problems in a social security hospital.
(227) [Elisa asked the doctor in charge about her father's diagnosis.
(228) [The doctor answered] '*he has a heart valve insufficiency*'. [Elvira inquired]: '*which valve is affected*? *The doctor was confused and answered in an authoritarian and rude way*: *I don't have to give you any further explanation. Besides that, you could not possible understand. It is not my duty to explain. I am just being kind to you by informing you... and he left*' (Cron, Md, Pd)[47].

(229) Students analysed different characteristics and consequences of Elvira's father heart valve problem, the consequences of being attended to in a social security hospital, the characteristics of the medical services and their new position in relation to doctors amongst other analyses.

Manuela, Pablo, and I matched the utterances with the correspondent process indicator as shown in appendix six. Here I give an example taken from process indicator one 'Emancipatory syllabus' (see box 5.11).

[47] For further information about data sources see pp 118-122 in this chapter.

BOX 5.11. EXAMPLES OF MATCHED UTTERANCES

CURRICULAR ASPECT	SELF-GROWING PEDAGOGY	STAGE 1	STAGE 2	STAGE 3
1.3 SETTING	Student's	8, 10, 23, 24, 45, 74, 78, 79	110, 113-117, 119-120, 125-127, 128-131, 186-194, 207-209, 214-216	214-216, 223-225, 237, 242-265, 272-285, 288-294, 295-296, 298-305, 311-316, 317-320, 321-323
1.4 CONTEXT	Collective. Non institutional.	8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 24, 27, 29	113-117, 145.1-145.2	231-236, 237, 238-239, 242-265, 267-270, 272-285, 317-320, 344-345
2.1 KNOWLEDGE EMPHASIS	Tools to translate. Tools to construct meaningful knowledge.	21, 56	125-127, 128-131, 146-170, 172-176, 177-181, 182-185, 186-194, 195-202	214-216, 324-327, 329-330

I drew conclusions about the CHTP's implementation based on the presence/absence of evidence for each indicator to answer the process questions raised in box 5.4 (p114). This analysis showed how close the actual implemented CHTP was to the programmed CHTP.

Step 8. Method for the analysis of outcome indicators

To assess the CHTP outcomes I constructed first a contextual baseline, as explained in p 115, to contrast CHTP results and evaluate change. The results of this base line are presented in chapters six (p130) and seven (p154). This baseline was enrichened by first CHTP observations and by the testimonies that the students provided during CHTP. Then, I looked for evidence of change for each of the fifteen outcome indicators. This evidence was taken from the numbered utterances described above in step six and also from other information collected and triangulated as described in previous sections in this chapter (pp118-122). I drew conclusions about how much change was achieved through the CHTP from the assessment of the outcome indicators. From these conclusions I answered the questions about outcome raised in box 5.4 (p114).

CONCLUSIONS

This research analysed and evaluated change that had occurred as the result of a particular pedagogic intervention. To do this I needed to assess first the present situation of a specific group of people, then to assess how close the practice of that

intervention was to the planned intervention and finally, to assess to what degree change had occurred and at what costs.

The focus on power, knowledge, meanings and values of this research required very close observation of the subjective and objective dimensions of specific persons. Also, the characteristics of the intervention required the development of confidence and accountability amongst teachers and students. For these reasons I selected a qualitative methodology.

I defined dialogue in this chapter as 'the practice and process of building individual and collective meanings, values and knowledge where two or more individuals share their own meanings values and knowledge aiming to interpret and understand reality from different points of view and in a better way when compared with isolated individual understanding'. I argued that, it is possible to use dialogue for the collection of data and explained why I considered the data that were produced during CHTP dialogic practices, triangulated data. I finally explained in this chapter that I analysed and evaluated CHTP processes and outcomes with the aid of indicators and showed how I constructed, analysed and evaluated them.

CHAPTER 6
MINO: GENERAL CHARACTERISTICS OF THE RESEARCH SITE

The third phase of this research was the implementation and evaluation of a pedagogic intervention specifically designed to improve the health of people participating in it. Chapters six to nine of the thesis result from this phase. In this chapter I present the research site and analyse and evaluate its general characteristics of power dynamics that will be considered as the baseline for the evaluation of change resulting from the pedagogic intervention. I use the concepts about power and social structures presented in chapter two to examine the situation of this site. First in this chapter I present the history of Mino and its general geographical and physical characteristics. Then I proceed to describe some of its socio-demographic characteristics: population, language, economy, local organisation, family, education and religion. This section has been constructed from documents and literature on the topic and also from fieldwork observations as described in chapter five (p115). The description of Mino helps in the examination of hegemony in Mino presented in the last part of this chapter.

MINO

At the entrance to a semi-desert area about two hours driving distance from Mexico City is the rural community of Mino. Until two generations ago, Mino was recognized by outsiders and local people as an Indian locality since they regarded themselves as *Hñä hñü*[48] and spoke their indigenous language.

Minoans' historical background

The Hñä hñü were the first habitants in this area (Mendizabal 1974 in Guerrero 1983, García 1992). The Hñä hñü presence is clear in regional legends and traditions,

[48] Hñä hñü is the name they give to themselves meaning '*hñä*' (to speak) and '*hñü*' (our people): those who speak our language.

paintings[49], in the towns' and communities' names and in the local language (Tranfo 1980:29). Their ancient Aztec rulers called the Hñä hñüs 'Otomí'. According to Tranfo (1980) Otomí is a derivation of the Aztec word 'ototac' (the one that walks) and 'mitl' (the arrow), indicating that the Otomí were known as hunters, always walking and carrying arrows. Otomí is also the fusion of two semantic terms: '*othó*', with no possession and '*mi*' the place, leading to a composed word meaning 'people without residence' that is, nomads. Since before the Spanish invasion in 1530, the Hñä hñü regarded land a collective responsibility. During the Spanish colonisation, the Spanish individualistic way of living clashed with the Hñä hñü collective life. In the XVI century the theologian Sepúlveda illustrated this collective understanding of life and also the Spanish contempt for it in the following quote:

> *...those little men in whom one can hardly find human traces, those who don't have any science, and don't even know the alphabet or keep any moment of their history but an obscure reminiscence of some things in their paintings neither they have written laws, but barbaric institutions ... nobody possess individually any thing ...* (cit in García 1994:14).

The Spanish kept the Hñä hñü as servants or slaves within the '*haciendas*'[50] and forced them to congregate in towns. There, the Hñä hñü population decreased due to diseases and poor living conditions.

After the demise of Spanish colonisation, the 1810 Mexican Independence and the 1910 Mexican Revolution the Hñä hñü historic situation of poverty did not improve considerably. The 1910 Revolution reassigned the *hacienda* to private-communal land ownership: the *ejido*[51]. There was very little change in characteristics of poverty the Minoans'until the 1960s. In the late 1960s, certain Hñä hñü areas were included in an agricultural water supply programme benefiting from residual water. Minoans did not

[49] Representative of this is the monastery of Ixmiquilpan (built by the Hña hñu) where the Hñä hñü paintings are mixed with the Spanish (Guerrero 1983).

[50] *Hacienda.* A way of local organisation and land ownership where an *hacendado* (the *hacienda* master) owns big amounts of land that is worked by *peones*, people living and working in the *hacienda*. The *peones* should use their scarce wages to buy food and goods in the *hacienda* shop. When the *peón* did not have enough money to buy basic food or goods, they should ask for loans in the *hacienda* shop. That kept the *peones* and their children always in debt with the *hacendados*. The *hacienda* is supposed to have been eradicated from Mexican laws, however in different parts of the Country, as is the case of the state of this research site, can still be found traces of it.

[51] *Ejido.* A way of land-tenancy created after the 1910 Revolution. The *ejido* belongs to a community as far as one man of each family works the land. Otherwise it is governments' property. The community can't sell it. It is through local organisation that the *ejido* is distributed between local families. The *ejido* was recognised by the government as a concession to the community. Presently, there had been law changes against the *ejido* property that leave marginal *campesinos* more exposed to loose their land.

benefit directly from that project. However, they moved towards more economic, social and cultural links with the city.

The development in the 1970s of a nearby industrial complex and the introduction of a motorway running across Mino, modified Mino's economy and environment. Since the 1980s, Minoans started a continuous migration to large cities, expelled by their poor living conditions. This migration rose in the 1990s (García 1998, Fournier 1993, García 1992).

The long history of local and regional natural resources exploitation and of the Hnä hñü themselves, has contributed to a panorama adverse to the survival of the community of Mino (Guerrero 1983).

General characteristics of Mino

Mino used to be a forest. However, throughout the years, the wood used to bake earth-pots in Mino was taken, and not replaced, from trees in the area. Now, Mino is semi-desert with an annual rainfall of around four hundred millimetres (López et al 1988). Its coldest month is February with frost from November to February. Mino's soil is poor in organic content, compact, alkaline and containing chalk, thus producing water filtration with little value for agriculture (García 1992).

Some houses are concentrated in a village centre and the rest scattered throughout Mino. In the village centre are the local church, a basketball field, a kiosk and a square. Surrounding, or close to, the square are most buildings used for collective purposes: the elementary school, the nursery school, the village hall where the local government has its offices, two private tortilla mills and another owned by the community, two *pulquerías*[52], a small grocery, the CONASUPO[53], a stationery and a small shop -which has the only telephone box in the village, which has only been working for two years-,

[52] *Pulque* is an alcoholic drink. It is fermented *maguey* milk. Until very recently it was used as the most important alcoholic drink and, before fermentation, as maternal milk replacement for small children. Once highly appreciated locally and regionally, it has been replaced by industrialised bottled beer in the last decade. '*Pulquería*': a place where '*pulque*' is sold.
[53] CONASUPO, a low price basic products shop with governmental subsidy.

two *maquila*[54] tailoring workshops, a recently built health clinic, a series of rooms built in the 1940s -where the first school teachers used to live- and two public latrines. About five hundred meters to the east of the square there is the just finished 'secondary school run through television' and the water wells for domestic and agricultural service. Only the main street in Mino is paved (García and Gómez 1998). In the last decade, some of the dwellings -traditionally built with perishable materials- were replaced by small houses made of endurable materials.

In the 1960s the people of Mino introduced water services through collective work and resources, thus most of the population has a water tap in their house yard. There are also public water taps constructed by the Health Ministry. The water comes from a well and is chlorinated by the Health Ministry. Most dwellings and houses have no sewage or latrines. Hence, most of the population defecates on the open soil. Almost every dwelling or house has electricity but there are frequent black-outs. Minoans get butane gas for fuel in portable containers but, since it is expensive for the local economy, they also use wood and dried *maguey* leaves as domestic fuel (García and Gómez 1998).

Population

Mino has fewer than 800 permanent residents. Young people below twenty represent about 45% of the population. 17% of the population older than fifty. About 47% are males. For the group 20 - 25 years old there is a proportion of 2.3 females to 1 male. The age group 25-29 has a relation of 1.5 females to 1 male. The scarcity of Minoan men can be explained by their emigration to the cities while women and children stay in Mino. In 1995 the Emigrant Population Accumulated Rate[55] in the area was 28.2, that is, 9.4 points above the national rate (INEGI 1997). Between 1994 and 1996, the total population in Mino had a tendency to remain constant. In 1997 the population decreased 10.7% even when the birth rate for 1000 habitants rose from 8.5 in 1994 to 38.2 in 1997. The decrease in the population cannot be explained by the rise in mortality -which in 1994 was 4.9% and in 1997 0.6%-, but by migration. In 1998,

[54] *Maquila* is the name of labour processing parts of a product. In this case, clothes and lingerie.
[55] Emigrant Population Accumulated Rate expresses the number of people born in a specific entity living on a different one, shown in relation with the total population per 100 inhabitants.

during this research fieldwork the population lost 21 inhabitants that is, about 2.6% (García and Gómez 1998).

Language

Until the 1950s all Minoans spoke Hñä hñü. Spanish was imposed at the end of the 1940s with the introduction of the elementary school whose teaching policy and practice was to 'incorporate' the ethnic groups to 'national life'. The grandparents did not have a command of Spanish; therefore their children got their language from school or from outsiders. In the last generation, the Hñä hñü language practically disappeared. In 1990 Mino had 99 (9.9%) registered Hñä hñü speakers (IX Censo General de Población 1990).

Economy

Minoans mainly produce corn, beans, *chile*, tomato and cabbage. Most corn and beans production is for family use. People in Mino keep cattle, poultry and other domestic animals as a family food reservoir for bad times or for social or religious celebrations. For instance, Minoans remember 1998 (when I started this research) as the worst dry and hot season they can recall. This resulted in death for their cattle. That year, the crops were planted as late as September and then torrential rains replaced the dry weather, also harming the crops.

Local tailoring workshops are one principal income source for Minoans living in Mino. In the last fifteen years Minoans, with the support of an NGO, organised three tailoring workshops owned by the workers and employing approximately 130 people, most of them local women. The *maquila*[56] work comes from merchants in Mexico City. Two other workshops were built with the municipal authority's support. In the middle of 1999, for the first time a new workshop as a family business was installed.

[56] *Maquila*: see foot note 53 in p133.

Minoans also produce *pulque*[57], pottery and bricks to contruct houses. *Pulque* production is sold directly to local people. *Pulque* sales dropped with the introduction of industrialised beer. In the past, the production of pottery was the source of the main family income in Mino. With the development of the plastic and metal industries local earth-pottery production collapsed and nearly disappeared (López et al 1988). There are two local families working as '*acaparadores*'[58], who sell pottery to city merchants or to tourists passing by on the motorway. The bricks produced in Mino are mainly for local use.

Minoans in the city receive salaries working as blue and white-collar workers, casual employees, masons, domestic workers, gardeners, etc. Some families in Mino receive part of those salaries as their only income. Other income for Minoans comes from their ownership of small local shops or stalls.

Local organisation

Because of the collective way of life and the size of Mino, it is not possible to make a distinction between its political and economic structures. Despite the cultural relations with Mexico City and the loss of their native Hñä hñü language, most decisions affecting Mino's collective life are taken in the local Assembly, which is their main authority and principal social structure.

Political and economic structure: The Assembly

The basic political and economic structure in Mino is the Assembly. Mino's Assembly shares the characteristics of Mexican and Meso-American indigenous assemblies described for example by Paoli (1998), Lenkersdorf (1996) and Castro (1989). Indigenous representations include their perception of one-whole-self where everything in nature (human beings included) is interlocked and has value in itself, for itself and for others. Mino's Assembly expresses those perceptions.

[57] Pulque: see foot note 51 (p132)
[58] *Acaparadores*: people that gets the production of small producers to sell it with high revenues.

The Assembly is at the heart of community life where all sort of collective and even individual matters are discussed. All adults, men and women, are expected to attend the Assembly that is summoned regularly, at weekends, every two months or when an extraordinary problem emerges. Minoans living in the cities attend the Assembly on a non-regular basis, often when their family interests are directly affected by some situation. All male adults will eventually become an 'authority' with the exception of those that are not recognised as respectable or capable, because they have shown 'irresponsible' behaviour, such as to be continuously drunk or looking for fights. Most Minoans and visitors or other people coming from outside Mino respect the Assembly agreements.

Standard Mexican forms of local government operate through the Assembly in Mino. Minoans refer to different people with a post in the Assembly that had been elected through the Assembly as an 'authority'. The Assembly is chaired by a 'delegate' that is in charge of the Assembly and local problems, a 'municipal commissioner' who is a link with the municipal (regional) government and the '*Comisariado ejidal*' that is the main authority for the *ejido*[59]. There are a maximum number of individual authorities in Mino. The authorities and their deputies are elected every year on a rota basis. Each authority is in charge for six months and then replaced by their deputies. There are 14 policemen coordinated by a police officer who, in couples, will be in charge of police duties one day a week for one year. The policemen are also elected on a rota basis. For specific tasks such as clean water provision, to look after the school, the health service and the church, there are specific committees composed on a semi-voluntary basis, ratified or elected by the Assembly. When necessary, the committees have to refer to the regional government for the solution to specific problems. All authorities and committees are expected to keep the Assembly informed about general and specific problems and take directions from the Assembly. The health committee does not only respond to collective or individual demands but also to institutional demands raised by the health clinic or through other Health Ministry activities.

An authority is expected to do as the Assembly decides. The authority and committees' duties are considered as a service to collective life and performed without payment.

[59] For an explanation of *ejido* see footnote 50 (p131).

Authorities are respected and their functions are seen as necessary, yet, to become an authority represents less time for farming and other economic labour. In that way authority posts are not sought after as political positioning or as a means to wealth or power.

A problem in Mino arises when their collective life's infrastructure, symbolic or material, is affected. Their infrastructure can be affected because of internal changes (material or symbolic) or because of non-Minoans' action affecting Mino's life. Examples of the first are the appointment of authorities, the weather influences on crops, internal production and market organisation, land boundary disputes, collective buildings maintenance and utilisation, local festivities' organisation, individual behaviours and, occasionally, disease problems. Examples of non-Minoan's action affecting Mino's life are: the behaviour or appointment of a school teacher, a nurse or a priest; political, health or other campaigns; water service provision; governmental, university or NGO projects or programmes proposals and implementation; and changes in land tenancy policies. Internally generated problems are regularly shaped through time. That gives Mino people the opportunity to think, talk, to look for explanations and possibilities outside the Assembly making of this a topic of family and street conversation. When the Assembly summons, the problem has been already located and discussed and a collective opinion already shaped. However, externally generated problems often must be swiftly attended to since they emerge unexpectedly. Therefore when the Assembly summons the decisions are taken based on individual opinions.

Since the Assembly is the structuring centre for collective life, it gives identity and belonging to Minoans. Nevertheless, during 1998 and 1999 Assembly attendance dropped. During this fieldwork, different people mentioned that the Assembly was too long and interfered with weekend activities such as weddings, christening's and other parties, rituals and family encounters. When interviewed, community authorities regarded Minoans as close and organized yet, they recognize that they were better in past decades and are concerned about the future of their collective life.

Minoans' relationships with other regional authorities.

The local government structures in Mino need to interact with regional, state and national political structures. Mino's local organisation had found their own way to accomplish this with the regional government and political parties without losing their autonomy. They receive political candidates for meetings in electoral periods and work in paid political party positions, but in the end, they vote according to their perception of who will respond to their demands and who '*will do less damage to our life*' (different men outside the Assembly). They are very critical, sceptical, untruthful, exigent and demanding towards the municipal authority. They face such an authority openly and collectively. Until ten years ago, most of the population were affiliated to the PRI [60].

In Mino, as in other marginal rural communities the *caciques*[61] are an ever-present possibility of trouble. From time to time the *caciques* make attempts to invade Minoans' land. Minoans defend themselves from the *caciques* through their collective organisation. Another threatening authority to Mino is the military platoons that circulate regularly in the region with no specific reason.

The *maquila* workshops

Over the last few decades the *maquila* workshops have become another form of local organisation. In the *maquila* workshops, practical responses towards women's necessities and wellbeing are incorporated in laws, norms and rules. At the beginning, the associates formulated an internal law and codes of conduct searching for working conditions that avoided violence or aggression against women and met women's necessities. In the last five years, the influence and pressure of other regional *maquila* and the city contractors; the recent incorporation of young local people with very little awareness about what it is like to work for *maquila* bosses in the city and the struggle to build up the workshops; and the recent incorporation of an outside administrator

[60] PRI. Institutional Revolutionary Party is the ruling political party in México since the first part of this century. It is well know because of its widespread corruption and lack of democracy.

[61] *Cacique*: a person with coercive power. A *cacique* takes its power from menaces, bribing, committing physical damage to property, people or families, etc., To do that this person has 'white' guards or patrols, control over civil servants, teachers or other formal authority, has local or regional political and economic power. Civil and penal law in Mexico prosecutes *caciques* and *caciquismo*. However, there are many examples of rural and urban *caciques* and *caciquismo* in Mexico.

have favoured productivity upon better working conditions or social security. The idea of autonomy has been vanishing in the scope of recent incorporated associates (according to testimonies of older associates), which prefer a fixed salary. Different points of view in the workshops had generated conflict amongst the associates, reflected in overall Mino organisation and life dynamics.

Workshops' associates also belong to the Assembly and recognise it as the main authority in Mino.

Family, life cycle and neighbourhoods in Mino

The family is a basic social structure in Mino. Because of the size of Mino in terms of population, most Minoans are related by first, second or third degree kinship and also by political affiliation. However, family is considered in Mino only first degree kinship and political affiliation.

When a man and a woman get married, they establish a new family. Most times, the new family builds a separate house or room on the land plot of their parents and gets autonomy when achieving economic self-reliance while often sharing the same kitchen and other services. The extended family is the most common family pattern in Mino.

Minoan families are mainly patriarchal. This also applies for families where the father is working or living in nearby towns or cities most of the time. However, women take most every-day-life family decisions.

Most Minoan families have at least one member working in the cities. Young migrants regard themselves as Minoans and frequently marry Minoan women. The women and children of the new families nearly always remain in Mino but others migrate permanently to the cities. Emigrant families leave behind land and houses abandoned or under the care of relatives. Some emigrants use the money they raise from city employment to build new modern houses in Mino with all services and larger than the traditional local houses. Emigrants use their new houses in Mino to take vacations. Some families return to Mino after facing urban living difficulties and unemployment.

There is an element of uncertainty in every Mino inhabitant: they don't know when they will need either to emigrate or to come back.

Family life in Mino also depends on the neighbourhood. The neighbourhood is a resource for small favours, lending of tools, security, exchanges of food or other goods, caring for the children, the old, crops and animals, conversation, information exchange, discussion of problems, or other. Life in Mino develops as in an extended house and family where the square, the small shops, the *pulque* shops, the street, paths, yards and other spaces and land are a place for living as much as their family house.

The life cycle in Mino is explained here. Babies are very rapidly incorporated in older children's activities and care while still under the supervision of the mother or other adult female. Once babies can walk and start to speak they pass to the stage of small children. Small children spend more time under the care of older children, playing around in the family or relatives' house, nearby plots of land or in the street. When they reach the age of six, they become school age children. School age children receive some domestic responsibilities such as helping in the fields, looking after smaller children, looking after cattle and making small buys in local shops. Children become adolescents either after elementary school (at about 12 to 14 years old) or once they repeatedly failed in school. At this stage most of them have three alternatives: to stay in Mino and fully join family responsibilities, to continue secondary school or to go to work in the city with a relative. Adolescence ends most times through pregnancy, marriage or formal employment.

Adult men can have an independent economic life or live at the expense of older adults. Women will look after the house, family, relations, will help in cropping and attend collective duties. It is frequent to find adult women working outside the home earning their own money. There is no specific way of transit from adult to an old person. Old-age can perhaps be defined by the performance of individual or collective duties and activities that depend on physical fitness that can diminish very promptly because of a '*hard life, hard work*' (different testimonies of old and adult people).

Despite their Hñä hñü roots and their collective lives, many old Minoans had been neglected and left behind after their families emigrated. Some of them also look after

their grandchildren who hardly know their parents. Some old people show signs of old bone fractures cured by them leaving behind the correspondent limb dysfunction and pain.

It seems as if the maladies of the old were a normal part of living. However, Mino authorities are concerned about them. Minoan adults mention that abandonment of the old is a recent phenomena that they explain through migration:

> *...no, before this did not happen, as far as your children survived you, you could get old in peace...but now, they go and say that they will come back, but they don't, they come and see their parents, leave a few money and then go again...* (an authority).

As authorities, they have conversations with the relatives and neighbours of abandoned old persons trying to make them '*come into reason and have respect and pity for those who gave them life*' (an authority).

There are some children in Mino that are neglected. Often, these children and old people receive food or clothes from other Minoans. The problems of children's or old people's abandonment are also discussed in the Assembly, which tries to find a way to bring back the relatives of the abandoned to reflection and responsibility. In this way, the community makes efforts to look after the poorer amongst the poor.

Education

Non-formal education

Education in Mino is gendered and centred in daily family economic, reproductive and domestic activities. Children, boys and girls, look after domestic cattle or poultry, help in the fields, fetch water, deliver messages and make small purchases for their relatives. The girls attend their younger relatives and babies and help in domestic work. Television and radio; the *maquila* workshops; church services and school; local and regional festivities and continuous interchange with the city through Minoan migrants represent also important educative experiences for Minoans. This will be expanded on in the next chapter.

Informal education in Mino is a family and community responsibility. The community as a whole regard physical punishment or violent adult behaviour against children

badly. When a child is treated with violence, the community authority in turn responds by speaking assertively with the aggressor even if he/she is the child's parent.

Formal education

In Mino there are one nursery school, an elementary school and a secondary school all taking part in a television- long distance education programme. The Education Ministry runs all schools. The nursery school is free and not compulsory, run by preschool education promoters who are community women trained through short courses by the Ministry of Education. The syllabus in the nursery school is fixed with goals that refer more to memory than to capacities development. Not all children attend nursery school mainly because it can be distant from their houses and because the constant requirements of school –clothes and shoes, working material, school repairs and the final graduation party- make it unaffordable for some Minoan families.

At the age of seven, children are admitted to the local elementary school run by non-Minoan teachers that have had a training of three years after secondary school. The elementary school gives much importance to festivals and celebrations. Its syllabus is closed, with no links to community life.

The parents involvement with school is low, they more or less only know their children's marks and hardly have any information about the educational processes. There is nearly no reading material in the school besides the Free Text Book series provided by the Education Ministry on a national basis.

Outside school, children seldom speak about curricular contents or activities; most conversations relating to school refer to fights, rumours, and gossip or to point out differences in marks or achievement. School absenteeism is high and depends mainly on children's diseases, temporary migration, economic family problems, necessities of extra hands required during the harvest cycle or other children's family duties. Often children abandon school before the last year, since the end of the elementary school is celebrated by a -relative to their income- expensive graduation party. To finish elementary school means getting a certificate and a family achievement.

The Mino 'tele-secondary school' is very recent. It started to work on its own premises in 1998. It is an option for those who can't afford to send their children to secondary school outside Mino. This option is less expensive than other regional secondary schools in terms of family expenses for children's transport, food, uniforms, schoolbooks, festivals, etc. Nevertheless, parents are aware of the quality difference between the local and regional secondary school.

About thirty minutes away by public transport, are two technical secondary schools[62]. Few children are sent to school in Mexico City with their migrant family. Not all children that manage to attend secondary school complete it.

If a Mino adolescent can afford to continue studying after secondary school, he/she can go to a regional pre-university school in a nearby town. Some Minoan adolescents try different options in large cities. If they succeed and finish their programmes, they seldom return to Mino.

[62] A technical secondary school is meant to cover the regular official secondary programme as well as a technical programme. The technical content varies according to the school staff skills. Minoan children attend to schools whose technical contents are concerned with the development of administrative, trading and clerical skills.

Literacy in Mino

Efficient reading and writing is not common within Minoans. Efficient literacy is low because of a lack of formal studies; poor school programmes and because of the lack of use of reading and writing skills developed through their scarce formal education. To read or write are regarded as school activities and confined to school. Books are important only to fulfil school demands or as school objects. Local schools in Mino have small libraries with few books that are very little used by children. There are some historical documents kept by specific persons or by the local authority and also some school books are kept in Minoans' houses but seldom read by children or adults. We implemented a library with a stock of four hundred documents open to the public. In two communities about 45 minutes walk from Mino, there exist libraries with a fixed book stock assigned by the Education Ministry to all municipal libraries. These are very neat and clean but underused. The newspaper does not reach Mino. In this way, reading is not of much use for Minoans.

Religion

Religion in Mino is mainly Catholic but recently some Evangelical groups approached the community and gained a few converts. The church represents the centre for religious practices in Mino. The church is opened for a weekly Service, for Sunday School and for events like weddings, graduations, etc. As will be illustrated later on in this chapter, the priest is not well recognized or respected by local people. The Sunday School -run by local young women-, is for children only and its objective is the First Communion, yet for several months it takes up much of the children's afternoon.

Minoans celebrate every festivity –religious or secular- with some religious contents and rituals. Every house has an altar and people frequently refer to God in their daily life and prayers. People mostly pray to find God's mediation to solve problems of different kinds, to put friends or relatives in God's hands, asking him for illumination and in particular moments of life such as dying, pregnancy or delivery.

Mino's capital

Mino is continuously losing human, social, cultural and economic capital. Examples of lost human capital are young people, men and even whole families leaving Mino and the decreasing interest in Mino's life. Examples of lost social capital are the lack of interest in joining collective work in the fields, some social networks to care for the ill and the old, etc. Local traditional knowledge, Mino's cultural capital, is increasingly dissappearing from Mino. The deterioration of the land for cropping, the lack of a young labour force, the diminished value of *pulque* and pottery are some examples of economic capital lost.

Some other capital has been gained through migration to the cities such as new skills, knowledge and information, links with potential employers and a place to stay when going to the cities, amongst others. Through the seamstress workshops gains are more than losses. Examples of gained capital are literacy, income, women's collective participation, knowledge, etc.

A few families in Mino had concentrated more symbolic and material capital than others. That is the case of family *O* that recently separated from a collective tailoring workshop to establish one of their own. They were also linked with a political party. Even when those circumstances raised much criticism and rumour, this family acquired more strength collectively and its members as individuals.

The capital that Mino uses in the region and in the cities is mainly economic, cultural, social and political. Mino's economic capital to use outside Mino is mainly composed of Mino's products, labour and expenditure. Also the community hall is frequently hired for neighbouring communities' parties and celebrations. Mino's annual religious celebration, local *pulque* and local food are recognised regionally. Social capital for Mino is the numerous relationships with friends and relatives in nearby communities and in the cities. Mino has votes that count as political capital during political campaigns and polls. Also the physical presence of Minoans is sometimes valued in private medical services, church and in religious or other celebrations around Mino.

Despite the central position of the tailoring workshops in Mino, their workforce has little value outside Mino since there are many other men and women coming from other poor regions of the country looking for labour in the cities in the tailoring industry.

The general characteristics of Mino described here will help to understand some of the power processes occurring in Mino that I present below.

CONSTRUCTING SUBORDINATION AND DIFFERENCE IN MINO'S EVERY DAY LIFE[63]

Because of their low expenditure capacity, Minoans remain marginal in the current geography regulated by the market. Mino appears from time to time in this market geography, for example, during political elections and when becoming part of the workforce in the cities. However, overall hegemonic action affects Mino's everyday life as will be examined in detail in the following chapters. Here I present some general ways in which the hegemonic processes are expressed in Mino and also a general examination of how doxa and difference are constructed through Minoans' everyday life.

Subordination and conformity

Conformity and subordination as the final result of hegemonic action, are expressed in Mino in many ways. Here I provide two representative examples of consolidated subordination and conformity:

In Mino's elementary school, celebrations such as graduations can be unaffordable for Minoan parents. Nevertheless, they are taken for granted as a school requirement and most parents do not think or raise their voice to complain or propose alternative celebration practices. When parents can't meet the school celebration demands, they take their children away from school even after considering that this decision will be

[63] For this analysis I am using the concepts developed in chapter two within this thesis.

adverse to their children's development. In this way, Minoan parents' individual behaviour of subordination opposes their regular collective behaviour and strengthens institutional power.

Social conformity can be observed in the perception of different informants about their role and place in society. This can be illustrated with the answer a middle age, married woman produced when invited to join a further remedial education project: '*Why, me? I'm just a humble merchant woman incapable of understanding*' where that woman perceives herself with specific capabilities and place in society. Another example is the arguments several people gave when invited to join the research intervention: '*I am as thick as two planks*', '*I won't succeed*', '*that* (training) *is for others, not for me*'. Subordination in Mino is often expressed in Minoan's practices when dealing with the medical institutions and through poverty and disease as will be illustrated in following chapters.

Hegemonic physical violence

Hegemonic physical violence mainly comes, though not only, from outside Mino. I recognise three hegemonic menaces hanging over Minoans' lives: the *hacendados*, the *caciques* and the military platoons. I give some examples that explain this.

It is well known in the Valley that the *caciques*[64] make use of physical violence to prevent the emergence of dissent or other interference with their territorial power. During this research's fieldwork a *cacique*, who was also a medical doctor and a pharmacy owner, interrogated the research participants about their community services plans and subtly let them know what was the extent of his power using phrases such as: '*Here, I am the doctor*', '*Watch out what are you doing here*' and *'no one interferes with me*' (Pablo and Teo's testimonies). The participants in the research interpreted these and other expressions and attitudes as a threat to us all if we interfered with the *cacique*'s medical business. Even though the *cacique* never took any action against the

[64] See footnote 60 in p138.

project participants, for some weeks that threat hung like an-always-present screen over theproject.

Another example of physical violence are the attempts at invasion of Mino's territory that the *hacienda*[65] 'Enho' carries out from time to time and the presence of military platoons that pass by or stay for some hours in Mino without any explicit reason.

Symbolic violence in the construction of subordination in Mino

Through observation and participation I was able to analyse different, brief, and apparently insignificant events that I interpreted as representative of how doxa is inculcated in Mino. One of them will be analysed here. It develops from an observation of a young 'mother' who was 'dragging' a child of about six years old that was wildly reading aloud every word that came into his sight without any comment or other apparent engagement by the mother with that reading activity. When the child read the name of a political candidate, for the first time the mother briefly turned and severely said '*to that* ('that' referring to the candidate) *we vomit on the face'*. The child stopped his reading for a moment and then continued reading words at random.

This analysis shows: First, the child did not attach any meaning to the candidate's name, that held no prior existence for him but perceived it only as written letters that he could pleasantly decipher by the utilisation of an emerging capacity for reading, until the mother's comment. A sudden idea of the existence of such a thing as 'there are people to whom 'we' can vomit on their face that don't even deserve to have a name' (he was 'that') was raised. Second, if there is someone to whom 'we' can vomit on his face, someone else could eventually vomit on my face. And third, as far as I remain a part of 'we' I am secure, less likely to become vomited in my face. Without realising it, the 'we' becomes important, not to be accepted as 'we' can threaten the child's security. Now the struggle for belonging, to remain as the excluder rather than the

[65] *Hacienda.* A way of local organisation and land ownership where the *hacendado* (the *hacienda* master) owns vast amounts of land worked by *peones*, people living and working in the *hacienda*. The *peones* should use their scarce wages to buy food and goods in the *hacienda* shop. That kept the *peones* and their children always in debt with the *hacendados*. The *hacienda* is supposed to have been eradicated in Mexico, however in different parts of the Country, as is the case of the state of this research site, can still be found traces of it.

excluded becomes vital, presupposing a 'we' existence. Without noticing or having any possibility of consciously structuring it, the idea of a 'we' existence can only be ensured within the mother's and, as extrapolation,the family's authorised realms. The mother's and other familiar authority will then be recognised without thinking or questioning. On the other hand, the recently acquired reading skills are not celebrated or considered by the mother who very seldom uses her own reading skills, since in Mino reading material, other than posters or advertisements, is generally considered to be of low value. Accordingly, it is possible, with this analysis, that in the child's self, world representations and identity, the value of 'us' as security, granted when recognising authority, is now internalised from an external structure to an internal one. In the meanwhile, reading and the pleasure of reading are also internalised as non-valuable for 'us'.

Complementary to that example of doxa inculcation with symbolic violence, is an observation that I recorded in a church service just before the Holy Communion when the priest said:

> *I must remind all people present that the Holy Communion is the link with God from whmo you will receive blessings that will last for the rest of the week. And also that it is a great offence to God to receive it if in major sin ... It is a major sin not to attend every* [remark] *service. If you have failed to come to even one* [remark], *then you must take confession before you receive His holy body. Those who want to be blessed through the Holy Communion please proceed towards the altar.*

Minoans' acceptance of the priest's authority goes beyond awareness of his non-responsible-to-community-expectation behaviour:

> *That priest...he didn't want to celebrate the service the very day* [the local venerated saint celebration day] *we still don't know if he is finally coming...he says he is busy... the celebration must take part anyway...even if the service is another day...but it won't be the same...* (Street conversation with a young woman).

In this way, through an invisible grid of experiences like these, authority remains unquestioned. That invisible grid is structuring structures such as those from where children react towards older children or any person with the slightest authority or from where adults react towards medical practices. To question the authority will represent for that child or those Christians 'to turn circular time into linear time, simple reproduction into indefinite accumulation' (Bourdieu, 1977:162).

A strong doxatic and habitus expression not constructed from present dominant power is Minoans' conception of reality as collective and integral. Perceived and thought of as collective, much Mino family problems are faced mostly through collective analysis, decisions and actions and also through linking the problems to the ways to find solutions.

Minoan's bonding for distinction

There are different bonded distinctions in Mino; one of them is in the women's field. The reasons why women are not considered to be authorities (Mino's top authority appointed by the Assembly) is not explored by men and women more than by saying that *'it is hard work not made for women', 'it entails risks women can't face'* (different informants men and women). Nevertheless, women can belong to certain committees, like the church's or the school's and also help men to fulfill their authority' or other collective duties. When women speak in the Assembly, often their interventions are heard but not commented on or discussed. Women's differences with men secure that none of them will become an authority thus men can be reassured in their internal collective power in Mino. That is also true for old people that may make use of a long time to make their points while the Assembly keeps a respectful silence but, once the old person has finished, nobody follows his or her ideas. Minoan men's production, provision and authority and women's caring and reproductive activities establish differences between them.

Children and young people in Mino establish links between themselves amongst others, by games and street playing, meeting when sent for small purchases or to deliver messages, when looking after the cattle, when purchasing junk food as advertised on TV and also by making reference to TV contents.

Advertisements and other TV programming create images of different social spaces where the audience will never belong, yet they generate the illusion of belonging through fetishes such as certain drinks, makeup, toys or other accessible goods. Those messages also let Mino people know that 'not belonging' yields exclusion and exclusion stands for social punishment. The symbolic contents transmitted through the

media are reinforced by conversations young people listen to when Minoan migrants visit Mino and also by the school and the church.

The inclusion of an expensive (relative to most Minoans resources) waltz ceremony as part of most life-cycle celebrations can be explained as a distinction necessity. In this ceremony not only the waltz itself, but some ornaments, clothes, makeup, 'the cake', etc., resemble those of the XVI Century French nobility and an image of Mexican's upper class celebrations, widely used not only in Mino but also in cities. However, these celebrations also include regional distinctive practices like the way in which food is prepared, from killing the animal to its presentation as the main course in a meal prior to the waltz. Minoan's waltz ceremonies include peculiar ways in which friends and kinship are involved at different moments.

To be a Minoan living in Mino or a Minoan living in the cities is a big distinction in Mino. Other distinctions are to work as a seamstress, merchant, mason, *pulque* or brick maker, or in other jobs; to work in Mino or in surrounding towns or cities; to cultivate their own plot of land or to be a *peón*[66]; education; behaviour when confronted by collective responsibilities; to be or not alcoholic; marital life characteristics; to have access to the water well or not; to have a brick house or not, and other criteria.

Minoans' orthodoxatic and heterodoxatic knowledge and practices

Heterodoxatic knowledge and the construction of fields of opinion are not often present in Minoan social practices. What is more frequent is resistance to authority with a greater or lesser degree of orthodoxatic knowledge that easily goes back to doxa and subordination. Minoan's resistance to authority is present in different social spaces. Resistance is not always a change possibility, since it is often not clear to what and how resistance is occurring, possibly because of the doxatic basis of domination.

In Mino, I found resistance with different degrees of efficacy to change. An example is the frequent 'out-of-law' pregnancies in Mino. Most Mino girls are ruled by doxatic conceptions of good or bad in respect of how they use their body. Those rules do not fit

[66] *Peón*: a peasant working someone else's' plot of land for meagre wage or some food.

with their sexual and social desire of accomplishing 'out-of -law' sexual intercourse. They can defend their right to use their body until pregnancy becomes physically evident. Then, they try to hide it for a while and finally accept their 'fault' and consequent guiltiness. This guilt will be reinforced by a social stigma that won't be removed until marriage takes place.

Other resistance examples are the lack of attendance at church and health services; the peculiar characteristics of Minoans' participation during political campaigns and old seamstresses resistance to productivity rules in their tailoring workshops.

Contradictions between the doxatic hegemonic promise and Minoans' material living conditions are not perceived as domination but as fate, as a normal condition for 'people like us', personal or collective mistakes, negligence, weather conditions or other reasons, where dominant power is not recognised and only blamed as a distant figure:

> '*you can see how he* (Mexico's president) *has us... probably he doesn't even know that we exist* (laughter)' (an adult man) or '*You see, after all that work, the price of the chile*[67] *is less that what one-self invested in the first place, but there you are, stubborn me,* (laughter) *I keep growing chile ... at least we can eat it*' (An old peasant).

Young Minoans and their parents often project themselves living in the cities or working outside Mino as a means of getting rid of their perceived poor living conditions and fate.

Transaction with power and counter-hegemonic antecedents in Mino

Transactions with power are common in Mino. I found clear examples of transactions with the hegemonic power in the agreements Minoans make with municipal people and politicians around political campaigns and elections and also in their relation with school and church authorities as was described in this chapter (p138).

The most relevant counter-hegemonic antecedent in Mino is the development of the seamstress workshops. I explain this here. During the historic block opening in Mexico

[67] *Chile*: a chilli pepper.

resulting from the 1985 earthquake when Mino seamstress working in Mexico City were trapped in their workshops due to their illegal shanty-town, slavery-like labour conditions (Poniatowska 1988) Minoan women took up counter hegemonic action. From that experience they developed an understanding of their situation and capacities and built up an independent way of looking at their '*patrones*'[68], as well as their role and place in society and developed the collective tailoring workshops described in previous sections (p138). In Mino, the presence of organic intellectuals can be traced to the advisors of an NGO who organised local study and reflection groups to support the seamstress actions about ten years ago.

CONCLUSIONS

The history of Mino is a history of hegemonic action upon marginal people. It illustrates how hegemonic power over the years and through different historic blocks constructed consensus and subordination in Mino. Mino shares its history with many other rural marginal communities that have recently lost their indigenous identity. Mino also shares with such communities a degraded physical environment, which provides little development opportunities to its habitants. However, inbuilt in its history, Mino has valuable capital to develop for emancipation in the search of better material and symbolic living conditions.

Mino's social structures enforce doxatic knowledge about health, authority, lack of capacities, illusion of belonging and others. Nevertheless those social structures also inculcate doxa with development possibilities to construct fields of opinion as counter-hegemonic action such as the collective and integrative meaning of life and living and the peculiar ways in which Minoans resist authoritarian practices. I see in the Assembly one element giving Mino a unique identity, self-respect, relative autonomy and a possibility of constructing heterodoxatic knowledge and fields of opinion.

In the next chapter I will examine Mino's knowledge and the health situation to complete the presentation of the context in which this research's pedagogic intervention was implemented.

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[68] *Patrones*: Employers that regard their employees more as servants than as workers.

CHAPTER 7
MINO'S KNOWLEDGE AND HEALTH

In the previous chapter I presented the research site and examined its broad hegemony/subordination situation. In this chapter I will analyse and evaluate the Minoans' health situation and will assess their characteristics as healthy subjects to complete the analysis and evaluation of the context of this case study. This analysis and evaluation are the base line to analyse and evaluate changes which occurred due to the pedagogic intervention (the CHTP).

Underlying the definitions of health and healthy subjects provided in chapter three (pp 69, 75) is a conception of the individual person as subjects with an objective material dimension and a subjective dimension. This chapter is organised correspondingly to those dimensions of the subject. I start this chapter with an examination of the repercussions of hegemony over Minoans' material context and over their physical bodies. Then I proceed to examine Minoans' knowledge and meanings that are constitutive of the subjective dimension of Minoan subjects. With the understanding derived from these analyses and evaluations and my learning from chapter six, I end this chapter with an evaluation of health in Mino and of Minoans' characteristics as healthy subjects. As a result of this evaluation, I will argue that, to carry out empowering counter-hegemonic health promotion in Mino, it is necessary to stop the processes leading to the construction of 'clients' and to promote the processes leading to the strengthening of healthy subjects.

The data presented in this chapter were collected as described in chapter five (pp118-122). There are some sections in this chapter supported in the description of Mino presented in chapter six. Some information supporting the analysis and evaluation of Mino's health situation has been collected from the Health Ministry programmes as they are implemented through the health clinic in Mino. Pablo and Manuela did the observations there, when delivering medical services as *pasantes* appointed by the Health Ministry. The Minoans' perceptions about public and private health care and about their diseases and disease care were observed during non-official medical

consultancies, conversations during house visits, in the street, in the Assembly, during CHTP work and also in the health clinic. In box 7.1 I present a summary of data sources for this chapter.

BOX 7.1. DATA SOURCES FOR THIS CHAPTER

SECTION	OTHER STUDIES	PREVIOUS CHAPTERS	CHTP	'IMMEDIATE DATA' NON CHTP TESTIMONIES	'IMMEDIATE DATA' MEDICAL CONSULTANCY	'IMMEDIATE DATA' OTHER DIRECT OBSERVATION
MINO KNOWLEDGE						
Sources of knowledge	X	X	X	X	X	X
Knowledge organisation			X	X	X	X
Perception of health services			X	X	X	
REPERCUSSION OF HEGEMONY						
Infrastructure to care for disease and health		X	X		X	X
Poverty	X	X	X	X		
Disease	X	X	X	X	X	X
Disease/hegemony		X	X	X	X	X
Doctor/patient		X	X	X	X	X
Diabetes knowledge		X	X	X	X	X
Basic health package		X	X	X	X	X

MINOAN SUBJECTS' MATERIAL CONTEXT AND BODIES

I will analyse and evaluate in this section the objective dimension of Minoan subjects through the examination of their material infrastructure to care for health and disease, the expressions of hegemony over their bodies and of their doctor/patient relationships.

Health and disease care material infrastructure

In Mino there is a small health clinic with a consulting room, a delivery room, one room with one bed for hospitalisation, a warehose-pharmacy and two bathrooms all taking up a total of aproximately 50 square meters. The unit was built by villagers and belongs to the community but is run by the Health Ministry. Since 1994 it is attended by a technician in primary health care appointed by the Health Ministry. At the beginning of 1998 it was equipped with larger health clinic furniture, but not all the furniture fitted in the small premises. It provides irregular service from Monday to Friday from 9 am to 3 pm. The service includes pregnancy follow-up, vaccination, first

aid, diagnosis and follow-up of diabetes and hipertension, water surveillance, family planning, diarrhoea and acute respiratory first aid and refers people to the Health Ministry general hospital or to the Social Security Institute rural hospital. There is a basic medicine stock supplied by the Health Ministry that is often incomplete.

From Mino people's testimonies and direct observation, I found that the three main public referral services –the Social Security Institute IMSS,the Family Care System DIF and especially the Health Ministry, are over crowded and unable to meet public demand. Most medical personnel lack in-service or other quality updating training. Available drugs and other materials are scarce and often non-existent. Institutional attention to patients is often rude, authoritarian, non-illustrative or explicative; therapeutic materials are charged to patients making therapy costs often impossible to face by poor families that are in continuous debt because they get money from loans and pawn-brokers in order to meet these costs.

People know that going to hospital not only doesn't always mean that they are going to be cured but that they can get worse after expending family resources and leaving behind their activities as this middle age mother explains:

> *'... there you are [in the General Hospital] waiting one day, and another, and another, and who knows if one will be cured ... you pay transport, one working day lost, and then they don't have the medicine and give you a prescription ... and all the same, to find the money ... X town is closer and you don't need to wait...'*

Seeking for better services, Minoans search for cures in private services which are in nearby towns about one hour walk away or thirty minutes by public transport during the day. The closest are four general practitioners and two chemist's in a municipality about thirty minutes away by public transport; three general practitioners and two chemist's in another municipality also about thirty minutes away by public transport and one homeopathic practitioner in a town about forty minutes away by public transport. Private services lack quality and represent an expense that often goes beyond most Minoan pockets. Nevertheless, they use the services by raising money from their local support social network, if they have one, or from small loans. After each disease event, they need to repay the debt for a long period of time. The private services usually recommend laboratory tests and/or tests requiring technologically advanced equipment, which they provide on the premises at high costs -if compared with average

costs in the closest city- and commercial drugs which they sell in their own pharmacies. Often the service includes intra-venous drips with 'vitamins', hospitalisation and some other procedures, which represent extra charges. For health consultations, such as pregnancy follow up, private doctors install a laboratory and technological routine. When the problem worsens, private doctors will find an excuse and quit the case. Then, if the patient is still able to raise the required money, they go to the next private alternative or to the public services.

People who have tried local or regional services and found them inadequate seek attention in Mexico City's medical services, finding a place to stay, often with relatives, from where to start a new odyssey round the health services. Often a solution is found in the city in private alternative services from acupuncture to esoteric health practices. An example of this is taken from a mature man (DM) with a high reputation because he has been a good authority in the past. In the 1970's, DM was diagnosed with TB in a Health Ministry hospital in Mexico City that specialised in this disease. During our stay in Mino, he developed TB symptoms again. I found a place for him in the hospital which he had attended before. DM rejected it on the grounds that he did not want to go again through a long stay in this hospital:

> *'No... I've been there before ...I don't like to be kept...a long time without proper food...away from my family, my problems, my crops... they just come and take your blood... take you as an object and move you here or there... they want you to spit when you don't want to... there you are with the clothes they give you, open at the back, they don't want you to wear your clothes...you miss your place, your things, your family... you wonder when you'll be back... your family can't see you, it's far away from here and also from my relatives in Mexico...I think you don't get well soon because of their food...'*

DM went to Mexico City anyway and stayed with relatives that took him to a person that gave him an alternative therapy in the form of a special diet. After about three months he came back without the TB symptoms.

People can also resign and go back to their home and wait for the ailment to improve or worsen without intervention or by the use of common sense, popular knowledge and resources at hand that can include allopathic medicines left in the house after other treatments of other relatives. When Minoans can't leave Mino for a long period of time because they need to look after their animals or crops, they invest large amounts of resources, relative to their income, on trips to the city.

In Mino, old local healing traditions are rapidly disappearing and being replaced by new ones. As explained before in this and the previous chapter (p134), since local traditional knowledge was codified in native languages, it is kept by those few Hñä hnü local speakers only. In a village at forty minutes away by public transport are bone-fixers and herb doctors which could represent a healing alternative yet, they are not often used. However, making use of recently created knowledge, most people use herbs, fruits, diets and massages as preventive and therapeutic measures. To traditional altars, prayers, stamps, amulets, herbs, practices and rituals are incorporated symbols and practices coming from allopathic or other medicines, beliefs or information they get from radio or television and also recommendations attached in industrially packed herbs available in larger towns and cities.

Lack of access to quality medical services affects Minoans as individuals, as families and collectively. This can be illustrated by two examples. At the end of the research fieldwork in Mino, couple X had problems in their relationship threatening their marriage and community work and couldn't find the necessary professional help. The couple play important roles in community life –one is a seamstress leader and the other is frequently elected as an authority or a committee leader- and up to this point their relationship is worsening without hope. The second example involves an old man who fell and broke his leg. He lay for some days without food or attention of any kind. He constructed a walking aid from tree branches and looked for attention in the health clinic in Mino. He did not receive attention there and couldn't do anything about it. He continued his every-day-life until his bones healed in the wrong position. At present he needs to struggle with all his farming and house labour with this disability. A relation of similar cases could fill up the whole thesis space, so I must let these two cases exemplify how restricted access to wealth impacts on collective, family and individual possibilities for facing disease.

Poverty, hegemony and disease in Mino

Most Minoans have restricted access to overall wealth and indeed their disease pattern is similar to that of the marginal populations throughout the world. The disease pattern in Mino corresponds with the transitional epidemiological disease pattern described by Laurell (1981) and the international agencies. A transitional disease pattern is characterized by the presence of diseases of poverty as well as diseases of development. Under-nourishment, alcoholism, seasonal diseases, delivery complications, respiratory infections, diarrhoea and skin diseases have been classified as diseases characteristic of poverty and are frequently found in the health clinic consultations in Mino. Chronic diseases (diabetes, hypertension) and non-infectious skin diseases have been classified as characteristic of development and are frequently found in Mino. Also frequent causes of Mino's medical consultations are bone and muscle problems, gastritis, headaches, accidents, *iatrogenic*[68] diseases, complications due to hospital rejection of sick people, abandonment of the old, domestic violence and wounds due to violence[69] (García and Gómez 1998).

In box 7.2 and below I present an evaluation of the relations between Minoans' restricted access to wealth and their body inscriptions[70]. The effects of restricted access to wealth over Minoans' bodies presented here are only those registered in the 1445 medical consultations provided by Pablo and Manuela in the local health clinic during 1998 and 1999. Sixty percent of those were first time visits to Pablo and Manuela. However, there were many more unregistered medical consultations outside the health clinic where Minoans felt more confident to approach Manuela and Pablo. Causes of these informal medical consultations with Pablo and Manuela were depression, leg ulcers, urinary infections and other that will not be analysed here since we don't have accurate records of them.

[68] *Iatrogenia*. Diseases provoked by medical action.
[69] As it will be described in chapter eight (pp184, 187), during this research development two intervention participants provided medical consultation in the health clinic. The data about diseases and causes of medical consultation provided here was collected from that activity.
[70] For the concepts of hegemony, poverty and body inscriptions of poverty; refer to pp 26, 53, 54 and 55.

BOX 7.2. SOME EFFECTS OF RESTRICTED ACCESS TO RESOURCES OVER MINOANS' BODIES

RESTRICTION OF GENERAL RESOURCES FOR:	IMPACT OF GENERAL RESOURCES RESTRICTIONS OVER SOME DIRECT RESOURCES RESTRICTIONS FOR MINOANS	SOME EFFECTS OF THE DIRECT RESOURCE RESTRICTION OVER MINOANS' BODIES*
AGRICULTURE	Food and income.	Undernourishment.
LABOUR	Income, clothing, commodities and rest.	Undernourishment, non-infectious skin-diseases and infectious skin and respiratory diseases and diarrhoeas, accidents, bone and muscle diseases and abandonment of the old, alcoholism and intra-domestic violence.
QUALITY FORMAL EDUCATION	Knowledge, functional literacy information and life alternatives.	Chronic diseases, seasonal diseases, traumatisms due to violence, intra-domestic violence, alcoholism, complications due to hospital rejection of sick people and *iatrogenic*[71] diseases.
VOICE AND DECISIONS	Laws and regulations and life alternatives.	Alcoholism, domestic violence, abandonment of the old, gastritis, head aches, complications due to hospital rejection of sick people, *iatrogenic* diseases and delivery complications.
COMMUNICATION	Information and knowledge.	Chronic diseases, seasonal diseases, delivery complications, *iatrogenic* diseases and complications due to hospital rejection of sick people.
QUALITY SERVICES	Housing, medical attention and sanitation, services for the mother, the children, the old and the handicapped.	Infectious respiratory and skin diseases and diarrhoeas, non-infectious skin-diseases, chronic diseases, seasonal diseases, delivery complications, complications due to hospital rejection of sick people, abandonment of the old and under nourishment.

* More frequent diseases and consultancy causes, 1998. Medical Consultancy in Mino's Health clinic(García and Gómez 1998 b).

Restricted access to resources for agricultural labour such as water, seed, fertilizers, fair crop prices, technological aids, information, etc., restrict -amongst others- Minoan's food availability and income causing undernourishment, accidents and bone and muscle diseases due to long and hard agricultural working days with few technological aids. Restriction in labour access directly restricts Minoans' access to income, clothing, commodities, services and rest. Un-employment or underemployment and its consequences also cause frustration, low self-esteem, boredom, family and collective judgements of negligence, unwillingness, sluggishness, laziness and so on. These are manifested in Minoan bodies as undernourishment, non-infectious skin-diseases, infectious skin and respiratory diseases, diarrhoea, accidents, bone and muscle diseases, abandonment of the old, alcoholism and domestic violence.

[71] *Iatrogenia.* Diseases provoked by medical action.

Restricted access to quality formal education or medium, high or university studies, restricts Minoan's life alternatives, knowledge and functional literacy. These restrictions diminish their possibilities to confront the medical institution, to understand the mechanisms of chronic and seasonal diseases and also create frustration and low self-esteem. These are expressed as chronic diseases, seasonal diseases, wounds caused by violence, domestic violence, alcoholism, complications due to hospital rejection of sick people and *iatrogenia.*

Restricted access to voice and decisions about regional or national problems, restrict Minoans influence over institutionally generated laws and regulations. It represents a major problem for Minoans when they can't fully benefit -and are often harassed- from institutional services. These restrictions include restrictions on life alternatives. Several gastritis, headaches and *iatrogenic* diseases reported through the medical consultations in Mino, can be related to these restrictions as well as some cases of alcoholism, domestic violence, abandonment of the old, delivery complications and complications due to rejection of sick people by regional medical services.

Restricted access to communication -because of limited vocabulary and low reading and writing skills quality or other ways of expression and also because of restricted access to written material and communication technology other than television or radio- makes it difficult for Minoans to have quality information about regional, national and international scientific, social, political, or other developments. Even when local community problems are efficiently dealt with through their collective organisation, the communication restrictions presented above make intra and inter-family communication difficult. These difficulties are also present in their relation with institutions and doctors. Lack of or low quality information can be expressed in how Minoans deal with chronic diseases; seasonal diseases that often become epidemic; pregnancy and delivery complications and in *iatrogenia* and disease complications because of hospital or medical rejection of sick people.

Restricted access to quality services undermines the possibility of housing improvements, medical attention and sanitation, services for the mother, the children

and the handicapped that are expressed in different infectious and non-infectious diseases, delivery complications, *iatrogenia*, abandonment of the old, undernourishment or other.

Besides the inscriptions of restricted access to wealth in Minoans' bodies, restricted access has some other expressions in their social relations outside Mino. Some examples follow. There are other regional politicians that take advantage of Minoan's restricted access to agricultural and labour resources when making non-plausible promises about improvements in land, labour, credits, or other issues, to raise votes and support. Also, through promises they develop docility when in interaction with institutions or authority and become a cheap labour force.

Restrictions to quality information, education and communication often make Minoans do as the media instructs them through the broadcasting of misleading and deceiving information. This results in the expenditure of Minoans' scarce resources on alcoholic drinks and cheap merchandise, especially junk food and bargain clothes. These restrictions also facilitate uneven transactions with the local school, church and the regional medical institutions. Restricted access to voice and decisions keep Minoans marginal in regional and national politics, invisible for central hegemonic power and outside institutional budgets. I will exemplify and discuss below how this marginality is expressed in Minoans' doctor/patient relationships.

Minoans' dominated health through their doctor/patient relationships

Hegemony over Minoans' health has different facets; one of them is the way in which Minoans relate with the medical institution through their doctor/patient relations and the utilization of public and private medical services. In box 7.3 I present my interpretation and analysis of the doctor/patient relation most frequently established by Minoans using the concepts of Bourdieu explained in chapter two (p29).

From a basic doxa namely 'doctors know-patients don't', the medical practices are often perceived by Minoans as a curing panacea. Hence, medical failures are frequently conceived more as personal failure, thus accepting medical actions without further questioning. Therefore, far from making the medical services a component of their

Mino field, Minoans position themselves marginally –as passive patient patients- in the field of the medical services. Thus leaving to the health services the definition of the limits, objectives, values and rules of the health field. This positioning is mainly achieved through their subjective and/or objective dependence on those services.

BOX 7.3. MINOAN'S DOCTOR/PATIENT RELATION ANALYSED THROUGH BOURDIEUAN CONCEPTS

CONCEPT	ALLIED CONCEPTS	EXAMPLES OF SIMPLE REPRODUCTION
HABITUS	DOXA	'Doctors know, patients don't know'
	PEDAGOGIC WORK	Symbolic violence
	SCHEME OF PERCEPTION	Medical instruments, practices and medicines as curing panacea
	SCHEME OF THINKING	Repetition, acceptance, personal guiltiness
	SCHEME OF REALISATION	Patient do not complain, accepts medical prescriptions and practices without questioning expends money to cover medical requirements
FIELD	CAPITAL VALUE	Defined by institutions. Minoans capital is very low valued.
	DISTINCTION	Patients construct bonding, amongst other, in their dependence on doctors, in their consideration of doctor's inaccessible knowledge and power, in their silence when in front of medical authorities and in their social and cultural belonging.
	LIMITS, OBJECTIVES, RULES, VALUES	Defined by institutions through strong exclusion of Minoans.
	POSITION	Marginal
	DISPOSITION	'Patient patient'
	POSITION TAKING	Passive

Overall, Minoan's doctor/patient relation shows the domination of the medical institution upon Minoans' life, disease and therapeutic values, meanings and knowledge. This relation shows characteristics of simple social reproduction where doctors and patients reproduce the medical institutional doxa and their subordination to the market.

Another facet of how hegemony is expressed in Minoans' doctor patient relationships can be seen in my interpretation of Minoans' health knowledge value, validity and validation as has been proposed in chapter two (p40). Through the following example, I am arguing here that much disease knowledge in Mino has different value, validity and validation if compared with medical understanding. Here follows the example. Diabetes, while defined by the medical institution as a metabolic disease, is related in Mino with hard life periods and patient rage and anger episodes as many testimonies

assert. However, when Mino people attend a medical consultation and express anger or a hard life as constituents of a diabetic person's illness, doctors frequently regard the patient as 'ignorant' or fanciful. From that example I can interpret diabetes knowledge validity, value and validation as presented in box 7.4.

BOX 7.4. MINOAN'S DIABETES KNOWLEDGE VALIDITY, VALUE AND VALIDATION FROM MINOANS, PATIENT AND MEDICAL DOCTORS' PERSPECTIVES

DIMENSION	MINOAN	DOCTOR	MINOAN PATIENT AFTER MEDICAL INTERVENTION
VALIDITY	HIGH It responds to Minoans' questions. It corresponds with Minoan's knowledge organisation, representations and experience	LOW. It does not respond to doctors' questions. It does not correspond with medical knowledge organisation, representation and paradigms.	HIGH It responds to Minoans' questions. It corresponds with Minoan's knowledge organisation, representations and experience.
VALUE	HIGH It is from this knowledge that people can figure preventive measures.	LOW It does not help doctors to understand and give medical treatment.	LOW in a subordinated doctor/patient relation., patients temporarily can't see their knowledge value.
VALIDATION	HIGH within local truth. LOW when disregarded by doctors recognised by Minoan's as authority	LOW It doesn't appear in textbooks, promoting exams or other medical knowledge validation icons or rituals.	DEVALUATED when doctor does not acknowledge it and also sees Minoans' knowledge with contempt.

While for Minoans their knowledge about diabetes is highly valued, is valid and validated; for doctors attending Minoans, that knowledge has low validity and value and they do not recognise the Minoans' validation. In Mino, diabetes knowledge validity comes from knowledge logic and organisation and its fitness with Minoans' practical and symbolic use. Diabetes knowledge value comes from its practical and symbolic efficiency when used independently from medical doctors and validated within a local truth. However, with medical intervention, diabetes knowledge medical validation becomes a barrier between Mino's diabetes knowledge validity and value. This is because Minoans need to abandon their diabetes knowledge to comply with the demands of a most common doctor/patient relation where Minoans are subordinated. In this condition, even when Minoans find their diabetes knowledge with external and internal coherence, they can value it lowly while trying medical prescriptions.

The subordinated Minoan/doctor relationships are reinforced by other subordinating practices discussed in previous chapter (p146) and by official health policies and practices. I explain this in the following paragraphs.

The basic health package seen from the Minoans' perspective

Another facet of medical hegemony in Mino is the way in which health policies and practices are locally implemented. Official health care in Mino is expressed through the 'basic health package' already introduced in chapter three (p66). My interpretation of how the health package is realised in Mino is done here mainly from information obtained through conversations, direct observation, the CHTP and medical consultancy observations carried out during the research fieldwork (see box 7.5 and pp118-122, 154).

BOX 7.5. THE BASIC HEALTH PACKAGE SEEN FROM FIELDWORK OBSERVATION IN MINO

ACTION	REQUIRED EXPERT SKILLS	KIND OF SERVICE	COST FOR GOVERNMENT	IMPACT OVER DISEASE PATTERN	IATROGENIC POTENTIAL
FIRST AID	Medium	curative/ palliative	low	medium/ high	high
MONITORING OF ARD* AND FEVER CONTROL	Low	palliative/ preventive	very low	medium	medium
ORAL REHYDRATATION IN ACUTE DIARRHOEA	Low	palliative/curative	very low	high	low
PRENATAL APPOINTMENTS (3) AND VAGINAL DELIVERY	Medium	palliative/ assistencial	medium	low	low to high
CONTRACEPTION MEASURES**	low to high	Regulatory	low	low	low to very high
VACCINATION***	Low	Preventive	low	high	low
CERVIX CANCER SCREENING****	Low	Informative	low	nil	low to medium
DIABETES SCREENING	very low	Informative	very low	nil	very low
HYPERTENSION SCREENING	very low	Informative	very low	nil	very low
SIGHT AND HEARING IMPAIREMENT DETECTION	very low	Informative	very low	nil	very low
HEALTH EDUCATION *****	Low	palliative/ regulatory	very low	nil	low to high
HEALTH ADVICE	Medium	Palliative	very low	nil	low to high
NUTRITIONAL ADVICE	Medium	Palliative	very low	nil	low to high

*ARD=acute respiratory disease; **ID, condom, pill, salpingoclasia; *** DPT, polio, measles vaccination and antiparasitary medication; ****screening by smear for cervix cancer; using labsticks for diabetes and using sphingomanometer for hypertension; *****occasional chats and posters.

Column one in this table shows the thirteen basic package practices. Columns two, three and four reflect the assessment of Pablo and Manuela as Health Ministry workers in Mino who needed to go on training sessions and to operate the health package in Mino. Columns five and six represent the assessment of Pablo and Manuela and also include the analysis of testimonies of people that joined this project intervention and other Minoans. Here I provide some explanation of and examples from these assessments.

The basic health package *per se* is characterised by proposing non-resolutive actions. Two of them, family planning and health education are direct regulatory practices since they are a Health Ministry means of health contents' and values' dissemination to families and neighbourhoods. Eight of those practices can be performed by semi-skilled workers at very low cost and can be considered palliative since detected diseases will not have referral possibilities because of a services shortage, inefficiency or low quality. Those actions account for potential and factual *iatrogenia*[72] as found in Mino's medical consultancy. Often those services are not available or offered incomplete.

In Mino, people find the basic health package services inefficient, not relevant and not adequate to meet their needs, as is the case of the thirteen preservatives each registered Mino women can get as a total monthly ration. Also, *Iatrogenia* is a common effect of the basic health package in Mino. The lack of medical practitioners' expertise and the deficiently equipped and attended services create new problems for Minoans. Examples of these are vaginal infections after cervical screening; uterus perforation when inserting the intrauterine devices; un-authorised or non-informed salpinx clipping; mistaken use of drugs; delivery of partial information about nutrition, sexuality or other issues and fear and impotence raised through 'education chats' or when detecting diseases without referral to resolutive services.

Official practices in Mino are characterised by an overwhelming hegemonic medical discourse assembled around disease, concealing the Minoans' alternative health

[72] *Iatrogenia*: diseases provoked by medical action

meanings, knowledge and practices thus reinforcing their dependence on medical doctors and their medicine and hastening medical hegemony. That is expressed in the reduction of local self reliance and quality medical preventive and therapeutic practices resulting in delayed attention -or no attention at all- of disease and *iatrogenia* that often complicates even more the Minoans' body inscriptions of poverty.

A final facet of hegemony presented here, is the lack of qualified and quality health personnel in Mino. Differential training of human resources for health presented in box 3.2 (p68), ensures that the hegemonic medical truth is inculcated through pedagogic work differentially in people belonging to different population groups and individuals. Mino, according to its place in the hegemonic market is attended, if at all, by health aids, medical students and health promoters trained by the Health Ministry or other health institutions through inexpensive fast track programmes. The situation of Mino confirms the argument presented in chapter three (p67) about the uses of training programmes for the realisation of hegemony[73].

As shown in this section, hegemony is expressed in Minoan subjects material situation in different ways. One way hegemony is expressed is in the restricted access to quality disease and preventive services and material infrastructure. Another way is in the Minoans' subordinated doctor/ patient relationships. Their situation of subordination is also revealed in their body inscriptions characterised by what has been called a pattern of 'diseases of poverty'.

To assess the present situation of health and healthy subjects in Mino -necessary as starting point for the implementation, analysis and evaluation of the CHTP-, I had shown in this section the condition of the Minoans' subordination through the examination of the repercussion of hegemony over their material context and bodies. Minoans' bodies are one of their dimensions as human subjects. I will explore next some characteristics of their health knowledge and meanings that are constitutive of their subjective dimension as human subjects.

[73] Refer to box 3.2 (p68) 'Some characteristics of official teaching programmes for the development of health personnel in México'. For further information and analysis about this problem see also chapters eight and nine within this thesis.

MINOANS' KNOWLEDGE AND MEANINGS

I will examine in this section some aspects of Minoans' knowledge, values and meanings that are constituents of the subjective dimension of Minoan subjects.

Through their life, Minoans are exposed to the knowledge sources described below from which they construct their meanings, values and knowledge.

Sources of knowledge in Mino

As it has been explained in chapter six (p134), Mino lost its Hña hñú language two to three generations ago and with it a big amount of the original traditional identity, values, knowledge and representations. When we asked people about traditional health practices, they often referred us to the remaining Hña hñú speakers: '*...we don't use that healing any more, but if you talk with DM, she will probably remember...*' (a young woman). As will be explained in next chapter (p200), during the CHTP implementation, one activity was to look for knowledge about chicken pox in the community. The students brought information about different interpretations of medical knowledge but none of that information referred to old traditional knowledge. The following experience in Mino can also exemplify this lack of interest in old traditional knowledge. During fieldwork I was staying overnight with a family and had a diarrhoea episode. When my hostess –a mature woman- found out about my problem, she offered to go and get the 'doctors' (Pablo or Manuela). I told her that she probably knew about some remedy that could help me and preferred to have it. Then she said: '*well, I keep collecting plants and renewing my stock... I don't offer them any more since nowadays people don't believe in them, they prefer doctors' medicine*'. Young Minoans and children have little access to this source of knowledge since they do not have much communication with the old.

For babies, young children and old Minoans, family life is the main knowledge source. School children and young people take much knowledge from interactions with other Minoans in every-day collective life since they spend much of their time outside home,

with relatives and family friends. As explained before, collective life is a life axis and principal knowledge source for adults, men and women.

With the construction of the motorway, poverty rose, the road was open, the city appeared, migration began and communication with nearby communities and the cities improved. That represented a change in Mino's economy and an abrupt change in Mino's life. The necessity to confront the new Minoan reality generated new ways to construct local knowledge, representations and identity. The road also facilitated access to the city, which has been since then a principal knowledge source for Minoans.

Minoans transform and adapt the city knowledge and representations to their circumstances. An example of this is taken from fashion and clothes. A characteristic of Minoans living in the cities is a 'defiant' way of using heavy black leather jackets that are expensive for Minoans. Children can use their regular jumpers or shirts and adopt the same 'defiant' gestures when talking to other children. Often this 'performance' ends with laughter. Another example is the transformation of Minoans conception of success and transcendency within Mino, to a new one often linked with the possibility of finding better living conditions in the city as will be shown in next section.

The political parties, school, church and other institutions, including the health institutions, transmit explicit knowledge besides doxa. That knowledge is learnt with the aid of textbooks and songs and through teachers, doctors or other pedagogic authorities' interpretations of reality. An example of this is a fieldwork observation during this research when we held a summer 'scientific week' project with children. During that week, some children chose to develop a topic about water and rain including scientific observations, reasoning and explanations. Simultaneously some of those children were learning in Sunday School that water and rain were gifts of God to people with good behaviour (contents in Sunday School booklets). On their part, the children perceived both discourses as separated and did not question or confronted them. I saw a teenager participating in the water project coming out from Sunday School and commented: '*So, we are getting to know water and rain and you are learning more things in church*'. She 'hid' the Sunday School booklet behind her, and replied: '*no, this is another thing, it's about God...*'.

Another source of doxa inculcation and explicit knowledge transmission are the media (television and radio). An example of this is this meaning of homosexuality registered in a shop in Mino, from a radio programme advertising a healing service in Mexico City: '*...if you suffer from headaches, diabetes, varicous veins, homosexuality, sadness, liver... and other diseases worrying you...*' Most TV and radio programmes are embedded with different forms of violence. National and international social, economic or political information comes as chunks within media programmes giving much attention to sensational notes, advertisements and political and religious propaganda. Violent episodes are often among the contents of street conversation.

Other knowledge sources are the communication Minoans have with nearby communities when visiting friends and relatives or when celebrating the frequent parties in Mino and nearby villages and towns. Once the celebrations or parties are over, all Minoans will comment on them for several weeks or months and will tell stories about how each of them experienced those events.

Church, school and health care are relevant institutions in Mino for the transmission of institutionalised knowledge. Presently, much doxa and explicit knowledge about Minoans' conceptions of health, disease and authority come from their relationships with institutions. Examples of these will be presented in chapters eight and nine.

As has been exposed in previous paragraphs, the knowledge sources in Mino are multiple and of different kinds. Some of the information reaching Mino can help in the construction of knowledge capable of upholding and/or rebuilding a Minoan identity that could cope with the current changing life situation. Some other has the potential to completely transform the life of this community. I will examine next some of the characteristics of the knowledge resulting from the relation of Minoans with their reality.

Characteristics of Mino's knowledge and meanings

In Mino the collective life and purpose appears different from the individualistic living proposed by hegemonic medical paradigms. Despite differences in perceptions and

representations, most Minoans share the values of collective life and problem solving. Minoans' knowledge is changing and constructed as *noema* and *noesis* from a vast amount of information coming from inside and outside Mino. Sometimes this information can only partially encompass Minos' reality. Here I give an example.

> '*...to have a health clinic. In that way also there will be preoccupation for the newborn, the mother, the care, the support, vaccines, everything. To have a trained person to be here, that can guide us, the community too, in their turn, can see which children have been vaccinated, which ones are due them, ... and so on. That trained person will say: you know? go and tell this one or the other and to those due for vaccination or bring him along since he's got a cough or flu or go and let me check their temperature.. a trained person who also have a proper place with the most necessary services*' (CHTP students' conclusion about the needs for the newborn and the mother)

Minoan people classify life events and people as what is good and what is bad and who is good and who is bad, as exemplified through the following testimonies taken from different adults in Mino.

What is good is often considered an individual quality expressed in action:

> -'*X is a good person, he works hard and cares about his family. He cares about what is going on in the village*' (an authority).
> -'*...I say. I will go to work to in Mexico, I said... I am not drunk, I am not on the binge, I save my money, come, find my piece of plot, buy it and build even if only two small rooms...*' (an adult woman).

What is bad is frequently related with bad behaviour and lack of understanding:

> -'*I strongly believe that it was X who committed the robbery. He is as thick as two planks; he is always out of school, poor boy...*(an adult with moral prestige).
> -'*That family is impossible, they don't understand, both* [parents] *are alcoholic... it is the duty of the authority to explain and try to make them come to their senses but they don't listen, they don't understand*' (an authority).

Minoans assimilate their own or other's collective or social roles also with underlying conceptions of what is a good or a bad performance:

> -'*We must go and see X, he is authority now*' (an adult male).
> -'*There is no use in seeing Y, even though he is an authority now, I don't think he will help. We better wait until the authority changes*' (another adult male six months later[74] referring to the new authority).
> -'*I'm not the right person, I'm only a mother*' (an adult woman invited to join this research project).

[74] As mentioned in previous chapter (p135), local authority changes every six months.

The body is an instrument to perform good or bad actions that, in return, can affect the body. In this sense good or bad behaviour is related to health. That is the case of R's father who has a bad leg injury and his family does not want to look after him. A neighbour mentioned '*He deserves it* [the injury and family abandonment], *because of the way he always behaved with his family*' (a middle age woman).

Minos' material conditions are often linked with practice as individual transcendental action where divine control and will is present:

> '*I say, God is to help me, pray he will not abandon me, pray he will not leave me without food or drink... God is like that, he says: this is for you to remember me since if you are fine and healthy you don't even remember me, isn't it true?* (an adult woman).
> -'*...they often say: God punished you. No, God does not punish, we punish ourselves because if we are sick, we don't attend to ourselves...*' (an old woman).

In Minoan conception, disease can hinder health, however a healthy person can have a disease and remain healthy as far as the disease does not interrupt his/her practical life. Health is also related with how well a specific family or individual performs their social roles probably finding similarities with what the Ottawa Charter in Health Promotion proposes as 'to cope with the environment'[75].

Common sense is the more accessible knowledge to Minoans and the kind of knowledge that helps them to solve local problems. Popular knowledge is also accessible to all Minoans and linked with local problems. There are Minoan experts holding expert knowledge. That is the case of the seamstress, the *pulque* and earth pottery producers, the peasants and the masons. Their knowledge is accessible to other Minoans and linked with local problems. Institutionalised knowledge is distant to Minoans' problems and access. Common sense and popular knowledge are the two levels of the knowledge taxonomy presented in chapter two (p40) that are less likely to be subordinated to hegemonic representations and are also the most frequently used knowledge in Mino.

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[75] 'Health Promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or *cope with the environment*' (Ottawa Conference in Health Promotion 1986:4)

The lack of access to expert health knowledge and practices in Mino, exposes Minoan people to a mixture of institutionalised and fake knowledge in the delivery of medical services. This is especially true for disease understanding and therapeutic practices dominated by the medical-market hegemony. Here I provide an example.

S, a middle age woman with major domestic problems developed a continuous headache, she was tired and not feeling well. She went to a public health care service. In her first consultation the doctor gave a diagnosis of diabetes based on no other information but the symptoms referred to above. S received a prescription for medicines to relieve her 'diabetes symptoms' and a laboratory order for one-blood-sample and general urine tests. The laboratory results showed normal sugar levels and some dubious urinary infection. The doctor, without any further enquiring, switched her diagnosis to a urinary infection and gave S two pills (a pharmaceutical company's gift sample) 'to be taken in the morning and in the afternoon'. S came to me seeking advice. We looked together in a drug guide for information about the prescribed medicine and found that those pills had an effect on the lower limbs venous blood circulation and should be taken, for vein therapy purposes, daily for a long period of time. I questioned the doctor's capacity and also the trust S had in his prescriptions. To my comments she said:

> '*I can see now that he is wrong, but what can we do? How can I know what is right and what is wrong? What can we do, if we are in need and we have been told that we should trust doctors?*'.

The interest of Minoans in knowledge is dominated by technical and practical interests as the following examples illustrate:

> '*I might not be educated, but I can cope with living, I have my hands and know things about cropping, and with my little animals I make my way*' (a middle aged man).

> '*I may not be complete; yet, I must attend all my peasant duties, if I don't do them, who will? ...I have hands, don't I?*' (a woman with a physical handicap).

> '*As long as God gives me strength my family will lack nothing*' (various informants).

> '*You see it is not that I don't want to do things; it is that my legs don't help anymore. I'm good for nothing. I walk so slowly, but take my breaks on the way. I come to get the tortillas*[76] *and do some cleaning for my son but sometimes I can't*' (an old woman with an adult son that abandoned her for several years).

[76] *Tortillas,* the basic food in Mino. Sort of flat pancake made out of corn.

The emancipatory interest in knowledge is also revealed in Minoans. Here follow some examples.

> '*Long ago I noticed that doctors were not doing well, but I thought it was me the one that was ignorant... everybody goes to doctors ... it couldn't be me who knew more than doctors...* ' (CHTP student).
>
> *'I can say, if I study I will understand better and catch up with what is going on ... so we will not be cheated* (young adult)'.
>
> '*We, as the women we are, could find a way to look after our family while working and helping our children to live better and to go to school... without patrones*[77] *that only care for their money and don't give a damn for us...*'
>
> '*...we don't know their* [institutions'] *way, we do things in our way, they don't know here, how we do things and our way, how things work out*' (a peasant adult male).
>
> '*I do what I can to attend church services, but you don't really know when will they take place. I need to go to X town on Sundays to the market and if the priest doesn't show, there you are, I need to go to X town... the priest will say that I am in sin but what? I need to work'*
>
> '*they* [politicians, administrators] *can say as they please, we get little from what they say, at the end of the day, who is going to work?... breaking your back, that is what counts*'(a middle aged woman).

However, their marginality and poverty, their strong relation and comparison with people, life and conditions in the city and the pedagogic action carried out by the media and the institutions, is eroding their local belonging and meanings, as many adults and old people testify:

> '*Things have changed; it is hard to maintain people in the Assembly. Increasingly, they don't care much about collective problems, that is why we need to lock the door during the Assembly...They should take example from DaM, she is so old and she nearly always attends the Assembly*' (a commissary).
>
> '*It's all right if I join that committee, but, why always me? I think the other compañeros*[78] *should take more responsibility*' (a woman in the Assembly).
>
> '*Now it is difficult to propose collective work, people prefer to go to the city and earn money and then to pay for their collective work share here, than to really get involved in collective work*' (a CHTP student).

[77] *Patron.* A person that hires people more as servants than as workers.
[78] *Compañero* a term referring to a peer person when performs a specific task. Also the way in which people refer to each other during the Assembly.

> *'Before we were all right, poor but all right. We cared for the village, everybody was responsible, we looked after each other. Now, the young people coming from Mexico to visit their families bring along ideas that are threatening our peace. We fear drugs. Drugs are coming into the village. And there is violence also, in the parties, they want to fight'* (an adult man).
>
> *'...see, it is all right here... I don't complain, God knows why are we here, ...*[but] *now we have nothing* [compared with the city], *we can do nothing but cropping, or what is here... young people need to think about going away...'* (a middle aged man talking about staying/leaving Mino).

Children and adolescents often think of themselves, their families and overall life in the city as an escape or a 'natural' future. An example of this is a frequent answer of children when asked about what will they do after elementary school: '*I will go to Secondary school to X town, Y city or Mexico* City' (different children between ten and twelve years). Even when success through migration to the city is often understood as '*...to live better...to give a better life to my family...to find a job to eat, to give education to my child...*' (different young and middle age men), a new representation of 'success' has been growing recently among children and teenagers: '*to meet important... amusing people*', '*to become important*' , '*to buy a car ... a leather jacket*' (different children in the scientific week referred to before). That new representation of success generates complementary representations that refer to Mino's reality such as '*I am the one that is not there*' (a male adolescent), '*I can't understand because I'm just sitting here*' (an adult man). Even when they are more individual than collective, these representations are immersed in a basic Mino collective representation: to forecast self in the city is only possible through an image of belonging to a social network as collective self.

In this way, Minoans' are in continuous construction and reconstruction of their knowledge and meanings. It is said here that, from emancipatory interests in knowledge, from their collective way of thinking and living, from their capacity to construct and adapt knowledge through the use of common sense and popular knowledge, Minoans can further develop *noesis* useful to construct or reconstruct and maintain their identity, break hegemonic paradigms and improve their living conditions.

I will present below an assessment of Mino's health and healthy subjects based on the understanding of the objective and subjective dimensions of Minoan subjects and their context constructed in this chapter and in chapter six.

HEALTH AND HEALTHY SUBJECTS IN MINO

After the analysis of Mino's general characteristics, poverty, knowledge, hegemony, fields, disease and infrastructure, in box 7.6 I present a final 'diagnosis' of health from the conception of health proposed in chapter three (p70): 'an embodied human capacity to construct trascendental feasible futures and achieve them'.

BOX 7.6. HEALTH 'DIAGNOSIS' FOR MINOANS

HEALTH	MINOANS
HUMAN CAPACITY	In continuous development through collective living.
TO DECIDE	Hindered by subordination and restricted access to overall wealth.
AND CONSTRUCT FUTURES	Hindered by diminished access to overall wealth.
FEASIBLE	Hindered by subordination and restricted access to overall wealth.
TRANSCENDENTAL	Whilst the mere geographic existence of Mino is challenged, they have in perspective a collective existence in the cities or an improvement of present conditions in Mino.
ACHIEVE THEM	Hindered by subordination and restricted access to overall wealth.
EMBODIED	Subordination and restricted access to overall wealth are written in Minoans bodies as a disease pattern of poverty.

Through this box I argue that Minoans' health has been seriously undermined because of their subordinated position resulting from their hegemony/subordination relations. It is also hindered by their restricted access to overall wealth. However, Minoans are still silently opposing hegemony through their collective representations of life and living.

While Mino's health knowledge increasingly develops subordination to market-medical hegemony becoming potential market subjected 'clients', Minoans have developed as healthy subjects (for a discussion about clients and healthy subjects refer to p75). I consider three constituents of a healthy subject that Minoans have. First, they construct their own knowledge by the interaction of common sense, popular and expert knowledge that they take from their objective and subjective worlds. This knowledge

has *noema* and *noesis* compounds and develops from technical, practical and emancipatory interests of knowledge. Second, Minoan systems of perception, thinking and realisation incorporate the relation between the subjective and the objective worlds. While increasingly with more market hegemonic contents, Minoans construct their unique values, meanings and knowledge mainly expressing their particular way of thinking and relating with their symbolic and material reality. In box 7.7 I compare the emerging Minoan 'client' characteristics and Minoans' healthy subjects characteristics. I argue here that Minoans are healthy subjects whose health has been hindered by subordination and restricted access to wealth.

BOX 7.7. MINOAN HEALTHY SUBJECT COMPARED WITH EMERGING MINOAN 'CLIENT'

EMERGING MINOAN CLIENT	MINOAN HEALTHY SUBJECT
Receives knowledge, representations, meanings and values from market agencies. Fake and institutionalised knowledge increasingly occupy the place of other knowledge. *Noematic* knowledge prevails over *noetic* knowledge. Practical and technical interests of knowledge prevail over emancipatory interests.	Constructs knowledge, representations, meanings and values from common sense, popular and expert knowledge and from technical, practical and emancipatory interests of knowledge in the form of *noema* and *noesis*.
Their systems of perception, thinking and realisation, increasingly more, separate the subjective and objective worlds.	Minoans' systems of perception, thinking and realisation link and incorporate the relation between the subjective and the objective worlds.
Increasingly relating with the practical world with actions sustained in values meanings and knowledge with market hegemonic contents.	Construct their practices from unique values, meanings and knowledge mainly expressing their particular way of thinking and relating with their symbolic and material reality.

It is considered here, following the discussions in chapters two (p24) and four (p81), that to carry out empowering counter-hegemonic health promotion in Mino it is necessary to stop the processes leading to the construction of 'clients' and to promote the processes leading to the strengthening of healthy subjects.

CONCLUSIONS

In this chapter I analysed and evaluated the repercussions of hegemony over the objective and subjective dimensions of Minoan subjects.

I showed in this chapter that hegemony is expressed in Minoans' subjects material situation in different ways. Expressions of hegemonic action are Minoans' restricted access to quality disease, preventive services and material infrasctucture and the strategies of Minoans to meet their disease problems. Another expression is the subordinated way in which Minoans' relate to doctors and the medical services. The inscriptions of hegemony in Minoans' bodies reveals as a pattern of 'diseases of poverty'.

I explored the subjective dimension of Minoans subjects through the analysis and evaluation of their knowledge and meanings. I argued that Minoans are exposed to a large amount of information -coming through people living in the cities, the media and other sources- that they construct as *noema* and *noesis* mainly using common sense and popular knowledge. The lack of quality expert knowledge in Mino opens way to the emergence of fake knowledge that mix with institutionalised knowledge. Even when technical and practical interests of knowledge dominate in Mino, emancipatory interests are also present in Mino.

I also argued in this chapter that Minoans marginality and poverty, their strong relation and comparison with people, life and conditions in the city and the pedagogic action carried out mainly by the media, is eroding their collective Minoans life that is a strong component of their identity, belonging and meaning. It is said here that, from their emancipatory interest in knowledge, Minoans can further develop *noesis* useful to construct and maintain their identity, break hegemonic paradigms and improve their living conditions.

After analysing and evaluating some subjective and objective dimensions of Minoan people, I argued in this chapter that Minoans are healthy subjects whose health has been hindered by subordination and restricted access to wealth resulting from hegemony/subordination relations. I also argued that, to carry out empowering counter-

hegemonic health promotion in Mino, it is necessary to stop the processes leading to the construction of hegemonic market clients and to promote processes leading to strengthening the development of healthy subjects.

With the assessment of the Minoans' health and healthy subjects characteristics, I completed the analysis of the context of this case study. This analysis and evaluation are the base line for the analysis and evaluation of change occurring due to the pedagogic intervention (the CHTP). In next chapter I present a description of the CHTP implementation.

CHAPTER 8
CHTP IMPLEMENTATION

The purposes of this chapter are to describe the four CHTP intervention stages presented in chapter five (p114) as they actually developed in Mino, and to provide data for the analysis and evaluation of the CHTP's process and outcome indicators. For a better understanding of this description, first in this chapter I present the stages in which the CHTP developed and the sources of the data sustaining the CHTP descriptions. Next I examine the CHTP's teachers' characteristics, selection and training. Then I continue with the description of each intervention stage. In appendix five, I give numbers to each utterance of this description. As explained in chapter five (p127), those utterances were used as CHTP process and outcome indicators' evidence to analyse and evaluate to what extent this emancipatory pedagogy was capable of helping to develop the CHTP's student's health and their characteristics as healthy subjects. This evaluation and analysis will be done in chapter nine.

As mentioned in chapter four (p102), this research intervention was conceived as a flexible critical health teaching programme (CHTP) sustained on a self-growing pedagogy capable of adapting to different rural contexts. Minoan's health situation -presented and discussed in chapter seven- and their acceptance of our project proposal, justified the implementation of a pedagogic intervention (the CHTP) to promote their health.

THE CHTP STAGES AND DESCRIPTION OF THE DATA SOURCES

As described in chapter five (p114), the CHTP's implementation had four overlapping stages: CHTP start up and establishment (August 1997 to January 1998); first CHTP teaching period (February 1998 to April 1998); second CHTP teaching period (April 1998 to October 1998); and third CHTP teaching period (October 1998 to March 1999). As has been presented in chapter five (box 5.4, p114), since I needed to be sure that the CHTP was implemented as intended - thus keeping the flexible characteristics of a self-growing

pedagogy-, I looked for aims to achieve and questions to answer as the CHTP advanced to evaluate and make necessary changes to the CHTP process. I also looked for outcome questions that could help in the analysis and evaluation of the CHTP's outcomes. I reproduce in box 8.1 the four CHTP stages, their questions and aims.

BOX 8.1. CHTP IMPLEMENTATION STAGES, AIMS AND QUESTIONS FOR PROCESS AND OUTCOME EVALUATION

STAGE	AIMS	QUESTIONS
STAGE 1 Aug 1997- Jan 1998 CHTP START UP AND ESTABLISHMENT	-To recognise the site. -To establish links with Minoans. -To achieve first agreements. -To find departure points for the CHTP. -To recruit candidates.	PROCESS 1.Were we on track? 2. Were there any problems that needed special attention? 3. What action did we take to improve the CHTP performance?
STAGE 2 Feb -Apr 1998 FIRST CHTP PERIOD	-To develop a self-growing environment. -To develop communication, dialogue, perception, observation, enquiring and study skills. -To find out student's conceptions about health, disease, teaching and learning. -To define CHTP problems through observation of students' perception of their reality.	PROCESS 1.Was the CHTP implemented as intended? 2. In which aspect were the greatest process benefits and costs? 3. How did this intervention proceed to stage three?
STAGE 3 Apr-Oct 1998 SECOND CHTP PERIOD	-To develop and consolidate a self-growing environment. -To approach problems raised by students. -To develop and exercise already developed communication, dialogue, perception, observation, enquiring, and study skills. -To identify students' developing identity. -To develop planning and performance skills.	PROCESS 1.Was the CHTP implemented as intended? 2. In which aspect were the greatest process benefits and costs? 3. How did this intervention proceed to stage four?
STAGE 4 Oct 1998-Mar 1999 THIRD CHTP PERIOD	-To strengthen a self-growing environment and self-growing skills and knowledge already developed. -To develop students' autonomy and self-reliance. -To face community demands to students.	PROCESS 1.Was the CHTP implemented as intended? 2. In which aspect were the greatest process benefits and costs? OUTCOME 1.To what extent were CHTP intended outcomes achieved? 2. In which aspects are the greatest changes shown through the CHTP'simplementation? 3. What were the costs of the CHTP's implementation for CHTP participants? 4. How did the CHTP influence knowledge and subordination/hegemony change?

The aims for stage one were defined before approaching the research site. Stage two (the first CHTP period) aims were mainly defined before approaching Mino, however they were adapted to observations derived from first contacts with the site and with Mino's Assembly. The aims for the third and four stages (the second and third CHTP periods) were progressively defined with students as continuous evaluation revealed the CHTP's

and the students' needs. The questions presented for each stage provided the process and outcome evaluation guidelines.

Data sources

As it has been argued in chapter five (pp115, 118-121), the 'vivid description' presented in this chapter is the result of triangulated information. In this description I am considering data triangulated through dialogue, only views or interpretations resulting from dialogic practices during CHTP sessions or from the evaluations with students or teachers. To build up this description, I also use data triangulated through registers or observers. I consider triangulated data only information about a specific object of reality that had been registered in the same way in at least three records or three different times or from three similar testimonies.

The records used to collect the information described in chapter five (p119) are: classroom observation notes (Cron), Manuela's diary (Md), Pablo's diary (Pd), tape recording (Tr), flipcharts (Fc), fieldwork notes taken outside CHTP (Fwon), my notes from evaluation with teachers and/or students (Etn, Esn), or outside observers' notes or reports (On).

The selection of the data to construct this 'vivid description' followed two guidelines. A first guideline was to ensure that the description reflected what happened in the CHTP.A second guideline was the indicators that I constructed to evaluate the CHTP's processes and desired outcomes.

In this way, each utterance in the description of the CHTP's implementation is triangulated data suitable for the analysis and evaluation in chapter nine.

CHTP TEACHERS

The selection and training of CHTP teachers was initiated before we introduced ourselves in Mino. To select teachers, three basic characteristics -from which to develop the ideal teacher profile- were considered: previous expert knowledge[79] about health; sharing this research's commitment to emancipatory health promotion and being persons who could learn and want to work within this self-growing pedagogic approach.

Pablo and Manuela were the CHTP teachers chosen. I spotted Pablo when he was my student on his first medical training course. He introduced me to Manuela who was also a medical student. We developed together some adult education projects before the CHTP and I discussed with them this CHTP project. I found in Pablo and Manuela the basic characteristics that would allow them to develop towards the construction of CHTP teachers.

Manuela, Pablo and I shared academic and political interests. Manuela's, Pablo's and my representations relevant to consider for this research project can be summarised as follows: representations coming from the hegemonic medical paradigm within which our first training experience took place; a set of representations coming from counter-hegemonic paradigms and from specific training to understand and transform poverty and disease; a third set of representations coming from previous training, work and knowledge about rural and indigenous communities; a set of representations coming from some aspects of our family origins; and finally, our own believes and practice options.

Pablo and Manuela witnessed and helped in this CHTP conception through their criticisms, experiences and comments, and looked for specific pedagogic training for health teaching. In box 8.2 Pablo's and Manuela's initial characteristics are contrasted with the ideal teacher characteristics presented in chapter four (p101), showing possibilities for them to develop towards ideal teachers. More information about Manuela's and Pablo's characteristics can be found in appendix two (p282).

[79] For a description of the conception of expert knowledge used in this thesis see chapter two (p45).

BOX 8.2. PABLO AND MANUELA'S CHARACTERISTICS AND SELF-GROWING IDEAL TEACHER

	IDEAL TEACHER	PABLO	MANUELA
TRADITION	Political, educational, cultural.	Raised within empowerment rural development projects.	Raised in a context with political commitment with the poor and underserved.
KNOWLEDGE	Common sense, expert, popular and institutionalized.	Common sense, health expert, popular and institutionalized.	Common sense, health expert, popular and institutionalized.
WORK	Political , ideological, pedagogic.	Student, political, pedagogic, manual.	Student, political, pedagogic.
CHARACTERISTICS	-Person with hope, faith and humility with understanding of historic block. - Performing group commanded tasks.	-Person with hope, faith and humility. -Had reflected about poverty and health context -Has time and possibility to meet the CHTP's demands in Mino.	-Person with hope, faith and humility. -Had reflected about family, women and community. -Has time and possibility to meet the CHTP's demands in Mino.
ROLE	-Interchangeable with students. -A mirror and interpreter that triggers processes and conducts them. -Is a group companion and an advisor when required.	-Experience in triggering and conducting pedagogical processes.	-Experience in triggering and conducting pedagogical processes.
AIM	-Insubordination raising. -To oppose arbitrariness, pedagogical action and pedagogical work and raise fields of opinion. -To develop a language of critique and possibility.	-To learn about emancipatory pedagogical processes and alternative health conception and practices.	-To learn about emancipatory pedagogical processes and alternative health conception and practices. -To practice family and community medicine.
PEDAGOGY	-Problem identification, inquiring, action and knowledge circulation through dialogic processes of discussion and study about problems of student's reality.	-He had previous experience of teaching through problem-based learning. -He has an inquiring mind, is creative and patient. -Receptive to criticisms	-She had previous experience of teaching through problem-based learning. -She is assertive, orderly, methodical, critically observant and has an itch for knowledge.

Manuela's and Pablo's specific training for the CHTP consisted of formal and informal activities described next. Pablo and Manuela obtained a Health Promotion Diploma that included: anthropology and sociology contents to understand people and institution's texts and discourses and to delimit health problems; communication and pedagogical contents to work with individuals and groups; planning and administration contents to organise actions around problems of reality. During this diploma course they met people from different

governmental and non-governmental organisations sharing with them their health practices, experiences and knowledge. During the two years previous to the CHTP, Pablo, Manuela and I held periodic sessions to comment, discuss and make reflections about their medical training, the hegemonic medical model in practice, medical habitus construction and 'patient's culture'. Manuela and Pablo had training and practical experience as teachers within a local government project in the state of Chiapas aimed at producing educational promoters in rural and indigenous areas. This training focused on the developing of local teachers to address local education problems. They also visited health, development and education projects aiming at people's empowerment through learning practical skills.

Ongoing training during the four intervention stages described below was fundamental for Pablo's and Manuela's learning and performance within the CHTP's self-growing environment. It consisted of observation and reflection about their teaching performance. Ongoing training was also done during weekend evaluation sessions with me where we elicited observed teaching characteristics that were or were not consistent with ideal CHTP teaching. In those sessions we proposed teaching changes and evaluated outcomes. Feedback from students was an important part of ongoing teacher training.

A quote from Manuela exemplifies that:

> '*I said: how am I going to explain diabetes, with all that it implies, it is a lot...They* [students] *needed to understand many things so they could solve a lot of problems that diabetic people present, it wasn't easy. It was great, just great, because we presented the basic explanation, but they said what they understood about what we were saying and from there they could solve the problems...*' (Etn).

Throughout the CHTP's development not only were Manuela and Pablo trained as self-growing teachers, but also the CHTP's students learned to communicate and construct self-growing environments where they could perform a self-growing teacher's role as will be shown through the description of the four stages of the CHTP presented below.

STAGE 1. START UP AND ESTABLISHMENT

This research intervention started with stage one when we were looking for the basic conditions to develop a self-growing pedagogy. Stage one's aims were: to locate the intervention site; to establish links with the Minoans; to achieve first agreements with the Minonans; to find a departure point for the CHTP and to recruit candidates to join the project (see box 8.1 p182).

Approaching and familiarisation with the CHTP site

I planned visits to Mino accompanied by personnel of an NGO that previously developed housing and productive projects in Mino and proposed Mino for this research. NGO personnel introduced Pablo, Manuela and me to different Minoans and also to Mino's Assembly. Six months previous to the CHTP's start, Manuela, Pablo and I visited Mino five times. Those visits included physical site familiarisation and meeting with Minoan authorities. Through interviews with key informants I collected useful information about Mino's history, social dynamics, economy and the dynamics of previous development projects in Mino, such as the seamstress workshops.

Pablo, Manuela and I attended two assemblies before the CHTP started. In our first meeting with Mino's Assembly we introduced ourselves and presented our broad teaching, service and research intentions. I presented Pablo and Manuela as project participants and also as medical *pasantes*[80] mentioning that we could not say anything about whether we could provide medical services at the moment. At that time, we were making arrangements with the Health Ministry to have Pablo and Manuela as *pasantes* doing their social service in a research modality thus avoiding bureaucratic work. We told the Assembly that if they accepted, Manuela and Pablo were going to live in Mino for one year. The Assembly showed interest and gave us another date to talk more deeply about this research intervention.

[80] Medical *Pasante* is a medical student in his/her last training year accomplishing compulsory social service. Most times social service is done in rural areas within governmental projects or services. It is also possible to accomplish social service joining a research project under university supervision.

In our second encounter with the Assembly, Pablo, Manuela and I presented this CHTP proposal by reading and discussing a written document specially prepared through questions and answers from where we supposed Minoans could get a better idea about this research intervention's aims and functioning (the full document can be found in appendix three). We asked the Assembly to accommodate Manuela and Pablo and to find a situation to make sure that they could be provided with food. The Assembly agreed to receive Pablo and Manuela in 'the teachers' rooms': two rooms, each with another smaller room attached, that they built in the forties for the elementary school teachers on one side of the *plaza*[81] and that since then had been used for different purposes. They discussed how they were going to get beds and linen and that the health committee should organise how they were to feed Pablo and Manuela.

Establishing links with Mino's people

When the Assembly finished, the health committee[82] informed us that different families in the community would feed Pablo and Manuela (and I during my weekend visits). According to a list prepared by Mino's health committee, Pablo and Manuela went for breakfast, lunch and dinner each day as invited by a different family in the community. In that way, from the very beginning they had family insight.

Insight into families gave Pablo, Manuela and me an idea of whole community functioning. This helped us gain an early insight into Mino's social relationships and the Minoan's problems and knowledge. A quotation from Manuela and Pablo illustrates that:

> *'That was marvellous since from the beginning, from the very first day, we started to get to know the families from inside... Besides getting to know the house, the family, you also start to get to know what's up with the community... You start to understand: ah! This family doesn't get on well with that one ... and things that if we had only arrived and work with the students and the medical consultations, we would never get to know, to know all that we knew through family visits...'* (Tr).

[81] *Plaza*. Mino's central square.
[82] As mentioned before (p136), Mino's local organisation includes committees responsible for specific problems: water, land tenure, school, festivities, and health amongst others.

However, they did not cover every family since there were a few that did not want to receive them. The health committee explained some of the reasons: they were shy; they thought that their 'poor food' was not at 'doctors' level. There were also some families that fed Pablo and Manuela in a very distant way:

> *'You could feel the tension, they did not start any conversation, did not sit with us. There were houses where it was evident that we were eating the things that they would never eat themselves. We were getting chicken, little fish and lots of green chilli sauce.'* (Tr)

Early links with Minoans were also built from informal conversations with people freely approaching Manuela and Pablo, such as children, adolescents and people providing help and orientation while Pablo and Manuela settled in Mino, such as authorities or members of different committees (for an explanation of the Assembly and other authorities see chapter 6:136).

Pablo's and Manuela's power

Since before approaching Mino, we analysed our sources of power and evaluated that we had far too much accumulated capital to play with in Mino and that this could be a first obstacle to achieve horizontality in the CHTP. I will explain this here. There is a strong *doxa* in Mino about the medical profession that makes medical doctors, even if they are students, persons with power (see chapter seven p162). Also, Minoans never had a live-in doctor and Pablo's and Manuela's presence would give them pride and prestige. Other empowering capital was that Manuela, Pablo and I were professionals coming from Mexico City backed by the university and the privileged place they had living in the teachers' rooms. The amount of Pablo's and Manuela's material and symbolic capital could represent a problem to achieve a self-growing environment for the CHTP.

One way to counteract that power was the fact that Pablo and Manuela depended on the families for breakfast, supper and dinner. Other ways were that they revealed to the Minoan's and the CHTP participants their lack of understanding of things occurring in Mino and explained their knowledge extents and limits whenever it was pertinent and

possible. Whenever they used medical jargon, they explained it's meaning and encouraged people to find an equivalent wording for it and also to remember the technical word.

Recruiting candidates

Pablo and Manuela spent the first week calling for CHTP candidates through home-visits and also in street conversations. The first twenty-four candidates were people of different ages and sexes, women prevailing over men and teenagers and young men and women over older people. Most of them came with a 'first aid' course in mind. The CHTP was a new concept for Minoans. In this period, the non-medical ideas of the project did not come across:

> '[We were] *continuously saying that it* [CHTP] *was an experiment, that much-unexpected things could happen. That was all the time. That health was not to give medical consultations, not first aid, etc., etc., It was very hard at the beginning, because people came ready to learn to give injections, pass intravenous liquids, measure temperatures, and stop*' (Md).

All candidates were accepted on the condition that they attend all sessions and bearing in mind that they were not going to learn first aid or at least that that was not this project's aim. As time passed, out of the twenty four candidates attending the first meetings, we had a more solid group of seven students coming from Mino and another four from surrounding communities with overall characteristics similar to Mino's.

Achieving first agreements and finding a departure point for CHTP

First agreements with the Minoans were taken in the Assembly. Candidates were submitted to an evaluation, which had several purposes: to find a local conception of health before our intervention; to start by giving the voice to the students; to identify a starting point for the whole process; to have some insight into students' overall characteristics; to evaluate students' communication skills and to set basic agreements for the development of a self-growing environment. That evaluation consisted of a collective interview, a questionnaire and a reading and writing proficiency test.

Reading and writing test

This test was the first CHTP formal activity. It was presented to candidates as a necessary assessment to give us insight into their reading and writing skills. Fourteen candidates took the examination: nine of them became CHTP students. The test consisted in reading aloud two texts. The first text was a metaphor and the second a landscape description. For the first text, candidates were asked to answer in writing, five questions relative to the understanding of the methaphor. For the second, they were asked to make a drawing showing the image described in the text and also to answer five questions relative to that description.

I asked candidates to read one paragraph each. After one reading round I decided to read the text myself, since candidate's reading was impossible to follow and understand. Their anxiety and shyness was adding to their reading failures. Candidates were shy to show their 'poor' reading and writing skills and concerned about showing their lack of understanding and 'hard head'.

Luz and Esther (two candidates that became students), spoke very little, only if required by us or with self-pejorative jokes or comments:

> *'I'm hard headed, but let's see what happens...' 'It's useless, you won't understand my writing...' 'They already said all what I had to say...' 'Let him say it, he says it better...'* (Cron)

At the beginning, candidates behaved as 'in school': peeping at each other papers; in complete silence; raising their hand to make questions; worried about speed and time and anxious because of a 'failing' mark possibility. Pablo, Manuela and I responded and complemented the candidate's attitude towards a traditional exam situation. As minutes passed by, we made jokes; gave straight answers to their questions; sat beside them and held brief conversations; made fun about the role of 'teachers' and 'students' in exam situations and made explicit our own anxiety and the worries we were perceiving. Finally there was a more relaxed environment where candidates laughed and mocked their answers and fears. They also encouraged each other and praised their individual skills.

Manuela, Pablo and I followed the candidates' arguments and ended with brief open discussions about their understanding, beliefs and points of view regarding the overall exam situation. In a final round of comments, Mundo mentioned:

> '*I can see now that this is not going to be like school, here we must speak and say what we know, what we understand. We must leave shyness aside and study to learn better what doctors teach us*' (Cron).

That activity closely resembled what Minoan candidates knew as 'teaching', fulfilling their learned-through-school teacher/student expectations and providing them with security and certainty. It also gave Pablo, Manuela and I practical experience with Minoan students.

During this activity, some hygiene measures (e.g. daily shower, water boiling, hand washing) came into the conversation. The candidates smiled and nodded when making comments such as:

> '*how are we supposed to boil water if it is too expensive*'; '*to take a daily shower, of course, when it is possible*'; '*in the fields it is not possible to wash your hands after going to the loo*' (different candidates, Cron).

Test results

Out of five candidates that did not become CHTP students, four could not solve the metaphor. Five, out of nine candidates that became CHTP students, could solve the metaphor. After analysing the elements used by the candidates in their drawings and their accuracy in reflecting the second text content, I found that candidates that became students used more elements in their drawings than those that did not become CHTP students but all represented the same image. Candidates did not ask for evaluation results nor did Manuela, Pablo or I talk about individual results, since we focused on collective results.

Even when the group of candidates that became CHTP students showed better understanding of the reading contents, just two of them, Alicia and Elena, could read and write fluently. Hence, one of the first tasks was to develop writing and reading communication skills.

Evaluation participants discussed the need to further develop group writing and reading skills with the support of each other.

Questionnaire

Fourteen CHTP candidates completed the questionnaire. Out of those, eight became CHTP students. The questionnaire had three sections: general data, multiple choice and open questions (a sample of the questionnaire is in appendix one). From the general data section we obtained a first idea of the candidates. As a whole, the candidates that did not become CHTP students were teenagers, did not have previous community responsibilities and were unemployed and out of school.

The logic and structure of the second questionnaire section was difficult to understand for the CHTP candidates, resulting in answers not comparable or useful for this analysis. Candidates were asked to complete the third section at home. Eleven questionnaires were returned. Answers included concepts with strong medical content. However, when referring to practice, they showed local knowledge content. When commenting on the open questionnaire I registered smiling and nodding when addressing recommended hygiene measures to the Health Ministry. However, answers did not include open critiques or opposition to medical structures, treatments or services. In box 8.3 I present examples of the above, taken from the candidates' answered questionnaires.

BOX 8.3. CHTP CANDIDATES' HEALTH CONCEPTION AND PRACTICE

HEALTH CONCEPTION AND PRACTICE	EXAMPLE
Health definition strongly influenced by disease	[I am not healthy] ... *because I am ill in the eyes, ears, kidneys, skin, etc.,* (Alicia).
Conception of health related with community	Recommendations for sick people are: *1. ...to go to the doctor; 2. Ask for help to the* compañeros; *3. go to a traditional healer* (Luz)
Family and medical doctors are the response to health problems	[First things to do when a person does not feel healthy are] *First I visit the doctor to see what symptoms I have, then I tell the doctor what I feel, then it depends on the doctor what he has to say and gives me medicine, then I follow the steps.* [When someone has a health problem] *I inform my mother first. If she knows about my disease, she gives me advice. If not, with my grandparents and they take me with doctors.* (Vanesa)
Health Ministry recommendations are learnt by heart	All candidates included in answers 8 and 9 (activities to keep yourself healthy and which of those are your responsibility): To wash fruits and vegetables, to brush your teeth, wash hands before eating and after using the toilet and to bathe yourself everyday.
There are local interpretations of disease problems	*I am not so healthy because I have a bladder problem, since the biliar fluid granulates and it does not run easily.* (Mundo)

Collective interview

The collective interview consisted of rounds of discussion about different life conceptions triggered by a set of pictures representing plausible scenes of rural life and pre-designed questions. This activity lasted over three weekend sessions. The collective interview became 'saturated' (give short repetitive answers) and the students bored after four sessions. After discussing it with the CHTP candidates, we decided to cut down on the remaining drawings. The collective interview helped to complete other purposes of the first evaluation: It helped candidates to feel more confident to say what they thought. As the collective interview advanced and the discussion became relaxed, some answers showed contradictions. An example is candidates' conception of men at the beginning:

> '[to a father a childbirth means] *to have more responsibility...to support his wife and the new being...*' (CIP 133-136) And several sessions later: '[men are] *manly, vicious,* parranderos[83] *...responsible or irresponsible...*' (Tr)

During the collective interview candidates had to discuss and take decisions. For example, changes in session dynamics. The collective interview helped us to recognise speaking,

[83] *Parrandero.* A man that goes out for drinking or other, leaving their families without support.

understanding, and other communication skills. Candidates often waited for teachers' reactions to confirm their 'right' answer but when not finding them, they proceeded without teachers' intervention. Candidates shared experiences that helped everybody to get to know each other and to develop awareness. A candidate mentioned: '*The pictures had awakened our way of thinking, why and how*' (TR:CR). This activity also provoked interest in the CHTP:

> '*A way to open our way is to get to know each other better ... things are coming bit by bit... next week we will be more confident ... the proof of how true this is, is that I brought Etelvina to join us*' (Tr).

After three weekend sessions, basic agreements and a departure point for the CHTP had been achieved. Basic agreements focused on teacher/student relationships and teaching-learning the CHTP's peculiarities and aims; the time and place for the CHTP sessions; individual and collective responsibilities and commitment; the necessity to construct learning problems and communication skills; awareness about how the contents were not first-aid but dependant on the CHTP's development and that the CHTP participants were involved in a research study.

The activities referred to above were useful to find a departure point for the CHTP. Especially relevant was the collective interview that gave room to discuss Mino's problems, candidates expectations and known learning processes. Because of what we learned in the set up stage, Pablo, Manuela and I foresaw that respiratory tract diseases could be the first CHTP problem. Manuela and Pablo started to attend the medical consultations in the local health clinic which they needed to provide as *pasantes*, but also because we saw the medical consultations as a plausible starting place for teaching.

The CHTP's first stage ended with a group composed of the eleven CHTP students whose characteristics are presented below. They attended regularly and wanted to follow the CHTP. During this set up and establishment stage a self-growing environment was emerging.

The first CHTP students.

Eleven students constituted the CHTP group: Goyo, Esther, Roberto, Guillermo, Teo, Elena, Alicia, Olga, Luz, Mundo and Elvira. In appendix two a brief profile of them is presented and in box 8.4 some of their general characteristics are summarised to help in the understanding of their performance and achievements during the CHTP's stages two to four presented below.

BOX 8.4. CHTP STUDENTS

	SEX	AGE	1	2	3	4	5	6	7	8
GOYO	M	18	S	0	Mino	Elementary	Campesino	Incomplete elementary	Irregular	Enthusiasm Lack of consistency and learning responsibility
ESTHER	F	30	M	3	Mino	Elementary, first aid	Shop attendant/seamstress	No school attendance *Mayordomo* father	Abandoned	Shares her knowledge and experiences. Experience in seamstress collective workshop. Lack of self-confidence and concentration.
ROBERTO	M	16	S	0	Mino	Middle upper. Incomplete medical clinical lab technician	Student	Complete elementary	Regular through stages one to three	Relatively to the group high reading, writing, inquiring and study performance. Reserved with the group.
GUILLERMO	M	26	S	0	Born in X, 6 yrs ago moved to Mino	Complete secondary	Working in a factory	Father incomplete elementary school. Previous family collective responsibilities in Mino.	Regular through stages one and two. Irregular during stage three	Enthusiasm, questions what the rest don't, moves the group for practical activities. Enjoys knowledge. Does not have interest in looking after others.
TEO	M	29	M	1	X	Complete secondary. IMSS health assistant courses.	*Campesino*, IMSS health assistant	Unfinished elementary. Father with community responsibilities.	Regular through stages one to three	Collectively appointed to the CHTP. Shares his knowledge and experience as institutional health promoter. Elicits and questions problems of reality.
ELENA	F	18	S	0	Y	Ongoing pre-university Nursery teaching aid course.	Tailoring workshop	Incomplete elementary.	Regular	Leadership. Relative to the group high reading, writing, inquiring and study performance. Collective work experience.
ALICIA	F	32	M	2	Mino	Incomplete pre-university. Unfinished nurse aid.	Tailoring workshop	Father is a schoolteacher. Father and mother with collective responsibilities.	Regular through stages one to three. Irregular in stage four.	Collective responsibilities. Likes reading, concepts and abstraction.
OLGA	F	33	M	2	Mino	Unfinished secondary	Housewife	Incomplete elementary. *Conserje* at the local elementary school.	Regular	Particular attitude and capacity to share and look after people. Quick to question and fast to learn.
LUZ	F	35	S	0	Mino	Complete elementary, first aid course	*Campesina*	Incomplete elementary	Regular	Keen in practical activities. Enthusiastic. Sharing. Practical experiences.
MUNDO	M	35	S	0	Z	Secondary, nurse aid course	Local pharmacy attendant	Incomplete elementary	Regular	Enthusiastic, shares experiences and knowledge, searches for information, enjoys teaching.
ELVIRA	F	36	M	3	W	Elementary	Tailoring workshop	Incomplete elementary	Regular	Enjoys searching and developing knowledge. Shares knowledge and experiences.

1. MARRIED/SINGLE. S=SINGLE, M=MARRIED; 2. NUMBER OF CHILDREN; 3. RESIDENCY; 4 EDUCATION; 5. EMPLOYMENT; 6 PARENTS' EDUCATION AND POSITION; 7. ATTENDANCE REGULARITY TO THE CHTP; 8. PARTICULAR POSITIVE AND NEGATIVE CHARACTERISTICS RELATED WITH IDEAL SELF-GROWING STUDENT

This general profile of the CHTP students shows that the CHTP students have the self-growing student characteristics presented in chapter four (pp94, 99) within this thesis. They are persons with hope, faith and humility thinking of the collective benefit and had exercised their common sense, popular and expert knowledge to solve problems at individual and collective level. They were ready to share their knowledge and experiences within the CHTP.

STAGE 2. FIRST TEACHING PERIOD

Stage two's aims were: To develop a self-growing environment; to develop communication, dialogue, perception, observation, enquiring and study skills; to find out students' conceptions about health, disease, teaching and learning; to define the CHTP problems through observation of the students' perceptions of their reality.

Teachers discussed with students the CHTP teaching methodology and aims and explained the first step: to collectively define a problem relevant to their communities. In classroom, the students defined the first CHTP problem, making reflections about their every-day experiences. As we expected from what we learnt during the first stage, 'cough' and 'coughing people', were the first problems to examine. It was agreed that we will learn also from the medical consultation taking part in the health clinic.

The Assembly was consulted about the students' presence at the medical consultations. They agreed and agreed a consulting charge. Students were asked to treasure the consultation fees, decide about fee exemptions and to inform about earnings and expenditures to the Assembly. The money was to cover basic medicines and some of the CHTP's teaching material. Resulting from a discussion with the students about Minoans' feelings, values, knowledge and representations, at the beginning they were observers during the medical consultations. The students asked each patient attending the health clinic about whether he/she wanted or not his/her presence.

After each medical consultation the students analysed the patient's problems with Pablo's or Manuela's help. During the weekend consultation experiences were also discussed within the CHTP group. Here follows an extract of one such analysis conducted by Manuela's questioning.

'Manuela. *What did you see during the consultation?*
Student. *Well, cough.*
M. *And why is it that people cough?*
S. ...
M. *Besides coughing, what else did you see?*
S. *Well, he was a bit bent.*
M. *And why is it that people can bend and have a cough?*
S. *Because something might be hurting.*
M. *Did X refer to pain?*
S. *Yes.*
M. *Where?*
S. *[...]*
M. *What does pain show?...*' (Cron).

The CHTP participants held two weekly sessions on Saturday afternoons and Sunday mornings, besides the shifts in the medical consultations. Schedules for those sessions were decided and agreed on amongst students.

For two months the CHTP participants worked on respiratory tract disease experiences. In that time they learnt about respiratory tract histology, immunology, syndromatic approaches, physiology, etc. and also about the environmental, social and family origins, repercussions, explanations, practices and possibilities in relation to those diseases in the specific context of Mino and surrounding communities.

Session dynamics

During the CHTP sessions special attention was placed on looking for information (verbal or writen, local or external) and for ways to circulate knowledge among other people in the community. Newly constructed or reconstructed knowledge always referred to other disease events they had seen in themselves, their family or community. An example of that is taken from a chicken-pox outbreak detected during the medical consultations.

After talking, discussing and looking for information, students were required to produce their own chicken-pox book including local knowledge and knowledge organised during the sessions. Teachers and students talked about how could they produce a book with available resources. Teachers asked students to test this book with their neighbours.
Next session students reviewed those books...

> '*We asked them about the books, if they had tested them ... each one commented and gave their opinion.... There were some very positive commentaries ... others very 'suggestive'...*' (Pd, Md).

A role-play, where students considered individual and collective chicken-pox characteristics, followed the book activity (the transcription of this role- play can be found in appendix four). Manuela and Pablo noticed that the role-play lacked local knowledge and that at the end of the role-play '*all 'school children' in the play were queuing to see 'the doctor*' (Etn). During the role-play discussion, a double problem was elicited: there was medical service overload while people didn't make use of their own knowledge. Pablo asked students to repeat the last role-playing scene and for the first time local knowledge was revealed:

> '*Señora*[84]*, what happened with your child?*
> *Look, he has chicken-pox and ... the doctor ...*
> ...
> *I have a remedy. Splash some* 'jarilla[85] *and leave it in warm water...*' (Tr).

From here the discussion revolved around different remedies that students not only knew but in fact had used or still use. Some of these remedies had been discovered during the search to create the chicken-pox book. That discussion included an insight of actual healing reasons and modalities: '[When a lady has a doctor's remedy and her friend's] *it does not interfere, it does no harm. In fact, both are caring measures too*'. (Tr).

Classroom sessions, discussed in detail in following paragraphs, included students' presentations followed by discussion, play models, animal dissection, case presentations, information search in books with reading exercises, representations and theatre, experiences exchange, expositions, vocabulary building, anatomic and physiology models

[84] *Señora:* Lady, madam, the way people address married or mature women.
[85] *Jarilla* is a wild plant with healing properties, often found in semidesertic areas.

construction, comparison with agricultural and family processes or known machinery, previous knowledge organisation, information and discrimination exercises, local information collection and analysis, book production, registers design, watching and discussing videos and other activities.

Session dynamics were designed by teachers and modified by students' interests making use of the teachers' creativity:

> '*We probably planned the first session hours and then it continued with what we imagined on the spot ... taking into account certain basic things ... also once students got the idea, we couldn't follow our plans since they were inspired by an interest and they followed it, and that was the key*' (Etn).

Session dynamics' success depended on the teachers' interest, which they got from the students' interest:

> '[Students' attitude] *fired you, when you are with them you spark yourself ... as they advanced we were constructing the teaching methodology ... the students that remained through the* [CHTP] *process each time were more astonished with what they were learning*' (Etn).

Even when students showed interest in all activities, practical activities -comprising manual work reinforcing knowledge construction- helped in the development of a collective interest. Guillermo was especially keen on translating knowledge into material models. That was the case with a respiratory cage model he made out of wire, foam, plastic tubes and other materials with the help of Roberto, Goyo and Pablo.

Especially relevant were the activities designed to improve reading and searching in technical texts. The main idea was to help students lose their fear of confronting technical texts and to be able to use indexes and other indicators to find what they were looking for. The following dialogue, recorded during one exercise where students in groups analysed different medical books with information about lungs is an example of the above.
This extract also shows the use of questioning in the CHTP.

> '(Manuela) ... *it is about what you had seen, even if you understood it or not, just tell us what did you see, what did you find.*
>
> (Student) *We found a complete respiratory tract X-ray picture.*
>
> M *Did you read what it says underneath? That? In the lower little paragraph?*
>
> St1. *It says that it has no lung problem, in the darker ones it means that it has i... the lungs that are not well, it has problems.*

St2. *Probably they are too beaten, finished, and the* peones[86] *are too worked out, there are people that work hard and that is why the X-ray is as it is.*
St3. *When we breathe we rest, isn't it?*'
...
M. *How did you manage to reach that drawing? How did you find it?*
St. *With the index.*
M. *What did you look for in the index?*
St. *Pulmonary function.*
M. *You read the entire index until you found that?*
St. ...
M. *What problems did you have to find it or to understand it?*
St. *To understand it, just some words where there was a brief definition, but there was also a brief explanation.*
M. *Were the words very odd to you?*
St. *Just some.*
...
M. *That is what is not understood, the words?*
St1. *Well, yes, you understand them.*
St2. *But you don't know what they mean* ...(Tr)

After some weeks, students had 'selected' their favourite books, also students had recognised that some of them were more skilled readapt reading and they helped each other to find information. They also brought materials they found useful for the CHTP to the weekend sessions. Examples are: a video on sexuality and one volume of a health encyclopaedia brought by Mundo, flipcharts on anti-contraceptive measures that Teo used for his institutional health promoter activities, and a leaflet brought by a Mino member of the health committee on juice therapy.

Animal dissections were one of the most successful activities to get rid of fear and to recognise self-value and possibilities. An example follows. Pablo and Manuela's proposition of performing dissections on a chicken was very welcomed by students. On the first dissection day students came with a pig's intact, fresh respiratory tract, heart and main vessels that they managed to save from the '*carnitas*'[87]. At the beginning they joked about how the pig's death was caused by the next-day's party. While performing the dissection

> '*...they were asked to decide the cause of death. Every body knew that the pig had been killed by a knife stab but, well, why did the pig die? ... then, they needed to find out the meaning of the blood flooding the alveoli and what happened with the oxygen mechanisms until they reached the biological cause of death'* (Md, Pd).

[86] *Peones*: The name given to a hired peasant, they do hard cropping work.
[87] *Carnitas* are pig meat and insides chopped and fried with an special mixture of herbs, orange juice and other ingredients. It is a main course during parties and festivities.

Discussion of personal experiences and testimonies was another important pedagogical tool. Here I present an example. It was discussed how words were used to replace knowledge and as a power source. A student's comment prompted one such discussion: Teo was worried because the authorities in his community have insistently asked him about his progress in the CHTP. Teo mentioned that he had learnt many words. An authority in his community had been pressing him to learn '*useful things as those I learnt in the IMSS*[88] *courses* [give injections, pass intravenous drips or other]' (Cron). Teo explained that those courses were deceiving, that they concealed real knowledge as he had discovered with the CHTP and that he was learning to learn, but he didn't get the approval of the persons pressing him. He then came with doubts to a weekend session and opened them up for discussion (Cron).

The vocabulary development helped understanding and communication skills development. Each student constructed a personal dictionary after discussing the importance of knowing medical terminology to understand medical information and to confront doctors. Through this, students' vocabulary widened. To construct words and analyse them became an enjoyable activity:

> '*...they already knew what was* taqui, hypo, *and other. We used to chop words and find out each piece's meaning and getting to know that words have an origin. They brought* 'tlacoyos'[89] [to a Sunday session during a collective lunch]. *Each one used to bring along water or what they could since the sessions lasted four or five hours. Then they started to make jokes constructing words from the words they had previously learned. All of a sudden they found themselves dissecting the words, rather than constructing them. They analysed the* 'tlacoyo' *word. They reached the conclusion that* 'tlacoyo' *came from the combination of two animals:* 'tlacuache'[90] *and* 'coyote'[91] '. *When they constructed their possibility they were laughing till they cried*' (Cron).

Teachers used small experiences to develop reasoning skills. An example is a comparison of six boxes of vitamin B a patient had received in a private clinic. In that comparison the students found out that it was the same active principle with six different names and packaging that had been charged to a patient. Another example is taken from another lunchtime where one student had hiccups. Everybody started to laugh and give remedies to

---

[88] Social Security Institute
[89] *Tlacoyos* maize thick pancake often filled with cheese or beans. It is served with a topping of onion, cilantro, fresh chopped tomato, cream, cheese and chilli.
[90] *Tlacuache*. An animal similar to the racoon.
[91] *Coyote*. A mixture of dog and fox.

stop hiccups. I asked: why do you think those remedies help? What is a hiccup? Through a why questions sequence, students localised hiccups as something occurring inside the thoracic cage which they had already seen in the pig's dissection referred to before. They analysed the intervention of muscles for hiccup production, especially the diaphragm. Then they proceeded to reconstruct a hiccups mechanism and found that a nerve must have been stimulated. Finally, students discussed how remedies work over the nerve and hiccups production...

> *'Then the students attitude changed, it started to become sort of exciting... through the understanding of things, they understood that knowledge was there, that they could have access to it'* (Md, Pd).

Those small events were also used as evaluation. An example is taken from an experience occurred after six months of the CHTP's implementation. A box labelled to the secondary-tele-school appeared in the community hall where the CHTP was taking part. Students said that it was not right to open it but encouraged themselves and found a tri-dimensional anatomic model. They recognised different concepts and knowledge through findings in the model. Students and I played questioning each other about different anatomy and physiology topics. Especially noticeable was how students collectively localised all endocrine and exocrine glands and their organic functions. Gland knowledge had not been a specific CHTP content but had been constructed through explanations of different body functions and disease mechanisms.

Pedagogical experiences included games and representations followed by analysis and discussions. After one such experience -named 'the blind and the guide'- aiming to develop understanding of interchanging student-teacher roles, Elena commented: '*...this morning I was shy, after 'the blind and the guide' I got rid of it ... we know more about ourselves...'* (Cron). That experience was linked with the medical consultations and students necessary differences with the allopathic doctors and the medical institution's services.

Outsiders' observation

After three months, CHTP students were bringing along problems -detected within their relatives or neighbours- for discussion in the weekly sessions. Chronic diseases appeared relevant to students' interests. Students had developed communication competence and skills for problem identification, searching for information, discussion and knowledge organisation. The CHTP's self-growing environment had developed. However, outsiders' observation carried out at the middle and end of this first CHTP period and evaluation with teachers revealed that the CHTP's teaching practices were '*not showing interchanging student/teacher roles*' (On). Teachers and I analysed and evaluated those observations and started to include more planned teaching opportunities for students.

STAGE 3. SECOND TEACHING PERIOD

The third stage's aims were: to approach problems raised by students; to develop and consolidate a self-growing environment; to develop and exercise already developed communication, dialogue, perception, observation, enquiring and study skills; to identify student's developing identity; to develop planning and performance skills.

Transition to the second CHTP period was a process that took about six weeks. During this period, students moved their interests from respiratory diseases to chronic diseases linked to specific persons. This stage was characterised by students' curiosity and pleasure when constructing knowledge or when understanding or solving, by themselves, some aspect of the problems they were bringing to the CHTP.

Overall the CHTP's pedagogic dynamic was the same as in the first CHTP period. However, there were some special characteristics of this second CHTP period. The second period lasted four to seven months.

To test knowledge and practice efficiency was a particular characteristic of the second period. As in the previous stage, this was a source of students' excitement making them want to know more and improve their searching abilities. To contrast cultural capital efficiency/trustworthiness/sources helped students to value their own cultural capital, recognizing their capacity to analyse and evaluate institutional texts. Their ongoing experiences with the medical institutions represented vivid first hand information to discuss and analyse in the light of their newly organized knowledge. The collective examination of this experience unveiled arbitrariness and *doxa* and also helped them to better understand that not all discourses, knowledge, values and practices are valid. This also occurred with media messages. Contrasting capital efficiency/trustworthiness/sources also helped them to analyse and evaluate the procedures of knowledge construction and validation.

An example of that is Teo's reaction when he found that he had been cheated by the Health Ministry and the Social Security Institue. Until the CHTP, he thought that his six years training as a health aid was what '*I can have*' and was a fair offer for peasants that had few years of school attendance. He found with the CHTP

> '*the knowledge that had been hidden from me...I can see now all that was behind it...they train us just to get cheap work from us... they don't even recognize it*' (Cron).

Another example is a discussion about what to look for in written or broadcast material and what to consider as valid, when Mundo brought in a leaflet on iridology[92]. A final example is the continuous discussions about scientific knowledge, popular knowledge and fake knowledge present every time the students found out that people in their families or communities had been cheated with vitamins, drips or other fake practices.

Teachers and students found how habitus limited our CHTP's practice. An example is a result of an evaluation with teachers showing teachers' unconscious resistance to accept local knowledge and practices, our difficulty to incorporate it as equal to scientific knowledge and the resulting increasing difficulty to discover and value popular and local

[92] Iridology. A practice of looking for diagnosis in the eye iris where all the body is represented according to iridologists.

expert knowledge. Manuela's testimony from an evaluation with teachers can exemplify that:

> *'I know that our scientific knowledge is incomplete, however it is hard for me to accept some things that I do not trust, I try to refrain myself from imposing but sometimes it's difficult, popular knowledge is OK but, when does a person's knowledge become 'popular knowledge? How can I know that it is 'popular' and not just one person's idea appeared because of a single experience or something?'* (Etn).

Through systematic personal and collective work Pablo, Manuela and I were able to accept criticisms and improved our CHTP practice. Teachers and students noticed changes in self-evaluation as the CHTP progressed. At the beginning criticisms were mild. As the process advanced we increasingly reconsidered our CHTP's assessments, finding out more valuable aspects to change.

Through the analysis of disease problems students found the multi-field origin of health problems. We had sessions commenting on texts and discourses, finding out who could possibly be behind them and what they wanted to obtain.

Dialogic testimonies

One characteristic of this period is the development of knowledge from testimonies through what I am calling here 'dialogic testimonies'. Students spontaneously brought to the CHTP sessions testimonies about their practices using the knowledge they had already developed through the CHTP. Those testimonies were built as a dialogue between the student spontaneously presenting his/her testimony and the other students and teachers.

An example of that is a testimony of Elvira's encounter with hospital medical doctors. Elvira's father is being attended in IMSS hospital because of heart problems.

> [Elvira asked the doctor in charge about her father's diagnosis. The doctor answered] '*he has a heart valve insufficiency*'. [Elvira inquired]: '*which valve is affected*?. *The doctor was confused and answered in an authoritarian and rude way: I don't have to give any further explanation. Besides that, you could not possible understand. It is not my duty to explain. I am just being kind to you by informing you... and he left'* (Cron, Md, Pd).

Students analysed and evaluated different characteristics and consequences of Elvira's father's heart valve problem, consequences of being attended to in an IMSS hospital,

characteristics of the medical services and their new position in relation to doctors amongst other analyses.

Developing cuidadores identity and expertise

During this stage, students had envisioned a panorama of their potential community role and knowledge scope. They valued the CHTP as personal and collective belonging and showed a strong will to make the CHTP succeed. An example of that is how they cherished their library -composed of about twenty books and documents; instruments -thermometer, sphyngomanometer, aesthetoscope and a set of surgery tools-; medical consultation money and the CHTP room key. Students in turns were responsible for their use and care.

Students started to question their identity in the middle of the second CHTP period. Their expertise and role did not correspond with health aids, promoters, assistants, nurses or doctors. Students recognised their work as caring for their community in an integral way. Their work resembled more the *parteras*[93] and healers work than that of medical doctors, nurses or health aids. They were caring people in the community, care in Spanish is '*cuidado*'. The person that cares is a *cuidador*. Therefore, students, Manuela, Pablo and I started to call students 'cuidadores'. Mundo defined a cuidador:

> '[A cuidador] *Is an important community foundation since he is a means for the community since he is close, he belongs to the same community, he can trust the others in the community more* [and the others trust him] *and in this way get to know more about community people, about their problems and community problems, their needs. And also, when nobody knows, we must search to reach to the starting point and in that way to help more. That is, many times not even doctors can help from the roots, since they come, they make their consultations but sometimes the patient does not trust him* [them] *enough, to tell him, to explain to him since the very beginning how it* [the problem] *started. Since sometimes there are shy people, isn't it? ...*' Luz added: '*To gain people's confidence, so they can trust themselves and see reality, not just like it is there or so, but understanding it ... economic problems, family problems, health problems...*' (Tr).

The collective dimension of a cuidador was present in cuidadores' conception. The following text shows that.

[93] *Partera:* A traditional midwife who's work includes caring for the mother, the child, the husband, other children, the house, washing the nappies of the new born, cooking or other with the intention to provide the mother with an adequate environment to heal from her delivery and also to help her to get on with breast feeding.

'[If there is an economic problem or a problem that a cuidador can't face by himself] *you should see all the problems, how many persons are in the same situation and find a solution collectively, since one is the key for them to think solutions... or to look a way ...to obtain the medicine or to see what institution can help us*' (Luz and Elvira, Tr).

The cuidadores' characteristics were discussed and listed on a flip chart. Here follows that list's transcription. This transcription keeps the order they gave to this list, thus showing how they organised their idea of 'cuidador'.

'*Specialised. With training.*
From the roots.
Working where not everybody would like to work.
The 'way' is different than that of other persons dedicated to disease.
Gives disease attention or advice.
We are part of a community.
We must explain to them.
It is understood, with a focus, in a different way.
Some follow us, others don't (they don't trust us).
We have a similar way to see or give solutions to problems.
When we give attention to someone, we can't put ourselves in a medical doctor's position. It is implicit in our own way and knowledge. Of course, we have new information.
The doctor does not know what is behind that.
We have no title [university diploma].
That diminishes our interest for money. We won't say 'I've burnt my eyelashes studying'
It is an advantage since it diminishes our 'ego'.
It is a disadvantage with the people that have doubts about our knowledge.
To find out what the problem is he is concerned with their job, the environment and with the economic environment.
Thinks in the way we have been moulded, as an example: the wrong idea of vitamins.
Enjoys learning.
Learns when solving problems.
Searches, inquires.
Is not proud, is humble.
The cuidador identifies, looks for, anticipates problems.
Cares for problems looking at all its parts.
Searches for information, the answers and necessary solutions where they are, at their reach' (Fc).

Teachers and students analysed what the services were they were going to offer. Those services would be written on a poster outside the cuidadores' room for public information. To be included, the services they offered should be mastered by all cuidadores. In future they could add new entries as they developed new knowledge, experience and skills. Here follows what the cuidadores offer:

'*HERE WE:*
Give advice about disease and treatment.
Sterilise female dogs.
We give advice about feeding, development and growing.
We give advice about alcoholism and drugs-addiction.
We give advice about contagious diseases.

We give advice about pregnancy, delivery, puerperium and fertility.
We heal wounds.
We perform plasters and sawing.
We perform measures and valorisations of weight, size, sight, hearing, teeth and feet.
We give advice about epidemics.
We give advice about skin diseases and attend some of them.
We give advice about cares for the aged.
We can minister vaccines.
We give first aid and advice for reference' (Fc).

By cuidadores they meant a group, a skill, knowledge, a responsibility, a position, a practice and an identity.

Cuidados[94]

Because of the way in which the cuidadores were performing within their community, special attention was placed in finding out which specific people the cuidadores were going to look after: the 'cuidados'.

Olga, Luz and Mundo recognised some relatives and neighbours as cuidados.
Elvira chose other women working with her in the seamstress workshop. Elena started to work as nursery teachers' auxiliary and wanted to work with children's parents. Alicia did not define her cuidados, nevertheless, she was asked to look after the cuidadores, helping them in their searches and inquiries; in their understanding of information; producing written material at cuidadores' demand and also making posters with information relevant to the whole community. Goyo looked after a diabetic old man going one or two times a day to clean his leg wound and then left the CHTP. Goyo got a good reputation in Mino for cleaning and healing chronic wounds. Roberto, Guillermo and Esther did not continue their cuidadores practice after leaving the CHTP.

To look after the cuidados was recognised by the cuidadores as a very important learning experience. The cuidadores' relation with cuidados' families helped them to look at disease problems from different angles and to accept responsibilities. An example of that is a quote

[94] *Cuidados:* 'the looked after'. People looked after by the *cuidadores*, chosen by the *cuidadores*.

from Olga explaining why she needed to leave some minutes before the rest of the students:

> '*With that cleaning I learnt, X's leg wound is really improving. I need to rush to see how he is today and tell him that I will go to clean his leg later on...*' (Md, Pd, Cron)

During the second CHTP period, there were big learning advances. An example is how Elena faced a cuidado's chronic kidney problem. She detected a man's kidney problem but had no tools to confirm it. She unsuccessfully called the *pasante* in her community several times. Then she went to the health clinic and emphatically asked for urine and blood reactive sticks and also managed to borrow a sphyngomanometer. She studied the case with the help of her CHTP notes and books until completing the diagnosis and suggested a treatment to be confirmed by the *pasante* medical doctor. She also prescribed non-allopathic general measures and performed them until the following day when she lobbied in the health clinic for the *pasante*'s attention. Finally Elena explained her problem to the *pasante* and demanded attention. The *pasante* reached the same diagnosis and treatment. As soon as Elena could, she let all of us know how well she and her cuidado felt and how much she had learnt. Her tale was accompanied by the other cuidadores questions, commentaries, expressions, etc.,

Supporting activities and projects

Developing planning skills

The CHTP included planning insight to confront collective health problems. The Health Ministry asked Manuela and Pablo to join the municipal dogs' rabies vaccination campaign. Students and teachers accepted the invitation as a group project. Former ministry's dogs' vaccination campaign lasted one week and reported 25 vaccinated dogs. Vaccines were administered in the health clinic.

Pablo, Manuela and the CHTP students collectively designed a strategy to reach the dogs in their houses. Cuidadores campaign planning included dog census brigades' organisation, training, resources assessment, informing and recruiting neighbours, and poster

composition. Teachers, students and I vaccinated about two hundred and forty dogs and some cats one Sunday morning, until we ran out of vaccine. The cuidadores mainly led the vaccination brigades. That Sunday, everybody had a chance to talk with the dogs' owners, to hold the animals, to prepare the syringe, to vaccinate, to fill in the registers, to talk about rabies and other problems caused by dogs and to care for the medications.

The vaccination activity gave students and teachers many discussion topics. It also showed what local and collective planning could achieve. After that activity, a child with hepatitis was identified by the cuidadores. Olga assumed the case as a collective health problem. She went to the primary school to warn the director about the hepatitis problem. She also produced some posters and placed them in the central plaza. Olga's work was the only one carried out to prevent a hepatitis outbreak. The municipal authority did not take notice of this, nor the Health Ministry. The cuidadores found later on that the school toilets were in a very bad hygienic condition. The cuidadores couldn't do much and there were three more known hepatitis cases. We analysed and evaluated the context and difficulties of carrying out health work; the institutions' nature and social role; the relations among social structures/health/education; and other issues.

Dog's sterilisation project.

The Health Ministry asked Pablo and Manuela to train municipal personnel for dog sterilisation. After the dog vaccination campaign, the cuidadores had seen the sterilisation as an unmet necessity and agreed to perform dog sterilisation with the support of a team of veterinary students. The cuidadores adapted the CHTP room as a surgery room and learnt to perform sterilisation on female and male dogs. Dog owners were required to help in their dogs' surgery where the cuidadores needed to explain and make comments about pregnancy, family planning; anatomy, surgical procedures, physiological processes and also the reasons for antiseptic measures.

Through dog sterilisation the cuidadores learnt about reproduction, family planning, surgery skills, antibiotic uses, skin infections, cardiovascular physiology, central and

peripheral nervous systems, uses of anaesthetic products, resuscitation manoeuvres, etc. They also practised their communication skills and had another opportunity to discuss cultural and social practices in Mino. Dog sterilisation was Luz's speciality and pleasure and Mundo disliked it. At this point students and teachers analysed and evaluated how each cuidador was unique and the importance of teamwork.

Reality is not plain!

Abstraction was difficult for the cuidadores. They could refer more to visible, tangible things than to ideas or non-visible things.

In July a supportive ten days fieldwork took place with the participation of twenty five first year university students under my academic supervision aiming to discover one invisible world: the microscopic. As part of the project, a laboratory was set up in the CHTP room where adults and children could see different materials such as insects, plants, water, blood, food, etc. through microscopes borrowed from the university. Triggered by the preparation and observation of blood, water and *pulque* samples, Mino's adults and cuidadores held long discussions about AIDS, infectious diseases and alcoholism, where teachers did not interfere.

That was the first time the cuidadores could reach the microscopic world, enjoying, learning, discovering, understanding and finding links they needed to make sense of concepts, descriptions and ideas they were finding in books and in their reflections. The following testimony of Pablo and Manuela exemplifies that:

> '*...when the microscopes arrived, oh god! it was like a dream... Luz, we said, Luz won't be able to get through, she can't read, she has difficulties learning ... she is very practical... She has only one eye...and then the microscope arrived and Luz was there all the time, she was the one that saw more samples...*' (Tr, Etn).

The diploma

Between the second and third CHTP period, a diploma signed by the university authorities was given to eight cuidadores: Guillermo, Teo, Elena, Alicia, Olga, Luz, Mundo and

Elvira. Before producing the diploma, the students, Pablo, Manuela and I discussed what the diploma meant for them and for the community. For Teo, the diploma was essential for community recognition. After receiving the diploma he left the CHTP. Later on he left his health promoter institutional and collective work. The rest of the cuidadores were happy to receive the diploma, but they considered that their accountability would come from their practice. I handed the diploma to the students during an Assembly without major rituals. After the Assembly we gathered in the CHTP room and discussed our intentions and further commitments. Elena, Alicia, Olga, Luz, Mundo and Elvira decided to continue. Nobody mentioned the diplomas afterwards.

During the second CHTP period, teachers and students found out that they were raising expectations within Minoans about cuidadores' capacities to attend disease problems. Students, Manuela, Pablo and I foresaw plausible rising demands for the cuidadores. That increasingly changed the CHTP to content not directly addressing actually occurring problems in Mino.

STAGE 4. THIRD TEACHING PERIOD

The Stage four aims were: to strengthen a self-growing environment and self-growing skills and knowledge already developed; to develop student's autonomy and self-reliance and to face community demands on the cuidadores.

The third CHTP period started alongside the second period. It lasted four to six months. In the middle of this period Manuela and Pablo left Mino as agreed from the beginning. This period followed a fixed content programme with specific rounding contents such as pregnancy, child- care, nutritional care, first aid and other. Despite the fixed contents in this CHTP period, the session dynamic was like the first and second CHTP periods.

Pablo and Manuela presented the contents until the cuidadores started to merge their previous knowledge using already developed skills such as the conscious use of common

sense, reasoning, discussion, linking and so on. That can be exemplified through Pablo's comment about this period:

> *'Our 'lectures' were introductions to what they* [the cuidadores] *were asking for... we could translate knowledge ... sessions' logic was to open the topic, then the* [cuidadores'] *questions and opinions started to emerge ... up to a point where they said more or less all that they knew, then we talked ... and look in this or that book, from here to there ... we prepared materials for them to read...'* (Tr)

During this period the cuidadores had little opportunity to apply new knowledge constructed from the exploration of fixed contents. They gave more attention to problems they were actually facing. Fixed contents left time for the analysis of problems. Often the cuidadores lost track of the sessions' sequence. When Pablo and Manuela left Mino, the sessions with teachers became more difficult to program. The cuidadores started to meet by themselves and took decisions about their own self-training without our intervention.

The cuidadores organised their room very much like a medical room and attended the patients differentially: Mundo used to sit behind a desk and Luz, Elvira and Olga standing besides patients. They went back to the study of recently detected problems supporting each other and continued dialogue. As the cuidadores went back to the study of problems of their reality, their interest was raised. They held discussions with the aid of the small cuidadores library. They used to mock and laugh when making fun of possible medical responses to the problems they were facing.

During Pablo, Manuela or my visits the cuidadores asked us for advice, information and written material about problems that they could not solve or proudly presented those that they had been able to solve. They referred also to pedagogical problems they were facing with their cuidados. Gradually we separated from the cuidadores not only because that was part of our self-growing teacher's role, but also because they developed their own group dynamic.

I consider this the end of third CHTP period. At the end of this CHTP period, Luz, Elvira, Olga and Mundo attended CHTP sessions regularly and Alicia came from time to time. Brief information about the students' decisions and practices after leaving the CHTP or at the end of fourth stage is presented in the following box.

BOX 8.5. WHERE ARE THE CUIDADORES NOW AND WHY DID THEY LEAVE THE CHTP

	REASONS TO LEAVE	RELATION WITH THE CUIDADORES
GOYO	He had personal and family problems.	Goyo adopted some surgery responsibilities and keeps doing free wound cleaning in Mino. He was often in the health clinic, cleaning or chatting. He felt very enthusiastic with the dog's sterilisation project.
ESTHER	She recognised concentration, reading and learning problems also was loaded with labour and family work.	While supporting the cuidadores, she does not perform any cuidadores' practice.
ROBERTO	Roberto decided to concentrate in his school activities.	He often joined the CHTP on weekend sessions or in complementary activities. He recognised that the CHTP had helped him in his studies and to think about his future in professions related with the biological sciences.
GUILLERMO	He couldn't cope with his factory shifts and the CHTP.	He continued studying and looking for information about topics of his interest. He enjoyed conversation especially with Pablo. However, he did not take care of any *cuidado* not even in his family where he often disagreed with his relatives.
TEO	He decided to resign from all health activities.	He liked the CHTP but never got community approval. Pressures over him continued. People in his community demanded his promoter work and never supported him. He was criticised. Also he needed to neglect his crops and family attending Health Ministry, Social Security and other institutional demands without payment.
ELENA	Decided to continue her studies in the city of Pachuca.	Continues performing cuidadora functions wherever she can. She has awareness about how she uses CHTP developed knowledge and skills in different aspects of her life and collective responsibilities.
ALICIA	Is fully engaged in her family's business.	The cuidadores still regard Alicia as part of the group. Until the end of 1999 Alicia accepted some group responsibilities. She still looks for information and finds pleasure by studying in cuidadores reading materials.
OLGA	She hasn' left.	Has adopted her cuidadora role as part of herself. She looks for opportunities to care. She is very keen and sharp to analyse institution services. She is an essential part of the cuidadores team.
LUZ	She hasn't left.	Is now working with an agronomist and a veterinary student. She is trying homemade fertilisers in her crops to show her neighbours the goodness of organic cropping. She also is the reference point for the cuidadores in Mino. She is always exploring possibilities and applying what she learnt in animal and human health.
MUNDO	He hasn't left.	Adopted teacher's attitude in front of the cuidadores, he is a 'gluing' element for them. He keeps looking for new materials, experiences and knowledge to share. He merged his previous therapeutic experiences with what he is learning in the CHTP. He has changed his regular curing practice in his community. He has adopted several families as 'cuidados'.
ELVIRA	She hasn't left.	Adopted her tailoring workshop and some families as cuidados. She also has collective health activities.

To the three CHTP periods analysed and evaluated in this thesis, followed a second CHTP phase aiming to explore collective work for health development and the inclusion of local therapeutic resources. This research work is limited to first, second, third and fourth CHTP periods[95] already described in this chapter.

In box 8.6 I present some aspects of the CHTP that Pablo, Manuela and I recognised to be characteristic of each period.

[95] From August 1997 to March 1999

BOX 8.6. THREE CHTP PERIODS

PERIOD	PROBLEMS	OBJECTIVES	CONTENTS
FIRST February 1998 to April 1998	-detected during the medical consultation -seasonal -coming out of remembrances -related with new constructed knowledge	-to build up communication competence -to build problem identification, search for information, discussion and knowledge organisation skills -to construct a self-growing teacher/student relation and pedagogic environment	-signs, symptoms, anatomy, physiology, propedeutics, etc; -vocabulary, reading and writing, communication, asking and listening; -observation and recording, analysis, search and inquiry; -logic thinking and reasoning, common sense, expert and institutionalised knowledge; -the biological, the social, the cultural and the affective, individual and group self-esteem.
SECOND April 1998 to October 1998	-constructed through 'dialogic testimonies' -detected within their relatives or neighbours -curiosity and pleasure - to answer questions raised by themselves/ neighbours/ family	-to construct practical knowledge useful to confront disease and health problems found within neighbours and relatives; -to develop communication competence; inquiring, problem identification, search for information, discussion and knowledge organisation skills; -to encourage feelings and identity development; -to identify change possibilities and implement actions for change; -to observe, analyse and evaluate medical discourses, services and fake knowledge; -to identify knowledge validity, value and validation mechanisms and sources.	-physiopathology, therapy and treatment, emergency and reference, red lights; -family records, family and collective health and health problems; -searching in written materials, selecting relevant information; inquiring; -team work, planning, action and evaluation -knowledge used to provide health services around Mino; -knowledge linking, integrating knowledge -institutional discourses and practices analysis, power relations -health, school and institution knowledge and rituals
THIRD October 1998 to March 1999	-those of period two plus -plausible demand on the cuidadores	Development and consolidation of all the former plus: -to construct identity and belonging; -to build up accountability -to develop and strengthen decision taking capacities -to mature autonomy -to round-up the CHTP	-most of the former plus: -rounding themes such as pregnancy, childcare, nutritional care, first aid, alcoholism. -teaching skills - perspectives

CONCLUSION

In this chapter I presented a description of the implementation of this research intervention. I explained that Manuela and Pablo had basic characteristics to develop as CHTP teachers and how they were trained to further develop those characteristics.

Responding to the flexibility of a self-growing pedagogy, the implementation of this pedagogic intervention had four overlaping stages. I presented in this chapter how each of these stages developed from the self-growing necessities of the students.

Also in this chapter I showed and exemplified the processes of knowledge construction during CHTP implementation and the kind of activities involved in that process. I illustrated the changes in the teaching environment occurred as CHTP advanced and the variety of choices that the students took regarding their problems, knowledge and activities preferences.

As explained in chapter five, each utterance in this chapter is triangulated data for the analysis and evaluation of CHTP process and outcome indicators. In next chapter this data will be used to analyse and evaluate these indicators.

CHAPTER 9
CHTP ANALYSIS AND EVALUATION

The purpose of this chapter is to evaluate the process and outcomes of this pedagogic intervention. This chapter has two main sections: the analysis and evaluation of the CHTP processes, and the analysis and evaluation of CHTP outcomes. The focus of the CHTP analysis and evaluation was to find out if the CHTP was implemented in line with the characteristics of a self-growing pedagogy. The focus of the outcome analysis and evaluation was on the changes in the cuidadores' subordination patterns. First in this chapter I present a summary of the questions and aims for each CHTP stage, and of the data collection and analysis methods presented in chapter five (pp118-122).

PROCESS AND OUTCOME QUESTIONS

Here I present the questions raised in chapter five for the analysis and evaluation of the CHTP processes and outcomes.

BOX 9.1. QUESTIONS FOR PROCESS AND OUTCOME EVALUATION

PROCESS				OUTCOME
STAGE 1 SETUP AND ESTABLISHMENT	STAGE 2 FIRST CHTP PERIOD	STAGE 3 SECOND CHTP PERIOD	STAGE 4 THIRD CHTP PERIOD	
1. Were we on track? 2. Were there any problems that needed special attention? 3. What action did we take to improve the CHTP performance?	1. Was the CHTP implemented as intended? 2. In which aspect were the greatest process benefits for the CHTP self-growing pedagogy? 3. How did this research intervention proceed to stage three?	1. Was the CHTP implemented as intended? 2. In which aspect were the greatest process benefits for the CHTP self-growing pedagogy? 3. How did this research intervention proceed to stage four?	1. Was the CHTP implemented as intended? 2. In which aspect were the greatest process benefits for the CHTP self-growing pedagogy?	1. To what extent were the CHTP intended outcomes achieved? 2. In which aspects are the greatest changes shown through the CHTP implementation? 3. What were the costs of the CHTP implementation for CHTP participants? 4. How did the CHTP influence knowledge and subordination/hegemony change?

To analyse and evaluate process and outcome indicators I proceeded as explained in chapter five (pp127-128).

In this chapter, in the text corresponding to outcome evaluation, the numbers in brackets refer to examples already presented in chapter eight. These received a sequential number in appendix five (p294). In box 9.2 I provide an example of how the reader is going to find chapter eight's utterances in the outcome analysis and evaluation made in this chapter.

The sources of information for process and outcome analysis and evaluation are: classroom observation notes (Cron), Manuela's diary (Md), Pablo's diary (Pd), my diary (Cd), tape recording (Tr), flipcharts (Fc), fieldwork notes taken outside CHTP (**Fwon**), my notes from evaluation with teachers or students (Etn, Esn), or out-side observers notes or reports (On). These sources will be presented in brackets when needed (see box 9.2).

BOX 9.2. EXAMPLES OF TEXT REFERENCES TO UTTERNACES IN CHAPTER EIGHT, AND SOURCES OF INFORMATION

Elvira implemented the CHTP activities in her own workshop *'to help the other compañeras*[96] *learn and know...'* **(Fwon)**. Olga enjoyed developing knowledge to look after her *cuidados* **(297),** and Luz enjoyed being capable of introducing new ways to improve Pino's life **(334-340). (More examples in 144-145, 370.2, 317-320)**.

PROCESS ANALYSIS

In following box, I present a summary of the process indicators evidence presented in appendix six (p317).

BOX 9.3. PROCESS INDICATORS PRESENCE/ABSENCE IN CHTP IMPLEMENTATION

PROCESS INDICATORS		STAGE 1	STAGE 2	STAGE 3	STAGE 4
FOLLOWING A SELF-GROWING PEDAGOGY	1. Open codes and framing	MP	MP	MP	P
	2. CHTP teacher's characteristics	P	MP	MP	MP
	3. Self-growing teaching and environment characteristics	NAP	MP	MP	MP
DEVELOPING PROCESSES TO DISLOCATE HABITUS	4. Self-growing practices related to cultural capital building, aiming to dislocate habitus	NAP	MP	MP	NAP
	5. Self-growing practices related to cultural arbitrariness aiming to dislocate habitus	P	P	MP	MP
	6. Self-growing practices related to habitus building processes, aiming to dislocate habitus	P	MP	MP	MP
	7. Self-growing practices related to medical field conformation and functioning, aiming to dislocate habitus	P	P	MP	MP

A=absent; NAP=not always present; P= present; MP=mostly present

[96] *Compañeras*. Other women working with her in the tailoring workshop.

Stage 1 (setup and establishment)

Question 1. Were we on track?

The CHTP start up and establishment accomplished most planned characteristics. As box 9.2 shows, not all process indicators were always present. There were two absences:

First, the Assembly did not appoint the CHTP candidates. However, the eleven students that constituted the CHTP group had completed at least elementary school, and attended on a voluntary basis. All adult CHTP candidates, except Guillermo, had a collective responsibility. Goyo and Roberto had no collective responsibilities because they were not adults. Next, the second part of the questionnaire had an inadequate design for the Minoan context. However, the collective interviews and the open questionnaire provided enough information to start the CHTP implementation.

Question 2. Were there any problems that needed special attention?

I found three main problems. First, even though all students had finished their elementary school not all of them had developed efficient reading and writing skills to confront and circulate written information. Second, Pablo and Manuela had a lot of power -relative to the power of the students- in the CHTP. To implement the CHTP as planned, that power difference represented a big obstacle. Third, a secondary but important problem, was the inadequate premises in which we had to implement the CHTP (a room in the community hall).

Question 3. What action did we take to improve the CHTP performance?

Pablo, Manuela and I conceived three actions to improve the CHTP performance. First, we considered writing and reading skills development a main aim for stage two; second, Manuela, Pablo and I developed the disempowering strategies presented in chapter eight (p189); and third, Pablo decided to turn one of the two rooms the Assembly assigned to him, into a CHTP room.

Stage 2 (first CHTP period)

Question 1. Was the CHTP implemented as intended?

In this stage the presence of process indicators improved. Most CHTP practices followed the CHTP self-growing model. There were four exceptions. First, even when the students selected cough and coughing, Pablo and Manuela mainly shaped coughing and cough as a respiratory tract problem (p198). However, the deep insight to all respiratory tract problems was introduced because of students' curiosity; and because these problems referred to known people and to previous experiences and knowledge. A second exception was that the teachers and students did not always interchange roles. A third exception was that CHTP knowledge circulation amongst the other Minoans was practically absent in this period. An attempt to circulate knowledge in the community was the production of students' books. The production of the chicken-pox book (p200) was useful to organise knowledge within the CHTP, but not for knowledge circulation outside the CHTP. Finally, at this stage it was difficult to unveil local knowledge. However, to pool recreated or generated knowledge to solve specific problems, to organize it and make it ready for further use was a successful activity to identify cultural capital, and to discuss it.

Question 2. In which aspect were the greatest process benefits and costs for the CHTP self-growing pedagogy?

Main benefits from stage two processes were: the development of a self-growing environment; teachers' development as CHTP teachers; students' interest to develop meaningful knowledge to solve collective problems; development of practical basic knowledge to understand problems related with the human physical body; and development of communication skills, including reading and writing skills. Even when the practice of knowledge circulation was mostly restricted to the CHTP students and teachers, the circulation of knowledge was successful to help them to appropriate and achieve a more horizontal perspective when giving value to medical cultural capital.

I did not find specific costs other than the general costs that will be analysed further on in this chapter.

Question 3. How did this research intervention proceed to stage three?

Closer to self-growing pedagogy, there was a shift from cough, coughing and respiratory tract problems to problems of students' relatives and neighbours. More teaching and learning opportunities for the students were included. We planned more collective teaching so, the students would be reassuring each other and recognising their knowledge, experience and capacities. Finally, to circulate knowledge, the teachers and the students selected problems that could involve more Minoans.

Stage 3 (second CHTP period)

Question 1. Was CHTP implemented as intended?

Overall, the implementation of the third stage followed the CHTP self-growing pedagogical model and all process indicators were, at most times, present. I found three main failures and two main improvements in this stage.

Failures

During this stage, there was not enough expert knowledge about the physical body, to circulate for free students' use. I explain this here. As students learnt more, they needed more written information to use to understand and solve more complex disease problems. Books available in the CHTP were mainly medical and specialised. Even when the students had developed their reading and writing capacities, and also had taken advantage of more efficient readers -such as Elena and Alicia-, there was necessity of having books, videos, or other material presenting knowledge organised in a way that responded to the CHTP problems. The CHTP also lacked basic medicines and other material resources necessary to respond to practical therapeutic problems.

Due to problems related with the students' restricted writing capacities -whilst in continuous development-; to the lack of material resources; to restricted time; and to the students' every day life responsibilities, the intended production of internal CHTP

written material was not done. However, the students developed capacities to write and keep their own organised knowledge in personal notebooks.

Improvements

In this CHTP stage the students participated more as teachers, and the teachers adopted more the student role. Knowledge circulation improved through collective work carried out during the vaccination campaign, dog sterilisation, Olga's hepatitis prevention campaign, and the 'Reality is not plain!' project (p211). Local practices and values came into the discussions more easily, and the CHTP students were always ready to pool their cultural capital as demanded by a self-growing pedagogy. To identify the sources of knowledge, practices and values, helped to expand, value and use cultural capital.

Question 2. In which aspect were the greatest process benefits and costs for CHTP self-growing pedagogy?

In this stage the CHTP self-growing environment and teaching strengthened particularly through dialogue development. Also in this stage the students' self-confidence and valuing developed; the students and the teachers developed pleasure and satisfaction when constructing, identifying, or using knowledge; and the speed of appropriating knowledge was raised. The development of practical knowledge helped to improve the CHTP processes. Students' inquiring, planning and decision- taking skills developed.

Besides the overall costs of CHTP presented in further paragraphs, I could not find specific costs of the implementation of this stage.

Question 3. How did CHTP proceed to stage four?

Pablo, Manuela and I made a search of written material suitable for the CHTP problems. However, we lacked enough resources to acquire all of them. The students used the new books as a starting point to make their information searches and then complemented it with the specialised medical texts they had since stage two. The

students and the teachers gave attention to local healing resources to meet disease problems. Finally, they defined a fixed list of problems identified through the consideration of a plausible demand on students' services. It is from this list that the contents of stage four were defined.

Stage 4 (third CHTP period)

Question 1. Was CHTP implemented as intended?

The continuous presence of process indicators fell in this stage. The need to get ready to meet a plausible service demand rose in the students. The teachers considered a priority to make sure that the students knew enough about what to do to face that demand avoiding *iatrogenic*[97] practices. At the beginning of this stage Minoan's possible demands shaped the CHTP contents, yet the problems constructed from a predicted demand were not meaningful for the students or for the teachers. There was much time and effort used to construct knowledge that vanished immediately. Following the self-growing CHTP model helped the students to regain focus on meaningful problems at the end of this stage.

Question 2. In which aspect were the greatest process benefits and costs for the CHTP self-growing pedagogy?

Stage four greatest benefits were the development of the students' autonomy, interchanging roles, and growth as self-growing subjects; the creation of their own definitons about problems of reality; and the recognition of individualities.

Even though time 'lost' and the decrease of the learning speed were costs of this step, the experience of working from non-meaningful problems helped everyone to recognise the importance of meaningful problems for the CHTP.

[97] *Iatrogenia.* Diseases caused because of medical practices.

Overall CHTP process

The students that left the CHTP did it mainly for reasons external to the program. One reason for leaving was the time needed to attend the CHTP activities. Only Esther left the CHTP because she found it too complex for her understanding.

Restricted access to wealth was manifested in the CHTP process mainly through students' inefficient reading and writing skills; the restricted reading material to search for and organise knowledge to meet the CHTP problems; the restricted premises, teaching/learning conditions and equipment; the absence of health learning alternatives in Mino; and the absence of financial support or other facilities to help the students to attend to all CHTP sessions.

The analysis and evaluation of the CHTP process showed that meaningful problems of reality as well as pleasure and satisfaction when discovering, constructing and using knowledge are necessary for the development of a self-growing environment. It was also shown that a self-growing teaching model can find its organisation, contents, activities and learning objectives as it advances without need to specify them in advance; and that to focus on processes rather than on contents is the key for the construction of meaningful knowledge. Finally this evaluation showed that people with basic reading and writing skills could appropriate and adapt medical knowledge to meet health problems arising out of their reality.

Overall, this analysis showed that the teaching conditions specifically planned to counteract hegemony were met through the implementation of the CHTP. Here follows an analysis of the degree to which this self-growing pedagogy was capable of developing healthy subjects through changes in their patterns of subordination.

OUTCOMES EVALUATION

As noted in chapter five (p124) the expected outcomes of this pedagogic intervention were changes in subordination, difference, subjugated knowledge and body inscriptions. In the analysis of the outcomes, the CHTP students will be referred to as

'cuidadores', since this is the name they gave to themselves as shown in chapter eight (p208). As explained at the beginning of this chapter, the numbers in brackets refer to examples already presented in chapter eight that received a sequential number in appendix five (p294).

Subordination change

In the next paragraphs I will assess five outcome indicators capable of showing to what extent subordination changed through the implementation of CHTP:

Indicator 1. Recognition of subordination
Indicator 2. Habitus awareness
Indicator 3. Emancipatory interest in health knowledge
Indicator 4. Development of 'voice'
Indicator 5. Construction of fields of opinion

Indicator 1. Recognition of subordination

In chapter two (p26) I argued that a first step for counter-hegemonic action was the recognition, by dominated people, of their condition of subordination. Here I present three specific examples of subordination recognition in CHTP.

Most representative of indicator one is Teo's statement about the health promoter courses in IMSS:

> '[I found through CHTP] *the knowledge that had been hidden from me...I can see now all that was behind it...they train us to get cheap work from us...they don't even recognise it*' (Cron).

Mundo wanted to become a medical doctor ever since he can remember. He developed his own healing knowledge through mixing different healing conceptions, he used to give to all his patients allopathic medicine following medical laboratories drugs guidance considering that that was first class medicine and giving remedies as complementary to those. In one session during the second CHTP stage, he said:

> '*I am now giving patients nearly only remedies and they are cured all the same... they* [patients] *save money... I've been selling medicines for them* [the laboratories] *without knowing that their medicines are not always needed... I trusted their publicity...but I don't think* [medical] *doctors will ever recognise it...no...it means money for them...and you know? My patients like them* [remedies]'. *I have this many* [fingers expression of a big amount] *of patients*' (Cron).

Olga recognised her subordination to her husband:

> '*...it is not just love, it's the children, its me...this* [beating] *is not right... I can look after my children and myself even if I will miss him*' (Fwon).

As a whole, the cuidadores became critical when reconstructing their subjugated relations with medical doctors.

The cuidadores recognised their subordinated condition when developing cultural capital and cultural capital awareness; awareness about how they were included or excluded from cultural capital access; skills to identify, value, construct, reconstruct and make use of cultural capital; and awareness about differences in cultural capital (48.1, 142, 145, 179-181, 186.1, 194, 221.4-221.9)[98].

Indicator 2. Habitus awareness

To change habitus requires of pedagogy work equivalent to that employed in constructing it (chapter two:29), so the CHTP could not aim to change habitus. However, to be aware of habitus can help the subjects to control it. Here I provide some examples of how habitus awareness rose with the CHTP.

To analyse and evaluate the attitude of the medical doctors when the cuidadores asked un-thinkable questions accounted for a great amount of cuidadores' awareness about fields, habitus and arbitrariness. The identification of the medical field and the culture of the patient was key to establish pedagogical relationships in accordance with the CHTP project (221.9.2, 221.12, 226-229).

The cuidadores' identification of their characteristics (237-266) included: '[A cuidador] *thinks in the way we have been moulded, as an example: the wrong idea of vitamins* [which medical doctors prescribe to us]' (259). Luz and Elvira mentioned when defining a cuidador: [A cuidador should] '*...gain people's confidence so they can trust themselves and see reality, not just like it is there or so, but understanding it...*' (237).

Most significant was the way in which Olga and Teo brought their personal problems to the CHTP dialogue disclosing doxa that was preventing them from changing their respective oppression (97-98, 91-92, 178-181, 221.10, 344-345).

[98] Numbers in brackets refer to utterances in appendix five (p294).

Doctor/patient and teacher/student habitus awareness expressions were present in most CHTP sessions. That was evident particularly in Olga and Elvira's self-perception of their relations with their husbands. A quote from Elvira can exemplify this: '*He* [her husband] *does not like me to come* [to the CHTP], *often I don't come, but sometimes I say: why not, I am not doing anything wrong, so why should I feel bad?*' (Fwon). However, developing awareness was not always expressed in habitus and doxa change. Probably the best example of this is a not fully accomplished student/teacher role interchange, characteristic of self-growing teaching (210). Illustrative of this is that - after observing that the cuidadores were alert to possible *iatrogenia*[99] and that they were careful not to go beyond what they knew- Pablo, Manuela and I recognised that we couldn't get rid of our fear of not being able to supervise all the cuidadores' activities. We considered that that fear rose in us as a component of our medical and teacher habitus (221.12, also 46, 75).

Indicator 3. Emancipatory interest in knowledge

In chapter two (p39) I identified that when the subjects were subordinated to the market, their interests in knowledge were mainly practical and technical. Thus, the development of emancipatory interests was a way to insubordination. Indicator three evaluates to what extent the CHTP was capable of developing these emancipatory interests in knowledge.

When the cuidadores approached the CHTP for the first time, their interest in the CHTP knowledge was technical and practical as shown by their initial idea of it as a first-aid course (25); and Teo's need for collective recognition (342-344). However, they were prone to develop emancipatory interests as could be seen after the first CHTP sessions when Elvira, Luz and Elena said:

> *'...a way to open our way is to get to know each other better...things are coming bit by bit ... next week we will be more confident... I can see now that this is not going to be like school, here we must speak and say what we know, what we understand*' (75,46).

Elvira implemented CHTP activities in her own workshop *'to help the other compañeras*[100] *learn and know...'* (Fwon). Olga enjoyed developing knowledge to look

[99] *Iatrogenia.* Diseases caused because of medical practices.
[100] *Compañeras.* Other women working with her in the tailoring workshop.

after her *cuidados* (297), and Luz enjoyed being capable of introducing new ways to improve Mino's life (334-340). (More examples in 144-145, 370.2, 317-320).

Indicator 4. Development of 'voice'

Restricted access to voice is one characteristic of poverty and subordination. The subjugation of voice leaves room for the imposition of hegemonic contents and also restricts access to self-constructed values, meanings and knowledge (chapter two: pp25, 34, 53-55).

Through the CHTP all the cuidadores developed to different degrees, their capacity of saying what they knew and wanted in a way that could be heard in their different fields. Examples of that are how Elena (299-304) and Elvira (226-229) confronted medical doctors in medical services; and how Olga raised her voice to face her husband's oppression by taking her case to DIF[101] lawyers and social workers:

> '*...the DIF social worker came and talked with him* [her husband] ... *he knows now that I am backed by DIF lawyers ...they told me that if I make my mind to divorce, they will help... it is now my decision...*' (Fwon)

Voice development was notorious in the fourth stage when the cuidadores confronted the Assembly to present their advances and needs:

> '*...Elvira and Mundo were very anxious when waiting for their turn in the Assembly...they had written the important points...each had a part for the information...kept saying it'll be all right, all right... Once in the cuidadores room, they were laughing, they even hugged, ...it was not that difficult said Mundo, but look at my hands, I am sweating...*' (Cd).

Another example of voice development can be seen when they regained focus on meaningful problems without the intervention of the teachers (362-367, 370.2, 371).

Indicator 5. Construction of fields of opinion

It has been argued in chapter four (p87) that from recognition of subordination; habitus awareness; development of emancipation; and development of emancipatory interests in knowledge and voice can arise new values, meanings and knowledge different from those of hegemony. Therefore, the construction of fields of opinion where limits, rules and aims of the field are defined from those different values, meanings and knowledge, is a visible change of insubordination.

[101]DIF. A governmental organisation, which provides legal support to women and children.

All cuidadores constructed heterodoxa and fields of opinion; and the CHTP itself became a field of opinion since it conformed to the characteristics of a self-growing pedagogy (see process evaluation, 221.9-221.9.2, 230.1, 222).

Elena and Elvira had developed heterodoxatic knowledge and practices before they participated in the CHTP (93-94, 103-104). However, the CHTP helped them to recognise, value and control the ways in which they were performing as opinion builders. An example follows. When Elena faced and gave solutions to a family problem where the father had not received attention in the health clinic, she involved all the family in criticisms and explanations about the health clinic's services, and also about how much could they do by themselves (299-305).

Teo constructed opinion within the cuidadores group raising issues of institutional oppression. He discussed his health promoter institutional situation with the other cuidadores and finally resigned from all health practices as the only way he could find to liberate himself from the institution (91-92, 2219, 344-345). The cuidadores were capable of changing the CHTP dynamics particularly at the end of the fourth CHTP implementation stage (353).

The teachers also constructed heterodoxa and opinion. An example of this is that Manuela's participation in the CHTP conception and development helped her to find her professional reasons, and to look for time and space to take better decisions about how she would continue to study and work as a health professional (Md).

Difference change

In next paragraphs I will assess the four CHTP outcome indicators capable of showing to what extent difference had built up and changed through the CHTP implementation. Four difference outcome indicators are:

Indicator 6.'Self' and 'other' awareness through CHTP practices
Indicator 7. CHTP participants' practice in cuidadores' individual fields and in CHTP field
Indicator 8. Development of health capital exchange networks
Indicator 9. Construction of specific cuidadores' meanings and values

Indicator 6. 'Self' and 'other' awareness

As discussed in chapter two (p29), to be aware of the differences between 'self' and 'other' is a way for a subject to recognise the fields in which he/she is playing. Immersed in this awareness is the recognition of self and other's values, meanings and knowledge bonding differences. This recognition can help to develop conscious bonding necessary for the development of heterodoxa and fields of opinion.

Most illustrative of 'self' and 'other' recognition, is the cuidadores' self-definition and characteristics (237, 239, 242-266, 271-285). That definition is making distinctions between the medical doctors and the cuidadores (244, 245, 252-257). In that definition the cuidadores recognise themselves as part of their communities doing a kind of work that 'others' couldn't do:

> '*working where not everybody would like to work...the way is different from that of other persons dedicated to disease... we are part of a community ...when we give attention to someone, we can't put ourselves in a medical doctor's position.* [What we are] *is implicit in our own way and kind of knowledge*' (244, 245, 247, 252).

Indicator 7. The CHTP participants' practice in their respective fields and in the CHTP field.

Difference can be visible in practice when a subject plays in a field[102].

Through the CHTP, difference was shown as individual choices of cuidadores' practice. Luz became 'the surgeon' (331), Mundo 'the teacher' (369), Goyo 'the wound healer' (292), Alicia 'the information searcher' (291), Olga 'the fieldworker' (290, 297); and Elvira and Elena 'health activists' in their respective workshops and with their neighbours (239, 290). The decision to leave by Roberto, Esther, Guillermo and Teo were respected by the rest of the cuidadores that encouraged them to make their decisions.

The teachers also developed particular ways of teaching and practising their cuidadores' activities (217-220, 269, 289-294, 331, 345). While Pablo and Manuela had noticed teaching, studying and medical conception differences between themselves and their university teachers, through the CHTP they compared their motivations,

[102] As explained in chapter two (p29), a field is a network of symbolic and material capital exchange.

practices, and practise results with those of their university peers; finding that they had changed their medical conceptions and practices, and that the medical knowledge acquired in their medical training had new meanings (144-145). Pablo referred to this when he stated:

> '*When we* (Pablo and Manuela) *went to a prescriptive university session with our university peers, I heard them talking about ...things that did not matter to me at all. They talked about how successful they were in terms of amount of consultation or ways to raise money*' (Etn)

Indicator 8. Development of health capital exchange networks

To achieve insubordination it is important not only to recognise the characteristics of the fields, but also to construct new ones and to improve and monitor the values, meanings and knowledge developing and ruling these new fields[103].

Most representative of the development of a health capital exchange network is the cuidadores network. They generated their boundaries, rules, meanings and specific practices as shown in their definition of cuidadores' characteristics:

> '[a cuidador] is *an important community foundation ... when nobody knows, we must search to reach the starting point ...one is the key for them to think solutions...some follow us, others don't (they don't trust us)...we have a similar way to see or give solutions...we have no title...that diminishes our interest for money...enjoys learning...*' (237).

Linked with previous indicators, each cuidador developed differently their own health capital exchange network in his/her respective family, neighbourhood, or work site (287-296). However, there were no links at all with other health experts doing similar work. I made contacts with other health promoters in Mexico City, but they never met.

Indicator 9. Construction of specific cuidadores' meanings and values

In the pursuit of difference, heterodoxa and fields of opinion, the sharing and construction of individual values and meanings are most important to achieve identity and difference at the time (chapter two: p24).

As individual constructions, each cuidador gave different values to their knowledge. An example of that is how Mundo organised the cuidadores' room furniture as a conventional medical room despite all the criticisms of medical practice and his cuidador identity (368-369). While Mundo organised the cuidadores room like that,

[103] See footnote 102 (p235).

Luz, Elvira and Olga did not care about furniture organisation. They sat anywhere, and used the desk to leave their bags and parcels on (368-369, Fwon).

An example of collective construction of specific meanings and values is the cuidadores' service offer (271-285). Here follow some extracts of that offer to exemplify their particular way of understanding their cuidadores' practices:

> '[Here we] *...sterilise female dogs...give advice about contagious diseases...heal wounds, perform plasters, and sewing...orient about epidemics...can administer vaccines...orient about care for the aged...*' (272, 276, 278, 279, 281-284).

As it has been illustrated in chapter six (p135) and seven (p169), the cuidadores had strong collective life representations from before the CHTP. However, through the CHTP they found particular meanings for their knowledge and practices very much within the parameters of their own collective representations (231-241, 242-265, 286).

Subjugated knowledge change

In the next paragraphs I will assess the five CHTP outcome indicators capable of showing to what extent the cuidadores' subjugated knowledge changed through the CHTP implementation. The five subjugated knowledge change outcome indicators are:

Indicator 10. *Noesis* development
Indicator 11. Knowledge value and validity conferred by cuidadores
Indicator 12. Awareness and identification of fake and institutionalised knowledge and their relation with the health market
Indicator 13. The CHTP participants awareness of their knowing capacity
Indicator 14. Developing and use of common sense, popular and expert knowledge to solve problems of reality

Indicator 10. *Noesis* development

Whilst the *noesis* and the *noema* forms of knowledge had been recognised in this work (chapter two:36) as immersed in and inherent to all knowledge, it has also been recognised that hegemonic practices of knowledge inculcation tend to restrict the development of *noesis*.

As a product of school education, the cuidadores considered at the CHTP beginning that they were going to receive medical information, that they could add to what they

already had, more as *noema* than as *noesis*. That can be exemplified with different cuidadores' comments during the beginning of the first CHTP stage:

> *'we will learn things that doctors have to teach us...I don't thing I will be able to learn all that... I will mix everything... I have a very bad memory... sorry for not coming to the last session, I don't know how many things I already lost...I will get a low mark because I don't remember everything'* (Cron).

Through the CHTP *noema* and *noesis* developed. Practical knowledge incorporating common sense, popular and expert knowledge was built as *noema* through the CHTP (357). The cuidadores and the teachers developed health knowledge also in the form of *noesis* (370.2-371.1, 359-360).

As the CHTP advanced, they recognised and discussed that *noematic* school knowledge has had not much value throughout their lives as Luz mentioned:

> *'...as the matter of fact I think we really learn very little at school, just what is necessary to get marks...to read, write, and make additions and that... but, what does that learning have to do here in Mino, with our crops, with our life here...'* (Cron).

Recognition of the little value that school knowledge has for Minoans' practical life was not a product of the CHTP. Minoans had experienced that they get their practical knowledge from social life in Mino as discussed in chapter seven (p169). What I considered an important product of the CHTP is that they constructed and recognised *noesis*. Then they were able to compare it with school knowledge and to question the un-questionable and think the un-thinkable in a collective way bringing doxa to orthodox and later to heterodox. From heterodoxatic knowledge they understood other ways in which institutions provide partial information about the symbolic and the practical worlds (226, 221.10, 304).

The cuidadores were alert to test knowledge against their reality. That continuous testing of knowledge against reality, helped to 'reveal the 'un-natural of the natural'. That revelation did not cause fear in the cuidadores, as supposed from the CHTP sustaining theory. On the contrary, the cuidadores lived their findings with pleasure. That revelation helped them to make more feasible proposals to solve problems, and also to identify that there were many problems that they thought they were coping with, but in fact they were not, with the consequent resources lost (212, 221.1-221.9, 321-322, 324-328).

The cuidadores not only developed *noesis* to solve their problems, but also for the affective reactions they had when feeling that they were understanding and really getting to know specific aspects of their symbolic and material worlds. An Example of affections generated through *noesis* is Alicia's and Guillermo's joy and pleasure when understanding things that they wanted to incorporate in their conversation; when using their understanding to solve health problems; or simply when they manage to 'understand' (145.2). Another example is Roberto's enlightenment regarding his decision about his higher education studies attained through the CHTP. A final example is Teo's rage when discovering that health knowledge meant much more than what he has been told by IMMS, and also that he could have access to it:

> '*...they* [institution] *cheat us, they cheated me, we expend so much time in those ...health promoters courses. I leave my family and my crops unattended, I need to work harder to accomplish IMSS responsibilities that are not improving my life condition nor my people's diseases...we don't even have enough material to perform the few manoeuvres they tell us to perform*' (Cron).

Indicator 11. Knowledge value and validity conferred by the cuidadores

As discussed in chapter two (p40), a way to dominate knowledge is to replace and impose validity to knowledge through institutional validation. I also argued in chapter seven (p46) that institutional knowledge validation represents an obstacle for Minoans to recognise their knowledge value and validity. Through the CHTP, the cuidadores validated the knowledge they were discovering, creating and organising, progressively overcoming institutional validation. The value of knowledge generated within the CHTP was practical insofar as specific knowledge was recognised important if it could give explanations to help understand and intervene in problems that they considered not only as CHTP problems, but as their personal, family, neighbours, work-site or community problems. That is probably not only a result of the CHTP implementation, since, as seen in chapter seven (p172), Minoans give value to practical knowledge when using it to solve every day life problems. What I interpret as a result of the CHTP is that they explored 'forbidden' knowledge, knowledge reserved for 'others' that they were 'capable' of understanding. The cuidadores could use and value knowledge, taking it in their hands without any institutional intermediation or obstruction. Within the CHTP the cuidadores sought for peer knowledge validation (228-229, 324-328, 337-338, see also previous indicators).

The cuidadores not only found that the knowledge they were constructing was giving account of their reality, but also that it gave them pleasure and satisfaction (196-202, 144, 145, 145.2, 185, 260, 340). They liked to see and differentiate the knowledge they were developing as part of their cuidadores' identity (230.3, 237, 242, 252). They enjoyed and valued the processes of constructing knowledge (171, 17-185, 188-194); of developing awareness of how health and other knowledge is constructed and monopolised (178-181, 221.9.2); and also the processes of studying and defining strategies to approach health problems in Mino (207-209, 216, 251). The cuidadores also valued as knowledge the skills to develop those processes (262, 311-316, 317-320).

The knowledge constructed through the CHTP was coherent with the cuidadores' reality thus showing knowledge external coherence (142, 176, 224, 251). The cuidadores developed particular ways of knowledge organisation with their own internal logic (142, 185, 271-285). From that organisation they could validate internal knowledge coherence. In this way, they could evoke, use and select common sense, popular and expert knowledge; and also construct their own expert knowledge. An example is the evocation of the cuidadores' popular knowledge to alleviate a child infected with chicken- pox in a role-play (132-141). Another example is how they organised their practices in the poster they fixed in the cuidadores' room (270-285).

During the first and second CHTP stages the cuidadores conferred value and validity to knowledge but they also sought for Pablo's, Manuela's or my validation (40-44). At the end of stage four, when Pablo and Manuela left Mino, the cuidadores made their own knowledge judgements using the knowledge screening procedures they had learnt through the CHTP (270.2). When Manuela, Pablo and I arrived on our weekend visits, the cuidadores were more telling us what they were doing rather than asking us if it was right (370-371).

Also the teachers developed their own medical knowledge validation. Manuela's and Pablo's considerations about the knowledge they had constructed during their medical training changed as can be seen through this Manuela and Pablo's quotation:

> '*... those were the same medical texts we studied during our medical training yet, when we read them here with or for the cuidadores, we find not only new concepts but also how*

mistakenly we had grasped them, and how inadequate and incomplete they are to give account of real disease problems' (Etn).

The cuidadores recognised the validation problem when trying to find apprenticeships to circulate their health knowledge developed through the CHTP. They couldn't find people wanting to learn from them since '[people] *think it is not the same* [to learn] *with us than with you* [doctors]' (Various students, Cron).

Indicator 12. Awareness and identification of fake and institutionalised knowledge, and their relation with the health market.

The discussion about knowledge presented in chapter two (p40), and in the analysis of Minoan knowledge (chapter seven:169) shows the leading role of fake and institutionalised knowledge for the construction of knowledge subjugation. One main CHTP practice leading to awareness of habitus, doxa and subordination was probably the identification and discrimination of fake and institutionalised health knowledge and their links with the health market.

Alongside the development of *noesis* and the development of their own knowledge value, validity and validation; the cuidadores and the teachers learnt to identify and discriminate fake and institutionalised health knowledge (74, 123, 142, 178-181, 186.1, 221.4-221.9.2, 225-229). By contrasting their cuidadores' practices with the medical services they examined the medical services relations with the market and the knowledge sustaining their practices, and found how empty fake and institutionalised knowledge are (226-229).

Indicator 13. CHTP participants' awareness of their knowing capacity

A way to subjugate knowledge is to veil the subjects' awareness of their knowing capacity (see chapter two:29,34). A result of emancipatory action is this awareness, manifested in the CHTP as questioning, pleasure, self-esteem, rage and other emotions. In the examples provided for indicators 10, 11 and 12 are also shown these manifestations.

The cuidadores recognised differences in the ways they could learn, and what they were learning. As the CHTP advanced their initial expressions of not being capable of

developing knowledge (39) faded, and were replaced by their knowledge input to the CHTP dialogue (146-176, 182-185, 187-194, 197-200, 216).

Indicator 14. Developing and use of common sense, popular and expert knowledge to solve problems of reality

It has been argued that institutional knowledge restricts the development of local popular and expert knowledge (p45); and that a self-growing pedagogy could rely on common sense to question institutional and fake knowledge for the development of popular and expert knowledge (p97).

Common sense, as discussed in chapter four, was the first knowledge source in the CHTP (p102). The use of questioning and dialogue contents relied on common sense (3, 74, 120, 131, 136-142, 150, 174-176, 185, 187-194, 199-202). How Elena solved the problem of the man with a kidney disease (298-305), and how Olga approached the problem of the hepatitis out-break (317-320) are just two examples of the development and use of common sense, popular and expert knowledge through the CHTP and the cuidadores' practices.

Through the CHTP, the teachers' knowledge shifted from institutional (65-65.e) to expert (136-170), and they developed skills to use common sense.

Body inscriptions change

However big or small, during the CHTP there were immediate individual and collective changes in the material inscriptions of subordination, difference and subjugated knowledge (p69). One spectacular material change attributable to the CHTP action was the difference in the numbers of dogs vaccinated as observed in a previous Health Ministry's campaign (twenty-five), and in the campaign organised by the cuidadores (two hundred and forty plus about twenty cats) (306-323). However spectacular those figures are, I can find much more gains in the way that campaign was organised and implemented through the CHTP. This showed changes in the cuidadores' subordination to Health Ministry practices, in the cuidadores' difference, and also in their subjugated knowledge (306-330). The CHTP showed material inscriptions of the cuidadores' changing practices other than human body inscriptions. Most relevant is the agriculture

and veterinary work that Luz is carrying out in Mino as a product of her knowledge development through the CHTP. In the following paragraphs I will present some of the multiple subjects' body inscriptions that changed because of the improved access to knowledge and meanings achieved through the CHTP.

Indicator 15. Body inscriptions change

Roberto, Guillermo, Alicia and Esther use their CHTP constructed knowledge to look after themselves and their direct families. Goyo is healing wounds (292).

Teo was relieved from his oppressing institutional health promoter demands. That helped him to better look after his family and crops, and gave him some peace of mind resulting in improvement of gastrointestinal and other problems originating from stress (Cron, Esn). Olga sued her husband. She still lives with him, but he takes more care of Olga and the children. He has also stopped beating them (process indicator1, Cron).

Elvira provides cuidadores' services in her workshop, looking for better working conditions, attending disease problems and finding solutions within the institutions when workshop women don't have enough resources to solve their disease problems (289). That extended to the seamstresses' children. Elena has extended her advice, attention and training to different places where she works and lives. Luz, Olga and Mundo are also giving health advice and attending sick people in their communities.

OUTCOME INTERPRETATION

After analysing some changes that occurred throughout the CHTP implementation in the cuidadores' subordination, difference, subjugated knowledge and body inscriptions, I can answer the questions presented at the beginning of this chapter (p222):

Question 1. To what extent were the CHTP intended outcomes achieved?
Question 2. In which aspects are the greatest changes shown through the CHTP implementation?
Question 3. What were the costs of the CHTP implementation for the participants?
Question 4. How did the CHTP influence knowledge and subordination/hegemony change?

Question 1. To what extent were the CHTP intended outcomes achieved?

After examining the outcome indicators, I can say that most of the CHTP intended outcomes were achieved. Exceptions are the further development of reading and writing skills, and the development of health capital exchange networks outside Mino. The CHTP proved its efficiency in achieving changes in hegemony/subordination patterns within the cuidadores. Collective cuidadores' knowledge certification and institutional recognition was restricted to the dog vaccination campaign and dog sterilisation. However, the CHTP proved its efficiency in coping with the un-expected as it can be seen through the way in which Elena responded to her cuidado's kidney problem, or Olga's response to the hepatitis outbreack.

Question 2. In which aspects are the greatest changes shown through the CHTP implementation?

Since the desired CHTP outcomes were achieved, benefits of the CHTP implementation in Mino are mainly change in cuidadores' subordination/hegemony manifested through improved access to health knowledge; construction of particular health meanings and practices reflecting the cuidadores' values; construction of a cuidadores' identity; creation of a language of critique and possibility; construction of fields of opinion, development of healthy subjects; and change in material and body inscriptions of dominance.

Question 3. What were the costs of CHTP implementation for CHTP participants?

CHTP implementation had costs for the cuidadores, the teachers and other Minoans. I explain this below.

Costs for cuidadores

I find cuidadores' costs in three aspects: expectations rose through the CHTP, time and material resources.

Cuidadores' expectations changed from first aid to an expert health practice possibility through the CHTP implementation. That change meant that they had to pass from the short term secure and better-known first aid practice, to a long term un-certain and un-known emerging health practice conveying life-long diverse collective and expert responsibilities. The cuidadores also needed to perform their non-paid time and resources-consuming health practices, as an aggregate to their regular activities.

Costs for other Minoans

Despite the individual benefits that some Minoans had experienced through the cuidadores' services, during this research intervention the cuidadores' expertise had not spread in Mino. A large number of Minoans did not understand what was the nature and possibilities of the cuidadores. Minoans were ready to understand a first-aid course, but not the particular cuidadores' services. Therefore, expectations raised in the first assemblies were not met. However, Minoans raised new expectations of the cuidadores' capabilities such as the dog sterilisation and individual disease attention showed.

Material costs to Minoans originated from feeding and housing Pablo and Manuela such as collective organisation, food, water, electricity and a room with furniture.

Costs for teachers

Manuela and Pablo were *pasantes* on compulsory social service in Mino. Social service for medical students in Manuela and Pablo's particular programme, is considered a final medical training stage where the students are supposed to attend a medical consultation. Medical consultation in the health clinic in Mino was scarce. I interpreted that scarcity as the result of the particular way in which they were delivering the medical services that did not meet the traditional Minoans' conceptions about doctor/patient relations. That situation diminished Manuela and Pablo's opportunities to further develop their medical practice as conceived in their medical training. However, they had the opportunity of delivering a medical practice alternative to what they learnt within the medical institution. Pablo, Manuela and I also expended some small personal money on transport and basic books and materials.

Teachers' training costs

The training of Manuela and Pablo was unique and specialised. There were material and affective costs involved, mostly covered by Pablo, Manuela and I. Pablo and Manuela considered that training as part of their overall medical training. Also Manuela and Pablo had used their teacher training in other health teaching projects.

Long- term costs

In this research I do not analyse or evaluate indirect outcomes or long-term costs. However it must be said that if the cuidadores continue spreading their practices, the local private medical services would be affected and that could reverse against the cuidadores as return-costs.

Question 4. How did CHTP influence knowledge and subordination/hegemony change?

I will answer this question in two parts. The first part will refer to practical ways in which the CHTP self-growing environment and teaching was achieved. The second part will consider how the CHTP influenced the cuidadores' habitus structuring processes.

Practical ways in which the CHTP self-growing environment and teaching was achieved

During the CHTP and particularly in stage three and at the end of stage four, the cuidadores made information and knowledge demands to understand and solve the problems they were bringing to the CHTP. As seen in chapter four (p97), this knowledge need is characteristic of a self-growing pedagogy. To get to know what they needed to improve health, the cuidadores needed first to develop a wide scope of general and health knowledge characteristics and possibilities. They also needed to recognise themselves as subjects with subjugated knowledge, capable of constructing and liberating knowledge. The self –growing teachers and teaching helped to open that scope and that recognition. Previous cuidadores' collective responsibilities, and the strong will that the CHTP participants had to make the CHTP succeed, were basic to build up the CHTP knowledge demand.

The knowledge, problems, emotions, values, explanations and understandings brought by the cuidadores to the CHTP self-growing environment, shaped the knowledge demand. Teachers' input into the self-growing environment was mainly expert knowledge selected and presented in response to the cuidadores' knowledge demand. In this way the teachers were mainly knowledge suppliers to a self-growing environment. The teachers were also providing tools to organise the self-growing environment. In the fourth stage, the cuidadores needed to provide for their self-growing environment by themselves, thus achieving autonomy.

The speed of knowledge construction in period one, where the basic tools to acquire and construct knowledge were developing, while fast, was lower than in stage three where meaningful problems of students' reality were the learning focus. The learning speed diminished when the CHTP focus shifted to fixed contents and activities, and

recovered when the cuidadores decided to turn the focus on problems of their reality. This reinforces the importance of bringing problems of students' reality to learning processes.

Another practical conclusion about the CHTP teaching is that Manuela, Pablo and I consciously used our doxa and habitus to trigger processes to unveil cuidadores' and our own doxa and habitus. Pablo, Manuela and I recognised that as 'necessary arbitrariness' to develop arbitrariness awareness.

How the CHTP influenced the cuidadores' habitus structuring processes

One important way to disclose doxa and habitus in this CHTP was the deconstruction of knowledge achieved through dialogue and the use of common sense to understand knowledge meanings and health problems. Through dialogue, conventional knowledge meanings were analysed and evaluated until the CHTP participants could understand how conventional health knowledge was originated and circulated and how accurate it was in giving an account of their health problems. The dialogue did not aim to develop conceptual discussions, but to find and deconstruct necessary 'conventional' health knowledge to construct meaningful knowledge to confront specific health problems worrying the cuidadores. In that way, there was coherence between knowledge construction and knowledge utilisation. When that coherence was dislocated, as happened in the last CHTP period, the cuidadores' need to construct useful health knowledge to confront their health problems caused the CHTP to recover knowledge construction/knowledge utilisation coherence.

The analysis of the CHTP processes and outcomes helped me to explain what the role of health problems in the development of doxa and habitus awareness was as follows.

Previous teachers' and cuidadores' inculcated doxa was not only affecting their values meanings and knowledge expressed as habitus. Doxa was also affecting the teachers and the cuidadores' individual internal processes of incorporating or rejecting those values, meanings and knowledge. Doxa then was affecting the cuidadores and teachers' 'thinking strategies' (see pp29-33). The CHTP was acting directly upon those thinking stategies by bringing problems of the cuidadores' reality straight to their thinking

processes. Problems brought by the cuidadores to the CHTP were meaningful for them and referred to their practical lives, and also to their own values and meanings; as opposed to problems shaped by the family, the school, the medical, the media or other institutions. Those problems, and the already existent cuidadores' and teachers' knowledge, were brought into deconstruction through dialogue. In that way, the doxatic intervention upon their thinking stategies, while not eliminated was reduced. However impossible it was for the CHTP teaching to reach doxa since it is by definition un-thinkable, it was possible to reach the cuidadores' and teachers' thinking stategies through the CHTP practices. An example of how the CHTP intervened in cuidadores' 'thinking stategies' is provided here.

What was preventing Teo from abandoning his institutional position and liberating himself from collective demands? Institutional action upon Teo's community and Teo had constructed doxa telling him that not to obey institution and local authority conveyed uncertain sanctions. Also it is doxa in Teo's community that institutions 'are helping us' and 'we most do as they say'. Doxa then told Teo that collective responsibilities are not to be abandoned, particularly if those responsibilities are related to institutional services. Doxa also told Teo that abandonment of his health promoter activities would result in institutional and collective sanctions. However, Teo felt oppressed, and developed basic resistance practices such as grumbling and complaining while obeying institutional directions. His thinking strategies were making sense of his situation by accumulating facts and unconformity. He saw health problems and his own problems mediated by institutional health problems interpretation. Through the CHTP he could deconstruct his community health problems and institutional interpretations and was able to compare and contrast them. He could then interpret by himself his community health problems and his own problems. His thinking strategies gave sense to his situation by ordering his feelings, values and knowledge; by recognising and weighting real sanctions and losses; and by generating options. Through direct CHTP action upon Teo's thinking strategies, he unveiled the institutionally inculcated doxa, and was able to find that he could take decisions about his life and way of living. Finally Teo resigned from all health promoter practices and relieved himself from institutional and community oppression.

The CHTP influence on Olga's thinking strategies was similar to Teo's. Olga maintained her oppression denying facts about her husband's oppressive practices and sublimating them, as her thinking strategies. Through the CHTP she could organise her feelings, knowledge and values; look for complementary knowledge and information; understand and evaluate her situation; and generate options and decide actions to change her children's and her oppression. Olga and Teo unveiled their doxa not only through contradictions but also through comparing and contrasting with a world of possibilities.

The CHTP influence on thinking strategies by bringing the cuidadores' meaningful health problems into dialogue; by the deconstruction of conventional knowledge; and by the construction of meaningful knowledge, can also be found in other cuidadores' oppression and subordination changes. I selected Olga's and Teo's changes because of the rapid and fundamental impact the CHTP had over their lives thus illustrating the potential of the CHTP influence on oppression.

From these examples and analysis I conclude that the role of meaningful health problems in the CHTP was to diminish doxa and habitus intervention in the cuidadores' thinking strategies.

OTHER LEARNING ABOUT THE CHTP

About self-growing pedagogy

This analysis and evaluation showed that this research intervention was implemented with self-growing pedagogy characteristics and was capable of producing the CHTP desired outcomes of changes in cuidadores' and teachers' subordination, distinction, subjugated knowledge and body inscriptions. However, this intervention could have been improved through better students' reading and writing skills; access to reading materials and other knowledge sources relevant to local problems; making links with other self-growing groups; helping the students and teachers with improved material and collective support; and, perhaps, with legal backing.

The CHTP outcomes were the product of the CHTP self-growing pedagogical processes more than the product of planned content or activities which, corresponding with the self-growing pedagogical characteristics of this research intervention, were used as initial tools with which to implement the CHTP processes. The reduction in the learning speed in the last CHTP stage, clearly showed the importance of the self-growing processes to achieve the construction of meaningful knowledge.

The self-growing pedagogy sustaining this research intervention is a result of the analysis and application of theories and experiences comprising pedagogic implications, and power dynamics explanations. Self-growing pedagogy is concerned with improving knowledge access and free meaning construction in a context of un-equal power relations where knowledge and meanings are used to exert and maintain power. The application of a self-growing pedagogy in the CHTP proved that free meaning construction and development of knowledge access resulted in changes in power relations.

Through the CHTP implementation it was also proved that changes in knowledge validation represents one key to power change. However, it is important to point out that validation was not sought through the CHTP, rather, knowledge was cherished by the CHTP participants because of the value and validity they conferred to it as it was capable of being used by them to gain an understanding of their problems. This is probably one aspect of what Freire called 'knowledge liberation'. In this way, liberated knowledge can be seen as knowledge that is meaningful for people, taking its value from its validity and not from the validation of any power agency.

Through the CHTP, alongside meaningful knowledge, a new capital exchange network (field) emerged. The CHTP students developed a particular identity accompanied by particular rules and bonding. Even when this field emergence was contemplated as a desired CHTP outcome, to construct it was not a CHTP focus. It evolved as consequence of the students' relation with knowledge, meaning and understanding of their reality. It can be seen as a product of what Bourdieu called the passage from doxa to heterodoxa, from which the cuidadores initiated their own field as a field of opinion. Within the cuidadores' emergent field, the struggle for power centred on the achievement of collective power to improve group practice and collective life. Power

also represented a possibility to enjoy knowing and knowledge, to understand and explain, thus shifting the very meaning of power constructed by hegemony.

Making use of common sense, the self-growing pedagogy facilitated the CHTP students to develop their awareness, and to appropriate and strenghten their history and popular knowledge that was veiled by medical market hegemony. The self-growing pedagogy also generated the cuidadores' particular expertise and health expert knowledge, preserving their values, meanings and practices in a context lacking experts and expert knowledge. Institutional knowledge was necessary to the CHTP amongst others, to understand how knowledge is used as a means of hegemony; to learn to discriminate knowledge through the exercise of unveiling its value and validity when compared and contrasted with Mino's reality; to disclose institutionally hidden discourses; to evaluate the knowledge and practice of institutions' personnel; and to generate feasible demands on institutions.

Students' and teachers' faith, hope and humility, and their will to liberate themselves from oppression and to liberate knowledge, proved to be important elements of the self-growing pedagogy success. Those characteristics are complemented by students' and teachers' commitments to collective life and sense of individual and collective identity. It also showed the relevance of maintaining real problems at the centre of the CHTP processes and a self-growing environment capable of providing for affective responses.

From the experience gained from the CHTP, it is concluded here that projects based on a self-growing pedagogy can better succeed if kept as local projects -rather than making of them grand national education projects-, maintaining objectives that are feasible and relevant to the students and teachers involved in each specific teaching project. To keep the self-growing health teaching projects at a local scale opens up possibilities for students and teachers to construct free-from-institutions space to move in. This is necessary to let the students to find and define problems that are meaningful to them. To keep self-growing health teaching projects to local scale does not prevent the incorporation of regional and national problems structured from local perspectives. It is proposed here that conscious change at a local level, incorporating regional or national perspectives, could set off endurable change in an inverted cascade. Changes produced

in this way could probably be more representative of people's needs than of institution's and policy makers' needs.

About doxa

When Manuela, Pablo and I first designed the CHTP, we were considering to un-veil doxa as the first CHTP action. However, we found that every time we thought that we perceived doxa, we were just looking at the immediate, superficial doxa we expected to find such as student/teacher, gender, doctor/patient or other doxa. We then understood by heart that there were much deeper doxa from which each CHTP participant was perceiving, thinking and acting in the CHTP. Superficial doxa was not enough to explain or show deep students' and teachers' doxa. Pablo, Manuela and I tried to find ways to interrogate doxa but couldn't find questions capable of helping in that interrogation and we felt that we were looking in the wrong place. We experienced and discussed that we could never find those questions since by definition doxa is doxa only if un-questioned, if invisible and un-thought. Through the CHTP I found that doxa is revealed when changes in thinking strategies occur. Doxa was disclosed when the thinking strategies of the cuidadores changed. Then, their fear of freedom diminished since doxa was disclosed as alternatives appeared, hence providing the cuidadores with new security contexts. I argue here that doxa can be revealed not only through a confrontation between reality and learned behaviour, but also by a change in thinking strategies.

Another remark about doxa is that I discovered that there was no way for us to escape from doxa. All the CHTP actions were sustained by doxa. Through the CHTP a language of critique and possibility was constructed and also new doxatic knowledge that neither students, teachers, nor I could see or question. One important element to trigger doxa and habitus awareness, was conscious and controlled use of the teacher's arbitrary role. From those considerations I can say that the CHTP participants used, adapted and constructed doxatic knowledge to liberate themselves from hegemonic medical doxa.

About the medical truth

To question the medical truth is to question doxa, implying changes in thinking systems that can devolve to the medical market clients their self-subjection and subject-body integrity as analysed and discussed in this research where the CHTP participants were capable of changing simple social reproduction to emancipatory social reproduction. From Bourdieuan concepts, in box 9.4 is presented my interpretation of simple and emancipatory social reproduction occurring in the CHTP participants as they constructed knowledge to understand their health problems.

BOX 9.4. SIMPLE AND EMANCIPATORY REPRODUCTION IN MINOANS' PEDAGOGIC ENCOUNTERS WITH THE MEDICAL SERVICES

CONCEPT	ALLIED CONCEPTS	EXAMPLES OF SIMPLE REPRODUCTION	EXAMPLES OF EMANCIPATORY REPRODUCTION
HABITUS	Doxa	'doctors know, patients don't know'	'am I ignorant? (ortodoxa) I know and can know more' (heterodoxa).
	Pedagogic work	Symbolic violence.	Rise of opinion.
	Scheme of perception	Medical instruments, practices and medicines as therapeutic panacea.	Medical instruments, practices and medicines are one possible way to confront disease.
	Scheme of thinking	Repetition, acceptance, personal guiltiness.	Reflection, analysis, decision taking.
	Scheme of realisation	Patient does not complain, accepts medical prescriptions and practices without questioning, and expends resources to cover medical requirements.	Patient looks for information and alternatives to solve their disease problems and problems raised in the doctor/patient relation.
FIELD	Capital value	Defined through institutional validation.	Defined by patients through validity.
	Distinction	Bonds in patients' dependence on doctors.	Bonding in patients' problems and self-reliance.
	Limits, objectives, rules, values	Defined by institutions.	Defined by patients, construction of fields of opinion.
	Position	Marginal	Central
	Disposition	'patient patient'	'no-patient' critical patient
	Position taking	Passive	Active

It is argued here that simple reproduction and a culture of 'patient-patients' is impairing Minoans' capacity to meet disease problems and to confront medical practitioners, knowledge and institutions. I also argue that the incipient emancipatory practices triggered through the CHTP have the potential to transform the local medical services,

practices, meanings and knowledge into efficient services to meet the Minoans' disease, and probably also their health problems.

Hegemonic medical power relations are reproduced through health teaching programmes aiming to train resources at different levels (Jarillo et al 1998, Caro 1977, Brown 1983, Navarro 1978). For Minoans, access to university health programmes is highly restricted, as the case of Mundo demonstrated. The CHTP represented for them a unique opportunity to open access to medical and other health knowledge. The CHTP training however, did not correspond with any conventional training. From a community perspective, the CHTP students were trained as health aids or health promoters, but were not sure about what to expect from them. The cuidadores for their part did not feel like health promoters or aids. Even when they did not care – with the exception of Teo - about institutional validation for their training, it was difficult for them to make themselves understood by their communities. It was through their practice with individual families that they became accountable for some persons in their communities. This presents a dilemma that I have not answered: to exert institutional power through the validation of studies -with consequent content and practices impositions and restrictions to the cuidadores' meaningful knowledge developement- in order to back the cuidadores' practices and knowledge for the benefit of other institutions and their communities; or to wait for the free development of the cuidadores and their communities without institutional backing, or legal support.

THE CHTP HEALTH AND HEALTHY SUBJECTS

In chapter three (p70) I defined health as 'an embodied human capacity to construct feasible futures and achieve them'. After analysing the CHTP learning processes and outcomes I found that through the CHTP the cuidadores and the teachers diminished their fear of freedom by reinforcing their active role in facing real problems. That fear was supported by doxatic knowledge constructed as a product of dominated thinking strategies. Through the CHTP action, their thinking strategies became liberated and the teachers and cuidadores were able to construct meaningful knowledge representing their values as liberated knowledge. Knowledge liberation permitted the cuidadores and teachers to integrate their material and subjective worlds and their individual body and

subjectivity. That helped the cuidadores and teachers exert and develop human capacities to create and recreate their world, body and subjectivity. Both cuidadores and teachers found ways to create options, to decide and to act towards the achievement of feasible futures. In this way I can say that, through a self-growing pedagogy, the cuidadores and the teachers developed their individual and collective capacity to construct feasible futures and achieve them, changing their subordination, difference, subjugated knowledge and body inscriptions.

Health enhancement through the CHTP was possible because of the development of the cuidadores as healthy subjects. Through the CHTP, the students' integration of their subjective and practical worlds strengthened. They used common sense, popular and expert knowledge to give meaning and value to the symbolic and practical worlds. They also constructed new knowledge to name and understand both worlds in an integrated way. Finally, the cuidadores were able to think and implement emancipatory health practices.

CONCLUSIONS

In this chapter I presented the analysis and evaluation of the processes and outcomes of this pedagogic research intervention following the methodology presented in chapter five.

This analysis of the CHTP processes showed that the CHTP met the conditions and characteristics of a self-growing pedagogy presented in chapter four. This evaluation showed that a teaching model following a self-growing pedagogy can find its organisation, contents and activities as it advances; and that people with basic reading and writing skills can appropriate and adapt specialised knowledge to meet their health problems. Through this evaluation was revealed the importance of students' pleasure and satisfaction when discovering, constructing and using knowledge for the development of a self-growing pedagogy. This evaluation also revealed that a self-growing pedagogy could improve the speed of knowledge acquisition, adaptation and production, revealing the importance of bringing problems of students' reality to the learning processes. It has been argued here that to focus on processes rather than on

contents, and to use dialogue to examine problems of students' reality, can result in students constructing meaningful knowledge from where they can better understand and cope with health and other problems in their every-day reality.

The analysis and evaluation of the CHTP outcomes showed that most of the CHTP intended outcomes were achieved. The CHTP proved also, its effectiveness in achieving changes in the cuidadores' patterns of subordination.

It has been argued in this chapter that the CHTP opened access to health and other knowledge through the development of the students' capacities to inquire, reason, search for information, and hold collective discussions to understand and confront problems of their reality; in a way that reflected their particular meanings, values and practices. The development of those capacities made possible the construction of what Freire called 'a language of critique and possibility', and of what Bourdieu called 'fields of opinion'.

I found through the CHTP analysis and evaluation that change was achieved by bringing meaningful problems of reality close to the students' thinking strategies and structuring structures, thus diminishing doxa interference in the interpretation and construction of their knowledge. This was attained through the deconstruction of conventional knowledge sustaining the way in which the cuidadores traditionally understood their health problems, and the construction or adaptation of knowledge in a way that was meaningful for them.

It has been argued here that the CHTP was capable of producing changes in the cuidadores' structuring structures giving way to the production of orthodoxatic and heterodoxatic knowledge, and to the development of the cuidadores' healthy subject characteristics. Hence, I can say that, through a self-growing pedagogy, the CHTP cuidadores and teachers developed their individual and collective capacity to construct feasible futures and achieve them; changing the characteristics of their patterns of subordination, difference, subjugated knowledge and body inscriptions.

Once I had the results of the CHTP process and outcome evaluation, I could say that simple reproduction and a culture of 'patient-patients' –sustained in doxatic

knowledge-, is impairing the Minoans' capacity to takle disease problems; and to confront medical practitioners, knowledge and institutions. I argued here that the CHTP teachers and students used, adapted and constructed doxatic knowledge to liberate themselves from hegemonic medical doxa.

CHAPTER 10
CONCLUSIONS

In this final chapter I present some conclusions and lessons learned from this research. I start with a summary of the arguments developed through this thesis. Then, in the light of the results I will answer the research questions and will argue how the understanding developed in this project contributes to the development of new knowledge about power embedded in the practice of health promotion. Finally I will present some perspectives for health promotion that take into consideration these research results.

SUMMARY OF ARGUMENTS

This research developed from the awareness of a perceived gap in knowledge about the individual and collective capacities and power to promote health. To acknowledge that gap in this thesis: I examined the policies and practice of institutional health promotion from a power perspective. Then, I examined the power dynamics in which local people of a rural community in Mexico are involved, and the impact of power upon their health knowledge, meanings, values, and practices. Finally, I looked for a critical pedagogic practice for health development that could help me to understand the mechanisms of power exertion over individual poor people, and how to enhance their individual and collective power to develop health. I present below a summary of the arguments developed through this thesis.

To meet the Ottawa Charter's definition of health promotion, the practice of health promotion should aim to identify and develop those characteristics of human subjects that enable them to identify and realise their aspirations, satisfy their needs, and change or cope with their environment.

The Ottawa Charter's definition of health promotion considers human subjects only possible if they exist in symbolic and material worlds that are constructed from power relations. Power relations are characterised by the ruling of all aspects of human life

through the control of knowledge, values, and meanings by a single class. This is what Gramsci called hegemony. The material object of hegemony is the subjects' physical body: to control subjects' knowledge, values and meanings in the symbolic world renders in hegemonic control of the subjects' physical bodies which is necessary to give direction to the economy.

The current hegemony is characterised by the overwhelming presence of the market, and as such, is a 'market hegemony'. The current market hegemony has restricted the access to overall wealth (income, services, voice, etc.,) for people with little capital to exchange in the market. The present patterns of poverty and disease are a result of market hegemony. In this way, the practices and discourses generated from hegemony –such as the official discourse of health promotion- are uneven practices of power and are not politically neutral.

If, drawing from the Ottawa Charter definition of health promotion, human subjects need to identify options, take decisions, and realise their aspirations then, hegemonic power is the main obstacle for the development of health. Hence, to remove that obstacle in order to promote health it is necessary to address and develop the subjects' power. I considered necessary to develop a concept of health that could help me understand its multiple dimensions while preserving the scope of the Ottawa Charter. I defined health as 'an embodied human capacity to decide and construct transcendental feasible futures and achieve them'.

Since hegemony is achieved through the control of knowledge and of the values and meanings immersed in it, to counteract the hegemonic power obstructing the development of health it is necessary to address the power contents of the production of health and other knowledge. Power immersed in knowledge can be visible through the examination of its value, validity and validation, and of the human interests behind these.

Emancipatory health promotion projects should aim to develop health and what I called in this thesis 'healthy subjects': free beings and ethical subjects shaping their symbolic and material worlds from the construction of knowledge embedded within their own values and meanings. To achieve health as defined here, it is necessary to stop the

processes leading to the construction of subjects as 'market clients' and to promote processes leading to the strengthening of the development of healthy subjects.

The development of healthy subjects requires unveiling the hegemonic values and meanings that have been inculcated by systematic hegemonic pedagogic work as invisible, unthinkable and unquestioned knowledge (doxa). The unveiling of doxa can open the way to the construction of opinion and new knowledge, values, and meanings alternative to the hegemonic.

In this thesis I explored the possibility of constructing meaningful knowledge for the development of the health of people marginal to the market hegemony through what I called 'self-growing' pedagogy. A self-growing pedagogy facilitates people to look for contradictions between doxa and praxis; to unveil, think, and question doxa, and to modify their knowledge, meanings, and values about their reality with consequent changes in their practice.

A self-growing pedagogy focuses on processes, and not on contents, and deconstructs real problems through dialogic practices. It develops skills and knowledge to investigate real problems to construct new understandings about them. From knowledge constructed in this way, it is possible to build options and take decisions different from those generated by the market. The self-growing pedagogy is a way to open up access to knowledge to people marginal to the market hegemony.

It has been shown through this research that a self-growing pedagogy has the potential to promote change in subordination patterns through the development of human capacities and the subsequent construction of what Freire called 'a language of critique and possibility' and of what Bourdieu called 'fields of opinion'.

I argued in this thesis that change was achieved by bringing meaningful problems of reality close to students' thinking strategies and structuring structures thus diminishing doxa interference in the interpretation and construction of knowledge.

It has been shown that through a self-growing pedagogy, CHTP teachers and students developed their individual and collective capacity to construct feasible futures and

achieve them, changing the characteristics of their patterns of subordination, difference, subjugated knowledge, and body inscriptions, thus, following the concepts underpinning this work, developing as healthy subjects.

SUMMARY OF FINDINGS

This research was guided by two main questions that I answer below in the light of the knowledge and understanding developed through this thesis.

What are the characteristics of the dynamics of power underlying relationships between health services and individual subjects who have restricted access to power and overall wealth?

The results of this research showed the overall effect of hegemonic medical practices, meanings and knowledge on the diseases and health of a group of people with restricted access to wealth. This analysis revealed the complex nature of health that makes it an ideal area for the exertion of dominance. The research results confirmed that the practices of dominance and subordination could be expressed in the lack of access to basic services and in the inscriptions of poverty in Minoans' bodies. I explain this below.

The current market hegemony uses economic parameters to 'value' human life to define international agencies, countries, and institutions' policies, budgets and programmes. Through these, the hegemonic health care systems strengthened and established dissimilarities in human value, social belonging, and access to health knowledge and services amongst different groups in society. In Mino, those parameters translate into lack of recognition of the value of local people's lives and knowledge with their consequent exclusion from health budgets, services, and decisions. From the research results I can say that people in Mino belong to the lower valued humans in the market hegemony. This is expressed in their disease patterns. In this way, I agree with Laurell (1979:7):

> *'...observed differences between different social classes in respect to the way they acquire diseases and the way they die, have at the end, little to do with medical services and much*

more relation with society's organisation and the role each [social] class performs within it...'

At the end of the power chain, and marginal in the market capital exchange networks, Minoans become captives of institutional and non-institutional fake medical practices and institutional discourses from where they take the meanings of the market. Besides the effect of the market discourses and practice over Minoans' lives, meanings, and values, the hegemonic influence on their physical bodies is achieved directly through those fake medical practices and through low quality, partial and restricted disease-prevention medical services.

Minoans' health and disease conceptions are increasingly more in tension and permeated by hegemonic market paradigms, where health does not exist except as 'disease free' episodes possible only through medical intervention. Resulting from this disease-centred paradigm it is possible to trace the disease and the medical exchange networks, their rules and boundaries in Mino. However, it is not so easy to trace the health field since it disappears when overwhelmed by hegemonic medical inculcation of disease meanings. That presents problems for Minoans' health development, since there is no explicit recognition of the existence of health as their capital to confront disease and other problems, derived from their restricted access to overall wealth, and of their subordination to the market. This expresses another effect of hegemonic medical practices over health: Minoans hardly use health as capital to play in the institutional and medical fields.

The medical market inculcates hegemonic meanings and values in Minoans through simultaneous and systematic pedagogic work carried out by different hegemonic agencies. That not only limits Minoans' access to knowledge but also to tools to construct knowledge. This generates restrictions on opinion and voice. Doxatic knowledge, limited access to medical knowledge, opinion, voice, and to tools to construct knowledge produce an added restriction of thinking strategies. As a consequence of Minoans' restricted thinking strategies, opinion, and voice, their subordination can be maintained, and the limitation of access to overall wealth is strengthened.

From the definition of health as: 'an embodied human capacity to decide and construct transcendental feasible futures and achieve them', I interpret that to dominate people's thinking strategies is to dominate people's health. It is from thinking strategies that people can imagine futures and achieve them. This research showed that market hegemonic medical practices not only affect the Minoans' physical bodies because they do not relieve pain or suffering, because they produce *iatrogenia*, or because they hide knowledge, tools, or means, but also because they interfere in the exercise of the Minoans' health capacity. Subordination is then achieved and maintained through health impairment at the individual level and expanded from this individual level to the collective social dimension in the material and symbolic worlds. Following these arguments, I can identify two aims of official health promotion and health teaching for people who cannot pay for merchandise in the health and medical market. The firstly is to create an illusion of attention to disease to control people's insubordination and the secondly, to relieve demand for medical services through inexpensive medical practices.

To construct an illusion of attention to disease, medical and health personnel are trained through inexpensive and low quality teaching programmes such as the institutional health courses Teo and Mundo attended. Through low quality and restricted access to medical knowledge, those courses also create in the students the illusion of participating in the medical world by adopting medical perception, thinking and realisation schemata and adapting them to their local reality. The practitioners resulting from those training programmes are physically controlled from the institutions through an institutional appointment, low wages, supply of materials such as condoms or vaccines, and continuous harassment as Teo described. Material control is used to ensure that the health personnel practices are carried out as prescribed by the institution, maintaining the institutions' values, meanings, and knowledge. In contrast, the health personnel training programmes aiming to solve disease problems for the population with access to wealth are expensive, and incorporate scientific and technological advances that can be transformed into merchandise, and sold to cure disease. However, these are not available to Minoans.

Is it possible to modify the health and disease situation of people with restricted access to wealth through changes in the dynamics of power resulting from a planned pedagogic intervention?

The results of this research showed that the knowledge developed through the CHTP self-growing pedagogy helped the cuidadores to change their health and disease situation as a result of insubordination. I explain this below.

Domination over meanings and values is created by inculcation of systematic doxa, shaping and limiting what probably Bourideu called individuals' 'thinking strategies'. Namely, that shaping is maintained through the development of individuals' fear of sanctions and exclusion. Thinking strategies limited in this way, prevent the individuals from producing personal opinions and options about their present and future. Thinking strategies limited by power result in a lack of recognition and improvement in individuals' meanings, values and knowledge, engendering knowledge subordination. The individuals, from technical and practical interests in knowledge, construct subordinated knowledge basically as *noema*. They unconsciously neglect their emancipatory interest in knowledge and the construction of *noesis*. In that condition, hegemonic institutional validation can suppress locally constructed health knowledge value and validity.

In this way, the systematic inculcation of official health doxa restricts access to thinking strategies; to the capacity to produce knowledge that is meaningful for free subjects' lives; and to knowledge produced by other people in society. To widen individuals' thinking strategies -through diminishing doxa influence upon them- was proved in this research analysis as one possibility to improve access to health knowledge and practices for people with restricted access to wealth. Widened thinking strategies helped the cuidadores to lose their fear of sanctions and exclusion, to develop free options, and to appropriate knowledge that was valued and validated when in confrontation with meaningful problems of their reality[104]. They could then construct *noema* and *noesis* responding to their awakened emancipatory interests in knowledge.

[104] I make a distinction between health problems of reality shaped by teachers or institutions, where knowledge and reality classifications express in the way they shape reality, and health problems of

Another effect of the cuidadores' widened thinking strategies, was the development of their capacity and possibility of appropriating and adapting medical knowledge -as any other knowledge- to local and individual contexts. However, from the research results, I cannot assess how durable the knowledge constructed in that way will prove to be.

The three characteristics of faith, hope, and humility proposed by Freire and taken in a self-growing pedagogy, belong to the subjective and symbolic worlds. The construction and validation of meaningful knowledge through its capacity to explain meaningful problems of reality produced affective responses in the CHTP students and teachers. These responses were manifested in the CHTP self-growing environment, enhancing the CHTP teachers' and students' faith, hope and humility. Affective input to the CHTP accounted for much dialogue and the CHTP success. To be able to express joy, fear, frustration, rage, pain, sorrow, achievement, failure, or other emotions without sanctions -but as a recognised valuable input to further the understanding of meaningful health problems, and to construct meaningful knowledge-, helped to diminish hegemonic medical doxatic action upon thinking strategies. The CHTP emancipatory outcomes resulted from chained processes triggered by liberated thinking strategies: liberation from medical doxa and knowledge liberation; reduction of fear and subordination; development of opinion; construction of options; and finally, development of voice, and action for desired change.

The CHTP participants developed *noesis* and *noema* from common sense, popular, and expert knowledge; valuable for explaining and changing meaningful health problems in a way that they recognised and reconstructed their own values and meanings. As such, the CHTP participants integrated their subjectivity, their bodies, and their material world as healthy subjects. The CHTP participants exerted their human capacities as power to create options for their future, and to decide and perform actions to achieve them. The exertion of their health capacity changed some of their bodies' inscriptions.

Through the CHTP, the cuidadores, as individuals and as a group, became insubordinate, but that insubordination did not spread as counter-hegemonic organised and collective action. However, the cuidadores' actions involved pedagogic relations

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reality shaped by students, where knowledge and reality classifications express as problems of reality meaningful for the students.

with people in their families, neighbourhoods, work-sites, and overall community requiring the cuidadores' services. The cuidadores' services are imbued with heterodoxatic knowledge and opinions and liberated thinking strategies. As such, there is a potential for the cuidadores to construct larger fields of opinion from where collective organised insubordination can emerge. Nevertheless, there is also a possibility that the cuidadores, as a group or as individuals, will not practise their widened thinking strategies, and this may open the way for a return to former limited thinking strategies.

From the research results it is not possible to predict whether the cuidadores will perform their counter-hegemonic organic intellectual potential in the future or not, since this depends on the options they construct and adopt as free healthy subjects. As such, the cuidadores' future action and role within their communities is unpredictable.

In this way it can be said here that knowledge developed and sustained through a self-growing pedagogy can construct resistance to medical hegemony through a particular way of developing of what Bourdieu called 'fields' and 'habitus', and the possibility for raising fields of opinion. It is also argued here that this CHTP self-growing pedagogic model has the necessary requirements to modify the prevailing subordination characteristics as a prior stage to counter-hegemony, and thus, to promote health.

CONTRIBUTIONS OF THE RESEARCH

About the theory

A prevailing practical approach to health promotion has limited the possibilities of making of it a more effective instrument to promote health. In scientific literature about health promotion, even when focusing on empowering health promotion, the problem of the hegemonic uses of the discourses and practices about health and the body, and of the body itself, is nearly non-existent. This research has proved the importance of considering this problem when making effective changes in health.

The theories of power and social structure developed by Gramsci and Bourdieu, and tested in this research, proved valid in the explanation of the situation of Mino. However, those theories, particularly Gramsci's, lack practical explanations about how dominance and subordination are achieved. Bourdieu developed the concepts of 'structural structures', heterodoxa and fields of opinion resulting from the inculcation of doxa. Through this research I showed how the structural structures in the cuidadores could be revealed and changed. This probably disclosed one mechanism of habitus construction.

Freire's concepts already used in my previous professional work and also used here, gave me the blueprint for the development of this research intervention. I also developed and researched concepts about poverty, health, disease, healthy subject, education, and pedagogy. Besides the value of the concepts for the overall discussion on health, health policies, and health practice -which the readers need to assess comparing them with their own experience and reflections- I found them valuable to change the perspective of inquiring into health promotion. This different perspective helped me to get closer to the mechanisms of the construction of subordination through health practices.

To approach the problem health-power-body from the perspective of an integrated subject, gave me grounds to develop the concept of the healthy subject to contrast against the situation of Minoans in general, and particularly of the cuidadores. That perspective also gave me the possibility of developing and testing a conception and practice of a self-growing pedagogy.

The taxonomy of knowledge proposed and developed in chapter two proved to be capable of establishing links between power and knowledge, and of explaining the uses of knowledge for power ends.

About this research methodology

This case study was possible because of the deep insight we had into Mino through the development of the research intervention. An insight like this can take much more time if observed from outside. Nevertheless, that deep insight conveyed affection and

subjectivity. That, plus the subjective character of domination, awareness and liberation under study, made this research particularly prone to unfeasible implementation and bias. Dialogue between students and teachers, and also dialogue with theory, represented an important tool to confront these problems. Also relevant to keep this research coherent and objective was the use of process and outcome indicators. Furthermore, the continuous evaluation of these indicators provided useful information to input to the CHTP process besides, accomplishing their function as research tools. Whilst an observer under observation always conveys the doubt of objectivity, in this research objectivity was also attained through triangulation.

To translate perceptions into objective observations, observations into objective data, and data into objective interpretation required continuous researcher and observer awareness through reflexive processes. However, reflexivity by itself could not prevent the participant researcher from becoming the observer of others' culture, capable of becoming 'the 'impartial expectator' ... condemned to see all practice as spectacle.' (Bourdieu 1977:1). In this research Manuela, Pablo, and I were under observation not only because we were researchers, but because we were also changing our hegemony/subordination patterns and awareness from where we were also observing our culture. The self-growing pedagogy allowed Pablo, Manuela and myself to participate in the construction of a new field (the cuidadores' field), helping through dialogue in the definition of field rules, meanings, and values without neglecting the perceptual and thinking differences between the cuidadores and us. This was another helpful element in making the observed reality our own. In this way, we achieved the necessary distance and closeness to observe and interpret the object under scrutiny.

These research results cannot be extended as valid for other contexts or critical health teaching programmes. However, through the application of a self-growing pedagogy, students recognised common contexts and problems; and adapted contents and practices to their respective realities. In this way, it can be said that this research project provided useful knowledge for the design, organisation, analysis, and/or evaluation of other emancipatory critical health teaching projects.

About medical domination. Minoans and the CHTP

Self, other, body, disease, and health meanings and values are disputed in power struggles to achieve dominance over people's minds and bodies. The non-medical world has noted the businesslike, fragmented and restricted ways in which medical doctors and institutions perceive of and think about the body, disease, healing, and health. Those perceptions are channelled into different alternative expressions, such as literature -for example Molière (1985), De Assis (1974), Chekhov (1964)- where different societies are represented. As this research shows, in Mino those perceptions are channelled into anger, rumour, and conversation. Nevertheless those expressions hardly become trascendental public discussions capable of questioning the medical practices -which function as hegemonic control over the population-, or of changing institutional agendas and policies.

Hegemonic health practices are mostly performed as pedagogic encounters where a person brings his/her physical body to medical scrutiny seeking medical judgements about, and practices on, his/her body. However, when a person seeks medical advice or treatment he/she is taking to the medical services his/her values and meanings. Minoans seeking medical advice have their own interpretation of the state of their body, and also their knowledge and experiences about their own lives and affections. From medical practices sustained by medical paradigms, the medical personnel attending Minoans often ignore, or do not fully understand, the person's subjectivity behind the physical body. In this way, hegemonic medical practices reduce the individual subjects to their material dimension: their physical bodies. From a biological approach, medical judgements and prescriptions ignore the affective, social, historical, and other dimensions of Minoans' lives.

The medical pedagogic relations, alongside punishment relations, have the unique characteristic of touching the physical body, and those who touch it are most times strangers to the person seeking healing (Foucault 1997, 1979, 1973). The body can be seen as the limit between the external world and the individual's subjectivity, or between the public and the private. For Minoans, laws, trial or open discussion with the patient or his/her supporting social network, do not mediate medical judgements and prescriptions. That confers to the medical personnel, and to the institution, specific

power over the people seeking healing, making the medical doctor/patient relation an unequal pedagogic relation. Hegemonic medical judgements and prescriptions can involve overall Minoan patients' lives by defining 'right' ways to exert sexuality, labour, family relations, recreation or other, thus imposing meanings and values over patients. In this situation the patients become medical services' objects, reducing their possibility to exert their capacity to imagine futures and achieve them. In this way, the hegemonic medical practices have a strong social controlling potential where the body becomes the place of power exertion to dominate patients' subjectivity, and dominated subjectivity the means to use the body for dominance purposes[105].

However, this research evidence shows that the medical truth is highly fragile when questioned by the users of medical services. It becomes hegemonic because of the mechanisms controlling the patients' questioning capacity through its unique characteristic of involving pain, suffering, and death, and not always because people find it truthful. From these considerations, to challenge the medical hegemonic control over patients' questioning appears crucial to improve medical practice and services.

About a definition of health and emancipatory health promotion

This research showed that the consideration of health as 'an embodied human capacity to decide and construct transcendental feasible futures and achieve them', helped to identify links between the material and symbolic worlds; to identify from where dominance hinders health; to better understand the mechanisms of power imposition; and to find ways to develop human capacities capable of improving individual and collective living conditions, access to wealth, and body inscriptions.

Correlative to the concept of health used in this research study is the concept of the healthy subject presented in chapter three within this thesis. The conception of 'emancipatory health promotion' presented here is linked with health and the healthy subjects' development. If the healthy environments proposed since the Ottawa Conference (World Health Organisation 1986) and particularly in the Sundsvall

[105] Arenal 1989, Laurell and Noriega 1987, Iglesias 1985, diCiaula 1982, Ricci 1981, Basaglia 1978, Menéndez 1978, Tomasseta 1978, and other authors have also described the control of workers through medical practices.

Conference[106] (World Health Organisation 1991a), could be seen as self-growing environments from an emancipatory health promotion perspective, then more clarity to make practical proposals to promote health and to evaluate health promotion action could be achieved. It is said here that to look from a health and emancipatory health promotion perspectives can modify not only health promotion research and evaluation, but also to find new questions to research into disease processes, and new health and disease indicators. New questions and indicators can also respond to administrators' claims for evidence about health promotion efficiency, forcing them to think seriously about health promotion as a practice worthy of support and investment. However, from this research analysis it seems that these will only convince those administrators who commit their work to the construction of healthy subjects rather than to those committed to the preservation of their work and institution. It seems to me that those administrators are more likely to be found in NGOs than in official institutions.

LOOKING AHEAD

The intrinsic relation between health promotion and the construction of meanings, points to an ethical dimension in the actions carried out as health promotion. I propose that doxa works as moral law and that healthy subjects are liberated when their moral law is defined from the individual or collective values where emancipation becomes part of that moral law. Hence, to improve the health of people with restricted access to wealth, health promotion needs major changes in health promoters and promotion ethics, reflecting changes in their moral law. A change in moral law could probably change the consideration of people as capital used for market ends, to persons as ethical subjects.

Practices taking place in the name of health promotion that inflict individual and collective material or subjective injuries, insofar as they are subordinating practices to dislocate the subjects' control over their bodies, can probably be seen as a major damage to human life and attempt against the human right of health. On the contrary,

[106] In that conference 'supportive environment' was understood as the physical and the social aspects of people's surroundings capable of (World Health Organisation, 1991 a: 6).

practices taking place in the name of health promotion, helping to integrate subjects as healthy subjects, can be linked with social justice[107] and human development.

The finding of fake health knowledge and fake health practitioners in Mino can be related to local corruption or to the breaking of individual and institutional moral law. However, as proved through this research, fake knowledge is a result and a means of domination tolerated, if not supported, by hegemony. The widely spread acceptance of fake knowledge points to the necessity of finding ways to help the individual subjects in the institutions to liberate themselves from fake knowledge, and to develop awareness of their ethical condition thus strengthening the aspects of their moral law capable of helping them to develop as healthy subjects.

Emancipatory health promotion challenges

This research work refers to the Minoan experience only. However, it can be said here that if self-growing environments and self-growing pedagogy for emancipatory health promotion could be extended to other contexts, they could represent a threat to hegemonic power. Emancipatory health promotion can push, what Gramsci called, 'the historic block' open with consequences for hegemonic power. I foresee the results of the success of emancipatory health promotion in the medical market as changes in market revenues, and in the medical services as a change in their traditional vertical relations. In this way, in emancipatory health promotion are inbuilt power struggles and its success depends on the particular dynamics and characteristics of the struggles.

The practice of hegemonic health promotion is a form of power exertion, which chooses and discriminates subjects, and aims to direct the conduct of others. Through emancipatory health promotion power can take different practical meanings for health and healthy subjects' development.

Leaving health promotion in the hands of administrators and practitioners only, and neglecting the need to develop theory about health promotion, will hardly change it

[107] For discussions about the links between health promotion and social justice, refer to Blinkhorn (2000) who regard that poverty requires resources and not just sympathy, and to Wallerstein and Freudenberg

towards emancipatory health promotion. A challenge to emancipatory health promotion is to examine its problems not only as practical problems but also as epistemological problems.

Another challenge for emancipatory health promotion is to bring its conceptions and methods to local, regional, national, and international discussions of health promotion and health resources training, in a way that those concepts and ideas can be heard and considered when the academic world, the governments and other agencies define their agendas, policies and budgets.

To face the health services personnel's and health training programmes' inertia is also a challenge to emancipatory health promotion. The concepts and methods of emancipatory health promotion demand changes in the personnel's perspectives of health and health practices; active learning, confrontation with new truths, meanings, and knowledge; self-responsibility, changes in every-day regularities and routines; and overall, in their feelings of security, belonging, and identity constructed from their traditional medical doxa.

A final challenge presented here is to confront the patients' culture in a way that patients do not feel lost with changes in health personnel and health services, while triggering the expectation and desire of becoming healthy subjects.

To think of health and health promotion from a perspective that is not necessarily linked with medicine, disease, and the market, represents the development of voice and opinion making plausible the creation of a health field with its own bonding, rules, capital and values. There are already many experiences of health projects aiming at people empowerment. Nevertheless, the construction of a field of opinion about health requires conscious efforts of health activists to develop health meanings, knowledge, and practices, from a systematic reflection about their experiences when attempting to promote health.

(1998) who regard that to integrate health promotion and social justice can strengthen the field of education.

Emancipatory health promoters should be aware of the personal risks they take when opting for emancipatory health promotion practice. This is so because to practice emancipatory health promotion is to promote social justice, and the promotion of social justice provokes power reactions from hegemonic power.

Possible applications of this research findings to the promotion of health

There can be ways of moving towards emancipatory health promotion even when its practice and meaning might clash against the market's needs and prescriptions.

I propose here some possible applications of these research findings to two different health promoters' contexts. Firstly, when the context allows relative material and symbolic autonomy to project and perform health promotion activities. And secondly, when the context allows minimum direct control of material and symbolic capital but opens some possibility to influence institutional discourses and practices.

For the first group of health promoters it seems plausible to aim for thinking strategies change by examining, adapting, reconstructing, applying, and developing a self-growing pedagogy. Basic conditions to try that, are the availability of students and teachers willing to undergo a self-growing experience for health promotion; to train teachers for self-growing demands; to achieve first agreements with students about the pedagogic experience scope, and a specific place and time devoted to self-growing organised pedagogic practices. A health promotion self-growing experience can take from some hours to many years and different amounts of resources, depending on the self-growing group's characteristics, agreements, and decisions.

For the second group of health promoters, which are more likely to be institutional workers, health promotion through a self-growing pedagogy and environment is more likely to represent an antecedent to thinking strategies changes and not change itself. For this group it is possible to influence institutional discourses through the production of written materials required by institutions, thought and organised as information and knowledge to be at stake in a self-growing environment, and also by including aspects of a self-growing pedagogy in their projects and documents. These health promoters can also influence the health personnel's formal and informal training, aiming to

produce changes in health personnel's self and work perceptions, from where a different personnel/public relationship can develop.

Different authors had criticised the idea of developing a profession of health promotion (see for example Cribb and Duncan 1999) arguing that health promotion actions should be included in different every-day-settings and in all institutional programmes. However, it has been said here that emancipatory health promotion requires special training and that some aspects of a self-growing pedagogy could gain presence in health training programmes if promoted by authorities, or students and teachers.

The benefits of using the mass media and the Internet for emancipatory health promotion are in doubt from these research results, mainly because of its non-dialogic character, and deficiencies in the provision of the required information to solve particular problems of reality. Probably one exception could be the creation of chat rooms on the Internet. It can be said here that the uses of mass media and the Internet for emancipatory health promotion purposes needs to be researched since its extended use for institutional health promotion has veiled its efficiency as an emancipatory health promotion tool while promoting subordination.

Emancipatory health promotion through a self-growing pedagogy can be used wherever a group in society has a problem to solve, or where a group in society detects a problem of another group. Institutions could largely benefit from this approach to health promotion and self-growing pedagogy if their aims were focused on people's problems. Nevertheless, because of the way institutions make use of power, it is not likely that the moral law of institutions as they are now-a-days will give them a chance to become emancipatory health promotion leaders. However, it is possible that health promotion indicators and desired health promotion outcomes can change, giving room -however small- to practise health promotion as proposed here. Agreeing with Outón (1998), to start emancipatory health promotion practices, the emphasis must be placed on consensus strategies rather than on confrontation. To make emancipatory health promotion succeed, is necessary to find the right model, the right place, and the right time to achieve first agreements with groups in society willing to solve problems of their reality, and to become healthy subjects.

Subordination/hegemony changes attained through the CHTP are probably small individual changes, however, for the individuals those changes are transcendental. This research work provided the participants with another view of their lives and problems. It can be said here that much research is necessary to develop knowledge useful to improve the life and living conditions of people immersed in human struggles for power.

APPENDICES

APPENDIX 1
QUESTIONNAIRE

This is a sample of questions of the original questionnaire applied at the beginning of this research intervention to all CHTP candidates.

A. GENERAL INFORMATION

NAME SINGLE, MARRIED OR DIVORCED
SEX AGE PLACE WHERE YOU WERE BORN
PLACE OF RESIDENCY TIME LIVING IN THAT PLACE
CONTACT ADRESS
WORKING, ADMINISTRATION OR SERVICE PREVIOUS EXPERIENCES
CHILDREN AGES
RELIGION AND/OR POLITICAL AFFILIATION
PARENTS, BROTHERS AND SYSTERS, GRANDPARENTS AND OTHER PERSONS CLOSE TO THE STUDENT
SEX, AGE, SCOLARITY, OTHER STUDIES, OCUPATION, POSSITION OF:
STUDENT
FATHER
MOTHER
PATERNAL GRANDFATHER
MATERNAL GRANDFATHER
PATERNAL GRANDMOTHER
MATERNAL GRANDMOTHER
RELATIVE 1
RELATIVE 2
BROTHERS AND SYSTERS
FRIEND 1
FRIEND 2

B. MOTIVATION

Please order the answers in the correspondent blocks in accordance with what you think. You should put the number one in the brackets of the answer that is more like what you think, then, the number two to the next more alike what you think and so on. In this way you will put the higher number to the answer that is less like what you think. I give here an example:

I think that the sun:
(3) Is the moons' partner
(4) Makes the earth cold
(2) Helps me to orientate
(5) Should disappear
(1) Rises every morning

Block 1.
It is important to me to study this because:
( ) There are many things I don't know and want to know more
( ) I don't want to see anybody in my family or myself, suffering or death
( ) When I was sick or when someone I loved was sick, I couldn't do anything to improve his/her situation
( ) People with this studies is better accepted by the others
( ) There are collective problems to understand and solve
( ) I have personal problems to understand and solve
( ) I have time now to use in this studies
( ) I will be able to cure people and solve problems
( ) I want to be successful in life
( ) I will be able to help other people to solve their own problems
( ) In our neighbourhood or family we want to be successful
( ) Some people in my family, social group or community thought that I should study this
( ) Each of us have to do what we can to change the actual state of things
( ) Other reasons you may have that are not included in this list. If you want, please explain this in the blank space provided below

Block 4.
I think that the health knowledge:
( ) Can be owned and understood by everybody
( ) Is hard to understand by simple people
( ) Is knowledge that everybody have in one way or another
( ) Is knowledge that belong to experts
( ) Other ideas that are important to and are not included in this list. If you want, please explain this in the blank space provided below

Block 7.
To take the decision to study this, it helped the presence, memory, conversation or advice with:
( ) Husband, wife, boyfriend or girlfriend
( ) Father
( ) Mother
( ) Grandparents, uncles or aunts
( ) Other relative or friend
( ) An acquaintance
( ) A group of organisation
( ) Other persons that are not in the list. If you want, please specify below who were or are those persons.

C. COSTS

Block 8.
The cost of studying this is mainly:
( ) Time
( ) Money
( ) Material resources
( ) Feelings and emotions
( ) Other things not included in the list. If you want, please specify below what are those costs.

Block 10.
If I were not using these resources for my studies, who else will be using them:
( ) Nobody
( ) A brother, sister, a godson or goddaughter of my parents
( ) Someone else in my family
( ) Myself in doing something else
( ) Someone else in my community to study instead of me
( ) Someone else in my community for other purposes
( ) Other person that is not in the list. If you want, please tell us who.

D. PEDAGOGIC PROCESS

Block 11.
In this course:
( ) I will receive the information I need
( ) I will learn to cure
( ) I will discuss and analyse health problems
( ) I will find ways to intervene in the health problems of the patients
( ) I will find ways to make interventions in community health problems
( ) Another idea that is not listed. If you want, please tell in the space below what is this idea.

Block 13.
Because I am a student I should:
( ) Do as the teachers say
( ) Ask and search for information
( ) Understand what is being taught to me
( ) Learn the programme contents
( ) Another thing that is not listed. If you want, please explain below your idea.

Block 18
I think that:
( ) People know what they need
( ) One should start by working with what people think they need and step by step let them know what they really need
( ) People do not know what they need, they think they know
( ) People do not know what they need but, if they receive some education, they will learn to find what are they needs
( ) Another idea not listed. If you want, please tell this idea below.

Block 21.
I think that the way in which I see things, think and behave:
( ) Is as it should be, according with what I learnt in my family and my social condition
( ) Is the result of my previous experiences
( ) Is the result of what has been imposed upon me.
( ) Is the result of impositions and of my own will.

OPEN QUESTIONS

E. BENEFITS

1. What WOULD YOU LIKE to be the benefits of your studies?
2. What DO YOU THINK will be the benefits of your studies?
3. Who WOULD YOU LIKE to benefit from your studies?
4. Who do you THINK will benefit from your studies?

F. HEALTH PROCESS

1. Are you healthy? Please explain your answer
4. If you have several health problems, how do you know how to start solving them?
8. Make a list with the first three things you do when you don't feel healthy
13. When in front of a collective health problem. Who should be informed? Who should be seek for advice? Who should decide about what to do?

APPENDIX 2
CHTP PARTICIPANTS

Pablo. When CHTP started, Pablo was twenty-four years old. Pablo's parents are a sociology professional (Pablo's father) and a social worker (Pablo's mother). Their work has always been related to adult education and to the developing of collective rural productive projects. Pablo's parents had previous work in Mino through an NGO. They introduced us to Mino. Through his life with his parents, Pablo developed skills to listen and understand problems of rural poor people life. He is creative, responsible and committed to help people.

Manuela was also twenty-four years old. Her mother is a housewife with pre-university studies. Manuela's father is a paediatric medical doctor involved in politics within an opposition political party in México. Manuela is orderly and methodical in her academic work and sharp in observation.

Goyo. Goyo was an 18 years old male, single, born and always resident in Mino. He completed elementary school and works as peasant in his family's fields. His father concluded the elementary school and was a mason. His mother is housewife and attended school up to the second elementary year. All his brothers and sisters completed the elementary school and only his youngest sister finished secondary school.

Goyo attended most sessions at the beginning. He was enthusiastic and proud of being in the group. Increasingly he started to separate and became obscure. Goyo nearly completed the first CHTP phase but abandoned it because of personal problems. After several months he reappeared enthusiastic and willing to join the dog's sterilisation team (see further on in this chapter).

Esther. Female, 30 years old, married with three children: eighteen, fifteen and three, born and resident in Mino. She completed elementary school and a first aid course. She worked in a tailoring workshop. Her father was *campesino* and had a community charge of "*mayordomo*"[1]. Her mother did not attend to school, is housewife and shares the *mayordomía*[2] with her husband. None of her brothers or sisters went to secondary school.

Esther attended CHTP regularly at the beginning and after two months she started to fail. She had concentration, abstraction and memory difficulties and felt not ready to follow the course. During CHTP implementation she was appointed responsible for the CONASUPO[3] basic food shop and left CHTP.

Roberto. Male, 16 years old, single, student, born and resident in Mino. Attending to middle upper education. He had some training as medical clinical laboratory technician

[1] *Mayordomo.* A person that is in charge of the church and the local religious festivity. It is a very respected position in Mino's society.
[2] *Mayordomía.* The charge of *mayordomo.*
[3] *CONASUPO* National Commission for Popular Subsistence. A governmental organisation that runs local small shops with basic food.

aid. His father completed the elementary school and had training as plumber and electrician and works as chauffeur outside Mino. His mother attended up to the 3rd elementary school year, she had courses in tailoring and works in the local workshop. Roberto wants to follow university studies.

Roberto attended CHTP regularly, enthusiastic, with a very high performance. He left because to meet his school responsibilities.

Guillermo. Male, 26 years old, born in a community one hour by foot from Mino and resident in Mino since he was a child. He has had collective responsibilities in Mino but has any at the time CHTP started. He works in a factory in a nearby city making night shifts. He is single and finished the secondary school. His father completed elementary school. His family owns one of the small groceries in Mino and are *campesinos*.

Guillermo enjoys learning and knowing. He is very enthusiastic and motivated the other CHTP students. He liked to make questions and to try to find answers by himself. Guillermo liked to develop practical images of what he was learning. The problems he brought to CHTP were problems not related with himself or his family. His night shifts in the factory were shattering and he needed day-rest that made him left CHTP.

Teo. Male, 29 years old, born and resident in a nearby community, where he has a collective charge as health assistant trained and supervised by an official health institution since six years ago. He is married and has one two- year old child. Teo finished the secondary school and has attended to community health aid courses run by an official institution. His father has unfinished elementary school, with community charges in the committees of water, lighting and road. His mother has unfinished elementary school and work in the community with responsibilities of a welfare governmental institution. All of them are *campesinos*. All his brothers and sisters but the eldest, have completed secondary school.

Teo has been working as health assistant for six years with a very low institutional salary. He attends a compulsory course every year where he learns to follow the basic manoeuvres defined by the institution for rural primary health care.

Elena. Female, single, 18 years old, born and living in a nearby community. She completed secondary school and is doing pre-university studies. She also attended to a nursery-teaching course. She works and stands in representation of a collective tailoring workshop in her community. Her mother is not married and completed three years of elementary school, housewife. She has no brothers or sisters. Elena has leadership capacities.

Alicia. Female, 32 years old, single, mother of two children: five and one years old, born and resident in Mino, seamstress in a local workshop. She has unfinished pre-university studies and one year of nurse aid studies. She has collective responsibilities as treasurer for the drinking water committee. Her father was a teacher and belongs to the drinking water

and fields watering committees. Her mother completed two years of elementary school, housewife, and treasurer in the church committee. Alicia's brothers and sisters completed secondary school. Alicia's family worked in the local tailoring workshops.

Alicia likes books, concepts and abstraction. She lives very close to CHTP room and is in charge of the students' room key. Alicia has been a supportive group element.

Olga. Female, married, 33 years old, two children: six and two years old, born and resident in Mino, unfinished secondary school, and housewife. She had training in tailoring. Her father attended three years to elementary school and is *conserje*[4]. Her mother completed two elementary school years and is housewife. Olga's brothers and sisters completed elementary school.

Olga has special attitude and capacity to look after and care for people. Her husband does not like her to attend CHTP.

Luz. Female, 35, from a Minoan family, was born in México City and is resident in Mino since 30 years ago, single. Formal school: complete elementary school and a first aid course. She lives with her sister who is a single mother, and with her three years old nephew. She lost an eye when she was 15. Luz is a *campesina* in charge of the crops, with the responsibilities traditionally assigned to men. Her father was a *campesino* with three years of elementary school. Her mother was housewife with no studies. All her brothers and sisters finished secondary school.

Luz is very keen in practical activities. She finds difficulties in making abstractions but has good memory and uses her logic to solve problems.

Mundo. Male, single, 35 years old, born and living in a community about ten minutes (public transport) from Mino. He worked as health assistant for the Health Ministry during six years, as shop attendant for three years and as a small chemist's attendant for the last three years. He finished secondary school in the Open Education System and went to a nurse aid course. He also had health promoter training from the Health Ministry. His father is a mason with two years of elementary school and has chronic heart problems. Mundo's mother is housewife with two years of elementary school. Two sisters haven't complete elementary studies and two brothers finished elementary school.

Mundo knowledge about health, disease and curing has developed from mixing different paradigms concepts and practices. He always had strong inclination towards medicine that he could never study. He decided to learn by himself. He has been attending people from La Loma where he is very well recognised as accurate and good for curing. He enjoys teaching.

Elvira. Female, 36 years old, married with four children. She was born and live in Sayula, a community about forty minutes (public transport) away from Mino. Her parents are

[4] *Conserje*: a person in charge of looking after some premises. In Mino represents a position with collective responsibility.

campesinos. She is not Catholic as different from the rest of CHTP students. Unfinished secondary school. She works in Sayula's local tailoring workshop. Her husband has a music band.

Elvira likes practical activities as well as searching and developing knowledge. She has leadership responsibilities in the tayloring workshop where she works, that sometimes interfere with her CHTP activities. Her husband does not want her to attend CHTP. She enjoys reading and looking for information.

Coni (this thesis author and CHTP teaching auxiliary). At the time of the implementation of CHTP I was forty-seven years old. My father was a journalist and political activist. My mother had initially elementary school formal education. She studied theology and worked as member and activist in the liberation theology movement and in the Grassroots Christian Communities and became lately a political activist. I became initially a medical doctor and specialised in health promotion. I am a teacher and researcher at Universidad Autónoma Metropolitana in México.

APPENDIX 3
PROJECT PROPOSAL PRESENTED TO MINO'S ASSEMBLY

Why to develop this project?

Many communities in Mexico in the cities as well as in the countryside have very important problems to solve. These problems arise from the difficulties people have to live their life with work, house, disease care, schooling or other. Many times people expect that these difficulties are solved by people with schooling or sent by the government and there you are, waiting and waiting and they never come or, when they come, they don't understand the ways of the people, Some other times they do a good job but then they left and there is the people waiting again.

Before the schools and the government projects existed, people had their own ways to learn and solve their problems. Even now, people that pass their experience and knowledge solve most problems. So, in some places, every body learn from each other to solve problems. In all times, it had been very important to learn things within our own community and family, but also to learn from what other people has to tell. In present time there are people with studies that come to the communities to tell what one should do and often what they know is important but has nothing to do with our ways and problems. It also happens that the people that know, since they have studies, don't want to help and prefer to use what they know to make money or for their own benefit without sharing.

If in the communities we could learn what our people know and also what other people know, probably we will need less the people with studies to come and tell us what to do. We will probably need less their presence here, we could probably know when to ask for advice and what thing they can do and what things they can't do for our benefit, besides that we could probably distinguish what things are more harmful than helpful.

We will like to train ten people of these communities to identify health problems, to study them, to decide what to do and do it. These ten persons, while they are learning, will need to inform the others about their learning. We need to study how these ten persons learn, how they use what they learn and if it is possible that by learning they can help in the betterment of the life in the community.

That is why we thought to do this project in a place where what counts is that people can use what they know and what others know to solve their problems. Also we thought when we were doing this project, that what some people learn should be shared with the others, so it will benefit everybody and he or her as well.

Why in Mino and surrounding communities?

This place is a beautiful place, with lots of people with very strong problems and with will to go ahead. We think that this is a place with people with necessity to learn. This is a place where people have shown that, by working together, big things can be achieved. Talking with X NGO advisors, we asked them what community in this area could possibly want to work with us, a community with people interested to help each other, in working together and willing to learn in the way we are thinking. They told us about the women and men in Mino and surrounding communities, about how they had managed to have work that is dignifying for women and men, where people and their life matter. About how these people had managed to sort out differences and to govern themselves according with their believes and desires, and how all this had been achieved by working together for everybody's sake. Then, we thought that probably you would like to work in this project. Also, because we live in Mexico City and we can come and go to Mexico because it is not so far away.

Who are we?

Now we are Manuela, Pablo and Coni Chapela. It is possible, if everything gets on well, that in the future some other people knowing something else could come, probably vets or dentists.

Manuela and Pablo are students from the university. They finished the studies in medicine necessary to do their social service, then, they are pasantes doing their social service. They will stay to live here at least one year in Mino. Coni is a teacher in the university; she is also a medical doctor and had worked with Pablo and Manuela since four years ago. Besides being a teacher, Coni is studying about different ways in which people can learn useful things about health. She is making a research about how people learn and new ways to learn that can be better for people and will need to write for the university about what happened during the training, who came, what they thought, how they learnt, what were the problems, etc. She will not live in Mino, but will be around for several days every month.

The university, X NGO and the Health Ministry, support us.

What are the people under training going to do?

They will discuss with Pablo and Manuela about how many hours a week can everybody work in this, the more, the better. Also they will discuss when and where will everybody meet.

They will attend project sessions where they will learn about existing problems I their communities; when necessary, they will accompany the ill persons to hospital or other things that are necessary. Also, they will visit and talk with people to identify what is helping and what is preventing the development of health; they will learn what the old, the

women and men, girls and boys know; they will teach Pablo, Manuela and Coni things that they don't know. They will think about what to do with the problems, things that are possible.

Finally, they will start a library and information centre for everyone wanting to get information about the situation of their health or of the community health and what can be done about the problems.

Who are the people that will be trained?

Young people, women, men or old people that are interested to do something about the health in their communities; that can find the way to have some time for their training; that are sharing and responsible, that can read and write, that are accepted and supported by their communities and that their communities think that are the right ones to get the training.

When and where will this project start?

At the beginning in February in Mino, later on from Mino they can go to other communities.

What is needed to be trained?

-To talk with Manuela, Pablo or Coni.
- To attend to the necessary activities.
- That you are very willing indeed.
- That you have are backed by your community.

What does the community has to do?

Feed Manuela and Pablo.
Find a place for them to live.
Find a place that can be of use as teaching room and library.
Find some furniture for that place.
Join the work attending the meetings, visits, campaigns or other necessary activities.

Who can we contact to tell that we want to be trained?

-Your community representatives
-Pablo, Manuela or Coni on the days they will come before February and every day after that here in Mino.
-The NGO advisors.

APPENDIX 4

CHICKEN-POX ROLE-PLAYING

(TAPE RECORDING)

(In school)
1. What is this one?
2. AAAA
3. And this?
4. EEEEE
5. And this?
6. IIIII
7. And this?
8. OOOO
9. And this?
10. UUUU
11. All right darlings, you have five minutes rest.
12. Panchito what is wrong?
13. You know... I have a headache and fell very hot, all my body, no? I feel very bad and all.
14. Let me see Panchito, come here ... go to your place.
15. What is wrong, Panchito?
16. Ah, I have a headache and have temperature, I feel all my body hot
17. Since when do you feel like this, Panchito?
18. Since this morning coming to school.
19. And you did not tell your mother?
20. No because I was already in my way.
21. OK Panchito go and tell your brother to come please.
22. I feel a bit bad.
23. I'm coming
24. That's all right
25. Yes, teacher?
26. Well, look, can I ask for a favor? Can you go and tell your mother that your brother is feeling a bit bad and if she can come please? I will tell your teacher and the school director.
27. OK, yes I'll be back soon.
28. Please.
29. Sit, Panchito, your mother is coming.

30. ... To go to see my brother who is at school, he is in class they sent this note.
31. I'm coming. Do you know what is the problem?
32. No she said nothing but she must get there immediately.
33. All right son, I'm on my way.

34. Let us see Carlos what letter is this?
35. Good morning teacher.
36. Good morning, please come in.
37. That you called me?
38. Yes, mmm, we have a problem with Panchito. He says he feels bad. Mmmm, I would like to ask you to take him to the doctor, a doctor should see him, please, yes?
39. Panchito you can leave with your mother who will take you to the doctor.

40. Yes, please come in.
41. Good morning.

42. Good morning.
43. Mmmm, I brought my son to you. He feels bad, I don't know. Honestly I don't know what is worng, the teacher told me.
44. Since when ... from school. How many ...how old is he.
45. He is eight years old.
46. ...years old
47. Your name?
48. Panchito [nick name]
49. Francisco [Christian name]
50. Yes
51. Pineda González [family names]
52. Let us see and see what we find.
53. Mmmm! He has fever and starts to have small spots
54. And, wht can this be, doctor?
55. Look, possibly it is chicken pox.
56. Ahh
57. Lets to, well, you will follow the instructions I'm giving to you.
58. Yes
59. Since, in reality, this disease does not have any special medicine. This is with basic care and all these.
60. It's all right, doctor.
61. Then you will bathe well him for me with warm water.
62. Yes, what else?
63. To give him a painkiller just if the fever goes up. But don't forget to bath him daily and keep him in rest.
64. Yes, doctor
65. Just if he goes to school... he won't have to go to school. He will remain at home until this problem goes away.
66. Mj
67. ... because this disease is contagious, it can spread the contagion to his other classmates.
68. All right.
69. Mj
70. Then, until he is all right you will send him to school.
71. Until he is all right he will go to school but in the meanwhile you will have him under observation, be sure he rests, that he does not go in hot places or hard wind.
72. Am I not taking him here again?
73. If its the case, because sometimes the itch appears. That is, he can have itch, lots of itch (laughter). For that, the only remedy is to spread him with talc, yes?
74. All right
75. Then that is what is going on with the boy. We will need to go and see the teacher to give her the measures about prevention so that other people are not contaminated, then...
76. Oh god, he is very contaminated, look, look, no, this is already chicken pox. Then take him to rest. And to bathe him and give him his food without fat, lots of liquids, yes?
77. Yes, it's all right, doctor. Let's go.

78. It's late...
79. Darlings, your homework for tomorrow is to study the ABC.
80. By the way, I would like to ask you for a favour, one of your classmates got sick and we sent him with... they took him to check if you are so kind to take your children and to... to avoid contagion latter on.
81. Yes? Please.
82. Yes, teacher, see you tomorrow.

83. Good morning. What's up?
84. We brought our children because it seems that one of the children got ill in class and then we came to have a check up please.
85. Yes, but they do not show any symptom?
86. Not for the moment.
87. OK.

88. Look we will take some [preventive] meassures, mm, special, yes? Because he must not to be in contact with...
89. the sick persons that had declared (laughter) the disease, yes? And, mj, we will need to see the teacher so she won't accept children already contaminated.
90. Yes, it's all right, doctor.
91. Then, let's go and see the teacher, yes?
92. Good afternoon, good afternoon.
93. Yes, could you tell me what happened with Panchito?
94. Listen, he is showing an infection. It is a infecto-contagios disease. Look, it's revealing an infection. This is an infectio-contagios disease, it is necessary to take some measures to stop the disease spreading, because it is contagios, isn't it? Now what I recommend is the first place is that the sick do not come to school, yes? So in this way the disease will not be spread yes? An we will not have bigger problems, yes?
95. OK doctor, and, the students, how do you find them? They do not have now...?
96. Well, now they don't show the disease, we need to have them under observation and if any presents the symptoms, come with me to give them my prescription.
97. OK doctor.
98. (Laughter)

END OF ROLE PLAYING

99. P. How did you feel?

100. Laughter
101. But the bacteria won
102. It did not show there (in the tape) because the bacteria were all time around.
103. The spots.
104. P. Did you plan it or it was a last moment idea?
105. P. And why did he did like this
106. Because it... cheatted
107. P. When everybody went to the doctor sort of you did ugly faces
108. He couldn't stand laughing
109. P. And why did she sniffed, I mean the microbe, to each person
110. To contaminate them... to check if the person was weak.
111. Because of having dirty hands ...
112. M. And the teacher sent all the children to checkup. All the school queuing. He couldn't cope.
113. P. And amongst all the mothers there was anyone knowing remedies, isn't it?
114. We forgot
115. Let's see the next time.

116. What about doing that scene again?

117. Señora, what happened with your child?
118. Look, he has chicken pox ... and the doctor ...
119. ...
120. I have a remedy that someone gave to me. That I should smash jarilla in warm water, take the water away, then wrap the child in a sheet so the jarilla can evaporate, and then, make a ...
121. Thank you señora. Then I will do that for him so he will become better.

Many speaking at the time.

122. The one at the riverside is jara and the one at the motorway side is jarilla and looks very much the same but is not... then you splash it and poor it into warm water? And with that have a bath? And they are wrapped in a bed sheet to evaporate...?
123. It can probably be the seed.
124. Another that they also use is alcohol and alfalfa, a friction of alcohol; they smash it and then they bath themselves with warm water and then the alfalfa will... the itch.
125. M. Hey, Luz why not to take them outside in the wind? Did she explain why?

126. Because outside they catch sunlight.
127. M. If they catch sun, they get worse?
128. Yes, you need to keep them in a place ...
129. M. But then it is possible to take them even if it is only in the afternoon. Early in the morning...
130. They told me that he should not see the sun neither the wind... because the spots will get inside and will never bloom.
131. ... and they rise from inside and the person can die. My mother in law told me, she used to cure.
132. A weed called yerbamora that is called like that because it is all the same sort of greeny and with spots, blacky, you do all the same you put it in water and it cools up with that.
133. P. What happens when the señora has the remedy given by her friend and the remedy given by the doctor?
134. You can use it... it does not interfere, it does not make bad. In fact those are also general cares too
135. P. Then, the doctor asked the señora to go with the teacher, why did every body go to the doctor?
136.****

137. Yes, it is good for them to get sick, but little by little.
138. Most of them are already married, so ...
139. When they are little, they must have it ...
140. M. How often have you seen that chicken pox comes?
141. The bigger girls get it with more strength.
142. There was an outbreak in X's middle education school.
143. I've known that it starts with a spot in the throat.

END OF THIS TAPE

APPENDIX 5
NUMBERED UTTERANCES IN CHAPTER SIX
CHTP IMPLEMENTATION

(i) CHTP TEACHERS

(ii) CHTP teachers selection and training initiated before we introduced ourselves in Mino. To select teachers, three basic characteristics -from where to develop ideal teacher profile- were considered: previous expert knowledge[5] about health; sharing this action-research commitment with empowering health promotion and being persons who could learn and want to work within this self-growing pedagogic approach.

(iii) I spotted Pablo when he was my student in his first medical training course. He introduced me with Manuela who was also a medical student. We developed together some adult education projects before CHTP and discussed with them this CHTP project. I found in them basic characteristics to develop towards the construction of ideal CHTP teachers. I had spotted two other CHTP candidates but they did not have the necessary time neither the possibility to live for one year in Mino.

(iv) Manuela, Pablo and I shared academic and politic interests. Pablo and Manuela witnessed and helped in this CHTP conception through their criticisms, experiences and comments and looked for specific pedagogic training for health teaching. In box 8.2 Pablo and Manuela's initial characteristics are contrasted with ideal teacher characteristics showing possibilities to develop towards ideal teacher. More information about Manuela and Pablo characteristics can be found in appendix two.

[5] For a description of the conception of expert kowledge used in this thesis see chapter three.

(v) **BOX 8.2. PABLO AND MANUELA CHARACTERISTICS AND SELF-GROWING IDEAL TEACHER**

	IDEAL TEACHER	PABLO	MANUELA
TRADITION	Political, educational, cultural.	Raised within empowerment rural development projects.	Raised in a context with political commitment with the poor and underserved.
KNOWLEDGE	Common sense, expert, popular and institutionalized.	Common sense, health expert, popular and institutionalized.	Common sense, health expert, popular and institutionalized.
WORK	Political , ideological, pedagogic.	Student, political, pedagogic, manual.	Student, political, pedagogic.
CHARACTERISTICS	-Person with hope, faith and humility with understanding of historic block. - Performing group commanded tasks.	-Person with hope, faith and humility. -Had reflected about poverty and health context -Has time and possibility to meet CHTP demands in Mino.	-Person with hope, faith and humility. -Had reflected about family, women and community. -Has time and possibility to meet CHTP demands in Mino.
ROLE	-Interchangeable with students. -A mirror and interpreter that triggers processes and conducts them. -Is a group companion and an advisor when required.	-Experience in triggering and conducting pedagogic processes.	-Experience in triggering and conducting pedagogic processes.
AIM	-Insubordination raising. -To oppose arbitrariness, pedagogic action and pedagogic work and raise fields of opinion. -To develop a language of critique and possibility.	-To learn about empowering pedagogic processes and alternative health conception and practices.	-To learn about empowering pedagogic processes and alternative health conception and practices. -To practice family and community medicine.
PEDAGOGY	-Problem identification, inquiring, action and knowledge circulation through dialogyc processes of discussion and study about problems of student's reality.	-He had previous teaching through problem based learning experience. -He has inquiring mind, is creative and patient. -Receptive to criticisms	-She had previous teaching through problem based learning experience. -She is assertive, orderly, methodical, sharp for observation and has itch for knowledge.

(vi) Manuela and Pablo specific training for CHTP consisted in formal and informal activities as follow:

(vii) During two years previous to CHTP, Pablo, Manuela and I held periodical sessions to comment, discuss and make reflections about their medical training, hegemonic medical model in practice, medical habitus construction and 'patient's culture'.

(viii) Pablo and Manuela obtained a Health Promotion Diploma that included: anthropology and sociology contents to understand people and institution's texts and discourses and to delimit health problems; communication and pedagogic contents to work with individuals and groups; planning and administration contents to organise actions around problems of reality. In this diploma they met people coming from different governmental and non-governmental organisations sharing with them their health practices, experiences and knowledge. Manuela and Pablo had training and practical experience as teachers within a local government project in the state of Chiapas aimed to produce educational promoters in rural and indigenous areas. This training focused on the developing of local teachers to attend local education problems. They also visited health, development and education projects aiming people's empowerment through learning practical skills.

(1) Ongoing training during the four intervention stages described below was fundamental for Pablo and Manuela learning and performance within CHTP self-growing environment. It consisted in observation and reflection about their teaching performance.

(2) Ongoing training was done also during weekend evaluation sessions with Pablo and Manuela where we elicited observed teaching characteristics that were or were not accomplishing with ideal CHTP teaching. In those sessions we proposed teaching changes and evaluated outcome. Feedback from students was an important part of ongoing teachers training.

(3) A quote from Manuela exemplifies that:

> "*I said: how am I going to explain diabetes, with all that it implies, it is a lot...They* [students] *needed to understand many things so they could solve a lot of problems that diabetic people presents, it wasn't easy. It was great, just great, because we presented the basic explanation, but they said what they understood about what we were saying and from there they could solve the problems...*" (Etn).

(4) Through CHTP development not only Manuela and Pablo were trained as self-growing teachers, also CHTP students learned to communicate and construct self-growing environments where they could perform self-growing teacher's role as it will show through the four stages described below.

(5) STAGE 1. START UP AND ESTABLISHMENT

(6) This action-research intervention started since stage one by providing the conditions to develop a self-growing pedagogy. Stage one aims were: to recognise the intervention site; to establish links with Minoans; to achieve first agreements with Minonans; to find a departure point for CHTP and to recruit students.

(7) Approaching and recognising CHTP site

(8) I planned visits to Mino accompanied by NGO personnel that previously developed housing and productive projects in Mino and who proposed Mino for this research site. NGO personnel introduced Pablo, Manuela and myself to different Minoans and also to Mino assembly. NGO people gave me useful information about Mino's history, social dynamics, economy and previous development projects.
(9) Six months previous to CHTP start, Manuela, Pablo and I visited five times Mino. Those visits included physical site recognition and meeting with Minoan authorities.

(10) Pablo, Manuela and I attended two Mino assemblies before CHTP started. In our first meeting with Mino assembly we introduced ourselves and presented our broad teaching, service and research intentions.
(11) I presented Pablo and Manuela as medical *pasantes*[6] and project participants and mentioned that we could not say anything about whether we could provide medical service at the moment since we were making arrangements with the Health Ministry to have Pablo and Manuela as *pasantes* doing their social service in the research modality controlled from the university thus avoiding institutional supervision and bureaucratic work. If the assembly accepted, Manuela and Pablo were going to live in Mino for one year. The assembly showed interest and gave us another date to talk more deeply about this research intervention.

[6] Medical *Pasante*. A medical student in his/her last training year accomplishing compulsory social service. Most times social service is done in rural areas within governemntal projects or services. It is also possible to accomplish social service joining a research project.

(12) In our second encounter with Mino's assembly, Pablo, Manuela and I presented this CHTP proposal by reading and discussing a written document specially prepared through questions and answers from where we supposed Minoans could get a better idea about this research intervention aims and functioning (the full document can be found in appendix three). We asked the assembly to accommodate Manuela and Pablo and to find conditions to make sure that they could be provided food and the assembly accepted.

(13) Establishing links with Mino's people

(14) The community allocated two rooms to house Pablo and Manuela, each of them with a small room attached, in one of the *plaza*[7] sides. People in the community took charge of feeding Pablo and Manuela (and I during my weekend visits). Every day, according to a list prepared by Mino's health committee[8], Pablo and Manuela went for breakfast, lunch and dinner to a different household invited by a different family in the community. In that way, from the very beginning they had access to some family activities.

(15) Insight into families gave Pablo, Manuela and me an idea of whole community functioning. This helped us for an early insight into Mino's social relations and Minoan's problematic and knowledge. A quotation from Manuela and Pablo illustrates that:

> (16) *'That was marvellous since from the beginning, from the very first day, we started to get to know the families from inside... Besides getting to know the house, the family, you also start to get to know what's up with the community... You start to understand: ah! This family doesn't get on well with that other... and things that if we had only arrived and work with the students and the medical consult, we had never get to know, to know all what we knew through family visits...'* (Tr).

(17) However, they did not cover every family since there was a few that did not want to receive them. The health committee explained some of the reasons: they were shy; they thought that their "poor food" was not at "doctors" level. There were also some families that fed Pablo and Manuela in a very distant way:

> *"You could feel the tension, they did not start any conversation, did not sit with us. There were houses where it was evident that we were eating the things that they will never eat themselves. We were getting chicken, little fish and lots of green chilli sauce."* (Tr)

(18) Early links with Minoans were also built from informal conversation with people freely approaching Manuela and Pablo such as children, adolescents and people approaching them to provide help and orientation while Pablo and Manuela settled in Mino, such as authorities or committees members.

Pablo and Manuela's power

(19) Pablo and Manuela material and symbolic capital could represent a problem to stablish horizontal relations within CHTP. We looked for dis-empowering strategies. Here follows an example.

---

[7] *Plaza*. Mino's central square.

[8] As mentioned before, Mino's local organisation include committees responsible for specific problems: water, land tenure, school, festivities, health amongst others.

(20) In Mino there are very few Minoans becoming university professionals, they never had a living-in doctor and there is a strong *doxa* surrounding the medical profession. All that gave Pablo and Manuela special power in Mino.
(21) To counteract that power they revealed to Minoan's and CHTP participants their lack of understanding of things occurring in Mino and precised their knowledge extent and limits whenever it was pertinent and possible. Whenever they used medical jargon, they explained it's meaning and encouraged people to find an equivalent wording for it and also to remember the technical word. Other empowering capital was that Manuela and Pablo came from Mexico City, that they were backed by the university and the privileged place they had in the teachers' rooms.

(22) Recruiting students

(23) Pablo and Manuela spent the first week calling for CHTP student candidates through home-visits and also in street conversation.
(24) First twenty four candidates were people of different ages and sexes, prevailing women over men and teenagers over older people.
(25) Most of them came with a 'first aid' course in mind. CHTP was a new concept for Minoans, outside their previous experience. In this period, the non-medical idea of the project did not pass through:

> "[We were] *continuously saying that it* [CHTP] *was an experiment, that much-unexpected things could happen. That was all the time. That health was not to give medical consult, not first aid, etc., etc., It was very hard at the beginning, because people came ready to learn to put injections, pass intravenous liquids, measure temperature, and stop*" (OIE:II).

(26) All candidates were accepted under the condition of attending to all sessions and bearing in mind that they were not going to learn first aid or at least that that was not this project aim.
(27) As time passed, out of the twenty four persons attending first meetings, we had a more solid group of seven students coming from Mino and other four from other nearby communities with overall characteristics similar to Mino's.

(28) Achieving first agreements and finding a departure point for CHTP

(29) First agreements with Minoans were taken in the assembly as described before.
(30) Once CHTP group of student candidates met with teachers, they were submitted to an evaluation with several purposes: to find a local conception of health before our intervention; to start by giving the voice to students; to identify a starting point for the whole process; to have some insight about student's overall characteristics; to evaluate students' communication skills and to set basic agreements for the development of a self-growing environment.
(31) That evaluation consisted in a collective interview, a questionnaire and a reading and writing proficiency test presented in chapter five.

(32) Reading and writing test

(33) This test was the first CHTP formal activity. It was presented to student candidates as necessary assessment to give us insight of their reading and writing skills.
(34) Fourteen candidates presented the examination: nine of them became CHTP students.
(35) The test consisted in reading aloud two texts. First text was a metaphor and second text was a landscape description. For the first text, candidates were asked to answer in written five questions

relative to the understanding of the metaphor. For the second, they were asked to make a drawing showing what the text described and also to answer five questions relative to text description.

(36) I asked candidates to read one paragraph each. After one reading round I decided to read the text, since candidate's reading was impossible to follow and understand.
(37) To reading fails, anxiety and shyness was added.
(38) Candidates were shy to show their 'poor' reading and writing skills and concerned about showing their lack of understanding and 'hard head'.
(39) Luz and Esther spoke very little, only if required by us or with self-pejorative jokes or comments: "*I'm hard headed, but let's see what happens...*" "*It's useless, you won't understand my writing...*" "*They already said all what I had to say...*" "*Let him say it, he says it better...*" (Cron)

(40) Student candidates behaved as 'in school': peeping into other students' papers; in complete silence; raising their hand to make questions; worried about speed and time and anxious because of a 'failing' mark possibility.
(41) At the beginning Pablo, Manuela and I responded and complemented candidate's attitude in a traditional exam situation.
(42) Later on we made jokes; gave straight answers to their questions; sat besides them and held brief conversations; made fun about the role of 'teachers' and 'students' in exam situation and made explicit our own anxiety and the worries we perceived.
(43) Finally there was a more relaxed environment where candidates laughed and mocked about their answers and fears.
(44) They also encouraged each other and praised their individual skills.

(45) Manuela, Pablo and I followed candidate's arguments and ended with brief open discussions about their understanding, believes and points of view regarding overall exam situation.
(46)In a final round of comments, Mundo mentioned: "*I can see now that this is not going to be like school, here we must speak and say what we know, what we understand. We must leave shyness aside and study to learn better what doctors teach to us*" (Cron).

(47) That activity closely resembled what Minoan candidates knew as 'teaching', fulfilling their learned-through-school teacher/student expectative and providing them security and certainty.
(48) It also gave Pablo, Manuela and I practical experience with Mino students.

(48.1) During this activity, students smiling and nodding when hygiene measures (daily shower, water boiling, hands washing or other) came into group conversation were accompanied by comments such as '*how are we supposed to boil water if it is too expensive*'; '*to take a daily shower, of course, when it is possible*'; '*in the fields it is not possible to wash your hands after going to the loo*' (different candidates, Cron).

Test results

(49) Out of five candidates that did not become CHTP students, four could not solve the metaphor. Five, out of nine candidates that become CHTP students, could solve the metaphor.
(59) After analysing the elements used by candidates in their drawings and the accuracy to reflect the second text content, I found that candidates that became students had used more elements in their drawings than those that did not become CHTP students but all represented the same image.
(51)
(52)

(52 a) Candidates did not ask for evaluation results neither Manuela, Pablo or I talked about individual results, since we focused in collective results.

(53) Even when the group of candidates that became CHTP students showed better understanding of the reading contents, just two of them, Alicia and Elena, could read and write fluently.
(54) Hence, one of the first tasks was to develop writing and reading communication skills.
(56) Evaluation participants discussed the need to further develop group writing and reading skills with the support of each other.

(57) Questionnaire

(58) Fourteen CHTP student candidates completed the questionnaire. Out of those, eight became CHTP students. The questionnaire had three sections: general data, multiple choice and open questions.
(59) From the general data section we obtained a first idea of candidates. As a whole, candidates that did not become CHTP students were teenagers, did not have previous community responsibilities and were unemployed and out of school.

(60) The logic and structure of the second questionnaire section was difficult to understand for CHTP candidates, resulting in answers not comparable or useful for this analysis.
(61) Candidates were asked to complete the third section in their homes. Eleven questionnaires were returned.
(62)Answers included strong medical contents insofar they referred to concepts.

(63) When commenting the open questionnaire I registered smiling and nodding when Health Ministry recommended hygiene measures -daily shower, water boiling, hands washing or other- came into group conversation
(64) However, answers did not include open critiques or opposition to medical structures, treatments or services. In box 8.3 are presented examples of the above, taken from candidate's answered questionnaires.

(65) **BOX 8.3. CHTP CANDIDATES' HEALTH CONCEPTION AND PRACTICE**

HEALTH CONCEPTION AND PRACTICE	EXAMPLE
Health definition strongly influenced by disease (65.a)	[I am not healthy] … *because I am ill in the eyes, ears, kidneys, skin, etc.,* (Alicia).
Conception of health related with community (65.b)	Recommendations for sick people are: *1. ...to go to the doctor; 2. Ask for help to the compañeros; 3. go to a traditional healer* (Luz)
Family and medical doctors are the response to health problems (65.c)	[First things to do when a person does not feel healthy are] *First I visit the doctor to see what symptoms I have, then I tell the doctor what I feel, then it depends on the doctor what he has to say and gives me medicine, then I follow the steps.* [When someone has a health problem] *I inform first to my mother. If she knows about my disease, she gives me advice. If not, with my grandparents and they take me with doctors.* (Vanessa)
Medical and Health Ministry recommendations are learnt by heart (65.d)	All candidates included in answers 8 and 9 (activities to maintain yourself healthy and which of those are your responsibility) To wash fruits and vegetables, to brush your teeth, wash hands before eating and after using the toilet and to bathe yourself everyday.

(66) Collective interview

(67)The collective interview consisted of rounds of discussion about different life conceptions triggered by a set of pictures representing plausible scenes of rural life and pre-designed questions. This activity lasted three weekend sessions.
(68) Collective interview became boring after four sessions and interviewees started to give short repetitive answers.
(69) After discussing it with CHTP student candidates, we decided to cut down remaining drawings.
(70) Collective interview helped to complete other purposes of first evaluation: It helped candidates to feel more confident to say what they thought.
(70.1) As the collective interview advanced and the discussion became relaxed,
(70.2) some answers showed contradictions, an example is students' conception of men at the beginning: "[to a father a childbirth means] *to have more responsibility...to support her wife and the new being...*" (CIP 133-136) and several sessions later: "[men are] *manly, vicious,* parranderos[9]*...responsible or irresponsible...*" (CIM,5)

(71) During the collective interview candidates had to discuss and take decisions. For example, changes in session dynamics.

[9] *Parrandero.* A man that goes out for drinking or other, leaving their families without support.

(72) The collective interview helped us to recognise speaking, understanding, and other communication skills.
(73) Candidates often waited for teachers' reaction to confirm their 'right' answer and needed to proceed by themselves without teachers' intervention.
(74) Candidates shared experiences that helped everybody to get to know each other and to develop their awareness, a candidate mentioned: "*Pictures had awakened our way of thinking, why and how*" (CRTR).
(75) This activity also provoked interest in CHTP: "*A way to open our way is to get to know each other better ... things are coming bit by bit... the next week we will be more confident ... the prove of how truth it is, is that I brought Etelvina to join us*" (Elena, Cron).

(76) After three weekend sessions, basic agreements and a departure point for CHTP had been achieved.
(77) Basic agreements focused on teacher/student relation and teaching-learning CHTP peculiarities and aims; time and place for CHTP sessions; individual and collective responsibilities and commitment; the necessity to construct learning problems and communication skills; awareness about how the contents were not first-aid but dependant in CHTP development and that CHTP participants were involved in a research study.

(78) All the referred activities were useful to find a departure point for CHTP.
(79) Especially relevant was the collective interview that gave room to discuss Mino's problems, candidates' expectative and known learning processes.

(80) Because of what we learned in the set up stage, Pablo, Manuela and I foresaw that respiratory tract diseases could be the first CHTP problem.
(81) Manuela and Pablo started to attend the medical consult in the local health post which they needed to provide as *pasantes*, but also because we saw the medical consult as a plausible starting place for teaching.

(82) First stage ended with the conformation of a group with the eleven CHTP students presented below. They attended regularly and wanted to follow CHTP. During this set up and establishment stage a self-growing environment was emerging.

(83) First CHTP students.

(84) Eleven students constituted CHTP group: Goyo, Esther, Roberto, Guillermo, Teo,Elena, Alicia, Olga, Luz, Mundo and Elvira. In appendix two a brief profile of them is presented and in box 8.4 some of their general characteristics are summarised to help in the understanding of their performance and achievements during CHTP stages two to four presented below.

(85-104) **BOX 8.4. CHTP STUDENTS**

	SEX	AGE	1	2	3	4	5	6	7	8
GOYO (85-86)	M	18	S	0	Mino	Elementary	Peasant	Incomplete elementary	Irregular	-Enthusiasm -Lack of consistency and learning responsibility.
ESTHER (87-88)	F	30	M	3	Mino	Elementary, first aid	Shop attendant/seamstress	No school attendance. *Mayordomo* father	Abandoned	-Shares her knowledge and experiences. Experience in seamstress collective workshop. -Lack of self-confidence, concentration and other learning problems.
ROBERTO (89-90)	M	16	S	0	Mino	Middle upper. Incomplete medical clinical lab technician.	Student	Complete elementary	Regular through stages one to three	-Enthusiasm, relatively to the group high reading, writing, inquiring and study performance. -Reserved with the group.
GUILLERMO (90.1-90.2)	M	26	S	0	Born in X, 6 yrs ago moved to Mino	Complete secondary	Working in a factory	Father incomplete elementary school. Previous family collective responsibilities in Mino.	Regular through stages one and two Irregular during stage three.	-Enthusiasm, questions what the rest don't, moves the group for practical activities. Enjoys knowledge. -Do not have interest in looking after others.
TEO (91-92)	M	29	M	1	X	Complete secondary. IMSS health assistant courses.	*Campesino*, IMSS health assistant	Unfinished elementary. Father with community responsibilities.	Regular through stages one to three	-Collectively appointed to CHTP. Shares his knowledge and experience as institutional health promoter. Elicits and questions problems of reality.
ELENA (93-94)	F	18	S	0	Y	Ongoing pre-university. Nursery teaching aid course.	Tailoring workshop	Incomplete elementary	Regular	-Leadership. Relative to the group high reading, writing, inquiring and study performance. Collective work experience.
ALICIA (95-96)	F	32	M	2	Mino	Incomplete pre-university. Unfinished nurse aid.	Tailoring workshop	Father is a schoolteacher. Father and mother with collective responsibilities	Regular through stages one to three. Irregular in stage four.	- Collective responsibilities. Likes reading, concepts and abstraction.
OLGA (97-98)	F	33	M	2	Mino	Unfinished secondary	Housewife	Incomplete elementary *Conserje* at the local elementary school.	Regular	-Particular attitude and capacity to share and look after people. Sharp to question and fast to learn.
LUZ (99-100)	F	35	S	0	Mino	Complete elementary, first aid course	*Campesina*	Incomplete elementary	Regular	-Keen in practical activities. Enthusiastic. Sharing. Practical experiences.
MUNDO (101-102)	M	35	S	0	Z	Secondary, nurse aid course	Local pharmacy attendant	Incomplete elementary	Regular	-Enthusiastic, shares experiences and knowledge, searches for information, enjoys teaching
ELVIRA (103-104)	F	36	M	3	W	Elementary	Tailoring workshop	Incomplete elementary	Regular	-Enjoys searching and developing knowledge. Shares knowledge and experiences.

1. MARRIED/SINGLE. S=SINGLE, M=MARRIED; 2. NUMBER OF CHILDREN; 3. RESIDENCY; 4. SCHOLARITY; 5. EMPLOYMENT; 6. PARENTS SCHOLARITY AND POSITION; 7. ATTENDANCE REGULARITY TO CHTP; 8. PARTICULAR POSITIVE AND NEGATIVE CHARACTERISTICS TO CONFORM WITH IDEAL SELF-GROWING STUDENT

(105) General student's profile shows that CHTP students have self-growing student characteristics presented in chapter four within this thesis.
(106) They are persons with hope, faith and humility thinking in collective benefit, had exercised their common sense, popular and expert knowledge to solve problems at individual and collective level. They were ready to share their knowledge and experiences within CHTP.

(107) STAGE 2. FIRST TEACHING PERIOD

(108) Stage two aims were: To develop a self-growing environment; to develop communication, dialogue, perception, observation, enquiring and study skills; to find out student's conceptions about health, disease, teaching and learning; to define CHTP problems through observation of student's perceptions of their reality.

(109)Teachers discussed with students CHTP teaching methodology, CHTP project aims and explained first step: to collectively define a problem relevant to their communities.
In classroom, CHTP participants defined the first CHTP problem, making reflections about their every-day experiences.
As we expected from what we learnt during the first stage, "cough" and "coughing people", were first CHTP problems to examine.
An agreement about learning from the health post medical consult was taken.

(113) The assembly was consulted about student's presence in the medical consult and
(114) agreed and assigned to patients a charge for each consult event.
(115) Students were asked to treasure consults fees, decide about fee exemptions and to inform about money and expenditures to the assembly.
(116) The money was to cover basic medicines and some CHTP teaching material.
(117) Resulting from a discussion with CHTP students about Mino's people feelings, values, knowledge and representations, at the beginning they were observers during the medical consult.
(118) Each patient attending the health post was asked by the student in turn about whether he/she wanted or not student's presence.

(119) After each medical consult the students analysed and evaluated patient's problems with Pablo or Manuela's help.
(120) During weekends consult experiences were also discussed. Here follows an extract of one such analysis conducted by Manuela's questioning.

"Manuela. *What did you see during the consultation?*
Student. *Well, cough.*
M. *And why is it that people cough?*
S. ...
M. *Besides coughing, what else did you see?*
S. *Well, he was a bit bent.*
M. *And why is it that people can bend and have cough?*
S. *Because something might be hurting.*
M. *Did X refer pain?*
S. *Yes.*
M. *Where?*
S. *[...]*
M. *What is pain showing?...*" (Cron).

(121) CHTP participants held two weekly sessions on Saturday afternoons and Sunday mornings, besides the shifts in the medical consult.
(121.1) Schedules for those sessions were decided and agreed amongst students.

(122) For two months CHTP participants worked from respiratory track diseases experiences.
(123) In that time they learnt about respiratory tract histology, immunology, syndromatic approaches, physiology, etc. and also about the environmental, social and family origins, repercussions, explanations, practices and possibilities in relation to those diseases in the specific context of Mino and surrounding communities.

(124) Sessions dynamics

(125) During CHTP sessions, special attention was placed in looking for local information or within written material and to look for ways to circulate knowledge among other people in the community. (126) Newly constructed or reconstructed knowledge was always referred to other disease events they had seen in their person, family or community.
(127) An example of that is taken from a chicken-pox outbreak detected during the medical consult.

(128)After talking, discussing and looking for information, students were required to produce their own chicken-pox book including local knowledge and knowledge organised during the sessions.
(129) Teachers and students talked about how could they produce a book with available resources.
(130) Teachers asked students to test this book with their neighbours.
(131) Next session students reviewed those books. "*We asked them about the books, if they had tested them ... each one commented and gave their opinion.... There were some very positive commentaries ... others very 'suggestive'...*" (Md).

(132) A role-playing where students considered individual and collective chicken-pox characteristics followed to that book activity (you can find this role- playing argument transcription in appendix four).
(133) Local knowledge was lacking in role-playing.
(134) At role-playing end, all 'school children' in the play were queuing to see 'the doctor'.
(135) During the role-playing discussion, a double problem was elicited: there was medical service overload while people didn't make use of their own knowledge
(136) Pablo asked students to repeat the last role-playing scene and for the first time local knowledge revealed:

(137) "*Señora*[10]*, what happened with your child?*
(138) *Look, he has chicken pox and ... the doctor ...*
(139) ...
(140) *I have a remedy. Splash some* 'jarilla'[11] *and leave it in warm water...*" (RPv).

(141) From here the discussion went around different remedies that students not only knew but also in fact used or use, some of these remedies had been discovered during the search to elaborate the chicken-pox book.

[10] *Señora:* Lady, maliciam, the way people address mature women.
[11] *Jarilla.* A wild plant with healing properties, often found in semidesertic areas.

(142) That discussion included an insight of actual healing reasons and modalities: "[When a lady has doctor's remedy and her friend's] *it does not interfere, it makes no harm. In fact, both are caring measures too*". (RPv).

(143) Classroom sessions included students' presentations followed by answers and questions, play models, animal dissection, case presentations, information search in books with reading exercises, representations and theatre, experiences exchange, expositions, vocabulary building, anatomic and physiology models construction, comparison with agricultural and family processes or known machinery, previous knowledge organisation, information and discrimination exercises, local information collection and analysis, book production, registers design, watching and discussing videos and other.

(144) Session dynamics were designed by teachers and modified by students' interests making use of teacher's creativity:

> "*We probably planned first session hours and then it continued with what we imagined on the spot ... taking into account certain basic things ... also once students got the idea, we couldn't follow our plans since they clang from an interest and they followed it, and that was the key*" (Tr).

(145) Session dynamics success depended on teacher's interest that they got from student's interest:

> "[Students' attitude] *fired you, when you are with them you spark yourself ... as they advanced we were constructing the teaching methodology ... the students that remained through the* [CHTP] *process each time were more astonished with what they were learning*" (Tr).

(145.1) Even when students showed interest in all activities, practical activities -comprising manual work reinforcing knowledge construction- helped in the development of collective interest.
(145.2) Guillermo was especially keen in translating knowledge into material models. That is the case of a respiratory cage model he made out of wire, foam, plastic tubes and other materials with the help of Roberto, Goyo and Pablo.

(146) Especially relevant were the activities designed to improve reading and searching in technical texts.
(147) The main idea was to help students loose their fear to confront technical texts and to be able to use indexes and other book- marks to find what they were looking for.
(148) The following dialogue, recorded during one exercise where students in groups analysed different medical books with information about lungs is an example of the above.
(149) This extract also shows one use of questioning in CHTP.

> (150) "(Manuela) ... *it is what you had seen, even if you understood it or not, just tell us what did you see, what did you find.*
> (151) (Student) *We found a complete respiratory tract X-rays picture.*
> (152) (M) *Did you read what it says underneath? That? In the lower little paragraph?*
> (153) St1. *It says that it has no lung problem, in the darker ones it means that it has i... the lungs that are not well, it has problems.*
> (154) St2. *Probably they are too beaten, finished, and the* peones[12] *are too worked out, there are people that work hard and that is why the X-ray is as it is.*
> (155) St3. *When we breathe we rest, isn't it?*"
> (156) ...

[12] *Peones*: The name given to a hired peasant, they do hard cropping work.

(157) M. *How did you manage to reach that drawing? How did you find it?*
(158) St. *With the index.*
(159) M. *What did you look for in the index?*
(160) St. *Pulmonary function.*
(161) M. *You read the entire index until you found that?*
(162) St. ...
(163) M. *What problems did you have to find it or to understand it?*
(164) St. *To understand it, just some words where there was a brief definition, but there was also a brief explanation.*
(165) M. *Were the words very odd to you?*
(166) St. *Just some.*
(167) ...
(168) M. *That is what is not understood, the words?*
(169) St1. *Well, yes, you understand them.*
(170) St2. *But you don't know what they mean* ...(Tr)

(171) After some weeks, students had 'selected' their favourite books, also students had recognised that some of them were more skilled to read and they helped each other to find information. They also brought to the weekend sessions materials they found useful for CHTP. Examples are: a video on sexuality and one volume of a health encyclopaedia brought by Mundo, flipcharts on anti-conceptive measures that Teo used for his institutional health promoter activities, and a leaflet brought by a Mino member of the health committee on juice therapy.

(172) Animal dissections were one of the most successful activities to get rid of fear and to recognise self-value and possibilities. An example follows.
(173) Pablo and Manuela proposition of performing dissections in chicken was very welcomed by students.
(174) On the first dissection day students came with a pig's intact, fresh respiratory tract, heart and main vessels that they managed to save from the '*carnitas*'[13].
(175) At the beginning they joked about how the pig dead was caused by next-day party.
(176) While performing the dissection

> "...*they were asked to decide the death cause. Every body knew that the pig had been killed by a knife stab but, well, why did the pig die? ... then, they needed to find out the meaning of the blood flooding the alveoli and what happened with the oxygen mechanisms until they reached the biological death cause*" (Md, Pd).

(177) Discussion of personal experiences and testimonies was another important pedagogic tool. Here is presented and example. It was discussed how words were used to replace knowledge and as power source.
(178) A student's comment propelled one such discussion: Teo was worried because the authorities in his community had been insistently asking him about his progress in CHTP.
(179) Teo mentioned that he had learnt many words. An authority in his community had been pressed him to learn '*useful things as those he had learnt in the IMSS*[14] *courses*' (give injections, pass intravenous drips or other) (Cron).

[13] *Carnitas* are pig meat and insides chopped and fried with a special mixture of herbs, orange juice and other ingredients. It is a main course during parties and festivities.
[14] Social Security Institute

(180) Teo tried to explain that those courses were deceiving, that they concealed real knowledge as he had discover with CHTP and that he was learning to learn, but didn't get approval of the persons pressing him.
(181) He then came with doubts to a weekend session and opened them for discussion (Cron).

(182) Vocabulary development helped understanding and communication development. Each student constructed a personal dictionary after discussing the importance of knowing medical terminology to understand medical information and to confront doctors.
(183) Through this, students' vocabulary widened.
(184) To construct words and analyse them became an enjoyable activity:

> (185) "*...they already knew what was* taqui, hypo, *and other. We used to chop words and find out each piece meaning and getting to know that words have an origin. They brought* 'tlacoyos'[15] [to a Sunday session during a collective lunch]. *Each one used to bring along water or what they could since the sessions lasted four or five hours. Then they started to make jokes constructing words from the words they had previously learned. All of a sudden they found themselves dissecting the words, rather than constructing them. They analysed the* 'tlacoyo' *word. They reached to the conclusion that* 'tlacoyo' *came from the combination of two animals:* 'tlacuache'[16] *and* 'coyote'[17]*. When they constructed their possibility they were laughing to tears*" (Tr)

(186) Teachers used small experiences to develop reasoning skills.
(186.1) An example is a comparison of six boxes of vitamin B a patient had received in a private clinic. In that comparison the students found out that it was the same active principle with six different names and packaging that had been charged to a patient.
(187) Another example is taken from another lunchtime where one student had hiccups.
(188) Everybody started to laugh and give remedies to stop hiccups.
(189) I asked: why do you think those remedies help? What is hiccup?
(190) Through a why questions sequence, students localised hiccups as something occurring inside the thoracic cage which they had already seen in the pig's dissection referred before.
(191) They analysed the intervention of muscles for hiccup production, specially the diaphragm.
(192) Then they proceeded to reconstruct hiccups mechanism and found that a nerve should have been stimulated.
(193) Finally, students discussed how remedies work over the nerve and hiccups production.
(194) *"Then the students attitude changed, it started to become sort of exiting... through the understanding of things, they understood that knowledge was there, that they could have access to it".* (Md, Dd)

(195) Those small events were also used as evaluation.
(196) An example is taken from an experience occurred after six months of CHTP implementation.
(197) A box labelled to the secondary-by-television appeared in the community hall where CHTP was taking part.
(198) Students said that it was not right to open it but encouraged them and found a tri-dimensional anatomic model.
(199) They recognised different concepts and knowledge through findings in the model.
(200) Students and I played questioning each other about different anatomy and physiology topics.
(201) Especially noticeable was how students collectively localised all endocrine and exocrine glands and their organic functions.

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[15] *Tlacoyos* maiz thick pancake often filled with cheese or beans. It is served with a topping of onion, cilantro, fresh chopped tomato, cream, cheese and chilli.
[16] *Tlacuache* . An animal similar to the racoon.
[17] *Coyote.* A mixture of dog and fox.

(202) Gland knowledge had not been a specific CHTP content but had been constructed through explanations of different body functioning and disease mechanisms.

(203) Pedagogic experiences included games and representations followed by analysis and discussions.
(204) After one such experience -named 'the blind and the guide'- aiming to develop understanding of interchanging student-teacher roles, Elena commented: '*...this morning I was shy, after 'the blind and the guide' I got rid of it ... we know more about ourselves...* ' (Cron).
(205) That experience was linked with the medical consult and students' necessary differences with the allopathic doctors and the medical institution services.

(296) Outsiders' observation

(207) After three months, CHTP students were bringing along problems -detected within their relatives or neighbours- for discussion in the weekly sessions.
(208) Chronic diseases appeared relevant to students' interests.
(209) Students had developed communication competence and problem identification, search for information, discussion and knowledge organisation skills. CHTP self-growing environment had developed.
(210) However, outsiders observation carried out at the middle and end of this first CHTP period and evaluation with teachers revealed that CHTP teaching practices were "*not showing interchanging student/teacher roles*" (On).
(211) Teachers and I analysed those observations and started to include more planned teaching opportunities for students.

(212) STAGE 3. SECOND TEACHING PERIOD

(213) Third stage aims were: to approach problems raised by students; to develop and consolidate a self-growing environment; to develop and exercise already developed communication, dialogue, perception, observation, enquiring and study skills; to identify student's developing identity; to develop planning and performance skills.

(214) Transition to second CHTP period was a process that took about six weeks.
(215) During this period, students moved their interests from respiratory diseases to chronic diseases linked to specific persons.
(216) This stage was characterised by students' curiosity and pleasure when constructing knowledge or when understanding or solving by themselves some aspect of the problems they were bringing to CHTP.

(219) Overall CHTP pedagogic dynamic was the same as in first CHTP period.
(220) However, there were some special characteristics of this second CHTP period.
(221.1) Second period lasted four to seven months.

(221.2) To test knowledge and practice efficiency was specially an CHTP second period characteristic.
(221.3) As in previous stage, this was a source of students' exitement making them want to know more and improve their searching habilities.

(221.4) To contrast cultural capital efficiency/truthness/source helped students to value their own cultural capital, recognizing their capacity to analyse institutional texts.
(221.5) Their ongoing experiences with the medical institution represented vivid first hand information to discuss and analyse at the light of their newly organized knowledge.
(221.6) This experience unveiled arbitrariness and *doxa* and also helped to better understand that not all discourses, knowledge, values and practices are valid.
(221.7) This also occurred with media messages.
(221.8) Contrasting capital efficiency/truthness/source also helped to analyse the procedures of knowledge construction and validation. .

(221.9) An example of that is Teo's reaction when he found that the Health Ministry and the Social Security Institute had cheated him. Until CHTP he thought that his six years training as health aid was what '*I can have*' and was the fair offer for peasants that have few years of school attendance. He found with CHTP '*the knowledge that had been hidden from me...I can see now all that was behind...they train us just to get cheap work from us... they don't even recognize it'* (Cron).
(221.9.1) Another example is a discussion about what to look for in a written or broadcasted material to be considered as valid when Mundo brought a leaflet on iridology[18].
(221.9.2) A final example is the continuous discussions about scientific knowledge, popular knowledge and fake knowledge present every time the students found out that people in their families or communities had been cheated with vitamins, drips or other fake practices.

(221.10) Teachers and students found how habitus limited our CHTP practice.
(221.11) An example is a result of a teachers evaluation showing teachers' uncounscious resistance to accept local knowledge and practices, our difficulty to incorpore it as equal to scientific knowledge and the resulting increasing difficulty to discover and value popular and local expert knowledge. Manuela's testimony from a teachers evaluation can exemplify that:

> (221.12) "*I know that our scientific knowledge is incomplete, however it is hard for me to accept some things that I do not trust, I try to refrain myself from imposing but sometimes it's difficult, popular knowledge is OK but, when does a person knowledge become 'popular knowledge? How can I know that it is 'popular' and not just one person idea appeared because of a single experience or some?...*" (Etn).

(221.13) Through systematic personal and collective work Pablo, Manuela and I were able to accept criticisms and improved our CHTP practice.
(221.14) Teachers and students noticed changes in self-evaluation as CHTP progressed.
(221.15) At the beginning criticisms were mild. As the process advanced we increasingly reconsidered our CHTP assessments finding out more valuable aspects to change.

(221.16) Through the analysis of disease problems students found the multi-field origin of health problems.
(221.17) We had sessions commenting texts and discourses, finding out who could possibly be behind them and what did they want to obtain.

(222) Dialogic testimonies

(223) One characteristic of this period is the development of knowledge from testimonies through what I am calling here 'dialogic testimonies'.

[18] Iridology. A practice of looking for diagnosis in the eye iris where all the body is represented according to iridologists.

(224) Students spontaneously brought to CHTP sessions testimonies about their practices using CHTP already developed knowledge.
(225) Those testimonies were built as dialogue between the student spontaneously presenting his/her testimony and the other students and teachers.

(226) An example of that is a testimony of Elvira's encounter with hospital medical doctors. Elvira's father is being attended in IMSS hospital because of heart problems.

(227) [Elvira asked the doctor in charge about her father's diagnosis.
(228) The doctor answered] '*he has a heart valve insufficiency*'. [Elvira inquired]: '*which valve is affected*? *The doctor was confused and answered in an authoritarian and rude way*: *I don't have to give any further explanation. Besides that, you could not possible understand. It is not my duty to explain. I am just being kind to you by informing you... and he left'* (Cron, Md, Pd).

(229) Students analysed different characteristics and consequences of Elvira's father heart valve problem, consequences of being attended in IMSS hospital, characteristics of the medical services and their new position in front of doctors amongst other analysis.

(230.1) Developing cuidadores identity and expertise.

(230.2)During this stage, students had envisioned a panorama of their potential community role and knowledge scope.
(230.3) They valued CHTP as personal and collective belonging and showed a strong will to make CHTP succeed. An example of that is how they cherished their library -composed by about twenty books and documents; instruments -thermometer, sphyngomanometer, aesthetoscope and a set of surgery tools-; medical consult money and the CHTP room key. Students in turns were responsible for their use and care.

(231) Students started to question their identity at the middle of second CHTP period.
(232) Their expertise and role did not correspond with health aids, promoters, assistants, nurses or doctors.
(233) Students recognised their work as caring for their community in an integral way.
(234) Their work resembled more the *parteras*[19] and healers work than that of medical doctors, nurses or health aids.
(235) They were caring people in the community; care in Spanish is '*cuidado'*. The person that cares is a *cuidador*.
(236) Therefore, students, Manuela, Pablo and I started to call students 'cuidadores'. Mundo defined a cuidador:

(237) "[A cuidador] *Is an important community basement since is the means to the community since he is close, he belongs to the same community, he can trust more the others in the community* [and the others trust him] *and in this way to get to know more about community people, about their problematic and community problematic, their needs. And also, when nobody knows, we must search to reach to the starting point and in that way to help more. That is, many times not even doctors can help from the roots, since they come, they make their consult but sometimes the patient does not trust him enough, to tell him, to explain to him since the very beginning how did it* [the problem] *start. Since*

[19] *Partera:* A traditional midwife who's work includes caring for the mother, the child, the husband, other children, the house, washing new born's nappies, cooking with the intention to provide the mother with an adequate environment to heal from her delivery and also to help her to get on with breast feeding.

sometimes there are people shy, isn't it? ..." Luz added: "*To gain people's confidence, so they can trust themselves and see reality, not just like it is there or so, but understanding it ... economic problems, family problems, health problems...*" (Tr).

(238) The collective dimension of a cuidador was present in cuidadores' conception.
(239) The following text shows that. "[If there is an economic problem or a problem that a cuidador can't face by himself] *you should see all the problems, how many persons are in the same situation and find a solution collectively, since one is the key for them to think solutions... or to look a way ...to obtain the medicine or to see what institution can help us*" (Luz and Elvira, Tr).
(240) The cuidadores' characteristics were discussed and listed in a flip chart.
(241) Here follows that list transcription.

(242) "*Specialised. With training.*
(243) *From the roots.*
(244) *Working where not everybody would like to work.*
(245) *The 'way' is different than that of other persons dedicated to disease.*
(246) *Gives disease attention or advice.*
(247) *We are a community part.*
(248) *We must explain to them.*
(249) *It is understood, with a focus, in a different way.*
(250) *Some follow us, others don't (they don't trust us).*
(251) *We have a similar way to see or give solution to problems.*
(252) *When we give attention to someone, we can't put ourselves in medical doctor's position. It is implicit in our own way and knowledge. Of course, we have new information.*
(253) *The doctor does not know what is behind that.*
(254) *We have not title* [university diploma].
(255) *That diminishes our interest for money. We won't say 'I've burnt my eyelashes studying'*
(256) *It is an advantage since it diminishes our* 'ego'.
(257 *It is a disadvantage with the people that have doubts about our knowledge.*
(258) *To find out what is the problem he is concerned with their job, the environment and with the economic environment.*
(259) *Thinks in the way we have been moulded, as an example: the wrong idea of vitamins.*
(260) *Enjoys learning.*
(261) *Learns when solving problems.*
(262) *Searches, inquires.*
(263) *Is not proud, is humble.*
(264) *The* cuidador *identifies, looks for, anticipates problems.*
(265) *Cares for problems looking at all its parts.*
(266) *Searches for information, the answers and necessary solutions where they are, at their reach*" (Fc).

(267) Teachers and students analysed what were the services they were going to offer.
(268) Those services would be written in a poster outside the cuidadores' room for public information.
(269) To be included, the services they offered should be mastered by all cuidadores.
(270) In future they could add new entries as they developed new knowledge, experience and skills. Here follows the cuidadores offer:

(271) "*HERE WE:*
(272) *Give advice about disease and treatment.*
(272) *Sterilise female dogs.*
(274) *We give advice about feeding, development and growing.*

(275) *We give advice about alcoholism and drugs-addiction.*
(276) *We give advice about contagion.*
(277) *We give advice about pregnancy, delivery, puerperium and fertility.*
(278) *We heal wounds.*
(279) *We perform plasters and sawing.*
(280) *We perform measures and valorisations of weight, size, sight, hearing, teeth and feet.*
(281) *We give advice about plagues.*
(282) *We give advice about skin diseases and attend some of them.*
(283) *We give advice about cares for the aged.*
(284) *We can minister vaccines.*
(285) *We give first aid and advice for reference*" (Fc).

(286) By cuidadores they meant a group, a skill, knowledge, a responsibility, a position, a practice and an identity.

(287) Cuidados[20]

(288) Because of the way in which the cuidadores were performing within their community, special attention was placed in finding out which specific people the cuidadores were going to look after: the 'cuidados'.

(289) Olga, Luz and Mundo recognised some relatives and neighbours as cuidados.
(289.1)Elvira chose other women working with her in the seamstress workshop.
(290) Elena started to work as nursery teachers' auxiliary and wanted to work with children's parents.
(291) Alicia did not define her cuidados, nevertheless, she was asked to look after the cuidadores, helping them in their searches and inquiries; in their understanding of information; producing written material at cuidadores demand and also making posters with information relevant to the whole community.
(292) Goyo looked after a diabetic old man going one or two times a day to clean his leg wound and then left CHTP.
(293) Goyo got good reputation in Mino for cleaning and healing chronic wounds.
(294) Roberto, Guillermo and Esther did not continue their cuidadores practice after leaving CHTP.

(295) To look after the cuidados was recognised by the cuidadores as very important learning experience.
(296) Cuidadores' relation with cuidados' families helped them to look at disease problems from different angles and to accept responsibilities.
(297) An example of that is a quote from Olga explaining why she needed to leave some minutes before the rest of the students: '*With that cleaning I learnt, X's leg wound is really improving. I need to rush to see how is he today and tell him that I will go to clean his leg later on...*' (Md, Pd, Cron)

(298) During the second CHTP period, there were big learning advancements.
(299) An example is how Elena faced a cuidado's chronic kidney problem.
(300) She detected a man's kidney problem but had no tools to confirm it. She unsuccessfully called the *pasante* in her community several times.
(301) Then she went to the health post and emphatically asked for urine and blood reactive sticks and also managed to borrow a sphyngomanometer.

[20] *Cuidados:* the looked after. People looked after by the *cuidadores*, chosen by the *cuidadores*.

(302) She studied the case with the help of her CHTP notes and books until completing the diagnosis and suggested a treatment to be confirmed by the *pasante* medical doctor.
(303) She also prescribed non-allopathic general measures and performed them until the following day when she lobbied in the health post for *pasante*'s attention.
(304) Finally Elena explained her problem to the *pasante* and demanded attention. The *pasante* reached to the same diagnosis and treatment.
(305) As soon as Elena could, she let all of us know how well she and her cuidado felt and how much she had learnt. Her tale was accompanied by the other cuidadores questions, commentaries, expressions, etc.,

(306) Supporting activities and projects.

(307) Developing planning skills

(308) CHTP included planning insight to confront collective health problems.
(309) The Health Ministry asked Manuela and Pablo to join the municipal dog's rabies vaccination campaign. Students and teachers accepted the invitation as a group project.
(310) Former ministry's dogs vaccination campaign lasted one week and reported 25 vaccinated dogs. Vaccines were administered in the health post.

(311) Pablo, Manuela and CHTP students collectively designed a strategy to reach the dogs in their houses.
(312) Cuidadores campaign planning included dog census brigades organisation, training, resources assessment, informing and recruiting neighbours, and posters elaboration.
(313) Teachers, students and I vaccinated in one Sunday morning about two hundred and forty dogs and some cats, until we ran out of vaccine.
(314) That Sunday, everybody had a chance to talk with dog's owners, to hold the animals, to prepare the syringe, to vaccinate, to fill in the registers, to talk about rabies and other problems raised by dogs and to care for the biologic.
(315) Brigades were mainly led by the cuidadores.

(316) The vaccination activity gave students and teachers many discussion topics. It also showed what local and collective planning could achieve.
(317) After that activity, a child with hepatitis was identified by the cuidadores.
(318) Olga assumed the case as a collective health problem.
(319) She went to the primary school to warn the director about the hepatitis problem. She also produced some posters and placed them in the central plaza.
(320) Olga's work was the only one carried out to prevent a hepatitis outbreak. Local authority did not take notice of this, neither the Health Ministry.
(321) The cuidadores found later on that school toilets were in very bad hygienic conditions.
(322) The cuidadores couldn't do much and there were three more known hepatitis cases.
(323) We analysed the context and difficulties to carry out health work; institution's nature and social role; relations among social structures/health/education; and other.

(324) Dog's sterilisation project.

(325) The regional Health Ministry asked Pablo and Manuela to train municipal personnel for dogs sterilisation.

(326) After the dog's vaccination campaign, the cuidadores had seen the sterilisation as an unmet necessity and agreed to perform dogs' sterilisation with the support of a team of veterinary students.
(327) The cuidadores adapted CHTP room as surgery room and learnt to perform sterilisation in female and male dogs.
(328) Dog's owners were required to help in their dogs' surgery where the cuidadores needed to explain and make comments about pregnancy, family planning; anatomy, surgical procedures, physiologic processes and also the reasons of aseptic manoeuvres.

(329) Through dog's sterilisation the cuidadores learnt about reproduction, family planning, surgery skills, antibiotic uses, skin infections, cardiovascular physiology, central and peripheral nervous systems, uses of anaesthetic products, resuscitation manoeuvres, etc.
(330) They also practised their communication skills and had another opportunity to discuss cultural and social knowledge and practices in Mino.
(331) This activity was Luz's speciality and pleasure and Mundo disliked it.
(332) At this point Students and teachers analysed how each cuidador was unique and the importance of teamwork.

(333) Reality is not plain!

(334) Abstraction was difficult for the cuidadores.
(335) They could refer more to visible, tangible things than to ideas or not visible things.

(336) In July took part a supportive ten days fieldwork with the participation of twenty five first year university students under my academic supervision aiming to discover one invisible world: the microscopic.
(337) As part of the project, a laboratory was implemented in CHTP room where adults and children could see different materials such as insects, plants, water, blood, food, etc. through microscopes borrowed from the university.
(338) Triggered by the preparation and observation of blood, water and *pulque* samples, Mino's adults and cuidadores held long discussions about AIDS, infectious diseases and alcoholism where teachers did not interfere.

(339) That was the first time the cuidadores could reach the microscopic world, enjoying, learning, discovering, understanding and finding links they needed to make sense of concepts, descriptions and ideas they were finding in books and in their reflections. The following testimony of Pablo and Manuela exemplifies that:

> (340) "*...when the microscopes arrived, oh god! it was like a dream... Luz, we said, Luz won't be able to get through, she can't read, she has difficulties to learn ... she is very practical... She has only one eye...and then the microscope arrived and Luz was there all the time, she was the one that saw more samples...*" (Tr).

(341) The diploma

(342) Between second and third CHTP period, a diploma signed by university authorities was given to eight cuidadores: Guillermo, Teo, Elena, Alicia, Olga, Luz, Mundo and Elvira.
(343) Before producing the diploma, students, Pablo, Manuela and I discussed what the diploma meant for them and the community.
(344) Especially for Teo, the diploma was essential for community recognition. After receiving the diploma he left CHTP.

(345) Later on he left his health promoter institutional and collective work.
(346) The rest of the cuidadores were happy to receive the diploma, but they considered that their accountability would come from their practice.
(347) I handled the diploma to the students during a collective assembly without major rituals.
(348) After the assembly we summoned in CHTP room and discussed our intentions and further commitments.
(349) Elena, Alicia, Olga, Luz, Mundo and Elvira decided to continue.
(350) Nobody mentioned the diploma afterwards.

(351) During second CHTP period, teachers and students found out that they were raising expectations within Minoans about cuidadores' capacities to attend disease problems.
(352) Students, Manuela, Pablo and I foresaw plausible rising demands to the cuidadores. That increasingly changed CHTP to contents not directly addressing actually occurring problems in Mino.

(353) STAGE 4. THIRD TEACHING PERIOD

(354) Stage four aims were: to strengthen a self-growing environment and self-growing skills and knowledge already developed; to develop student's autonomy and self-reliance and to face community demands to the cuidadores.

(355) Third CHTP period started alongside second period. It lasted four to six months.
(356) In the middle of this period Manuela and Pablo left Mino as agreed from CHTP beginning.
(357) This period followed a fixed content programme with specific rounding contents such as pregnancy, child- care, nutritional care, first aid and other.
(358) Despite the fixed contents of this period, CHTP session dynamics was alike first and second CHTP periods dynamics.

(359) Pablo and Manuela presented the contents until the cuidadores started to merge their previous knowledge using already developed skills such as the conscious use of common sense, reasoning, discussion, linking or other.
(360) That can be exemplified through Pablo's comment about this period:

> (361) "*Our 'lectures' were introductions to what they* [the cuidadores] *were asking for... we could translate knowledge ... sessions' logic was to open the topic, then the* [cuidadores'] *questions and opinions started to emerge ... up to a point where they said more or less all what they knew, then we talked ... and look in this or that book, from here to there ... we prepared materials for them to read...*" (Tr)

(362) During fourth stage the cuidadores had little opportunity to apply new knowledge constructed from the exploration of fixed contents.
(363) They gave more attention to problems they were actually facing.
(364) Fixed contents rested time to the analysis of problems.
(365) Often the cuidadores lost track of sessions sequence.
(366) When Pablo and Manuela left Mino, sessions with techers became more difficult to program.
(367) The cuidadores started to meet by themselves and took decisions about their own self-training without our intervention.

(368) The cuidadores organised their room very much like a medical room and attended the patients differentially:

(369) Mundo used to sit behind a desk and Luz, Elvira and Olga standing besides patients.
(370) They went back to the study of presently detected problems supporting each other and continued dialogue.
(370.1) As the cuidadores went back to the study of problems of their reality, their interest raised.
(370.2) They held discussions with the aid of the small cuidadores library. During this stage, the cuidadores were critical with their cuidadores practices, contrasting them with medical practices that they kept analysing. They used to mock and laugh when making fun of possible medical responses to problems the cuidadores were facing.

(371) During Pablo, Manuela or my visits the cuidadores asked us for advice, information and written material about problems that they could not solve or proudly presented those that they had been able to solve.
(371.1) They referred also to pedagogic problems they were facing with their cuidados.
(371.2) Gradually we separated from the cuidadores not only because that was part of our self-growing teacher's role, but mainly because the cuidadores developed their own group dynamic.

(372) I consider this the end of third CHTP period.

(373) At the end of this CHTP period, Luz, Elvira, Olga and Mundo attended regularly to CHTP sessions and Alicia came from time to time.

(374) To the three CHTP periods analysed in this thesis, followed a second CHTP phase aiming to explore collective work for health development and the inclusion of local therapeutic resources. This research work is limited to first, second, third and fourth CHTP periods already described in this chapter.

(375) In box 8.6. are presented some aspects of CHTP that Pablo, Manuela and I recognised characteristic of each period.

APPENDIX 6
PROCESS INDICATORS

In this appendix I am presenting four tables where the numbered utterances of appendix five had been matched with direct process indicator. Those tables are adapted from correspondent tables presented in chapter four when conceiving this research pedagogic intervention and in chapter five when defining direct process indicator. Those tables are:

A. Evidence of process indicator 1. Emancipatory syllabus
B. Evidence of process indicator 2. Teachers' characteristics
C. Evidence of process indicator 3. CHTP self-growing teaching and environment
D. Evidence of indicators 4,5,6 and 7. CHTP practices aiming to dislocate habitus

A. EVIDENCE OF PROCESS INDICATOR 1. EMANCIPATORY SYLLABUS

CURRICULAR ASPECT	SELF-GROWING PEDAGOGY	STAGE 1	STAGE 2	STAGE 3	STAGE 4
1.1 STUDENTS	At least basic reading and writing skills. Attending in a voluntary basis. With a collective responsibility.	24, 26, 27, 33-36, 49-53, 84-105			
1.2 TEACHING PERSONNEL	Experts with general medical, planing, communication and research skills and knowledge. Acquainted with local context. Ideal teacher potential.	1, 2, 3, 9, 14, 15, 16, 17, 18, 21, 30, 48, 72, 78, 79	144, 145, 146-170, 211	221 13, 221 15	
1.3 SETTING	Student's	8, 10, 23, 24, 45, 74, 78, 79	110, 113-117, 119-120, 125-127, 128-131, 186-194, 207-209, 214-216	214-216, 223-225, 237, 242-265, 272-285, 288-294, 295-296, 298-305, 311-316, 317-320, 321-323	354
1.4 CONTEXT	Collective. Non-institutional	8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 24, 27, 29	113-117, 145 1-145 2	231-236, 237, 238-239, 242-265, 267-270, 272-285, 317-320, 344-345	354
2.1 KNOWLEDGE EMPHASIS	Tools to translate. Tools to construct meaningful knowledge.	21, 56	125-127, 128-131, 146-170, 172-176, 177-181, 182-185, 186-194, 195-202	214-216, 324-327, 329-330	358-361
2.2 SOURCE OF KNOWLEDGE	Common sense. Popular knowledge. Expert knowledge. Institutionalised knowledge	3	128-131, 137-140, 141-142, 146-147, 171, 182-185, 186-194, 195-202	298-305, 317-320, 324-327, 336-338	358-361, 367, 370-371
2.3 USES OF KNOWLEDGE	To solve problems. To critically analyse subjective and objective world. Change.		128-131, 137-140, 141-142, 182-185, 195-202, 207-209	214-216, 223-225, 231-236, 237, 242-265, 267-270, 272-285, 288-294, 295-296, 298-305, 311-316, 317-320, 321-323, 324-327, 329-330	359-361, 368-371
3.1 FOCUS	Problems and processes.	56	111, 119-120, 122-123, 128-131, 172-176, 186-194, 207-209	214-216, 223-225, 231-236, 237, 242-265, 298-305, 311-316, 317-320, 321-323, 324-327, 329-330	359-361, 367, 370-371
3.2 AIM	Set by students and teachers	56, 69, 77	110-111, 128-131, 144, 207-209	214-216, 311-316, 329-330	368-371 1

(continues...) A. EVIDENCE OF PROCESS INDICATOR 1. EMANCIPATORY SYLLABUS.

CURRICULAR ASPECT	SELF-GROWING PEDAGOGY	STAGE 1	STAGE 2	STAGE 3	STAGE 4
3.3 SYLLABUS	Contents should be decided as demanded by problem understanding. A basic set of contents used as tools.	3, 54, 56, 80	119-120, 122-123, 125-127, 128-131, 143, 144, 172- 176, 182-185, 195-202	214-216, 223-225, 231-236, 237, 242-265, 272-285, 288-294, 295-296, 298-305, 311-316, 317-320, 321-323	360, 367
3.4 POSED PROBLEMS	Exclusive Local. Consideration of local, regional and national context. Looked as a fraction of complex problems of collective relevance.	8, 9, 11, 15, 16, 17, 20	118, 122-123, 128-131, 141-142, 207-209	214-216, 223-225, 242-265, 295-296, 298-305, 311-316, 317-320, 324-327, 336-338	367, 370
3.5 METHOD	Identifying-enquiring-practice-circulation	53-56	125-127, 128-131, 141-142, 203-205, 207-209	214-216, 223-225, 242-265, 295-296, 298-305, 311-316, 317-320, 324-327, 336-338	367, 370
3.6 LEARNING PROCESS	Reflection, contrasting.	74	119-120. 125-127, 141-142, 143, 146-170, 172-176, 186-194, 195-202, 207-9	223-225, 295-296, 297, 298-305, 311-316, 321-323, 324-327, 339-340	359-361, 370
3.7 LEARNING *LOCUS*	Collective	56, 67, 74	111, 141-142, 145.1-145.2, 146-170, 172-176, 182-185, 186-194, 195-202, 203-205, 207-209	223-225, 237, 288-294, 311-316, 321-323, 324-327	367, 370.1
3.8 COGNITIVE PROCESS	Linking. Categorising Integrated codes.	53-56	119-120, 141-142, 172-176, 182-185, 186-194, 207-209	295-296, 298-305, 339-340	359-361, 367, 370-370.2
4.1 VALIDATION	Contrasting with reality Collective and peer recognition.	52a	125-127, 128-131, 141-142, 186.1	214-216, 223-225, 231-236, 237, 242-265, 272-285, 286, 288-294, 295-296, 298-305, 311-316, 339-340	359-361, 367, 370-370.2
4.2 CERTIFICATION	Collective recognition.	56		311-316, 342-343, 344-345	
4.3 SYMBOLIC VALUE	Satisfaction Recognition	52a	128-131, 145.1-145.2, 177-181, 194	214-216, 223-225, 237, 242-265, 286, 288-294, 297, 298-305, 311-316, 339-340, 346-350	367, 370.2-371
4.4 MATERIAL VALUE	Tool to ease collective problems.	55-56	128-131	214-216, 223-225, 231-236, 237, 242-265, 267-270, 272-285, 286, 288-294, 297, 298-305, 311-316, 346-350	367, 370-371

B. EVIDENCE OF PROCESS INDICATOR 2. TEACHER'S CHARACTERISTICS

TEACHER'S CHARACTERISTICS	STAGE 1	STAGE 2	STAGE 3	STAGE 4
Self-growing subject	v, 2-3, 19, 21	144, 145, 207-209	221.13-221.15	
Person with hope, faith and humility	19, 21	144, 145, 207-209	221.13-221.15	371.2
Performs group- commanded tasks.	3, 69	144, 145, 146-170, 203-205, 207-209, 221.13-221.15	214-216, 221.13-221.15	371-371.2
Understands role tasks.	V	144, 145, 146-170, 203-205, 207-209, 221.13-221.15	221.13-221.15, 311-316, 324-327	359-361, 371.2
Interchanges role with students.	4	203-205	311-316, 329-330	359-361
Is a mirror and an interpreter.	4, 45, 69	119-120, 144-170, 172-176, 182-205	223-225, 231-236, 267-270	371-371.2
Is a group companion and advisor when required.		119-120, 125-127, 128-131, 144, 146-170, 172-176, 182-185, 186-194, 195-202, 203-205	223-225, 231-236, 267-270, 311-316, 324-327, 337-338	359-361, 371.2
Triggers processes and conducts them.	2, 31, 45	109, 119-120, 122-123, 125-127, 128-131, 132-136, 141-142, 143, 144, 145, 146-170, 172-176, 182-185, 186-194, 195-202, 203-205	231-236, 267-270, 311-317, 324-327, 329-330, 337-338, 371	359-361
Creatively identifies necessary knowledge contents to approach problems of Mino's health reality	2, 54, 81	119-120, 122-123, 128-131, 143, 144, 145, 177-181, 182-185	311-316, 329-330	359-361
Designs self-growing activities and teaching aids.	30, 45, 67, 81	125-127, 128-131, 132-136, 143, 144, 145, 146-170, 172-176, 177-181, 182-185, 186-194, 195-202, 203-205, 211	311-316, 324-327, 337-338	359-361
Seeks problem identification, inquiring and action over problems of reality.	81	119-120, 128-131, 143	223-225, 267-270, 311-316, 337-338	359-361
Seeks knowledge circulation through dialogic processes of discussion and study.	56	119-120, 125-127, 128-131, 13-136, 141-142, 143, 144, 146-170, 172-176, 177-181, 182-185, 186-194, 195-202	223-225, 311-316, 324-327, 329-330	359-361

C. EVIDENCE OF PROCESS INDICATOR 3. CHTP SELF-GROWING TEACHING AND ENVIRONMENT

CHTP SELF-GROWING TEACHING AND ENVIRONMENT	STAGE 1	STAGE 2	STAGE 3	STAGE 4
A recognised finality set by the student	56	111, 144-145.2, 172-176, 182-185, 207-209	214-216, 223-225, 231236, 237, 267-270, 272-285	363, 367, 370
Knowledge available and accessible for free students use.	2	143, 146-170, 171, 172-176, 177-181, 182-185, 186-194, 195-202	214-216, 223-225, 336-338, 339-344*	359-361
Problems of reality brought about and shaped by students.		111, 119-120, 125-127, 128-131, 143, 172-176, 207-209, 214-216	223-225, 231-236, 237, 242-265, 295-296, 297, 298-305, 321-323	370-371.2
Adapting of teaching and students roles to self-growing education.	2, 3, 45, 54, 69	128-131, 132-136, 143, 144, 145, 171, 172-176, 182-185, 186-194, 195-202, 203-205	223-225, 311-316, 324-327, 329-330, 336-338	359-361, 371.2
Identification, understanding and giving practical response to body inscriptions of restricted wealth access		132-136, 137-140, 141-142, 207-209	214-216, 223-225, 231-236, 237, 242-265, 267-270, 272-285, 288-294, 295-296, 298-305, 317-320, 328	363, 371
Dialogue between participants	3, 45, 46, 56, 69, 71	111, 128-131, 141-142, 144, 177-181, 182-185	221.13-221.15, 223-225, 231-236, 237, 267-270	359-361
A pedagogic environment, which enables reflective confrontation with reality and decision taking	69, 70, 71, 75	125-127, 128-131, 132-136, 141-142, 143, 177-181, 186.1, 207-209	214-216, 221.13-221.15, 223-225, 231-236, 237, 242-265, 267-270, 288-294, 311-316, 321-321, 324-327, 336-338, 346-350	359-361, 371
A collective multi-focal basis	71	111, 122-123, 128-131, 132-136, 143, 146-170	223-225, 231-236, 237, 238-239, 242-265, 267-270, 272-285, 288-294, 295-296, 311-316, 317-320, 321-323, 328, 336-338	370.1
A differentiated pace according to student's and group characteristics and needs	30, 54, 56	144, 171, 172-176	288-294, 298-305, 311-316, 324-327, 331-332, 339-340	370.1
The possibility of peer, non-sanctioning interlocutor and conscious symbolic violence avoidance or awareness	4, 42-44, 45, 46, 69, 71	144, 146-170, 182-185, 203-205	223-225, 242-265, 298-305, 324-327, 331-332, 339-340	370-370.2
Certainty of knowledge worthiness		172-176, 177-181, 182-185, 186-194, 195-202	223-225, 237, 242-265, 272-285, 288-299, 298-305, 317-320, 321-323, 324-327	371
Emotion and motivation when discovering knowledge		144, 145, 172-6, 182-185,, 186-194, 195-202, 203-205	214-216, 221.13-221.15, 223-225, 242-265, 298-305, 324-327, 331-332, 339-340	
Satisfaction when using newly acquired or constructed knowledge to understand or solve a specific individual or collective problem.		172-176, 186-194, 195-202	214-216, 221.2-221.3, 223-225, 237, 242-265, 288-294, 297, 298-305, 311-316, 331-332, 339-340	

D. EVIDENCE OF PROCESS INDICATORS 4,5,6 AND 7. CHTP PRACTICES AIMING TO DISLOCATE HABITUS

CHTP PRACTICES	STAGE 1	STAGE 2	STAGE 3	STAGE 4
PROCESS INDICATOR 4. CULTURAL CAPITAL (CC)				
Develop an account of Mino's CC by pooling knowledge recreated to solve specific problems and make it ready to be used and further **developed by the social group it refers to.**		128-131, 132-136, 137-140, 141-142	221.4, 267-270, 272-285, 328	370.2
Identify 'outside' CC useful to help in problem solution and add it to **CHTP knowledge pool identifying its original source.**		141-142, 145-202	223-225, 298-305	370.2
Identify, find value and validate common sense, popular and expert knowledge through the identification and solving of reality problems.		128-131, 132-136, 141-142, 146-170, 172-176, 177-181, 182-185, 186-194, 195-202	221.4, 221.10-221.11, 223-225, 226-229, 242-265, 272-285, 288-294, 297, 298-305, 311-**316, 317-320, 321-323, 324-327**	367-370.2
PROCESS INDICATOR 5. CULTURAL ARBITRARINESS				
Systematically develop awareness about what kind of CC is being used to solve problems.		128-131, 132-136, 141-142, 146-170, 172-176, **177-181, 182-185, 186-194, 195-202**	221.1-221.9, 226-229, 298-305, 311-**316, 324-327, 329-330**	
Systematically test CC against efficiency in problem solving.		128-131, 172-176, 186-194, 195-202	223-225, 226-229, 288-294, 295-296, 297, 298-305, 311-316, 317-320, 324-**327**	
Identify truthfulness and source of CC.		128-131,	221.4-221.11	
Identify procedures of knowledge construction and validation		**128-131, 172-176, 177-1181, 182-185, 186-194**	**221-5-221.11, 324-327, 337-338**	
Continuously make a 'catalogue' revision to delete non-validated knowledge and incorporate self constructed validated knowledge.		186.1, 221.5-221.8, 221.9	221.5-221.9, 272-285	
Reveal the 'un-natural of the natural'.		132-136, 186.1, 202-205	221.4-221.9, 223-225, 242-265, 298-305, 329-330, 337-**338**	
Identify symbolic violence in doctor/patient and teacher/student relations	2, 40, 42, 43, 45	177-181, 186.1, 202-205, 221.9	226-229, 242-265	

(continues...) **D. EVIDENCE OF PROCESS INDICATORS 4,5,6 AND 7. CHTP PRACTICES AIMING TO DISLOCATE HABITUS**

CHTP PRACTICES	STAGE 1	STAGE 2	STAGE 3	STAGE 4
PROCESS INDICATOR 6. HABITUS				
Systematic self and collective reflective work about habitus, medical habitus, how a person can turn into arbitrariness agency and **health and medical discourse and texts.**	21, 25	132-136, 177-181, 186.1, 202-205	221.5-221.11, 226-229, 231-236, 237, 242-265, 298-305, 321-323, 324-327, 329-330, 344-345	371.2
Continuous work framing and contrasting with local reality and original purpose.		128-131, 132-136, 141-142, 177-181	221.9-221.11, 223-225, 231-236, 237, 242-265, 267-270, 272-285, 288-294, 295-296, 298-305, 311-316, 317-320, **321-323, 344-350.**	364-367
Systematic identification of the possible and the feasible.		128-131	231-237, 242-270, 272-285, 288-296, **298-305, 311-323, 344-345, 346-350**	
Circulation of findings and knowledge.		128-131, 144-145.2	272-285, 317-320, **328, 337-338**	
PROCESS INDICATOR 7. FIELD				
Identification of the medical field.	21, 25	132-136, 141-142, 186.1, 202-205	221.5-221.9, 223-237, 242-265, 272-285, 298-305, 314-**315, 321-327**	371.2
Identification of the 'culture of the patient'.		132-136, 186.1, 202-205	221.1-221.8, 223-229, 231-237, 242-**265**	
Analysing others attitude when faced with an 'inpatient patient' who knows about his/her ailment.		226-228	223-229, 231-236	
Taking and analysing testimonies.		177-181, 222-229, 305	**223-229, 298-305, 317-323**	
Identifying the different health facades and their interrelation.	25	141-142, 186.1, 221.5-221.8	221.5-221.8, 221.16, 226-229, 231-237, 242-265, 267-270, 272-285, 288-294, 295-296, 298-305, **311-323, 337-338**	
Identification, comparing and contrasting of health institutions and media transmitted health-related texts and discourses.		177-181	221.9, 226-229, 242-265, 311-316, 321-323, 344-345	
Identification and analysis of local health practitioner's discourses and **texts and local health practices.**		141-142, 186.1	221.10-221.11	

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