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Health Care and Human Dignity

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BEFORE AND BEYOND OBJECTIVES AND GOALS: THE VISION

Summary:

It is not the stated goals and objectives of a community programme that make it vital or viable - but rather the vision, unwritten and evolving, shared by the members of the programme and community as they change and evolve together.

In the planning and evaluation of health programmes, often a great deal of discussion is devoted to "objectives" and "goals." Goals tend to be more general, objectives more specific, but both are — or, it is commonly agreed, should be — clearly defined. They become the fixed landmarks towards which the ship sets sail.

But there is something bigger and more subjective that precedes objectives and goals and that contributes to both their formulation and the strategy of their pursuit. This is the dream of where we would like to go: the vision.

The difference is figuratively — and too often literally — a matter of life and death. Goals and objectives lie "out there," fixed and defined. They are static, like rocks or ports. But a vision is boundless, fluid and evolving. It is both inside us and beyond us. It is the human response of past and present trailing into the future and beyond. It can be noble or selfish, and is often a mixture of both. It cannot be objectified or tied down in time and space. It changes and grows constantly. It soars!

This may sound very abstract and philosophical, scarcely meat for a ministry of health. Yet such considerations are ultimately pragmatic. For it is the vision of man that shapes and distorts his "objective" choices — and which leads him to both his gas chambers and cathedrals.

— Does it mean "fertility control" through payment of women to take (or pretend to take) the pill, and raids by "health police" to sterilize women and adolescent boys by force to meet required quotas (as we know is happening)?... Or does it mean facilitating social and political changes that will permit the poor to improve their economic base and so discover for themselves — as have the rich — the benefits of a small family?

— Does it mean modifying (yet preserving) a social order that produces increasingly poor health among the rich as it perpetuates poor health among the poor, because it is fundamentally unfair and corrupt?... Or does it mean working together toward a new social order that is sensible, just, and kind?

— Does it mean preserving our "human right" and inalienable "freedom" to exercise unlimited greed while one third of mankind goes hungry?... Or does it mean struggling to overcome human selfishness through human understanding and love?

— Does it obstruct, or does it open the way, for more equitable distribution of power?

Whether the vision of those behind a government or community health programme is the shared vision of many or the elite vision of a few, whether it is basically authoritarian or humanitarian, will have a lot more to do with the practical reality of the programme than will its stated goals and objectives.

The World Health Organization (WHO) has set as its overall goal "the provision of basic health care to all the world's people by the year 2000."

An admirable goal — or a frightening one! — depending on how it is interpreted and by whom. As has already been demonstrated, it means radically different things to different people.

— Does it mean extending our existing professionally controlled, centralized and stiflingly paternalistic health services to "penetrate" the "target" populations of poverty?... Or does it mean working to change the socio-politico-economic structure that perpetuates poverty, hunger, and ill health?

— Does it mean increasing the dependency of the poor on existing institutions that would keep them both poor and powerless?... Or does it mean helping the poor to organize at the family and community level to take greater control over their lives and health?

David Werner

HEALTH CARE AND HUMAN DIGNITY – A SUBJECTIVE LOOK AT COMMUNITY-BASED RURAL HEALTH PROGRAMMES IN LATIN AMERICA*

by David Werner

Permit me to begin with an apology. I am not a medical professional. My experience lies in grassroots medicine in Latin America. For the past eleven years, I have been involved in helping foster a primary health care network, run by villagers themselves, in a remote mountainous sector of western Mexico.

During the past year, a number of my coworkers and I have visited and studied nearly forty rural health projects, both government and private, throughout Central America and northern South America (Mexico, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica, Ecuador, Colombia and Venezuela). Our objective in visiting these different village health programmes has been to help foster a dialogue among the various groups, as well as to try to draw together many respective experiences, insights, methods and problems into a sort of field guide for health planners, so that we can all learn from one another's experience.

I would like, on this occasion, to look at rural communities, and to explore with you the ways in which existing health programmes help either to cripple communities or to make them whole.

The idea of a health care project or programme being a crippling force may come as a surprise. Yet, as I will try to clarify, to whatever extent a village health care service creates a one-way dependency on outside resources and directives, it becomes a crippler as well as a crutch to the community.

In Latin America, as elsewhere, modern medicine has been a two-edged sword. Not long ago, there were countless remote villages that, for better or for worse, stood on their own. They had their own medicine men, midwives, bone-setters, tooth-pullers, psychic healers and priests. Life in these villages was at times hard and at times gentle, at times long, too often brief, but it was fairly much in balance. The village community was a more or less complete entity, largely self-sufficient with the pride, integration and dignity that come from self-reliance and self-direction. Then came that new magic, that new mystique – Western Medicine – with its esoteric priesthood of university-trained practitioners. Their renown and their wonder drugs, if not their physical presence, quickly spread to the most remote jungles and mountain valleys. In spite of attempts by the medical profession to legally sanctify its stronghold over prescription drugs, a clandestine market sprang up. Soon, folk healers, bone-setters, midwives and mothers had added antibiotics, oxytocics and a range of other pharmaceutics to their gamut of herbs and home remedies. A new breed of "modern" folk healer, the *medico practicante,* or empirical doctor, arose, assuming in the villages the same role of self-made diagnostician and prescriber-of-drugs that the neighbourhood pharmacist has assumed in the larger towns and cities. The magic of the injection held special power over people's imagination, and soon nearly every remote village had its *inyectadoras* or women who inject.

Needless to say, the abuse and misuse of modern medications by this army of empirical healers have been enormous (as, in fact, have been the misuse and overuse by the medical profession itself!). Yet the net impact on morbidity and mortality has been, at least from a short-sighted perspective, positive. With the introduction of antibiotics, antiparasiticals, and to a lesser extent, vaccines, fewer children have died of infectious disease. As the population has correspondingly increased, the crippling impact of malnutrition has gone forth and multiplied. Under the growing pressures of population, the inequities

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of land tenure and distribution of wealth have become more oppressive. As a result, rural communities which once were self-sufficient and proud have come to depend more and more on outside help: for medication, for food supplements, for education, and — most demeaning of all — for values and direction. In response to the growing plight of rural populations, the political/economic powers-that-be have assumed an increasingly paternalistic stand, under which the rural poor have become the politically voiceless recipients of both aid and exploitation.

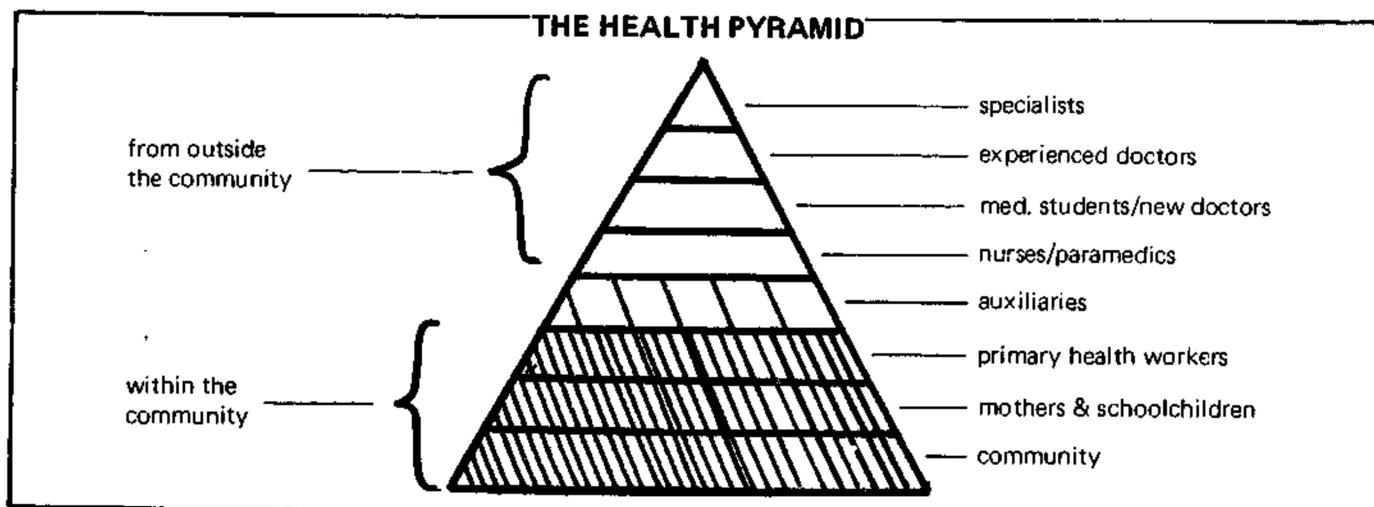
This state of concomitant *aid and exploitation* still dominates the health care picture in much of Latin America today, as it does in many parts of the world. The medical empire has geared its services, its medicines and its hardware (even its textbooks) to such tremendous profits that it has, in large part, priced itself out of reach of the majority of the people, thus making subsidized services the only obvious alternative. Compounding this dependence on charity is the fact that, in Latin America, the professionals, although rarely willing to serve communities where the needs are greatest or to work for an income that will truly serve rather than bleed such communities, have been notoriously reluctant to share their knowledge or rights-to-practice with members of these communities who are eager to learn and who would willingly serve their people's health needs, voluntarily or for modest remuneration.

When we asked the pioneers of rural health programmes we visited in Latin America what they saw as the major obstacles to bringing effective health care to the people, the most common replies were "doctors" and "politics".

However, over the past decade, a change has been underway. There has been a general awakening, or at least the beginnings of an awakening, to the need for a more realistic, more truly equitable approach to health care. The trends which have been taking place in this recent renaissance of health care are summarized in Outline 1.

The overall trend, at least in theory, is from a fragmentary to a wholistic approach to health care. It involves a shift from providing high-cost curative services to a select few, to providing low-cost preventive and curative care to as many of the people as possible and, ideally, to all. To do this, the concept of the health "team", or skills pyramid, has been introduced, of which the basic work force is composed of local, modestly-trained village health workers, often referred to as *promotores de salud* (health promoters). In some programmes, the base level of the health team or pyramid is considered to be composed of mothers and schoolchildren — whose collaboration as health workers is fundamental — or the base line of the health team may, and I think should, be regarded as the community itself.

Perhaps one of the most important trends, but one we found actually happening in relatively few areas, is the effort to have more and more of the skills pyramid filled by local members of the rural community, and progressively less by outsiders. One programme in eastern Ecuador, working with the Shuar Indians, has set its goal to eventually replace all its field professionals — nurses, doctors, veterinarians, agronomists and even legal counselors — with persons from the Shuar villages. The programme is providing the necessary scholarships and encouragement. Whether or not the chosen few, once they get their degrees, will return to their villages and work for the modest earnings the communities can afford, is yet to be seen. Unfortunately, our formal education systems do far more to wean people away from the rural environment than to prepare them for staying there. New ways need to be explored, and new education opportunities designed, which will allow villagers to



substantially increase their technical knowledge and skills *without* tearing them away from their communities.

As is indicated in Outline 1 under "Focus of Action", there has, of course, been a trend in rural health care not only from curative towards preventive medicine, but, by taking into account the causes behind the causes of poor health, towards the integration of health care with other aspects of community development. Hence, the most recent trend is now to include health care as but one sector of an Integrated Development Programme which also covers education, community leadership, agricultural extension, communications and marketing improvements, intermediate technology, etc. In fact, some of the most exciting work we saw, with the greatest impact on the health and vitality of the communities involved, had its major thrust in agricultural extension rather than on health care *per se*. In one programme in Guatemala, sponsored by Oxfam and World Neighbors and focusing on agriculture, the resultant increase in food production has not only directly improved the nutrition and health of the people, but has generated an income which has permitted the community to cover costs of other improvements rather than be dependent on outside help.

If integrated development is to be taken seriously, and if a programme is really trying to confront the underlying issues which affect the health, well-being and future of a given people, it must, of course, take into consideration the sociopolitical situation, including the debilitating influence of paternalism and exploitation. Such considerations have led some rural health projects to work through group dynamics to promote *conscientization* or social awareness and to become involved with land and social reform. However, many of the groups we visited in Latin America would have nothing at all to do with such politically "hot" issues, either because they didn't dare to, or because, for obvious reasons, they didn't care to.

However, even if a programme does not touch upon issues of land reform or social justice, even if it does not hold discussion groups to encourage *conscientization*, if it is truly trying to help the community stand on its own feet, issues of social injustice and land inequity will eventually come up, if indeed they are limiting factors to people's well-being. This can be a serious consideration in nations where 10% of the populace owns 90% of the land and wealth. And it can be a serious consideration for foreign or international health and development agencies.

Perhaps the key question, then, is whether the outside agent-of-change, or sponsor – be it a private, religious or government group, be it domestic, foreign or international – really wants, or can afford, to allow rural communities to have substantial choice, or voice, in matters of their own well-being.

As is indicated at the bottom of Outline 1, another of the recent trends in rural health care has been a shift from many small pilot projects operating in circumscribed geographic areas, to large regional or even national programmes. Many of the early attempts at community-based health care, including the training of village health workers and cooperation with traditional midwives, were launched by private or religious groups, many of them "expatriate" (American, Canadian, British, German, etc.). Throughout Latin America, there has been a proliferation of these "pilot projects", some of them successful and enduring, others appearing and disappearing, here and there, like fireflies. Often there has been a lack of communication even between nearby projects, and sometimes a not-so-healthy competition. However, some of the most exciting and effective community activity we observed is being fostered by small non-government projects. One of the key questions today is *if* and *how* such activity can be replicated to reach more people. As a foreign consultant in El Salvador puts it, "We've had enough pilot projects. It's time we stopped reinventing the wheel and got busy helping it to roll! "

And so we find that on the heels of the many private and religious projects, and sometimes nipping at their heels, has come a wave of regional or national programmes administered by respective ministries of health. Today, nearly all the countries of Central and South America are engaged in launching or expanding "community-oriented" rural health programmes incorporating the use of marginally-trained health workers and the so-called "control" of traditional midwives.

Surprising similarities exist in the format and structural details of many of these different government health programmes; surprising until one realizes that nearly all of them are aided and monitored by the same small complex of foreign and international agencies: WHO/PAHO, AID, IDRC, IDB, UNICEF, FAO, Millbank Foundation, Rockefeller Foundation, Kellogg Foundation, etc. Often, a single health or integrated development programme will have financial or advisory input from as many as three or four of the above agencies or foundations.

An entire jargon has evolved for those who are "hip" on community-based rural health care. From country to country, one hears identical motifs, e.g.: "Primary decision making by the members of the community", "Response to the felt needs of the community", "The primary health worker chosen by the members of her community", "Priorities must be determined by the community itself". The ideas behind these axioms are, of course, fundamen-

tal. But, too often, they are as foreign to the communities they are aimed at as to the health ministries on which they have been superimposed. If there were a little less rhetoric behind these slogans and a little more reality, the state of rural health care in Latin America might be far better off than it is today.

In our travels through Latin America, we were struck by the fact that often the policies or activities of the many different health programmes we visited tended to fall somewhere along a continuum between two diametrically opposing poles:

1. **Community-supportive** programmes or functions are those which favourably influence the long-range welfare of the community, that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision making and self-reliance at the community level, and that build upon human dignity.

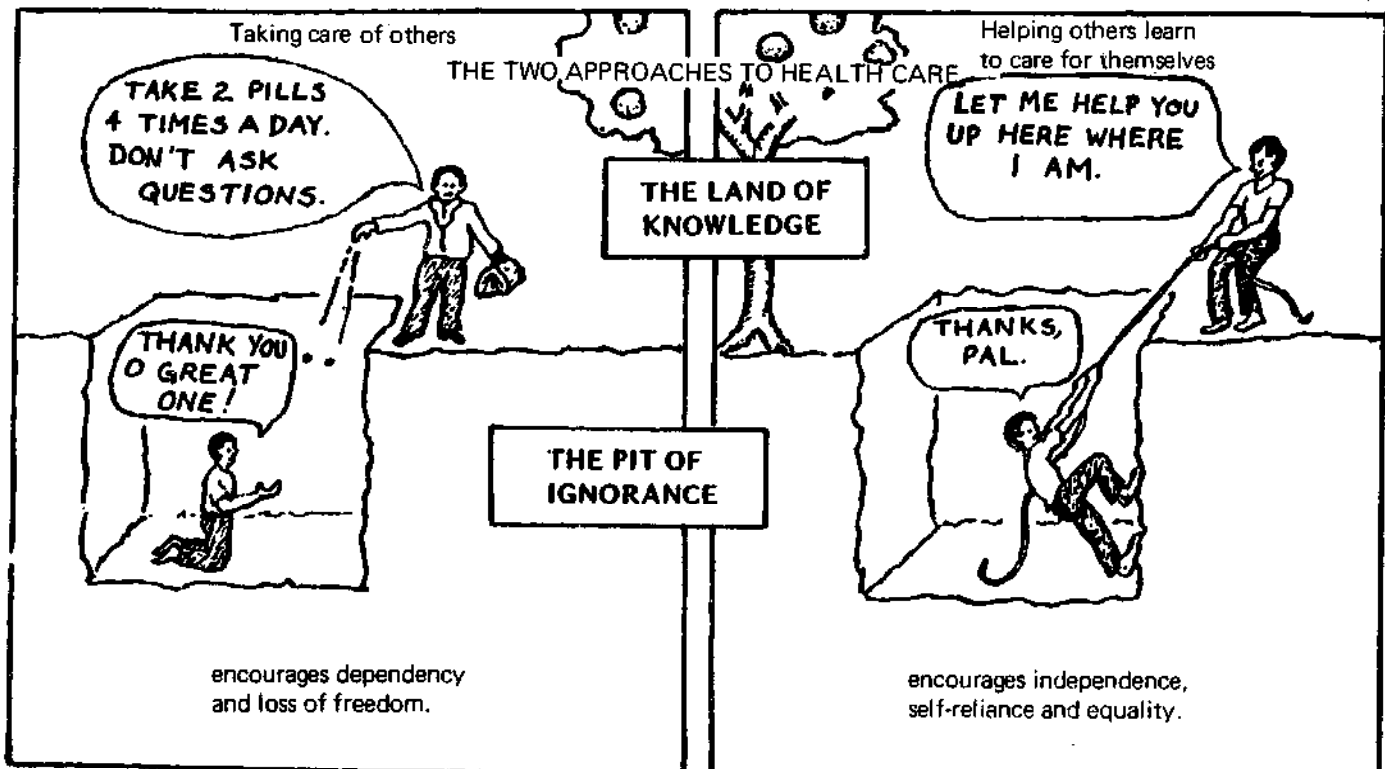
2. **Community-oppressive** programmes or functions are those which, while invariably giving lip service to the above aspects of community input, are fundamentally authoritarian, paternalistic, or are structured and carried out in such a way that they actually encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions; those which, in the long run, are crippling to the dynamics of the community.

In Outline 2, I have tried to summarize some of the various features of rural health programmes, and to point out how different approaches tend to make each feature either community-supportive or community-oppressive. I do not ask that everyone necessarily agree with me on every aspect. Often, the differences in approaches turn on "human" factors such as dignity and caring, which are hard to measure yet are, in my belief, immeasurably important. This outline, then, is intended primarily as a guide (or perhaps goad) to stimulate those involved in the planning or process of rural or periurban health care to think through each aspect of their programme and its policies in terms of what may ultimately be for the good of the community.

Needless to say, no health or development programme will explicitly profess to be community-oppressive. Nor, in any of the programmes we visited, did we encounter any in which every aspect was either oppressive or supportive. In each there was a mixture of strengths and weaknesses, as is indeed human.

However, it is interesting and, I think, somewhat disturbing, to observe that (with some notable exceptions) the programmes which, in general, we found to be more community-supportive were small, private, or at least non-government programmes, usually operating on a shoestring and with a more or less *sub rosa* status.

As for the large regional or national programmes: for all their international funding, for all their highly-trained (and highly-paid) consultants, for all their glossy bilingual brochures depicting community participation, we found that, when it came to the nitty-gritty of what was going on in the field, many of these ambitious "king-size" programmes actually had a minimum of effective community participation and a maximum of handouts, paternalism and superimposed, initiative-destroying "norms".



Perhaps the biggest challenge today concerning rural health care is: how can more people become responsibly involved in caring for their own health? Or to put it more explicitly: *How can the people-supportive features of outstanding, small, non-governmental, pilot projects be adapted for regional or country-wide outreach?*

Attempts have been made. Results have, at best, been only partially successful.

I would like to explore briefly some of the steps which are being taken, or might be taken, to implement a regional or national approach to rural health care that is genuinely community-supportive. To do this, let us focus on some of the major obstacles or limiting factors.

LIMITING FACTORS IN THE EVOLUTION OF A COMMUNITY-SUPPORTIVE HEALTH CARE SYSTEM

1. Attitudes

It has often been said, in community health work, that modifications which require changes in attitude or in the traditional way of doing things are those which are accomplished most slowly and require the most time and patience. Usually, such statements are made in reference to villagers or the marginally-educated, but, as many pioneers of health care alternatives will testify, often those whose attitudes and traditional approach are most difficult to modify are not the villagers but the professionals. Many regional or national health care programmes which "draft" young doctors or nurses find many of them unable or unwilling to adapt to working supportively with paramedics and village health workers in the rural setting. Their training not only does not prepare them for such involvement, it actively conditions them against it.

As an example, let me mention to you two classes of medical students, one first-year and one fourth-year, who were taken, on separate occasions, to visit an outstanding regional rural health programme in Costa Rica. The first-year medical students were so enthusiastic about the director's portrayal of the programme, with its "health circuses" and its community-built and -operated health posts, that they questioned him for hours and finished with a standing ovation. By contrast, the fourth-year students who visited were clearly bored, asked almost no questions, and drove back to the city as soon as they could, without even bothering to look at any of the health posts. These budding MDs seemed to feel themselves above primary care or community involvement. Their skills, and their concern, clearly related to sickness, not health!

Obviously, if doctors are to become part of a rural health team, their schooling must be radically different. It must have new content and a new set of values. Above all, it must teach the doctors-to-be that their knowledge is not sacrosanct; and that their first duty is to share it. It must help them to be humble. Some of the medical schools in Latin America are trying to work towards these changes. But many administrators and professors are still firmly set in their attitudes. It will take a long time.

2. Hazardous emphasis on safety

There seems to be a tremendous reluctance on the part of health care planners to teach or permit village health workers to do very much in the way of diagnosis and treatment of common diseases. Many programmes limit the curative role of their health workers to the symptomatic treatment of only three or four problems, such as "fever", "simple diarrhoea", "cough" and perhaps "worms". Except for aspirin and maybe piperazine, the medicines they are permitted to use have little or no clinical value. But, as is pointed out, they are "safe". Such programmes seem to ignore the fact that village stores sell to anyone over the counter a wide range of drugs — everything from chloramphenicol to vitamin B12 and pitocin — all of which are commonly used and misused by the people. Yet, because these drugs are "dangerous", the health worker is taught nothing about them: neither their uses, nor their misuses, nor their risks. Hence, the popular rampant abuse of drugs continues unabated. What is more, the village workers' trivial knowledge of medicine, in a community where many medicines are widely used, reduces the people's respect for them and makes them less effective, even in preventive measures. We found that, in villages with these insignificantly-trained health workers, far more people still used the services of *médicos practicantes* — or self-made medics — than sought assistance from the official health workers.

In Colombia, a health officer told us of a village worker, or *promotora,* who, at a time when the rivers were in flood and all transportation was cut off, was called to see a child with acute pneumonia. The health worker desperately thumbed through her official Manual of Norms. But the only instruction under "Fever with cough and difficulty breathing"* was "Refer patient to doctor". This being impossible at the time, she referred the sick child to the local shopkeeper, who at once injected the youngster with penicillin. Fortunately, the child responded.

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* The designers of the Manual of Norms had carefully avoided "difficult scientific terminology" like *pneumonia,* apparently unaware that this and many other medical names for diseases are a standard part of village vocabulary. Such inappropriate oversimplification is common to many of these official manuals.

I asked the health officer if perhaps *promotores* working in such isolated areas should not be taught something about pneumonia and the use of penicillin, or at least be given a simple reference book where they could look such things up. She replied that, officially, the health department's policy was that *promotores* administer antibiotics only with a doctor's prescription . . . and that it would "not be good for them" to have a reference book explaining things "outside their norms".

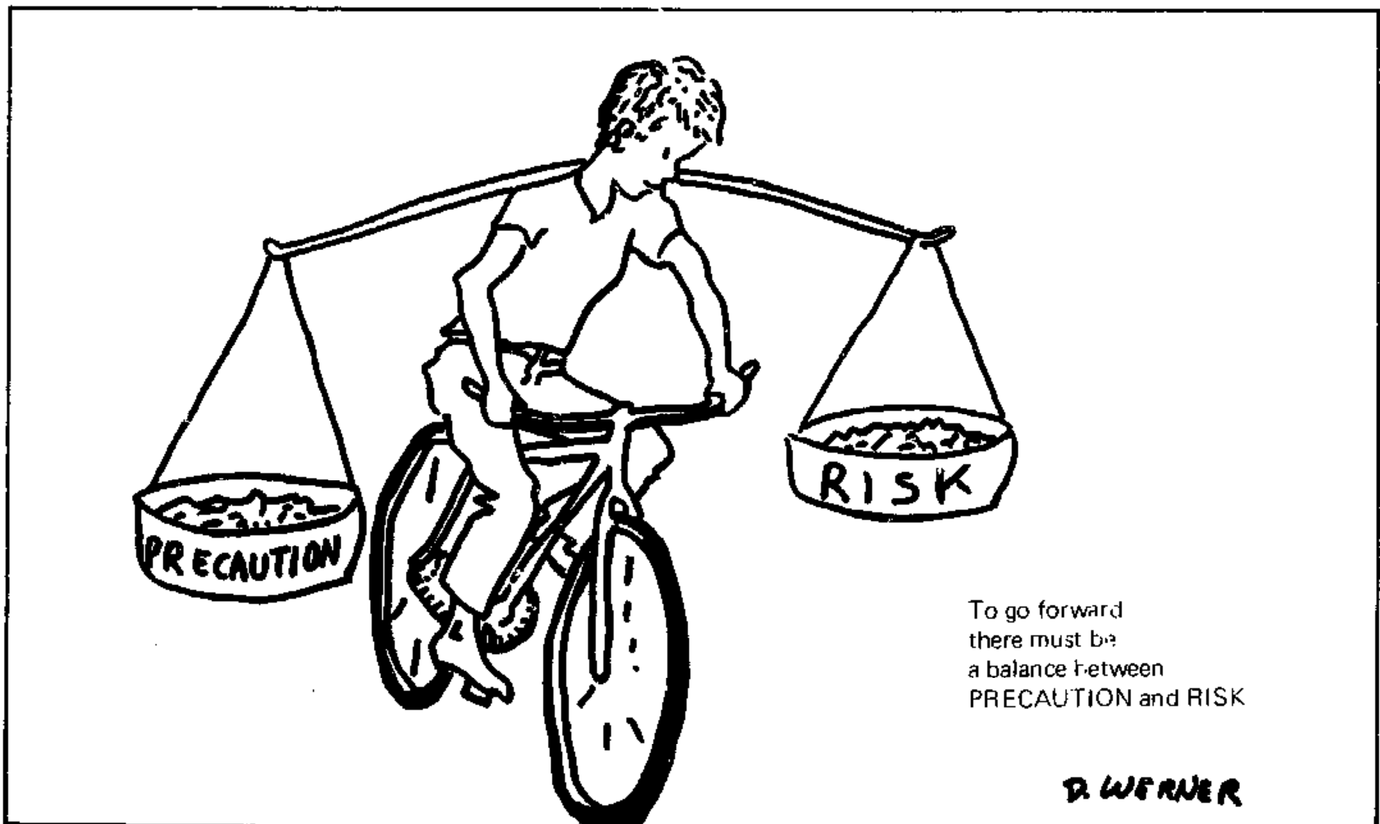
To give another example, in many programmes we found that, although village health workers were perhaps taught how to attend a normal childbirth, in the case of postpartum haemorrhage, their only instruction was, once again, to refer the patient to a doctor. Both uterine massage and use of ergotamine were considered "too risky". For health workers living hours or days away from health centres, such political over-precaution could, and surely has, cost many lives.

Basically, what we often found lacking on the part of the planners of these large health programmes was a realistic perception of what really goes on in the villages. Time and again, we found that primary health workers were taught and permitted to do far less medically than the villagers were already doing for themselves. By contrast, many of the leaders of smaller non-governmental health projects seemed to have a much better comprehension of village life, as well as greater appreciation for the ability and potential of their primary health workers. While helping their *promotores* recognize and work within their limitations, they trained them in a far wider range of skills. As a result, the health workers in these programmes were more challenged, worked with greater pride and enthusiasm, and, because of their wider knowledge and skill, had the fuller confidence of their people.

A programme which is truly community-supportive, it would seem, must help and encourage both the village health workers and their communities to learn and function to their full human potential. To do this, of course, involves certain risks. I refer to risks for programme management rather than for patients. Patient risk, in many cases, is actually reduced by giving non-professionals greater medical responsibility. But to verify this, programme planners and officials must be willing to stick their necks out, to risk the slings and arrows of an outraged medical monopoly. Risk must, of course, be balanced with precaution. Yet programmes which are top-heavy with precautions get nowhere.

3. Bureaucracy

Bureaucracy is the hobgoblin of giant programmes! Red tape, excess paperwork, waste motion, wasted money, inefficiency, poor communications and, ultimately, graft and corruption seem to inevitably enter into the picture when operations get too big (or, as one programme leader in Honduras describes it, when the superstructure overpowers the infrastructure). The very large regional or national programmes we visited characteristically suffered from breakdowns in communications, supervision and supplies, sometimes to the point where health workers became totally ineffective. One internationally-acclaimed regional programme we visited in southern Mexico was so out of touch between office and village that it was still sending paychecks to a



To go forward
there must be
a balance between
PRECAUTION and RISK

community worker who, six months before, had moved to another village and was collecting another salary from the Forestry Department.

The question is, how do you regionalize or nationalize an approach to rural health care without bogging it down in bureaucracy? For the answer, which is simple but not easy, I think we might look to E.F. Schumacher,[1] and consider decentralization. In a decentralized plan, the role of the ministry of health could be to coordinate and advise rather than to control and restrict. This would be true at all the intermediate levels down to the community itself. At every level, the maximum amount of self-sufficiency and self-direction would be encouraged. This would not only decrease bureaucracy, but increase personal involvement and responsibility at every level.

4. Commercialization

In Honduras, an open-minded director of one of the regional health programmes referred us to a *curandero* or native herb doctor who was acclaimed for his healing powers. His fame for curing patients not relieved by doctors had grown to the point where he was invited to Tegucigalpa by an official of the health ministry, who asked him, among other things, why it was that with his people, modern medicine was so often ineffective. The herbalist replied, *"Porque lo han comercializada! "* — because they have commercialized it!

The problem of commercialization of health care is many-sided. It has often amused me how some of the big health programme officials, many of whom receive salaries twenty to thirty times that of the average villager, can talk to a community about how important it is that the village health worker be voluntary, working for the joy of helping others and the personal satisfaction he gains from serving his community. These officials always seem so surprised and disillusioned when they discover that a health worker has been selling medicines that are supposed to be free, or is otherwise turning his "service to the community" into a lucrative business. In truth, the health worker is merely following the example of his role model.

Here again, in certain of the smaller less formal programmes, where many of the outsiders — sometimes even the doctors — are voluntary or work for minimal wages, it somehow rings truer when people speak of service for the joy of it. In general, doctors and other professionals not only *cost* too much for rural or periurban communities, they *earn* too much to serve as role models in community health programmes which would purport to be equitable. I can see no getting around this problem until we can foster a new breed of medical practitioner, who comes from the community he will serve, and who is willing to serve his community for modest earnings.

The other side of the commercialization of medicine, namely the flagrant overpricing and false promotion of pharmaceuticals, I will only touch upon. The alarming facts are painstakingly disclosed in Milton Silverman's new publication, *The Drugging of the Americas,*[2] and in other writings. Beyond doubt, the unnecessarily high cost of critical medications is one of the major obstacles to the financial self-sufficiency of community-based health activities. Honduras and Peru have begun their own production and low-cost distribution of basic medicines. Other countries would do well to follow suit. I might also dare to suggest that, if the international health agencies really want to give a boost to developing countries, rather than hand out more free medicines, they might pressure for honest promotion and fair pricing of drugs by the multinational corporations, for amendments of drug patent laws, and for other measures to bring medicines to their users, not free, but at a price nearer the cost production. (In case anyone thinks this would make a small difference, I might mention that in Colombia the hidden profits on Valium, for instance, have run as high as 6000 percent).[3]

The commercialization of medicine, and the legitimized exploitation of people by other people can perhaps be dealt with only through major social change. Yet these problems do exist and can no longer be ignored. Equitable health care at the village level will surely remain a pipe dream in countries where medicine as a whole continues to be such a flagrantly profitable institution.

5. Politics

I have already mentioned that politics are considered by many to be one of the major obstacles to a community-supportive programme. This can be as true for village politics as for national politics. However, the politico-economic structure of the country must necessarily influence the extent to which its rural health programme is community-supportive or not.

Let us consider the implications in the training and function of a primary health worker. If the village health worker is taught a respectable range of skills, if he is encouraged to think, to take initiative and to keep learning on his own, if his judgement is respected, if his limits are determined by what he knows and can do, if his supervision is supportive and educational, chances are he will work with energy and dedication, will make a major contribution to his community and will win his people's confidence and love. His example will serve as a role model to his neighbours, that they too can learn new skills and assume new responsibilities, that self-improvement is possible. Thus, the village health worker becomes an internal agent-of-change, not only for health care, but for the awakening of his people to their human potential . . . and ultimately to their human rights.

In countries where social and land reforms are sorely needed, where oppression of the poor and gross disparity of wealth is taken for granted, it is possible that the health worker I have just described knows and does and thinks too much. Such men are dangerous! They are the germ of social change.

So we find, in certain programmes, a different breed of village health worker is being moulded . . . one who is taught a pathetically limited range of skills, who is trained not to think, but to follow a list of very specific instructions or "norms", who has a neat uniform, a handsome diploma and who works in a standardized cement block health post, whose supervision is restrictive and whose limitations are rigidly predefined. Such a health worker has a limited impact on the health, and even less on the growth of his community. He spends much of his time filling out forms.

I would not like to assert that there are necessarily political motivations behind the shaping of either one or the other of these two types of health workers. Perhaps there are other reasons why national and regional programmes so often generate the second, more subservient type, hemmed in by norms and forms. Nevertheless, governments in countries with enormous inequities in land ownership, earnings and wealth must necessarily think twice before backing, or even tolerating, rural health or development projects that are community-supportive in the fullest sense.

I'm afraid I don't have any easy answers to the problems of politics. Yet political factors do influence both health and health care in ways we can ill afford to ignore. I would strongly recommend that those agencies, foundations and individuals that are truly interested in the well-being of people take a careful look at some of the recent trends in health care, and what is really going on.

Before closing, I would like to summarize a few of the steps that are now being taken, or might be taken, to implement a regional or country-wide approach to rural (or periurban) health care which is more genuinely community-supportive.

1. Decentralization. This means relative autonomy at every level. Advice and coordination from the top. Planning and self-direction from the bottom.

2. Greater self-sufficiency at the community level. This is, of course, implicit in decentralization. The more a community itself can carry the weight of its own health activities, both in cost and personnel, the less paralyzed it will be by breakdowns in supply and communications from the parent agency.

3. Open-ended planning. For all the talk about "primary decision making by the community", too often a programme's objectives and plans have been meticulously formulated long before the recipient communities have been consulted. If the people's felt needs are truly to be taken into account, programme plans must be open-ended and flexible. It is essential that field workers and representatives from the communities — not just top officials — attend and actively participate in policy planning and policy changing sessions.

4. Allowance for variation and growth. If a programme is to evolve, alternatives must be tried and compared. Substantial arrangements for conceiving and testing new approaches, methods and points of view should be built into the ongoing programme. Also, private or non-governmental projects should be observed and learned from, not forced to conform or stamped out.

5. Planned obsolescence of outside input. If self-sufficiency at the community level is indeed to be considered a goal, it is advisable that a cut-off date for external help be set from the first. All input of funds, materials and personnel should be conscientiously directed towards reaching the earliest possible date when such assistance is no longer needed. Thus, the outsider's or agent-of-change's first job, whether he/she be a medic or an agronomist, should be to teach local persons to take his/her place and, in so doing, make him/herself dispensible. Outside funding, likewise, should not underwrite ongoing activity, but should be in the form of "seed" money or loans to help launch undertakings which will subsequently carry their own ongoing costs.

6. Deprofessionalization and deinstitutionalization. We have got to get away from the idea that health care is something to be delivered. Primarily, it should not be *delivered*, but *encouraged*. Obviously, there are some aspects of medicine which will always require professional help, but these could be far fewer than is usually supposed. Most of the common health problems could be handled earlier and often better by informed people in their own homes. Health care will only become truly equitable to the extent that there is less dependency on professional or institutionalized help and more *mutual self-care*. This means more training, involvement and responsibility for and by the people themselves. It should include continuing education opportunities for villagers which reinforce their staying in, and serving, their communities.

7. More curative medicine. For a long time, health care experts have been pushing for more preventive medicine at the village level, and with good reason. But too often, this has been used as a convenient excuse to keep curative medicine completely — or almost completely — in professional hands. Clearly, preventive measures are basic. However, the villagers' felt needs have consistently been for curative measures (to heal the sick child, for

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In the town of Chimbote, Peru, a social promotion group of women learn skill of practical everyday use and discuss how to improve their lives and environment.

instance). If primary health workers are to gain the respect and confidence of their people, they must be trained and permitted to diagnose and treat more of the common problems, especially those when referral without initial treatment increases the danger to the sick.

I should point out that when I say, "more curative medicine", I don't mean "more use of medicines". Over-medication, by both physicians and villagers, is already flagrant. I mean *more informed use,* which, in many cases, will mean far more limited use, of medications. But this will require a major grassroots demystification of Western medicine which can only happen when the people themselves learn more about how to prevent and manage their own illnesses. To promote such a change, village health workers must have a solid grasp of *sensible medicine* and, in turn, help reeducate their people. It is, of course, doubtful whether such a metamorphic awakening to sensible medicine can ever happen outside the medical institution until there has been some radical rethinking within it.

8. More feedback between doctors and health workers. When health workers refer patients to a doctor, the doctor should *always* provide feedback to the health worker, explaining in full, clear detail and simple language about the case. This can, and should, be an important part of the health worker's and the doctor's continuing education.

9. Earlier orientation of medical students. From the very beginning of their training, medical students should be involved in community health, and be encouraged to learn from experienced village health workers and paramedics.

10. Great appreciation and respect for villagers, their traditions, their skills, their intelligence, and their potentials. Villagers, and especially village health workers, are often treated liked children or ignoramuses by their more highly-educated trainers and supervisors. This is a great mistake. People with very little formal education often have their own special wisdom, skills and powers of observation which academicians have never acquired and therefore fail to perceive. If this native knowledge and skill is appreciated, and integrated into the health care process, this will not only make it more truly community-oriented and viable, but will help preserve the individual strengths and dignity of health workers and their people. I cannot emphasize enough how important it is that health programme planners, instructors and supervisors be "tuned in" to the capabilities and special strengths of the people they work with.

11. That the directors and key personnel in a programme be people who are human. This is the last, most subjective and perhaps most important point I want to make. Let me illustrate it with an example:

In Costa Rica, there is a regional programme of rural health care under the auspices of the health ministry which differs in important ways from the rural health system in the country as a whole. It has enthusiastic community participation and a remarkable impact on overall health. It may well have the lowest incidence of child and maternal mortality in rural Latin America. Its director is a paediatrician and a poet, as well as one of the warmest and hardest-working people I have met. The day I accompanied him on his trip to a half-dozen village health posts, we didn't even stop for lunch, because he was so eager to get to the last post before night fell. He assumed I was just as eager. And I was; his enthusiasm was that contagious!

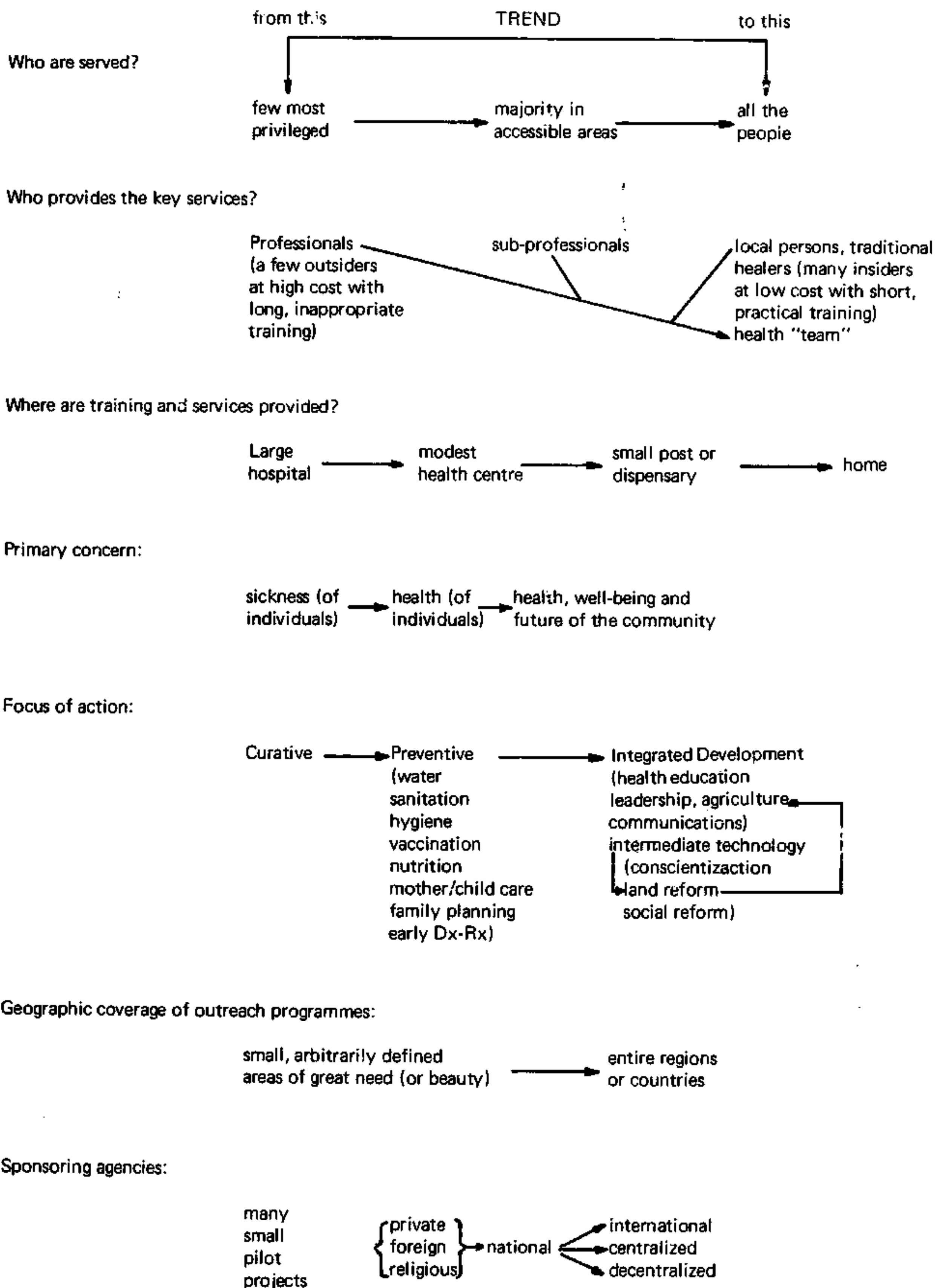
I will never forget our arrival at one of the posts. It was the day of an "under-fives" clinic. Mothers and patients were gathered on the porch of the modest building. As we approached, the doctor began to introduce me, explaining that I worked with rural health in Mexico and was the author of *Donde No Hay Doctor.* Frantically, I looked this way and that for the health worker or nurse to whom I was being introduced. As persons began to move forward to greet me, I suddenly realized he was introducing me to *all the people,* as he would to his own family. Obviously he cared for the villagers, respected them, and felt on the same level with them.

This, I must confess, was a new experience for me. I was used to being marched past the waiting lines of patients and being introduced to the health worker, who was instructed to show me around and answer my questions, while the patient, whose consultation we had interrupted, silently waited.

"This man is an exception! " I thought to myself. In our visits throughout Latin America, we found almost invariably that the truly outstanding programmes have at least one or two key people who are exceptional human beings. These people attract others like themselves. And the genuine concern of people for people, of joy in doing a job well, of a sense of service, and the sharing of knowledge permeates the entire programme clear down to the village worker and members of the community itself.

People are what make health care work.

OUTLINE 1: RECENT TRENDS OF RURAL HEALTH CARE PROGRAMMES



OUTLINE 2: RURAL HEALTH PROGRAMMES IN LATIN AMERICA

TWO APPROACHES

	COMMUNITY-SUPPORTIVE	**COMMUNITY-OPPRESSIVE** (CRIPPLING)
Initial objectives	Open-ended. Flexible. Consider community's felt needs. Include non-measurable (human) factors.	Closed. Pre-defined before community is consulted. Designed for hard-data evaluation only.
Size of programme	Small, or if large, effectively decentralized so that sub-programmes in each area have the authority to run their own affairs, make major decisions, and adjust to local needs.	Large. Often of state or national dimension. Top-heavy with bureaucracy, red tape, filling out forms. Superstructure overpowers infrastructure. Frequent breakdown in communication.
Planning, priorities, and decision making	Strong community participation. Outside agents-of-change inspire, advise, demonstrate, but do not make unilateral decisions.	Theoretically, community participation is great. In fact, activities and decisions are dominated or manipulated extensively by outsiders, often expatriate "consultants".
Financing and supplies	Largely from the community. Self-help is encouraged. Outside input is minimal or on the basis of "seed funds", matching funds, or loans. Agricultural extension and other activities which lead to financial self-sufficiency are promoted. Low-cost sources of medicine are arranged.	Many giveaways and handouts: free food supplements, free medicines, villagers paid for working on "community projects". Village health worker (VHW) salaried from outside. Indefinite dependency on external sources.
Way in which community participation is achieved	With time, patience, and genuine concern. Agent-of-change lives with the people at their level, gets to know them, and establishes close relationships, mutual confidence and trust. Care is taken not to start with free services or giveaways that cannot be continued.	With money and giveaways. Agents-of change visit briefly and intermittently, and later on discover that, in spite of their idealistic plans, they have to "buy" community participation. Many programmes start with free medicines and handouts to "get off to a good start", and later begin to charge. This causes great resentment on the part of the people.
Data and evaluation	Underemphasized. Data-gathering kept simple and minimal, collected by members of the community. Includes questions about the people's felt needs and concerns. Simple scheme for self-evaluation of workers and programme at all levels. Evaluation includes subjective human factors as well as "hard data".	Over-emphasized. Data gathered by outsiders. Members of the community may resent the inquisition, or feel they are guinea pigs or "statistics". Evaluation based mainly on "hard data" in reference to initial objectives.

	COMMUNITY-SUPPORTIVE	COMMUNITY-OPPRESSIVE (CRIPPLING)
Experience and background of outside agents-of-change	Much practical field experience. Often not highly "qualified" (degrees).	Much desk and conference room experience. Often highly "qualified" (degrees).
Income, standard of living, and character of outside agents-of-change. (MDs, nurses, social workers, consultants, etc.)	Modest. Often volunteers who live and dress simply, at the level of the people. Obviously they work through dedication, and inspire village workers to do likewise.	Often high, at least in comparison with the villagers and VHW (who, observing this, often finds ways to "pad" his income, and may become corrupt). The health professionals have often been drafted into "social service" and are resentful.
Sharing of knowledge and skills	At each level, from doctor to VHW to mother, a person's first responsibility is to teach: to share as much of his/her knowledge as possible with those who know less and want to learn more.	At each level of the preordained medical hierarchy (health team), a body of specific knowledge is jealously guarded and is considered dangerous for those at "lower" levels.
Regard for the people's customs and traditional folk healing, use of folk healers	Respect for local tradition. Attempt to integrate traditional and Western healing. Folk healers incorporated into the programme.	Much talk of integrating traditional and Western healing, but little attempt. Lack of respect for local tradition. Folk healers not used or respected.
Scope of clinical activities (Dx, Rx) performed by VHW	Determined realistically, in response to community needs, distance from health centre, etc.	Delimited by outsiders who reduce the curative role of the VHW to a bare minimum, and permit his/her use of only a small number of "harmless" (and often useless) medicines.
Selection of VHW and health committee	VHW is from and is chosen by community. Care is taken that the entire community is not only consulted, but is informed sufficiently so as to select wisely. Educational prerequisites are flexible.	VHW ostensibly chosen by the community. In fact, often chosen by a village power group, preacher, or outsider. Often the primary health worker is an outsider. Educational prerequisites fixed and often unrealistically high.
Training of VHW	Includes the scientific approach to problem solving. Initiative and thinking are encouraged.	VHW taught to mechanically follow inflexible, restrictive "norms" and instructions. Encouraged *not* to think and not to question the "system".
Does the programme include conscientization (consciousness raising) with respect to human rights, land and social reform?	Yes (if it dares).	Issues of social inequities, and especially land reform, are often avoided or glossed over.

	COMMUNITY-SUPPORTIVE	COMMUNITY-OPPRESSIVE (CRIPPLING)
Manual or guidebook for VHW	Simple and informative in language, illustrations, and content. Geared to the user's interest. Clear index and vocabulary included. All common problems covered. Folk beliefs and common use and misuse of medicines discussed. Abundant illustrations incorporated into the text. The same time and care was taken in preparing illustrations and layout as villagers take in their artwork and handicraft. Manual contains a balance of curative-preventive, and promotive information.	Cookbook-style, unattractive. Pure instruction. No index or vocabulary. Language either unnecessarily complex or childish, or both. Illustrations are few, inappropriate (cartoons), or carelessly done. Not integrated with the text. Useful information is very limited, and some of it inaccurate. Many common problems not dealt with. May use misleading and/or incomprehensive flow charts. Manual often strong on preventive and weak on curative information; overloaded with how to fill out endless forms.
Limits defining what a VHW can do	Intrinsic. Determined by the demonstrable knowledge and skills of each VHW, and modified to allow for new knowledge and skill which is continually fostered and encouraged.	Extrinsic. Rigidly and immutably delimited by outside authorities. Often these imposed limits fall far short of the VHW's interest and potential. Little opportunity for growth.
Supervision	Supportive. Dependable. Includes further training. Supervisor stays in the background and never "takes over". Reinforces community's confidence in its local workers.	Restrictive, nit-picking, authoritarian, or paternalistic. Often undependable. If supervisor is a doctor or nurse he/she often "takes over", sees patients, and lowers community's confidence in its local worker.
Encouragement of self-learning outside of norms	Yes. VHWs are provided with information and books to increase knowledge on their own.	No. VHWs are not permitted to have books providing information outside their "norms".
Feedback on referred patients (counterreference)	When patients are referred by the VHW or auxiliary, the MD or other staff at the referral centre gives ample feedback to further the health worker's training.	Doctor at the referral centre gives no feedback other than instructions for injecting a medicine he/she has prescribed.
Flow of supplies	Dependable.	Undependable.
Profit from medicines (in programmes that charge)	VHW sells medicine at cost which is posted in public. (He/she may charge a small fee for services rendered). Use of medicines is kept at a minimum.	VHW makes a modest (or not so modest) profit on sale of medicines. This may be his/her only income for services, inviting gross over-prescribing of medicines.
Evolution towards greater community involvement	As VHWs and community members gain experience and receive additional training, they move into roles initially filled by outsiders — training, supervision, management, conducting of Under-fives' clinics, etc. More and more of the skill pyramid is progressively filled by members of the community.	Little allowance is made for growth of individual members of the community to fill more and more responsible positions (unless they graduate to jobs *outside* the community). Outsiders perpetually perform activities that villagers could learn.

	COMMUNITY-SUPPORTIVE	COMMUNITY-OPPRESSIVE (CRIPPLING)
Openness to growth and change in programme structure	New approaches and possible improvements are sought and encouraged. Allowance is made for trying out alternatives in a part of the programme area, with the prospects of wider application if it works.	Entire programme is standardized with little allowance for growth or trial of ways for possible doing things better. Hence, there is no built-in way to evolve towards better meeting the community's needs. It is static.
RESULTS:	Health worker continues to learn and to grow. Takes pride in the work. Has initiative. Serves the community's felt needs. Shows villagers what one of their own can learn and do, stimulating initiative and responsibility in others. Community becomes more self-sufficient and self-confident. Human dignity and responsibility grow.	Health worker plods along obediently, or quits. He/she fulfills few of the community's felt needs. Is subservient and perhaps mercenary. Reinforces the role of dependency and unquestioning servility. Community becomes more dependent on paternalistic outside charity and control. Human dignity fades. Traditions are lost. Values and responsibility degenerate.
If outside support fails or is discontinued...	Health programme continues because it has become the community's.	Health programme flops.
TACIT OBJECTIVE	Social reform: health and equal opportunity for all.	"Don't rock the boat". Put a patch on the underlying social problems – don't resolve them!
SPONSORING AGENCIES	Often small, private, religious, or volunteer groups. Sometimes sponsored by foreign non-governmental organizations.	Often large regional or national programmes cosponsored by foreign national or multinational corporate or governmental organizations.

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