

INTRODUCTION

Health for all by the year 2000 has become the goal of the World Health Organization (WHO) and most countries around the earth.

Such a world-wide goal is very worthy. But in some ways it is dangerous. For there is a risk of trying to reach that goal in ways that become so standardized, so impersonal, so controlled by those in power, that many of the human qualities essential to health—and to health care—are lost.

There is already evidence of this happening. In the last 10 or 15 years, a great many attempts have been made to bring basic health care to poor communities. Billions have been spent on large national or regional programs planned by highly trained experts. But the results have often been disappointing. In most countries, the number of persons suffering from preventable or easily curable illness continues to grow.

On the other hand, certain community health programs have been more or less successful in helping the poor meet their health-related needs. Studies by independent observers* have shown that **programs generally recognized as successful, whether large or small, often have the following things in common:**

1. Small, local beginnings and slow, decentralized growth. Even the more successful large programs usually have begun as small projects that gradually developed and evolved in response to the needs of particular communities. As these programs have grown, they have remained *decentralized*. This means that important planning and decision making still take place at the village or neighborhood level.

2. Involvement of local people—especially the poor—in each phase of the program. Effective programs recognize and try to deal with the conflicts of interest that often exist between the strong and the weak, even in a small community. Not just local leaders, but the most disadvantaged members of society, play a leading role in selecting their own health workers and determining program priorities. A conscious aim of such programs is to help strengthen the position and bargaining power of the poor.

3. An approach that views planning as a 'learning process'. The planning of program content and health worker training does not follow a predetermined 'blueprint'. Instead, planning goes on continually as a part of a learning process. Participants at every level (instructors, student health workers, and members of the community) are invited to help shape, change, and criticize the plans. This allows the program to constantly evolve and adapt, so as to better meet people's changing needs. Planning is both local and flexible.

*See, for example, David Korten's analysis of successful programs in Asia, "Community Organization and Rural Development: A Learning Process Approach," *Public Administration Review*, September/October, 1980, p. 480-510.

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4. **Leaders whose first responsibility is to the poor.** Programs recognized as effective usually have leaders who are strongly committed to a just society. Often they have had intense personal experience working with the poor in community efforts to help solve critical needs. Even as their programs have grown and expanded, these program leaders have kept up their close relations with the poor working people in individual communities.

5. **A recognition that good health can only be attained through helping the poor improve the entire situation in which they live.** Successful programs link health activities with other aspects of social development. Health is seen as a state of wholeness and well-being in which persons are able to work together to meet their needs in a self-reliant, responsible way. This means that to become fully healthy, each person needs a clear understanding of himself or herself in relation to others and to the factors that influence all people's well-being. In many of the most effective health programs, activities that help people to develop a more critical awareness have become a key part of training and community work.

In view of these features common to success, the failure of many national and regional 'community health' programs is not surprising. Most are carried out in quite the opposite way. Although their top planners speak proudly of "decision making by the community," seldom do the people have much say about what their health workers are taught and told to do. 'Community participation' too often has come to mean "getting *those people* to do what *we* decide." Rather than helping the poor become more self-reliant, many national health and development programs end up increasing poor people's dependency on outside services, aid, and authority.

One of the biggest obstacles to 'health by the people' has been the unwillingness of experts, professionals, and health authorities to let go of their control. As a result, community health workers are made to feel that their first responsibility is to the health system rather than to the poor. Usually they are taught only a very limited range of skills. They become the servants or 'auxiliaries' to visiting doctors and nurses, rather than spirited leaders for change. They learn to follow orders and fill out forms, instead of to take initiative or to help people solve their problems on their own terms. Such health workers win little respect and have almost no influence on overall community health. Many of them get discouraged, grow careless, become corrupt, or quit. Results have been so disappointing that some experts, even within WHO, have begun to feel that the goal of 'health for all through community involvement' is like the pot of gold at the end of the rainbow—a dream that has been tried, but failed.

In spite of the failure of most large, centrally controlled programs to achieve effective community participation, in many countries there are outstanding examples of enthusiastic community involvement in health. This is especially true in small, non-government programs that take what we call a *people-centered* or *community-strengthening* approach to health care.

Within these community-based programs, there is a wealth of variety in terms of innovation and adaptation to local conditions. But at the same time, there is a striking similarity in their social and political objectives in many parts of the world—Pakistan, India, Mozambique, the Philippines, Mexico, Nicaragua, Honduras, El Salvador, and Guatemala.

In these community-based programs, a new kind of health worker has begun to play a leading role. These health workers speak out for the 'voiceless' poor. Their goal is health for all—but health that is founded on human dignity, loving care, and fairer distribution of land, wealth, and power.

To us, one of the most exciting aspects of this new world-wide community-based movement, decentralized and uncoordinated as it may be, is that it goes far beyond any rigid religious or political doctrine. Most of the leaders in these programs recognize the dangers to ordinary people in any large, centrally controlled system, be it capitalist or communist. They have far greater faith in small, self-directed groups of working people. Rather than accept any established dogma, they are asking searching questions. They welcome criticism, and encourage others to observe for themselves and form their own conclusions. They believe in helping the powerless to gain strength through a greater understanding of the factors that shape their health and their lives.

Around this practical human vision has gradually grown a whole new approach to the training, role, and responsibilities of community health workers. Ideas and methods are being shared and further developed through a series of informal networks around the world.

Many of the ideas in this book have been gathered from these networks of community-based health programs, and especially from Project Piaxtla, a small, villager-run program based in Ajoya, Sinaloa, Mexico.

