

Health Care as if People Mattered

CHAPTER 5

Concepts That Need to Be Challenged

In this chapter we will briefly raise the following issues, in the hope that readers will keep them in mind as we proceed in Part 2 of this book with an in-depth analysis of the global campaign to control childhood diarrhea:

1. Technological solutions to social problems: Can they succeed?
2. Survival versus quality of life: Is survival enough?
3. After Alma Ata: What happened to community participation?
4. Health through behavioral change and female education: Blaming the victim.
5. Social mobilization: UNICEF's shift from bottom-up to top-down.
6. From awareness-raising to brainwashing: "Social marketing."

1. Technological Solutions to Social Problems: Can They Succeed?

The story of Rakku in Chapter 1 is an example of how medical technology failed to save a child's life because planners and providers failed to take into account the economic, political, and social factors leading to a child's death. The journals of health and development policy are replete with attempts to solve the problems of the poor through technological "magic bullets." Sometimes the results are positive, but just as often the proposed technological solutions seem to backfire, placing the very people whom they were intended to help at an even greater disadvantage.

A good example is the introduction of tube wells in rural Bangladesh.³⁵ In villages with long dry seasons and severe water shortage, UNICEF provided tube wells hoping that the increased water supply would help poor families to grow more food and improve their hygiene and health. But repeatedly, big landholders volunteered to install the wells on their land, and subsequently took control of water distribution. They charged prohibitively high rates and denied water to those who either could not afford to pay or resisted such exploitation. The net

result of the new technology was to increase the wealth and power of the rich landholders, while making the poor poorer, more dependent, and more exploited.

Not until Gonoshasthaya Kendra (The People's Health Center) began to organize groups of poor farmers to analyze their situation, and to put in and maintain their own tube wells (still donated by UNICEF), did the wells begin to effectively meet the water needs of poor families. At the same time, the people gained confidence in their ability to work collectively for change.

The lessons from this experience—and many others like it—are apparent: any technology, however appropriate it appears, can be used either for or against those in greatest need, depending on who controls it and how it is implemented. Moreover, when technological solutions are promoted to resolve problems in isolation from their social context, they often backfire.

2. Survival Versus Quality of Life: Is Survival Enough?

Millions of children like Rakku's baby die every year. But what happens to the far greater number of children in similar circumstances who somehow manage to survive? They enter health statistics as successes, but at what cost?

If we recall the story of Rakku's baby, we remember that most children at high risk of dying from diarrhea are undernourished and live in very difficult or even devastating conditions. Thus, efforts that focus on saving children's lives without adequately combating the causes of the poverty and malnutrition may result in decreases in mortality, but may also increase both the number and proportion of malnourished, sickly, and developmentally delayed children. There is evidence of this happening in several areas of the Third World, for example, the Philippines, Chile, and the state of São Paulo in Brazil.³⁶

This approach is unacceptable on two counts. First, high levels of hunger and sickness mean that children's quality of life is deplorable; second, in situations where children remain hungry and sick, or living standards are deteriorating, it is unlikely that progress in reducing mortality can be sustained. Already, in some countries where child survival interventions have resulted in reduced child mortality rates, economic recession and

structural adjustment measures have slowed or even reversed these gains.³⁷

Almost no one would argue that children's lives should not be saved wherever possible. *But survival is not enough.* As George Kent points out,

Improved children survival rates are not very meaningful if children reach their fifth birthdays but are doomed to lives of misery.... Successful child survival programs improve the survival rate not as an isolated phenomenon but as part of overall improvement in the quality of life.... Child survival is an integral part of development and should not be separated from it.³⁸

3. After Alma Ata: What Happened to Community Participation?

The Alma Ata Declaration emphasizes the importance of *strong community involvement* and *self-determination*; the signatories of the Declaration recognized that all health initiatives must possess these features if they are to succeed. There are three main reasons for this.

First, good health is not a product that can be delivered in discrete packages. It results from a process over which people themselves need to take charge. Indeed, for individuals, families, communities, and nations alike, direct involvement in the decisions that influence their well-being is part of what it means to be healthy. Health and self-determination are inextricably intertwined.

The second reason is pragmatic. There may never be enough professionally trained doctors, nurses, or even health workers to meet everyone's health needs. Therefore, in order for improvements in health to be sustained, the community itself needs to become involved in maintaining its own health.

Third, health is determined to a large extent by levels of equality and social justice. Better health depends on improvements in living conditions, nutrition and other basic needs. In order to address the underlying social and political determinants of health, the Declaration calls for accountability of health workers and health ministries to the common people, and for social guarantees to make sure that the basic needs—including food needs—of all people are met. recognizing that socially progressive change only comes through organized demand, it calls for strong popular participation.

Although the Alma Ata Declaration stresses the importance of *strong community involvement* and *self-deter-*

mination to the successful implementation of Primary Health Care, these essential elements have too often been undermined or ignored. The relative success of those programs and policies which have maintained this community-oriented approach, and the failures of those programs and policies which have not, only underscore its importance in attaining health for all.

4. Health Through Behavioral Change and Female Education: Blaming the Victim

The ill health and high death rates of poor children necessitate that far reaching changes be made. But change what? The debate around this issue centers on whether what is needed is social change or behavioral change. This in turn depends on whether the situation is viewed from the perspective of those at the top or those at the bottom. We will use Rakku's story again to illustrate these perspectives.

A top-down perspective tends to blame the situation on the behavior of the poor. So, in Rakku's situation, the health workers entering Rakku's hut would note the unsanitary conditions of the floor, water, etc. They would blame Rakku's "unhealthy behavior" (resulting in her child's death) on her lack of education. They would then try to educate her in how to change this, for example, by instructing her on a few priority health measures that would "empower" her to take care of her baby. They may instruct her on how to breastfeed, where to buy packets of ORS, and when to take her child for vaccination. Or they might encourage her to take her children, especially her girls, to school, so that future generations might make more informed health decisions. If, in spite of these instructions and assistance, the mother's behavior and living conditions remained unaltered, they would blame her for inadequate effort, or possibly ignorance. This paternalistic approach puts the onus on the victim, rarely examining the responsibility of the larger players in the picture—big landowners, politicians or development agencies.

In contrast, a bottom-up perspective analysis starts from a different premise and arrives at a different conclusion. It recognizes that the poor are more adept at coping with life-threatening circumstances than most health experts, and thus usually know best what it takes for them to survive. In this view, the unhealthy living conditions result not from ignorance, but from powerlessness. To combat this predicament, health promotion should aim to equip the poor with the skills and confidence they need to change the system that is stacked against them—that is, to work toward removing the underlying social causes of poor health and poverty.

An example of the first approach, a top down perspective, can be seen by looking at the new “Communications Strategy” of the Child Survival and subsequent “Safe Motherhood” initiatives. These focused on bombarding the “target audience” with essential health messages. UNICEF’s publication *Facts for Life* begins:

A Communication Challenge. The health of children in the developing world could be dramatically improved if all families were empowered with today’s essential child health information. That information has now been brought together in *Facts for Life* . . . *Facts for Life* is a challenge to communicators of all kinds—politicians, educators, religious leaders, health professionals, business leaders, trade unions, voluntary organizations, and the mass media. It is for all those who can help to make its contents part of every family’s basic stock of child-care knowledge.³⁹

At first glance all this sounds quite palatable. But a closer reading reveals some disturbing assumptions:

- 1) Children’s poor health is blamed on parents’ (especially mothers’) *lack of knowledge*;
- 2) Therefore, the knowledge that parents need most is about *technical interventions* and *behavior in the home*. Nothing is said about poor people’s need for *knowledge about their rights, grassroots organizing, and strategies for social change*;
- 3) The proper role for persons in positions of power (politicians, religious leaders, etc.) is to *benevolently help remedy the ignorance of the poor*. Rather than making it clear that the powerful are a major part of the problem, *Facts for Life* portrays them as part of the solution; rather than calling on them to share their power and wealth, it invites them to help lift their less fortunate fellow citizens out of their ignorance and self-created misery. This has the effect of legitimizing the dominant position of social elites. It deflects any moral demand that they relinquish some of their privileges (and assumed superiority) as a step toward a more equitable, healthier society.

UNICEF’s emphasis on female education is another example of a message that has the potential to be victim-blaming. (Recall that female education is one of the three F’s in the expanded version of GOBI.) Numerous studies have supported the assertion that female education is one of the factors most closely correlated with reduction in child mortality.

The point is valid, as far as it goes. As Kent states,

Maternal education is clearly and strongly associated with children’s mortality, in that a child’s probability of dying is inversely related to the mother’s years of schooling. Maternal education is one of the strongest socioeconomic factors associated with children’s survival.⁴⁰

But why? True, literacy permits women to access written information. But it may well be that it benefits women even more by better equipping them to defend their rights. Education—especially the learner-centered, problem-posing type—can be an important stepping stone toward empowerment and change.

Nonetheless, stressing female education as a solution to child mortality reinforces the victim-blaming idea that women’s ignorance is its principal cause. A more positive approach might be to emphasize women’s empowerment rather than female education. This way the fault-finding finger would shift from ignorance (blaming the victim) to powerlessness (holding the powerful responsible). It would make clear that technical information is not enough: that what is needed is to give women, children, and other disadvantaged groups a stronger, more equal position in society. As Kent puts it: “the more fundamental issue may be women’s autonomy rather than education.”⁴¹

5. Social Mobilization: UNICEF’s Shift from Bottom-up to Top-down.

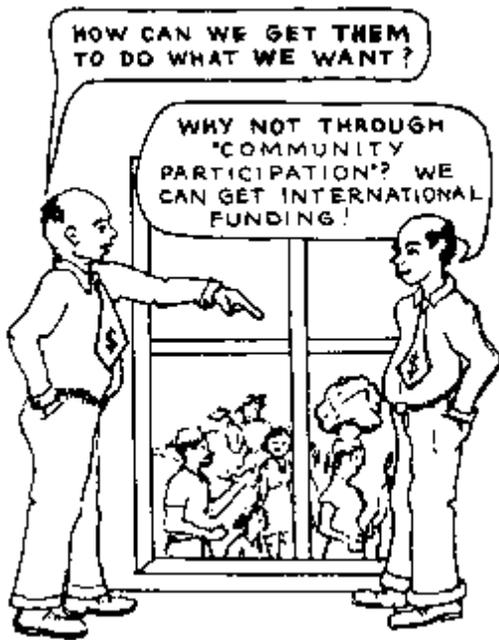
Mobilization no longer means what it used to. It was once a politically loaded term used by social activists for mass action in a popular struggle: a grassroots process of achieving popular power. But high-level health and development strategists have co-opted this and other terms like *community-based*, *participation*, and *empowerment*, stripping them of their progressive political content.

Today social mobilization is not aimed at activating the poor, but at recruiting the powerful. As the term is now used in the promotion of Child Survival initiatives, it signifies the courting and enlisting of prominent decision makers, opinion leaders, funding agencies, schools of public health, etc. It solicits movie stars, sports heroes, politicians, and other popular idols to promote the products of Child Survival with the same seductive advertising gimmicks used to sell cigarettes. George Kent draws the distinction between this current concept of mobilization and empowerment:

While *mobilization* commonly refers to recruiting people to act on someone else’s agenda,

empowerment means increasing people's capacities to pursue their own agenda (italics in original).⁴²

The most disturbing aspect of this meaning of mobilization is that it reflects a shift in solidarity on the part of agencies like UNICEF from those at the bottom to those at the top. In the 1960s and 1970s UNICEF took some important stands in defense of the disadvantaged. It even went so far as to call for changes in unjust structures. On several occasions the positions UNICEF took angered the US government, which retaliated by threatening to stop funding the agency. Faced with the conservative climate of the 1980s, UNICEF became more cautious. In 1983 it introduced a new, watered-down strategy for protecting children. This strategy replaced *participation* with *compliance*—in practice, if not in rhetoric. It interpreted *equity* to mean nothing more than *universal coverage with health services*. And it transformed *social mobilization* into the manipulative, top-down technique called *social marketing*.



In 1986, David Werner asked one of the authors of UNICEF's *The State of the World's Children Reports* why UNICEF did not take a stronger position and call for member governments' action to end suffocating debt, devastating adjustment mandates, unfair trade policies, and other root causes of poverty and poor health in the 1980s. He replied, "UNICEF'S goals are the same as yours. We are just more realistic than you are. We recognize our limitations and work within them."

6. From awareness-raising to brainwashing: "social marketing."

In a 1984 article called "Marketing Child Survival," UNICEF's late Executive Director, James Grant, complained that, "in a world where information technology has become the new wonder of our age, shamefully little is known about how to communicate information whose principal value is to the poor."⁴³ In response to this call, the commercial sector helped adapt advertising techniques to create the new health promotion technique of "social marketing." Glenn Wasek, Director of the Marketing Services Group of John Snow Inc. (a private public health consulting firm), in a book called *Child Health and Survival*, describes social marketing as "a specialty within the management discipline of marketing, [which] incorporates an entire approach to planning, executing, and advancing ideas, concepts, behaviors, services, and/or products to reach the objectives of international public health programmes." He goes on to present "the powerful tools, techniques, and overall approach of social marketing."

This approach was in sharp contrast to the bottom-up, awareness-raising approach widely used in previous decades. The methodology of informal learner-centered education for health and community action in the 1960s and 1970s—strongly influenced by Paulo Freire, the controversial Brazilian educator—promoted "awareness-raising" (or "consciousness-raising"), along with "structural analysis" (analysis of the social causes of people's problems). These became the watchwords of the community-based health and development movements. (For a fuller discussion of Paulo Freire's innovative teaching methodology, see page 132.)

In the 1980s, however, social marketing quickly became the norm. This technique resembles the "banking" approach to education described by Freire. It involves winning the hearts and minds of the people in order to persuade them to accept a pre-designed health care package. Preliminary studies are made, with interviews of the prospective "target population" to determine what sales strategy and product packaging will be most seductive. Then a blitz of advertising is launched through the mass media: radio, television, and village loudspeakers. Movie stars, popular singers, and other public figures (including, in the case of the Child Survival campaign, the Pope and the United States President) are recruited to bolster mass enthusiasm. Unlike Freire's open-ended, problem-posing approach promoted in the 1960s and 1970s, social marketing does not give people the opportunity to make their own decisions and take autonomous action. It often comes closer to brainwashing than awareness-raising.

CONCLUSION TO PART 1

Structural Adjustment Programs (SAPs), privatization of health services, and the World Bank's powerful new role in shaping health care policy have ushered in the demise of primary health care. Later, in Part 3, we will examine in greater detail how economic policies instituted by international financial institutions and global power structures are widening the gap between rich and poor, and stalling or reversing improvements in children's survival and quality of life. We will explore how these policies violate not only the guidelines and spirit of the Alma Ata Declaration, but also of the United

Nations Declaration of Human Rights and the more recent Declaration of the Rights of Children.

One of the clearest examples of how global economic policies have adversely influenced the potential of health promotion can be found in the field of diarrheal disease control. Despite a concentrated global effort focusing on prevention and treatment of diarrhea, the diarrheal diseases remain a leading killer of children.⁴⁴ How can it be—despite an all-out effort by WHO, UNICEF, and global public health leaders—that common diarrhea continues to claim millions of children's lives each year? This is the subject of Part 2.