

Health Care, Empowerment, and Social Change

CHAPTER 16

As has been stressed throughout this book, far-reaching improvements in health depend more on social, economic, and political factors than on either medical breakthroughs or health care interventions per se. Countries with the most striking and durable improvements in health tend to be those with a commitment to equity that is broad-based and multisectoral. It has been argued that the health gains of poor countries that have pursued this sort of development model have seldom proved sustainable. However, it is important to recognize that the reasons for this have been largely external. Time and again, such countries have been attacked or destabilized by powerful, less egalitarian nations whose rulers fear that such people-centered endeavors may be contagious.

There have, of course, also been internal reasons for the difficulties in sustaining a need-based model of development. In some countries, following liberation from unjust regimes, there has been a reconcentration of power and a weakening of popular support. Commitment to equity has eroded as well, making health improvements hard to sustain. (In Chapter 21, we show how health improvements gained following national independence are being undermined by such reconcentration of power and wealth.)

The current stagnation and reversals of health and living standards in a growing number of countries demonstrate that the conventional, increasingly globalized development model is in many ways counterproductive: it makes the rich richer and the poor poorer. The pursuit of *growth without equity* (the neoliberal paradigm of development) has become the major obstacle to health for all. Even the World Bank now asserts that the alleviation of poverty is a precondition to a healthy society, and it calls for cost-efficient measures to meet all people's basic needs. Yet the Bank's reformed blueprint is still based on economic growth that benefits the rich and adjustment policies that further deprive the poor. Clearly, alternatives are needed.

Equity, Participation, and Empowerment

To achieve the equity essential for a healthy society, it appears that a strong, organized demand for accountability of government to the people may be a key prerequisite. Tacit recognition of this dynamic explains the

Alma Ata Declaration's call for strong community participation. (It also explains why the ruling elites in the North and South joined forces to trivialize the Declaration, as we discussed in Part 1.)

To achieve and sustain the political will to meet all people's basic needs, a process of participatory democracy—or at least a well informed grassroots movement—is essential. And because the opposition to equity-oriented social development has become so pervasive, a coordinated global effort is urgently needed.

Recognizing the importance of such popular participation is a key to successful health care initiatives. This is illustrated by the impressive achievements of China's mass public health campaigns in the 1950s,¹ as it is by Nicaragua's mass immunization campaigns in the 1980s (see Chapter 20). Even at the provincial or district level the health benefits of popular involvement are excellent. The state of Kerala in India and the San Ramón district of Costa Rica are good examples. This latter initiative involved strong community participation in service provision as well as in planning. Guided not by health professionals but through large community gatherings, San Ramón District achieved the best health and child mortality statistics in all of Latin America, with the exception of Cuba.²

In countries where the political climate is not conducive to such popular participation or to equitable development (i.e. most countries), what approaches can be taken to meet the health needs of underprivileged groups? Should health activists work within the system, outside it, or both? Is it possible for community health work to become an arena for cultivating the political awareness and organization needed to introduce a more equity-oriented approach to health and development?

Two examples we cite in the next chapters (Mexico and Nicaragua) indicate that community health initiatives can be an entry point in organized pursuit of a healthier, more equitable society—although the difficulties and limitations may be great. Whether working under a repressive or progressive regime, health activists can facilitate a comprehensive empowering approach that helps people address their immediate ills while starting to tackle those problems' root causes. Examples from diverse situations show that *it is possible for health workers to function within an inequitable social order*

while working to transform it.

Solutions that Empower the Poor

Health initiatives that are limited to technological interventions are, at best, limited in their impact. They perpetuate the misconception that health problems rooted in poverty and inequity can be solved by medical or health care alone, while leaving the causal inequities in place. As we have seen, UNICEF/WHO's strategy for promoting oral rehydration therapy (ORT) is at best a stop-gap solution. No matter how well designed and funded, it is unlikely to significantly decrease child deaths from diarrhea, for two reasons. First, as typically promoted, ORT campaigns seek merely to combat dehydration rather than to combat the socioeconomic conditions that make diarrhea deadly. Second, the emphasis on ORS packets fosters dependency, adds nutrition-depleting costs, and medicalizes what could be a simple solution. UNICEF/WHO's recent emphasis on the home management of diarrhea with "increased fluids and food" is a step in the right direction.

A more empowering approach is to help people improve their understanding of health problems and to build on their skills for dealing with them. This can help to break both the monopoly enjoyed by experts as well as people's dependency on needless commercial products. Encouragement of appropriate health technologies can help to reduce the indiscriminate adoption of sophisticated, extravagant, and mystifying ones.

As we discussed in Part 2, appropriate technologies for home use need to be implemented *at all levels* of the health care system, so that people will not consider them second best. With ORT, this means promoting the use of home drinks not only in homes but also in health centers and even in hospitals, as was done in Zimbabwe. Unfortunately, UNICEF and WHO recommend that health posts and clinics rely on packets, and reserve home fluids as first aid until "real" ORS can be obtained.



Diarrhea Management as a Process of Empowerment

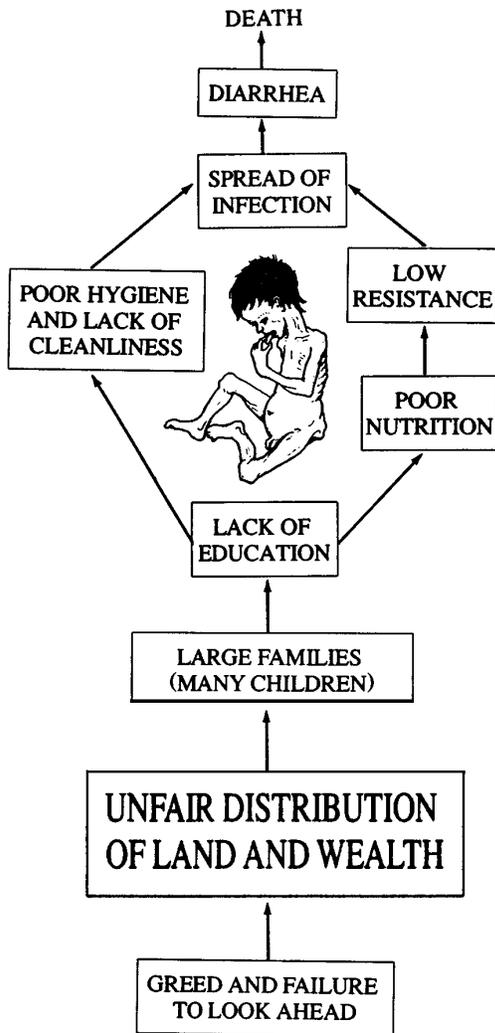
For health interventions to have a significant and lasting impact, they must go beyond a merely curative or management focus to a truly preventive and promotive one. They need not only work to demystify and democratize health services, but also to help communities identify and address the root causes of their health problems.

As we saw in Chapter 1, the problem of child diarrhea provides an example of the chain of causes that can lead to a child's death. Successive levels of causal factors can be analyzed. The deeper we go (or the further back on the chain) to combat the problem, the more effective and lasting our efforts are likely to be. Consider the following example, adapted from a paper by David Werner (*Health Care and Human Dignity*):

Each year millions of impoverished children die of diarrhea. We tend to agree that most of these deaths could be prevented. Yet diarrhea remains among the biggest killers of young children. Does this mean our so-called preventive measures are merely palliative? At what point in the chain of causes which makes death from diarrhea a global problem ... are we coming to grips with the real underlying cause. Do we do it:

- by preventing some deaths through treatment of diarrhea?
- by trying to interrupt the infectious cycle through construction of latrines and water systems?
- by reducing high risk from diarrhea through better nutrition?
- [or] by curbing land tenure inequities through land reform?

Land reform comes closest to the real problem. But the peasantry is oppressed by far more inequities than those of land tenure. The existing power structure both causes and perpetuates crushing inequities at the local, national, and multinational levels. It includes political, commercial, and religious power groups as well as the legal profession and the medical establishment. In short, it includes ... ourselves ...



Where, then, should prevention begin? Beyond doubt, anything we can do to minimize the inequities perpetuated by the existing power structure will do far more to reduce high infant mortality than all our conventional preventive measures put together. We should, perhaps, carry on with our latrine-building rituals, nutrition centers and agricultural extension projects. But let's stop calling it prevention; we are still only treating symptoms. And unless we are very careful, we may even be making the underlying problem worse, through increasing dependency on outside aid, technology and control.

But this need not be the case. *If* the building of latrines brings people together and helps them look ahead, *if* a nutrition center is built and run by the community and fosters self-reliance, and

if agricultural extension, rather than imposing outside technology encourages internal growth of the people toward more effective understanding and use of their land, their potentials and their rights ... then, and only then, do latrines, nutrition centers and so-called extension work begin to deal with the real causes of preventable sickness and death.³

Thus, in evaluating any health or development strategy, we must constantly ask ourselves:

To what extent does the strategy promote the active, meaningful participation and the empowerment of those with the worst health (usually the poorest and most powerless members of society)? And do the methods used help or hinder the long-term process of correcting the underlying social, economic, and political causes of ill health?

By looking at the process of enablement or empowerment of marginalized people, we can learn something about the strategies and methods that seem to work. Then we can try to apply these at the local, national, and international levels.

The Empowerment Process

Empowerment is the process by which disadvantaged people work together to take control of the factors that determine their health and their lives. When high-level planners say that their programs or technologies will empower people, they therefore misuse the word. By definition, one cannot empower someone else: empowerment is something which people do for themselves. However, sometimes concerned health workers or facilitators can help open the way for poor people to empower themselves. Power cannot be given; it must be taken.

There is no formula for empowerment. It is a dynamic process that can happen in several ways. However, there are some constants. Empowerment is at once a personal and a group process. It is part of a process of building collective self-confidence. This is needed for people to shed the feelings of powerlessness and resignation which result, at least in part, from the lack of skills and confidence required to change their condition. Frequently this confidence is forged in a common struggle—whether it be against gender or ethnic oppression, economic exploitation, political repression, or foreign intervention.

The Methodology of Paulo Freire Applied to Health Care

In Part 1 we described briefly a methodology for helping people to empower themselves which the Brazilian educator Paulo Freire, in the 1960s, described as “education for liberation.” The methodology was originally designed for an adult literacy program, but has since been adapted to community health. A small group, such as the residents of a shantytown neighborhood, is brought together in a dynamic problem-posing interchange in which everyone learns from each other. In this guided awareness-raising process, or *conscientization* the group moves from *discussion* of common problems, to *analysis* of the problems’ underlying social causes, and then to *collective action* to remove these causes. (This typically involves a strategy for confronting the local, national, and/or international power structure). After a pause for *reflection* the sequence is repeated.

As the group’s experience and confidence grows, it can begin to tackle more difficult problems, probe deeper in its analysis, and push for more basic changes. But the group needs to recognize the implications of this course. It must understand that as it progresses toward pursuing more fundamental changes, the risk of backlash increases. The logical conclusion of the empowerment process may be an attempt by disadvantaged people to redistribute wealth, land, other resources, rights, or power so that everyone has a fairer share. Such a step is likely to bring the group into confrontation with the privileged class and their guards, and thus expose its members to danger. Facilitators therefore have an obligation to make sure that all participants or trainees understand possible dangers from the outset. The group needs to weigh benefits against risks, and formulate strategies that maximize the former and minimize the latter.



Paulo Freire: Educator, Author, Revolutionary

Paulo Freire, the controversial Brazilian educator and author of *Pedagogy of the Oppressed*, designed an approach to adult literacy based on helping poor people learn to read and write through analyzing for themselves their problems of daily life, and then taking personal and collective action to “transform their world.” Freire’s approach was so successful in awakening people to their rights that he was exiled from Brazil after the military coup in 1964.

Freire distinguished between two concepts of education: the “banking” approach and the “problem-posing” approach. In the banking approach, all-knowing teachers pour a predetermined body of information into “ignorant” learners, like water into an empty jug. Freire branded this form of teaching an “instrument of oppression.” It permits society’s rulers to shape the views and attitudes of the poor majority, thus keeping them in their place. In the problem-posing or “awareness-raising” approach, on the other hand, the facilitators relate to the learners as equals. They help them value and analyze their own experience and create their own plans of action to meet the needs which they themselves identify and prioritize. Freire considered this approach to learning to be an “instrument of liberation.”

Groups or movements working for social change must be prepared to encounter repression on three successive levels: local, national, and international. At the local level, the first line of defense may consist of hired goons or the police. If these are unable to put a stop to the groundswell for change, the army may be called in. Or more powerful nations whose elites have an economic or political stake in the country in question may intervene to preserve the status quo.

In the struggle for equity-oriented change, mass mobilization is critical. To avoid being crushed by the ruling minority, marginalized groups need to unite with each other to form larger coalitions, and to recruit as many supporters as possible. If a substantial portion of the community is mobilized, the dominant forces may be more hesitant to crack down on the movement.