Pioneers in Health

Although the Health-for-all strategies have been widely accepted, a substantial gap still remains between theory and practice.

In most countries innovative ideas have been generated, some of which have been tested and tried successfully. But often they are not incorporated in the national health policies and strategies. Many countries, with willing political leaders at the top, are already committed to health for all and have sufficient bureaucrats and technicians to formulate plans and programmes based on established strategies; at the next level there are competent managers to carry out the programmes to a successful end; and finally, there are the ordinary people who are interested in their health, and whose enormous potential for development must be mobilized.

With all these avenues to bring about change, why is there still a gap between policy and implementation? History shows that leadership stimulates action. Is it possible that the pioneering spirit at the political, managerial, social and technical levels is lacking?

How do pioneers succeed in mobilizing people and provoking action for health for all? What are the driving forces? The three articles that follow describe three very different pioneers in health. They had one characteristic in common: the urge to act. Their stories might help us to go from ideas to action.

Readers may also like to refer to the Round Table on "Leadership in health" in World Health Forum, Vol. 9, No. 2 (1988), pages 147–174, and the article on Florence Nightingale on pages 175–177 of the same issue.

Joseph W. Bastien

The making of a community health worker

Community health workers have greatly improved public health in many small communities in the Department of Oruro, Bolivia. Sixty-four function in their communities, not only as health workers but also as change agents and mediators between traditional and modern medicine. They are elected by members of their communities and are unpaid.

The training of community health workers by Project Concern and the Ministry of Health began in Oruro during 1982. The community was educated about the need for public health measures and the role of

The author is Professor of Anthropology, University of Texas at Arlington, Arlington, Texas 76019, USA.
community health workers. The people then elected local farmers to fill this role, having been dissuaded from choosing religious proselytizers, who openly confront traditional medicine. The farmers were given two-week training courses each month for three months. Instruction was given in the native languages of Aymara and Quechua. Herbalists and ritualists explained the use of medicinal plants and of symbolic factors in healing. The present author also covered medicinal plants and distributed copies of his manual on the subject. Some participants who initially objected that they were interested in only "modern" medicine were advised that their role was to support traditional medicine as well. They were also taught about primary health care, the construction of latrines, stoves, and greenhouses, and crop improvement.

By 1985, 46 community health workers were working effectively. Most of them had built greenhouses, ovens and latrines. They maintained rudimentary dispensaries and were active in mothers' clubs. Most significantly, they became leaders in their communities. Regrettably, doctors and auxiliary nurses rarely visited them and provided little support. The community health workers felt they were on the bottom rung of the health ladder, and many doctors wanted a hierarchical system. Doctors supportive of the programme were assigned to supervise the community health workers.

Community health workers are not paid wages, nor do they receive remuneration in kind. When they complained about this, we suggested that they use ayni or exchange of services. For example, if they cannot tend their flocks or take care of their fields because they are administering to the sick, other members of the community should stand in for them.

Celestino Lara is 36 years old and a native of Sora Sora, a community of 750 people in the Department of Oruro. He has been associated with the fight against tuberculosis, the growing of vegetables, the preservation of produce, the provision of veterinary services and the coordination of modern and traditional medicine. When he became a promotor in 1984, Sora Sora was a rural community of about 150 families who lived in tiny adobe houses with straw roofs and no windows. There was no road, and so trucks were unable to bring in supplies. The people had to walk or cycle to Totora, 21 kilometres away, where the nearest health worker, an auxiliary nurse, was stationed. The infant mortality rate was estimated to be 260 per 1000 live births, many deaths occurring because of diarrhoea, neonatal tetanus, and acute respiratory infections. Tuberculosis debilitated the majority of adults and caused early death, the average life span being only 30 years.

Training

When Celestino began attending the training course for community health workers in 1984 he was timid and a slow learner. After he had completed the course its directors doubted whether he would accomplish anything. The organizers viewed leadership

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in a Western light and scarcely appreciated that the Aymaras, on the other hand, were inclined to regard it as being embedded in the cosmological (ritualistic) and social life of the community. Participants, for example, were uncomfortable with competition and awards for outstanding students, because
they were very sensitive to group consensus and attitudes.

Peasant communities have limited goods and these have to be shared. Among the Aymaras there is a cosmological and ritualistic symbolic system that encompasses the limiting economic and corporate social structure. Certain Aymaras transcend the corporate structure of the community because they are accepted as part of the cosmological system; for instance, the shaman mediates between Alajja Pacha (Upper Earth) and Jana Pacha (Lower Earth).

Celestino helped the organizers to realize that instead of training community health workers to stand out from the community, they should be encouraged to immerse themselves deeper into its social, cultural and religious life. However, many candidates see the job as a step towards becoming an auxiliary nurse and leaving the community. Consequently, ambition has to be carefully evaluated. Celestino was able to introduce many valuable changes through his selfless involvement in the life of his village.

**Personal experience**

After he finished his training and returned to Sora Sora, his wife became sick. He diagnosed susto (fright) and thought that someone had bewitched her. He asked a curandero to effect a cure with rituals and medicinal plants, but this proved unsuccessful. He then took her to the hospital in Totora, where pulmonary tuberculosis was diagnosed and antibiotics were supplied to Celestino for the 366-day treatment. After five months she reacted to the medicine with peeling skin and swelling of the body. Relatives criticized him for having used this medicine on his wife and asked him to abandon it. The doctor at the hospital also discouraged him from continuing, but he was determined to finish the treatment. His wife’s family would not speak to him and threatened punishment if she died. By the ninth month she had recovered, and her relatives and the rest of the community then accepted him as a healer.

Recognizing symptoms of tuberculosis, Celestino diagnosed the disease in an uncle and a second cousin, and began treating them. He frequently walked to Totora to deliver sputum samples, obtain drugs, and provide progress reports. He made the journey at night because he had to farm during the day. Patients had customarily gone to Totora for treatment but Celestino felt this aggravated the condition. By 1986 he had treated many more patients with tuberculosis and, indeed, had begun eradicating the disease from his village. He also conducted a child immunization programme against tuberculosis and other diseases. At his suggestion, the villagers formed health, agricultural and education committees. They also requested the Ministry of Rural Health that Celestino be taught to suture wounds and treat complicated diseases.

**Collaboration with traditional healers**

Celestino was one of the first community health workers to collaborate with curanderas. He recognizes his limitations and their
contributions to health. He refers pregnant women to a midwife curandera for delivery. He has taught her about sterilization methods, and she informs him of complicated deliveries. Because there is a shortage of synthetic drugs, a healer called Clementina Wilka has provided him with a list of medicinal plants obtainable in Sora Sora; in return, he has instructed her about additional therapeutic uses of the plants as indicated in the herbal manual. The following medicinal plants are frequently used: Escalonita micrantha for diarrhoea and colds; Mithostachys andina for colds; and Eucalyptus globulus and Gnaphalium guadalupianum for coughs. With a view to integrating their work, Celestino, Clementina and the midwife attended a seminar on public health in Totora. The community largely supports them because of its perception that they provide a collaborative health programme. However, Celestino still has opponents; one curandera, for example, openly criticizes his efforts and refuses to work with him, even though he respects her work.

Many of the villagers are related to Celestino and to the traditional practitioners; professional interests become lineage property and this often results in feuds. Celestino defuses potential rivalry by pursuing the interests of the majority, integrating traditional specialists into the health programme, and respecting those who oppose his programme.

Food production

Through his efforts, Sora Sora has increased its productivity and has developed a market economy. Technicians have instructed Celestino in agronomy and veterinary medicine. For many years the people suffered from malnutrition because they lacked vegetables, which could only be obtained by travelling long distances. In 1985 Celestino introduced underground hothouses to the village, and within two years every family in the community was growing tomatoes, carrots, radishes and turnips. There is now a surplus of vegetables, some of which are sold in a weekly market. Part of the surplus is stored to cover requirements when no crops can be produced. Beet is stored by burying it in the earth and covering it with herbs, an ancient practice in the region. Dried fodder is stored in rock caverns so as to supplement the sparse winter grasses on which the livestock would otherwise depend. Celestino also treats diseases of sheep, llamas and pigs with veterinary medicines. As a result, the flocks are more productive than formerly.

Celestino is aware that the environment is an important factor affecting the health of the community. Overgrazing depletes the soil and erosion washes away the thin layer of humus. With help from an agronomist he has encouraged the planting of Buddleia incana trees as windbreaks.

As a tribute to his efforts the villagers asked that he be trained as an auxiliary nurse, and agreed to pay his salary after he qualified.

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They also decided to build a health post. Celestino qualified as an auxiliary nurse in 1987, and the health post was then inaugurated. In the room where the patients are treated there are stocks of synthetic medicines, medicinal plants, and instruments. A second room has a bed for
sick patients, who may be referred to the
doctor in Totoro. A third room serves as a
store for tools and equipment used in
agricultural and community development.
Celestino is committed to working for
health, increased productivity, and the
integration of modern and traditional
medicine. He has helped to give life to a
dying community and demonstrates just how
effective community health workers can be.

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To be successful, community health workers
have to be actively involved with the people
they serve in health development. The most
successful share the people’s beliefs, values
and customs. They know how to introduce
Western medicine and integrate it with
traditional medicine. Ultimately, even
people who are resistant to change recognize
the benefits of this approach. The success of
community health workers in Sora Sora
owes much to the effort made to adapt to
the Andean style of leadership, one feature
of which is that it is less an innate quality
than something embedded in the cultural,
social, ritual and cosmological system of the
community. This is recognized in the
training of community health workers,
which covers Andean rituals, symbols and
folklore. Candidates are thus encouraged to
immerse themselves in the cultural milieu.
Unfortunately, training courses elsewhere
may set community health workers apart
from their cultural tradition by
concentrating unduly on modern medicine
or by teaching technical jargon and skills
that tend to create an elite.

Unsuccessful community health workers
usually have ulterior motives for their
involvement. Whereas ambition, motivation,
leadership skills, energy and intelligence are
frequently associated with success in
Western society, these qualities are not
always found in Aymara leaders. Community
health workers with these qualities may be
unsuccessful. Ambition often implies a
desire to gain skills and to move to the
cities. The result is frequently that the
community health worker becomes
competitive with other members of the
community. Decision-making in most
communities is achieved through a
conservative consensus. It can be influenced
by hard-working community members who
respect traditions. Many people in Bolivia
oppose the petty tyranny of the new
generation of village technocrats (engineers,
doctors and teachers) and their aura of
intellectual authority. Community health
workers are grass-roots people who retain
their agricultural interests. They perform
their new role as a service to the
community, whose members select, support
and retire them. The success of community
health workers is related to sociocultural
knowledge and studies that prepare the
ground for primary health care in
communities. Anthropological methods
assist health workers to collect data from
communities with non-Western patterns of
thought and little formal schooling;
participant observation, interviews, mapping,
and the taking of life histories are involved
(1). These activities provide data, identify
community belief systems that affect
behaviour, and help to bring Western and
traditional medicine together.

It has to be realized that Andean people do
not wish to go over entirely to the Western
medical tradition, but rather aim to take
from it what they can use in their own
culture. Against this background, community
health workers fill the role of cultural
brokers.

Reference

1. Buzzard, S. Look, listen and learn: preparing the
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