The Chimaltenango Development Program

Written in 1974, 1975 & 1982:

For the past nineteen years, I have lived and worked with the Kaqchikel of Guatemala – a proud, dignified, life-loving but impoverished people. Their cultural heritage stems from the Mayan civilization that lavished artistic, architectural and intellectual riches through the areas of Southern Mexico, Yucatan, Guatemala, Belize and Honduras many centuries before the Spanish conquest. I have gone to school with the Kaqchikel, letting them teach me – a North American doctor trained in the complex technology of modern medicine – the simplicities of what they believe is needed to live and prosper in the highlands of Guatemala. This is an area where nearly four million agrarian Maya now eke out a bare existence beneath the slumbering volcanoes that dominate this land of majestic beauty and sordid poverty.

I have learned more from my Mayan friends than they have learned from me, and I have come to believe that much of what I have absorbed here has application to the rural poor throughout the world. What I saw and heard in the course of surveys of mission hospitals in Africa and Asia confirmed my suspicion that basic problems in Guatemala are widely duplicated elsewhere. Despite important differences of culture, language and race, the rural poor of all continents share a commonality forged of poverty, exploitation, disease, malnutrition and land hunger.

As a result of my "student days" with the Kaqchikel and my travels among peoples facing similar problems, I have reached a number of conclusions concerning the great public health question of the day – how do they, how do we, how do they and we together break the back of disease among two billion rural poor in the less developed regions of the world? In 1962 when I arrived in Chimaltenango from a medical practice in Kansas, I would have said that curative medicine was the primary strategy. I have learned otherwise the hard way. The answer proved unrealistic both in terms of reaching by means of clinics and hospitals the ailing people in jungles, savannas and mountains, and in terms of keeping them healed when they return to the conditions which can fell them again within months, often within days, of their treatment.

Today the answer seems at once more simple and more complex. Impossible as the problem appears to many, I am now convinced that a fruitful beginning can be made by people outside the health bureaucracies of the world. I am also convinced that, with careful nurturing and persistence, an impact can be made from humble and inexpensive beginnings. I think we have proved this in Guatemala, although we still have a long, long way to go. Let me describe the origin and evolution of our experiment in the Guatemalan highlands.

These highlands are like many other areas of the "developing" world when seen through the lens of economic and public health statistics. They are predominantly agricultural and poor in cumulative resources. The wealth that exists is concentrated in the hands of an elite class. While the gross national product is increasing, largely through farm exports, the great mass of the people do not share in the benefits. The economic condition of the Kaqchikel is reflected in their state of health. The infant mortality rate is one of the highest in the world. Respiratory infections, malnutrition and intestinal disorders are primary causes of death; and many other diseases, such as measles, tuberculosis, whooping cough and influenza – no longer considered threats in the industrialized countries – still stalk the ridges and valleys.

This is one of the few areas in Latin America where the pre-Columbian population is still predominant. Mayan descendants make up more than three-fourths of the inhabitants of the highlands. They have held tenaciously to their culture and preserved their communities with a high degree of success. This requires that work with them be done on their own terms. While they are adapters, they have little appetite to copy modern cultures.

HOW THE PROJECT BEGAN

I came to Chimaltenango, a hub of the Guatemalan highlands, two decades ago under sponsorship of a Lutheran church body. During the first weeks I did little more than walk around town, get acquainted with the people and play with the children. Gradually, I was invited into their homes to have coffee with them or sit down to a meal of tortillas and beans. This went on for three months until I became known and accepts in the town and until I felt confident that I could fulfill a need.

That moment arrived when I accompanied a man, who was carrying a child's casket (not the first he had carried) to his home. Intravenous feeding mercifully turned back a case of prolonged diarrhea and extreme dehydration in his infant child. During the days that followed I practiced in the square, accompanied by a nurse recruited from Guatemala City who helped train local women as aides. Then I rented a house for $25 a month and opened a clinic. The first day 125 patients came. I was in the business of curing.

It did not take long to realize that I was trying to empty an ocean of disease and malfunction with a medical teaspoon. While this is not the place to analyze my personal transformation, let me illustrate a fundamental change that took place in my thinking and attitudes by recounting what happened to Jorge.

I met Jorge about a year after coming to Chimaltenango. He was a handsome five-year-old boy but he was suffering that day he came to the clinic with his mother. He had puffy eyes, swollen feet, pigmentation blemishes on his arms and legs and stains the color of port wine. I found that he lived in the village of San Jacinto in the rugged mountain country near Chimaltenango. Since he was not the first child from San Jacinto to come with this problem, I decided to go to the town for a look at conditions there.

I drove by jeep to San Jacinto with two women helpers. Though the village is only five miles from Chimaltenango, the journey was a long one. There was no road at that time and our wheels often became mired in mud holes. At last we left the vehicle and walked the rest of the way. The trouble in San Jacinto was not hard to diagnose. Almost every child we saw was malnourished and diarrhea was common in both adults and children. A great deal of coughing could be heard. As we visited the thatch-roofed huts we learned that the common diet included very little protein. The village lived almost exclusively on tortillas and greens.

Why? The people had no land to farm, only miserable little plots in areas where the soil was poor. San Jacinto was almost completely surrounded by large plantations operated for the benefit of absentee owners. The men of the village, seeking to earn a bare living, customarily

packed up once a year and went to work on the big coffee fincas on the Pacific coast. Going from the cool highlands to the hot lowlands they fell victim to a variety of tropical ailments and many returned to the village with tuberculosis. When the two nurses from our clinic made a house-to-house survey, they found that 150 of the 450 residents had active tuberculosis.

We realized that, no matter how many times we treated Jorge and other youngsters from San Jacinto, they would never be health until basic changes were made in the village. We began in a simple, tentative way. A Peace Corps volunteer attached to the clinic made weekly visits to San Jacinto, gained the confidence of the men and began to teach better farming methods to a group who tilled their plots for survival. Later, we lent money from our initial operating funds to twenty-five families who wished to raise chickens and produce eggs. Soon the people began to eat more protein – “an egg a day” became a slogan in the village. The loan was repaid in full, the borrowers giving us a portion of their egg production in lieu of cash.

Gradually our work expanded in San Jacinto. A Kaqchikel health worker who was trained with us in Chimaltenango opened his own small clinic in the village and began treating the most common ailments on a fee-for-service basis. On request of the villagers, native extension workers of the Chimaltenango program taught health care, nutrition and farming methods. Ten families banded together and bought some land held by an absentee owner, borrowing from our operating fund and paying us back conscientiously as crops began to bring a dribble of cash to the town. Year by year, more land was purchased with the help of a revolving land-loan fund, which was set up with the aid of grants from international foundations. The women of the village organized a weaving and marketing club which brought more income than the handful of coins they had formerly gained through individual efforts.

Today San Jacinto is a reasonably healthy, economically viable community. Malnutrition has all but disappeared and the dreaded tuberculosis has been controlled. You can walk through the village today without hearing much coughing. Jorge himself is a robust young man. While San Jacinto is still poor, it has a new vibrancy compounded of protein, cash, work, and hope.

True, San Jacinto is not the world, but a million San Jacintos might transform the world. As our program evolved, we came to see dozens of San Jacintos in the Guatemalan highlands and came to feel that we were on the right track. In brief, what started as curing the sick broadened into a general community program geared to activities that the residents want and need and that result in self-empowerment.

These experiences have hammered home a strategic truth. Institutionalized charity from outside accomplishes little beyond the cosseting of the egos of the helpers. The Kaqchikel receive no charity from us. They pay for the services they want, borrow at reasonable interest rates, and select the people who are to work with them. All of our health promoters are Maya, as are most of our nurses and extension workers. The clinical staff now includes two Guatemalan doctors, one of whom serves as the medical director. If we outsiders do not plan ways of doing ourselves out of a job we are probably not doing the job at all.

The Chimaltenango program never abandoned curative medicine. Indeed, without curing, our expanded program would have been difficult to initiative or to sustain. However, changes were required even in our medical practice. During the early years our work was subsidized by a Lutheran church body and we also had access to some free and discount medicines. If these arrangements were to continue indefinitely, however, the local people would become dependent on outside aid that is not entirely reliable. During our first years, moreover, we were able to deal with infectious diseases on an outpatient basis through antibiotics, electrolyte solutions and immunizations. But as word spread, many more sick people began arriving. Some came from great distances, sometimes on the back of a porter, and were too ill to make the long, hard journey home. So we had both to intensify our curative services and to adjust familiar medical practices.

THE HOSPITAL

Conventional hospitals are a very expensive proposition. Poor rural areas cannot afford the hotel services and elaborate facilities of modern hospitals. Moreover, impressive buildings with

sophisticated rules of procedure are almost certain to alienate people who are used to being cared for by family members.

Already in 1962, as demands grew in Chimaltenango, we decided to build a very modest hospital with a difference. Here families could stay with their patients and would be responsible for preparing food and providing basic care. This arrangement turned out to be not only far less expensive but also far more humane. Costs to the patient in our hospital, including all services and medicine, now work out to about three dollars per day. This payment does not cover all our expenses, but that is because we accept any and all patients regardless of their ability to pay and because unequal ancillary services like transport are funded from the general budget.

Though the hospital enabled us to treat more patients for longer periods of time, there were still many people living at great distances who could not afford to travel to Chimaltenango and many others who remained suspicious even of the modest "modern" services we offered. Here we faced a new set of problems. Having reformulated the concept of "hospital," we now challenged that of "doctor" as well.

HEALTH PROMOTERS

As a medical professional I was at first disposed to think of duplicating the functions of the medical physician in medically deficient communities by creating mini-doctors who would provide services patterned after those offered in Chimaltenango. I then discovered that this device of dispatching mini-doctors would not prove acceptable, given the high suspicion that prevails on the part of the people with respect to impositions from outside their own community and culture. Moreover, such service delivery might diminish the multiple initiatives that are needed on the part of the people themselves. A new type of community worker had to be created, one that was not patterned after the doctor but was rather a product of the community itself.

During the first years of seeing 125 to 200 patients a day, we began to realize that a bright Kaqchikel, given a certain amount of inexpensive training, could treat the most common diseases just as well as a university-trained doctor. Not only would the investment of time and finance be

far more modest, but the ability to work in accordance with the customs of the people could prove invaluable in pursuing community arrangements for health and in gaining acceptance of some unfamiliar medicines and procedures. From the mid-1960's we began training responsible young Maya to recognize and alleviate the most common health problems. This program grew to include more than seventy health promoters from fifty villages.

Although the formal education of our promoters had ended, on average, after the third grade of elementary school, they were for the most part alert, eager to learn and quite skillful at treating ailments within their competence. One day we took an American specialist in tropical medicine on a tour of the health promoters at work. He was skeptical that persons with little formal education could administer adequate medical care, but as the day wore on and he saw promoters dealing knowledgeably with one ailment after another, his skepticism abated. Finally, he thought he had caught one of the promoters giving an incorrect treatment. "You have the right disease, but the wrong remedy," he said to the promoter. "The specific indicated here I penicillin." The young Kaqchikel shook his head. "Yes," he replied, "but this person is allergic to penicillin."

The manner in which trainees came to be selected is of critical importance. At first we accepted those who were recommended to us by a local priest or a Peace Corps volunteer. In two cases local curanderos, who practiced traditional healing, elected to enlarge their service by becoming promoters in our program. Later our approach was to encourage each community to set up a local improvement council, which included a health committee. Then the community health committee selected a person for training. The promoter thus represented his community and was also accountable to the community. In cases of discipline, the community could decide to retain him or recommend his dismissal.

As part of their training, health promoters are asked to come once a week to Chimaltenango and spend an entire day with us. Their day begins with hospital rounds in the company of a doctor or supervisor. They see patients, hear the interviews and observe the treatments, then give consideration to how those very problems could be handled – and prevented – in their home villages. We usually do not speak of diseases by name but rather talk of the patient's symptoms, since symptoms have meaning to the people while classifications do not. I wish to emphasize

my belief that any program for training lay workers that does not include facilities for demonstration with patients cannot be effective. A living demonstration accomplishes as much as six hours of lectures. Films, books, pamphlets and seminars are adjuncts but no substitutes for this.

Our program of health promoter training is a continuing one. Before a promoter dispenses medicines or gives injections, he has attended observation and reflection sessions for at least a year. Nearly all promoters, even those who began their training more than ten years before, return on a regular basis to gain new insights and observe treatments. We conduct periodic reviews in which promoters are asked to describe what they see in a patient, how they would proceed with the patient, and what is to be done in the patient's home and village to prevent a recurrence in the future. Promoters are visited on the job by a supervisor, an experienced Mayan worker, who is in charge of the program.

Although they identify and treat most diseases in their communities and work with as many as a thousand patients a year, there are some medical tasks that are beyond the competence of the health promoters. They are trained to recognize these and to make referrals to the clinic in Chimaltenango or to another nearby health center. For example, an elderly man with swollen feet and shortness of breath probably has heart disease. The promoter is responsible for seeing that this sufferer receives professional help, even if it means carrying him out of the village in a chair tied to a porter's back. Generally, on the basis of such understandings, the promoters do very well.

Promoters do not carry drugs with potentially serious side effects, such as corticosteroids and digitalis preparations. Given this limitation and firm agreements against overuse, the buying and selling of medicines is carried on in a businesslike way. Our clinic places the orders for common medicines in Guatemala City, since we can buy at reduced hospital prices. All supplies are then passed to a promoters' medicine cooperative at our price plus a 10 percent handling fee. The medicine cooperative, in turn, sells directly to the promoters at the co-op's purchase price plus 10 percent for its expenses. Thus, medicine is available to promoters and their patients at reduced prices, much below those quoted by the pharmacies.

Each local health committee receives a price list for medicines and the promoter is expected to charge accordingly. In addition, promoters may charge a fee of 50 cents for their call or services. The profit motive naturally affects their attitude toward their job, but they are not expected or encouraged to make a livelihood from their medical practice. They are, without exception, more secure financially than they were before training, while rendering a service never before performed in their village. No promoter receives any pay from the parent organization in Chimaltenango.

Since the promoters generally work with poverty-stricken people, some of whom cannot afford to pay cash, they have developed a system of credit that is both effective and reliable. The success of this system derives in part from the culture of the highland peoples. Responsibility, respect and honesty belong to the local tradition.

In addition to the curing aspects of their labors, health promoters become community catalysts and organizers. They educate with respect to family nutrition and foster community provisions for health. Immunizations, tuberculosis control and treatment, water projects, literacy programs, family planning, agricultural extension, introduction of fertilizers, new crops and better seeds, chicken projects, improved animal husbandry – all may come into the promoter's purview.

AGRICULTURAL EXTENSION SERVICE

A natural outgrowth of our work in health promotion was agricultural extension work, which we began in 1966. The people of the Guatemalan highlands are mostly farmers. By tradition the staples of their diet are corn and vegetables, particularly beans. A farmer must raise sufficient corn to supply his family with tortillas from one harvest to the next. If the harvest is poor, their livelihood is directly threatened.

But the typical farmer is land poor. Land holdings, already small, become further fractionated as the Mayan farmer, in accordance with tradition, divides his holdings equally among his sons. There are, however, a significant number of large estates that are left fallow by indifferent

absentee owners, who maintain title only because of prestige or family tradition or as an investment. Some people live on these estates as tenant farmers.

Help is available to these farmers through extension agronomists who have received training in government-sponsored programs or from senior workers in our program. Our agricultural extension activities initially concentrated on obvious measures – use of fertilizers, better seeds, soil improvement, crop diversification including vegetables and cold-weather fruits, introduction and improvement of chickens, veterinary medicine and similar strategies that help the subsistence farmer produce more nourishing food for himself and his family. Many farmers have increased their yields two to three times, and in some cases, improvements have been even more dramatic.

Our program has remained tentative and flexible with respect to the use of manufactured agricultural accessories. Large mechanical implements, such as tractors, are less attractive here because of the rugged terrain and the cost of buying and maintaining machinery. We have, however, been strongly tempted by some chemical fertilizers. These have been introduced after analysis of soil samples and have definitely improved yields. Today, however, because of a worldwide shortage of manufactured fertilizers and a consequent rise in price, we are once again reminded of the hazards of relying on outside technology. Just as our medical approach must emphasize disease prevention, thereby releasing people from dependence on manufactured pharmaceuticals, so must our agricultural efforts stress implements and resources that the people can supply themselves. Accordingly, our program has increased experimentation with composts and natural fertilizers that control the balance of elements in the soil.

The primary limitation on innovations is the poverty of the average small farmer, who does not have ready money to invest in experiments. He finds loans extremely difficult to obtain or available only from a private money-lender who charges an intolerable rate of interest. To meet this need, the program has set up a revolving fund to provide farmers with credit on easy terms for specific agricultural projects. Gradually this revolving loan fund is being replaced by a local agricultural savings and loan cooperative that is managed and controlled by the people themselves.

THE LAND LOAN PROGRAM (ULEU)

The most formidable obstacle to the success of our agricultural work has been the shortage or inequitable distribution of land. Indeed, land hunger is at the root of almost every major problem in these Guatemalan highlands. We have noted how farmers who own no land or only a piece too small to meet family needs are forced to migrate seasonally to the tropical coffee and cotton plantations of the Pacific slopes. There they receive low wages, live in squalid conditions, aggravate the primary health problems of infectious disease and malnutrition – and lose time they might otherwise spend improving crop yields in their own highland village.

Moreover, when farmers do not own a suitable piece of land in the highlands or share in land ownership through a collective, they have scant incentive to improve the soil. Were they to introduce extensive conservation measures by building terraces and contour ditches or using fertilizers and a simpler plow, the yield and value of the land would rise and the owner would demand more rent – possibly pricing the farmers out of the very land they have improved. As a result, many farmers refuse to employ techniques they know would improve land yields.

Responding to this dilemma, we established in 1970 a program to make loans available to communities of Mayan farmers who wish to buy their own land. Loans are made only to groups, since large purchasers enjoy a better bargaining position and since this will reduce the cost of extension services. Our revolving loan fund program is called ULEU, a Kaqchikel word for "land," and is governed by a board of directors composed of extensionists and representatives of the cooperatives – all local people. The loans are long-term with low interest rates by Guatemalan standards. The farmers do their own negotiating with the owners or former landlords to determine a sale price and payment plan.

We my no means suggest that this is a sufficient approach to the historical and deep-seated issues of land reform. But it is a good option for a voluntary group that undertakes to discover what people can do if they have the opportunity and if they undertake to work together. We hope to show that land reform can prove very effective when it is taken up by a community and

supported by a complex of skills and capacities. We also hope to demonstrate how closely land reform is tied to public health.

WOMEN'S PROGRAMS

When first established, our agricultural extension program was oriented toward men, since it is they who work in the fields. Many health problems, however, are associated with activities around the home. With this in mind, we began in 1972 to train experienced Kaqchikel women who would travel to various villages demonstrating and encouraging aspects of household health such as nutrition and hygiene, sewing, home gardens and chicken projects. Because these extensionists were Mayan women who spoke the Kaqchikel tongue and wore the typical garb, they have been successful communicators.

Family planning is a part of this activity, though it is approached with sensitivity and respect for local traditions. The Mayan culture is dedicated to family, God and the earth; it does not take readily to limited life or distorting nature. The people are suspicious of outsiders who come with the suggestion that they should limit their numbers. We should remind ourselves in the industrialized countries that each new child in the Guatemalan highlands will use during its lifetime only a tiny fraction of the irreplaceable natural resources (oil, iron, aluminum, etc.) that a child born in the United States will use. It requires 26 tons of ore to sustain the average citizen in the United States, compared with a fraction of a ton for the average Mayan resident of Guatemala.

Family planning sessions, offered exclusively by Kaqchikel women, do not bluntly raise the subject of birth control nor move quickly to showing what can be done with a particular apparatus, pill or injection. Rather, our workers sit down with a family and consider with them their own views of the situation. Any technicalities wait until the family is fully involved in the decision making on its own terms. Since the family makes the decision, the drop-out rate is low.

The people want positive results, not merely a limitation of offspring. They know that half their children now die of diseases linked with malnutrition. They want to know that those who follow

them will have land and food. Thus, agricultural extension, nutrition advice and land reform programs all become integral parts of family planning.

WATER PROGRAMS

Lack of potable water has been a persistent health hazard in the highlands. In 1979, to combat this problem, we joined forces with the Guatemalan Ministry of Health and with Agua del Pueblo, an institution dedicated to improving sanitation and water resources. Together we formed SARUCH (Servicios de Agua Rural de Chimaltenango), an organization which works to increase supplies of pure water. The people receive loans to install not pumps but gravity-type systems, which are not subject to energy and mechanical problems.

It should be emphasized that these are more than "water projects," deposited on communities. They are, rather, a mobilization of people to address their most basic need and an excellent point of departure for dealing with the whole panorama of health-related problems. The people are themselves in charge of gaining participation, planning, forming objectives, managing the work and repaying loans.

This mobilizing dynamic becomes visible as children carry the pipes, men volunteer days away from their farming to dig the space for holding tanks and trenches for the kilometers of pipes which must be laid. On the great days of inauguration, entire villages rejoice in the gift of water and in the utility which they themselves have built.

PROGRAM EVALUATION

Having reviewed the course of our program to here, we might wish to ask: What in fact has been accomplished? What are the strengths of the program and what are its shortcomings? Unfortunately, few comprehensive studies have been made and baseline data, which might later have served for comparative purposes, were not always collected. Given limited resources, we used what we had to help people, not make measurements. Nonetheless, several outside evaluations have been undertaken and their criticisms have been instructive.

According to one report, written by a Canadian nurse in 1978, we were falling short in our pursuit of a primary objective. "The chief flaw which I observed in the otherwise excellent program was the fact that Dr. Behrhorst was still personally treating all the outpatients that came to the hospital" (Bent 1978). This was a largely valid complaint and one that we have struggled to correct. If programs like ours do not take root in native soil under local direction, they will wither the moment the foreign helpers cease their aid. We have not taken the steps, both legal and organizational, to assure that the program will be governed by a local board and administered by local staff on their own terms. The program is licensed as a private agency under Guatemalan law, with all policy matters in the hands of a local board of directors.

Another criticism, despite our best intentions, is a lingering overuse of drugs. Like the medical system itself, we have tended to rely too heavily on pharmaceutical preparations in the healing process. We have taken several corrective steps: we are restricting drug use to a limited list, substituting explanation for medication whenever possible and making better use of local herbal remedies.

Our clinical efforts have been criticized for their lack of support services and controls. Treatments are administered on the basis of clinic practice and not always backed up by more sophisticated laboratory testing. There is some merit to this complaint, and we are improving our laboratory procedures and record-keeping. However, we remain convinced that the most important factor in the health process is the patient, not records documenting the condition.

The work of our health promoters has proved gratifying in many ways, but even here we have had some problems. There are risks involved in placing medical responsibilities and tools in human hands, whether in Boston or in Comalapa. At times promoters have overtreated or overcharged their patients or have not dedicated themselves to total community efforts. For the most part, however, careful supervision by senior staff has prevented excesses of this kind. If, moreover, a promoter does not maintain acceptable standards of treatment and care, the community can discipline him or the medicine cooperative can refuse to sell him medicines.

Some outside observers have called into question the "capitalistic" practice of charging patients on a fee-for-service basis, suggesting that the community at large should pay for health services, not the individual. This sounds attractive but it would not work at present in the Guatemalan highlands. The Kaqchikel are skilled traders with an acute business sense, who believe that anything worthwhile must be earned and paid for. Public sector charity programs have met with little success here. Given these considerations, direct payment by the patient to the healer seems the preferred system, with the special provision of a credit system and use of the Robin Hood principle –charging slightly higher fees to those who can afford to pay and considerably lower fees to the very poor.

Most observers have been impressed by the integral approach taken by our program (Glittenberg 1974, Heggenhougen 1976). In areas where our extension workers have been active there is direct evidence of crop improvement, more cash income, less malnutrition and infectious disease, improved hygiene and sanitation, cleaner and more available water, and a greater number of immunized children. The land and agricultural loan programs have had the additional positive effects of freeing farmers from the need to migrate to the plantations of the south coast. What they require for their livelihood they are now producing on their own land.

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The Violence

Part I: The Conflicts in Guatemala as they Bear on the Chimaltenango Development Program (May 8, 1981)

Recent intense political conflicts in the Chimaltenango area have interrupted program activities, even to the point of the kidnapping and killing of program workers. Although our work is explicitly apolitical and dedicated to the middle-of-the-road course in behalf of its mission, it is also clear to us that political goals are relevant to health. Lest any forget, disease has definite economic and social etiologies, so an overall strategy may demand political interventions as well as medical remedies. To imagine otherwise would be as foolhardy as to imagine that military strategies all by themselves are sufficient to resolve problems that have rooted economic and social causes.

Because of its community activities, the Chimaltenango program has become affected by the local political conflict. Community action, whether by social, educational, religious or development groups, has been viewed by government security forces as sowing sees of "subversion." Hundreds of private and public workers have come under suspicion, but those fostering community action have been seen in particular as supportive of the guerrilla movement in the local countryside. Eight of our program workers have thus far been threatened or killed, or have disappeared and are presumed dead. People living in the communities served by these workers are often convinced that the kidnappers were with the government forces. In one case an army commander admitted as much in response to an inquiry by a health promoter.

Local Guatemalan newspapers testify to violence and excesses in various areas of the highlands, particularly in the department of Chimaltenango. Massacres of dozens of people in nearby villages have been confirmed. Since investigations of these events are seldom forthcoming, there can be only speculation and rumor as to who is guilty of particular gross excesses. Both government forces and guerrilla elements are accused of brutality and atrocities.

In mid-March, 1981, letters were received by Guatemalan social institutions (reportedly five in number) indicating that the recipient agencies were staffed by "communists" and that all staff must leave the country within thirty days or suffer the consequences. The following week letters were sent to private voluntary institutions engaged in development work. These letters said that all foreigners involved in program efforts must leave the country or be "eliminated." Both groups of letters were signed by "Ejercito Secreto Anti-Comunista."

The Behrhorst Clinic was included in the second listing along with Church World Service, the Mennonites, Roman Catholics engaged in the agricultural program in San Lucas Toliman, and some Norwegian groups. All of these agencies have relations with the Comite Nacional de Reconstruccion and internationally with various funding groups.

Several days later, recipients of this letter were called to the office of the chief of the Comite, who told us that the letters were really a locura, that the intent may have been to threaten the Comite itself. A consensus, shared by board members of the local Behrhorst Foundation, is that these letters had their origin with a reactionary sector of the government and were intended as a tool to destabilize and demoralize non-governmental institutions that have been involved in community work, particularly in the departments of Chimaltenango, Solola, and Quiche.

The government security forces are determined to control the countryside and eliminate the guerrilla movement at all costs. Any programs or individuals are suspect that do not collaborate with the government, especially if they are supportive of community efforts in areas of guerrilla activity. In terms of this mentality, all individuals and groups devoted to community action must either be controlled or else eliminated.

II The Chimaltenango Development Program – Its Evolution 1961 to 1982 (From a 1982 draft)

It is appropriate here to discuss briefly the role of health promoters with respect to their function and future in communities involved in political conflict and civil war. These health workers assume the role of change agents in dealing with basic community issues that bear on the health of the people. A primary strategy in their work with the poor and powerless is the promotion of

processes that are self-empowering on the part of the people themselves. Such community activity can indeed prove liberating and transforming. It should be noted that palliative measures like those of curative medicine do not fulfill this activating role.

Acceptance of community activist roles in areas of deadly political conflict can leave health workers vulnerable to suspicion by those who interpret community efforts as threatening or subversive. This is precisely what happened in our program between 1980 and 1982, with the death or disappearance of eleven workers in the Department of Chimaltenango and eight in northern Quiche. A painful question has arisen: In training community health workers do we also destine them to death?

Valid answers to this complex question do not come from outside sources, from salon-type or desk-top revolutionaries who propose or endorse strategies form the security and comfort of living rooms or tenured posts. For us here in Chimaltenango, where people have suffered two years of terror, it seems clear that it is for those who daily face these problems and issues, including the possibility of death, to make the decisions that bear on their own destiny and that of their people.

If a health promoter, in the face of terrible tragedy all around – which may have included the loss of family members – makes the decision to continue or reactivate his community efforts in spite of the risks involved, that that worker should be supported. The worker should have access to proper resources as always. To deny a health worker the right and the means to serve his people is irresponsible and immoral, regardless of the jargon to be heard on either side of the political spectrum.

The morality and practicality of training community activists in oppressive societies remains a knotty and heavily complicated question. Suffice it here to say that the line between a worker's role as an agent of change and his or her perhaps inadvertent involvement in political crusading is indeed thin. Ultimately, the worker and the community must make the decisions concerns whether and how to do things – including whether and how to adjust to local realities, particularly when their own survival is at stake.

This is not to say that, for any of us, the goals of power and justice should now become fuzzy or that actions may justifiably become unprincipled. It is not to say that any of us is morally free to abandon the struggle or to seek personal security in some place far removed from it.

A Brief Policy Statement (1983) – Formulated by the board in Guatemala and communicated to program constituencies, supporters, and leaders on both sides of the conflict.

The Fundacion Guatemalteca para el Desarrollo "Carroll Behrhorst" is about to embark on its twenty-second year of work with the people of highland Guatemala. Despite the violence and frustration that have been part of daily lives for the past three years, the program continues to pursue its objectives: healing the sick and encouraging processes that bring hope of a better life to the many deprived. But the fact that Guatemala itself now faces an uncertain future raises questions about the status of the program, its ongoing purposes and its relationship to opposing elements in the local political spectrum.

The purpose of this policy statement is to clarify several issues which have caused concern both in Guatemala and among the program's many friends outside Guatemala. Like any human endeavor with people who are submerged in a sea of social, economic and political problems, our work has always been characterized by ambiguities, trials and conflicts. The program staff admit with candor that, together with many successes along the road to health in the highlands, the program has made some false started, adopted some inappropriate strategies and suffered confusions. Against a backdrop of immense deprivations, it is not easy to keep in motion the wheels of change by which highland people can transform widespread poverty and illness into a more acceptable living environment. When, in addition, a tremendous loss of human and material resources is added to ordinary insecurities, the task becomes vastly more complicated. The recent escalation of political violence in Guatemala not only heightens our awareness of the conflicts attending health and development, but now has the potential of threatening our very survival.

The program has survived to date, even though volunteer health workers have lost their lives in their areas. One major reason for this survival derives from the program's capacity to maintain relationships with the local people by respecting their traditions and their actions in an apolitical, nonaligned manner.

The program enjoys a large reservoir of respect and confidence from all the various groups engaged in the current political struggle, as well as from a majority who remain unengaged. Even the extremes of right and left respect the program because of its constructive activities, which transcend political ideologies. The program takes official sides with no political group in Guatemala. In responding to requests from leaders of government we have given advice in matters related to health and development, but nothing more. They did not seek and did not get relationship, participation or commitment.

This neutrality has been misunderstood by some and challenged by others, particularly by non-Guatemalans who observe the current crisis from afar. Our answer is that, in the work of health and related development assistance, it is imperative that non-alignment be a part of program policy. We will not succumb to a polarization that might expose the program to reprisal by any side. This policy has the unequivocal support of the local board of directors, whose membership reflects various shades of the Guatemalan political spectrum.

Our political nonalignment does not, of course, allow us to proceed along an ill-defined course without definite purpose or principle. Our commitments are on the side of community stability and of justice for all. The pursuit of these very goals requires some flexibility in taking account of local realities, particularly when the survival of the program and its staff are at stake. No one can respond to fellow humans from beneath six feet of earth in an unnamed burial ground.

Development is an art of the possible, requiring both risk and patience. Our program in Chimaltenango will continue on its determined course.

IV Something from Chimaltenango (June 13, 1984)

Today is el dia de San Antonio which, by a centuries-old tradition, should see great dumpings of rain all around. San Antonio is doing his thing. Last night and early today the heavens opened and poured torrents of water inundating the place. Tomorrow, custom also says, the sun will show itself and will do so in increasingly regular turns until el dia de Santa Ana, July 28, when downpours will return.

This rain is important not only because it favors the crops and recharges the ground water, but also because people can once again talk and jest about the avalanches and drenches of water that befall them all. For a long time feelings and humor have been suppressed. The terrible violence gave low priority to ordinary talk about the rain.

Now work goes on again in all sectors of our program. Long-sought goals are one again being set in view. Objectives can be names and achieved. Dedication to people, and loyalty to those who paid the ultimate price during the violence, makes this work both possible and imperative.

V A Report to Former Medical Students in the Chimaltenango Program: Reflections on Recent Years (March 1986)

I feel like a "prodigal father" embracing his offspring after years of absence. A decade separates many of us. More than 200 medical students, after working in Guatemala, have gone on to successful careers and rewarding practices. During these years an earthquake reduced Chimaltenango to senseless rubble and decimated its people. An innovative health plan based on educating local people as health promoters expanded beyond expectations to produce astonishing results and then was almost destroyed by civil war.

Now at age 63, looking back on these events, I have come to claim the young doctors who worked with me during earlier years as part of my transamerican family. No one who has lived in Guatemala for even a short time can fly home without leaving a part of himself or herself behind. When asked about your time in Guatemala, you no doubt told stories of a lush paradise inhabited by peaceful, self-reliant Mayans. Then, amid all the rumors from 1980 to 1983, you

probably wondered how they and we survived by the blood baths. I know that a lot of questions have arisen, from news accounts of the earthquake to those of tragic acts of violence to those of the more recent elections. Many details are still too painful for me to easily recall.

After the earthquake of 1976, our work grew rapidly, both in the hospital and in the extension programs. But beginning in 1980 activities were severely curtailed by political violence in the highlands. First, all communication and transportation came to a sudden halt. Guatemala froze as in a dark age. Bus service was stifled in all highland communities, including Tecpan, San Martin, Comalapa, San Jose Poaquil, and Quiche. Chimaltenango stood immobilized. Those few buses that managed to circumvent obstacles were stopped at checkpoints; passengers were made to get off and were searched and sometimes shot on the spot by one political faction or another. Human lives were regarded as expendable. Worse, they were seen as imply insignificant.

The whole world stood aghast, as witnesses to an unbelievable holocaust. Entire towns were annihilated – Las Lomas, Patzac, Xiquin Sinai, begin a long list. Women and children were tortured and killed. The few survivors who managed to escape left behind an empty shell of a village as a memorial to a wretched period marked by barbaric excesses and destruction of human life. Many relocated temporarily to the South Coast or Guatemala City. People from areas up north, such as Huehuetenango and Quiche were able to seek refuge in Mexico. As a correspondent succinctly put it, “Guatemala has become a nation of widows and orphans.”

Many of you have asked specifically about members of the hospital staff. Some died, literally, for what they believed, as martyrs to a cause they had chosen. It was a confusing time – every human soul became a battlefield. We do not judge but only admire the inestimable courage of staff members who pursued their chosen cause to a sacrificial end. It was with the same unconditional fervor that they had thrown their heart and soul into the work of the foundation. Their committed love, humanitarian work and dedication to people will remain forever embedded in the foundation’s walls.

The foundation as such as maintained a nonpartisan posture and function, which has granted it some immunity and longevity. We dream that it will eventually become an accepted structure of Guatemala akin to the volcanoes, that it will survive civil war, ethnic discrimination, lack of funds and dependence on outside resources both human and material. We could not risk this long-term strategy for the immediate gratification of engaging in politics or of formally choosing sides between political factions – between the tyranny and inhumane excesses of the military and the revolutionary illusion that swift armed violence will deliver Guatemala from its ingrained miseries.

Chimaltenango was hit hardest in 1980-81. After all the other volunteer groups, including the Peace Corps, had pulled out of the area, the foundation board met in 1981 to decide whether to close the hospital or continue. There were no more medical facilities available here at that time. All private programs had closed and public programs were virtually nonexistent. Despite a lower attendance at the hospital, its need was sorely felt. To abandon the people during a time of crisis was unthinkable. A decision was reached to announce *personally* the foundation's nonpartisan stance to the warring parties on both sides, stating our intention to continue functioning on a health and development basis. Meeting with the military in person to convey this information was difficult but essential. We were criticized severely for this by some. Looking back, we consider that these talks were probably the single most important factor in keeping the foundation alive and functioning on its own terms to this day.

It seems inconceivable that any land or people with such a profound spirit and potential, who have every right in the world to prosper, should suffer so much for so long. Our extension program was devastated. Of forty-seven health promoters in the Chimaltenango area, only fifteen remain. ULEU, the land loan program, had been a dream for the future of Guatemalan children – children who suffer one of the world's highest mortality rates. This flourishing program was crippled by the death and displacement of ULEU member-borrowers in the outposts of San Martin, Patzun, and San Andres Itzapa. The manager of ULEU, like many others during that period, was first targeted, then trapped and eliminated by security forces.

Watching this program suffer, with dozens of people losing their lives for what they (and we) believe, was indeed a devastating experience. Participating in its rebirth is like participating in a human miracle. For example, one of our health promoters from San Martin escaped two years ago with only the shirt on his back – his family had been massacred and his village destroyed. He has returned to ask our help in reestablishing a health program for the few survivors in the village. The land loan program is now being reactivated in response to insistent demand, reflecting the indomitable spirit of the Maya and life's longing for itself. I am continually overwhelmed by the insurmountable courage possessed by the people in the face of tragedy – their ability to pick up and begin again.

The hospital census has been rising slowly. It has been a long-cherished dream to see the program become a self-supporting system independent of all foreign help, including my own, and relying totally on native nurses and doctors. That will be a foundation build on national heritage and pride, replacing the debasing image of "white knights," and moving by its own lights and on its own feet into the next century.

Today, as I try placing the last decade in perspective, I sense that what I am writing is not a eulogy but a commencement. The rebuilding of extension programs, health education, nutrition training, family planning, animal and agricultural cultivation, all by Kaqchikel workers rather than by Peace Corps volunteers, amounts to a rebirth on more solid ground. A hospital served by local doctors and a Guatemalan board providing local leadership for the foundation are evidences that the program's chief resources are its own people.

If human life is our most precious possession and death is the highest price that humans can pay, then the people here have paid the price of their continued tenure and future existence in this land a thousandfold. The fact that the foundation has survived the past five years and is being rebuilt by Maya-Kaqchikel people who endured those years means that they have now paid for it. A new foundation will be built on their terms –not mine or yours.

Thoughts From Guatemala on Primary Health Care

LECTURE NOTES: TULANE SCHOOL
OF PUBLIC HEALTH AND TROPICAL MEDICINE, 1982 – 1990

"Primary health care," (PHC) is now a world topic. It refers to initiatives needing to be taken literally everywhere in the world. The modern concern began with threats to health in industrialized environments and now extends to conditions bearing on the health of the poorest peoples in the world. We will not here ask the question whether or to what extent the conditions of ill health in both settings have been caused by the very dynamics of modern industrialization and the ideology that tends to go with it.

Public investment in health differs greatly from society to society. In industrialized countries public expenditures on infrastructure and care on, on average, 140 times greater per capital than in Guatemala, to say nothing of the vastly larger difference between private expenditures on both sides, and those differences are widening.

International health conferences in the late 1970s began by making two "reaffirmations": that health is a state of well-being and not merely the absence of disease, and that health is a fundamental human right rather than a privilege. A goal was projected of attaining basic health conditions for all people by the year 2000 – such as would permit them to lead socially and economically productive lives or, more generally, to function in ways acceptable to themselves and the community of which they are a part. This was to be achieved through cooperation at many levels. It would include initiatives that take account of vast international inequities. It would also include the understanding that "people have the right and duty to participate individually and collectively in the planning and implementation of their own health care" (world Health Organization 1978).

Such was the Declaration of Alma-Alta in 1978, where primary health care was made a focus of worldwide attention. In 1981 the World Health Assembly, a general organ of the World Health Organization (WHO) adopted a "Global Strategy of Health for All," calling for a social contract

between governments and peoples as well as for international cooperation. Since leaders and tools for this kind of health care were not generally available, WHO also convened technical and training consultations (World Health Organization 1979, Mahler 1988).

The experience in highland Guatemala played a role in achieving this international focus. What we wish to do here, however, is not to claim success or influence but to set forth some of the major problems we have encountered, as well as some procedures and guidelines we have adopted in our work with economically pressed communities that are seeking to plan and implement their own health care.

THE WHY OF COMMUNITY PARTICIPATION

Advocates of primary health care point to what a society should do at various levels to assure conditions in which people can be healthy. The Alma-Alta Declaration described this as "essential health care" which, it said, should become "universally accessible to individuals and families in the community through their full cooperation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (alma-Alta VI).

Differences begin when people try to specify what goes into those "essential" provisions for which communities and societies bear responsibility. In previous decades public health was identified with engineering works that eradicate environmental causes of disease, but the line between such prevention and some uses of medicine faded with the discovery of bacterial and the growing use of immunization techniques. Today discussion of public efforts includes the control and prevention of communicable infections and health education as well as environmental improvements.

The Alma-Alta Declaration acknowledges that specific community responsibilities would evolve from the local conditions and the special characteristics of the people as they address their own problems of promoting, maintaining and restoring health. It nonetheless tries to make a list of what such primary health care "includes at least": education concerning prevailing health

problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning, immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common injuries and diseases; and provision of essential drugs (alma-Alta VII).

Such attempts to state the "basics" raise controversies, as do different descriptions of the proper governmental and professional roles in securing them. Primary health care advocates also point to the important function of nonmedical sectors such as agriculture, animal husbandry, food, industry, housing, public works, communications, etc. but the usually shy from pursuing these because this tends to dissolve the distinctive meanings which are important for offices and departments of public health. Reference is simply made to "maximum community participation" and to using a variety of health and community workers as applicable including traditional practitioners as needed (Alma-Alta VII:5,7).

All this serves to underscore what has been our primary theme: namely, that affected communities are the locus for posing their particular health problems. A two-fold strategy seems required: one which insures, first, that communities actually exercise initiative, inquiry and responsibility in planning and conducting health activities, and one which also insures that relevant information is available to them with respect to resources and available technical possibilities. The process and the problems of gaining community participation and of bringing these two factors together are not set forth in official statements but are what I want to discuss here.

FACING THE PROBLEMS

Elsewhere we have described the potential benefits of community participation. More will be accomplished in this way than can possible be achieved when measures are merely imposed or are merely therapeutically reactive. Professional approaches to health care simply do not allow for timely and adequate coverage and are more costly. Moreover, participation has intrinsic value for the participants. It offers more possibilities that felt concerns will be taken up. Once in

motion, it can be extended to address further community problems and efforts. Thus, community participation may be seen to encourage a local ongoing process of achievement, activities at lower cost, freedom from dependency, and growing conscientization and understanding.

We have also described the nature of participation as the exercise and celebration of the self in a communal process directed toward problem solving. This process was seen to include the steps of problem identification, planning, action and evaluation. The elements of such a process can be further specified to include: the adoption and use of procedures that are accepted as just and equitable by the people; a practice of common reflection as a way of doing things together; the identification of powerful interests inside and outside of the community; the conduct of community assessments based not merely on data gathered by outsiders but on expressions by the people; an analysis of felt problem to their causes; the development of information, precedents, strategies and resources for addressing identified problems; and the performance of adopted programs using impact studies and reviews at decisive points along the way. All these elements will be qualified by local perceptions. Both conditions and beliefs vary from place to place, and any proposed strategy is likely to have not only economic but social, political and cultural implications.

Problems emerge not when we draw up such a list of elements but when we try to go to work on them. At every step along the way the character and vitality of the community are tested. Communities themselves may suffer in some measure from ill health or malfunction. Their structures are often fragmented. Their priorities are often oriented to specific persons or groups, so that even well intentioned programs become co-opted to enhance the already powerful.

Hence the familiar complaints. There seems a lack of enthusiasm by the people. The same old people dominate the process. Common reflection and intergroup communication are hard to achieve. There is a lack of adequate or genuinely accepted leadership. Goals remain unclear and strategies are not really accepted. Evaluations are flawed and do not really reflect realities. The evaluation indicators are not appropriate.

The reasons generally given for failing to secure participation by the people are apathy, obedience to arbitrary authority, or a reluctance to take risks. None of these is a reason to give up a community health effort. All of these responses – or non responses – have causes which can be identified. Indifference may result from a lack of the information needed to make decisions – facts about existing conditions or available tools or about what has been achieved in the past by people in similar situations. Elitist technicians, including doctors, have found it easier or advantageous to withhold information and skills, so that these now seem distant and mystifying; nor have these technicians dealt with the most basic issues of health. Data and information have tended to flow up from the people to the technician, while decision making has flowed down from above. Illiteracy and fragmented communication networks may also thwart the flow of information.

It is because of such deficits that people are not disposed to take risks, even though they see injustice and believe in their community. Moreover, the people will stay that way until they have actually expressed, or even shouted their own pain together and *want* a problem to be solved. This is the first inescapable step toward community participation. The second preliminary step is equally necessary: they must see an objective as within their reach, which means seeing some ways and means, before they will take bold steps together.

For all these reasons, a strategy is required for the very problem of achieving community participation. This strategy may need to be used again and again when a community is impressed by obstacles and is in danger of slipping back into apathy. Central to this strategy (here we borrow some terms that are not being used by similar communities elsewhere in the world) is the work of "animators" who elicit "generative themes" and present "codes" (Hope and Timmel 1984).

Trained animators are persons who clearly and acceptably share the local identity and who have also acquired an open attitude. These persons deliberately engage community people in conversation on casual occasions and in comparatively unstructured meetings, perhaps in times of crisis. They are trained to listen. What are the people really thinking? What concerns, fears, deprivations and aspirations do the people express? What are the traditions, values and patterns

that shape what they say? What achievements do they recall from the past? Why were these important? How did they come about? What do they see as their strengths and who do they see as their leaders?

Emerging from such conversations are generative themes or clusters of issues about which the people do have strong feelings and which gain responses from person to person. Since these themes are emotionally charged, they bring forth both thought and passion. Once they are brought out into the open, people begin to doubt their doubts and to look at their problems again.

By way of taking up these themes together, the animator then forms and presents what may be called codes. These are concrete "insider" presentations of the expressed concern of the people by means of pictures, cartoons, stories, diagrams, masks or plays. Such presentations cause excitement, humor, hilarity, commonality and energy. Energies so aroused may then be channeled toward actually posing a problem together, inspecting that problem for its causes and breaking down larger problems into a sequence of smaller ones for solution. In the course of this procedure, leadership can emerge. The community initiatives required for primary health care can begin anew.

We have not here treated the serious external obstacles which may be encountered along the way. "Expert" visitors can sometimes subvert a community process. The people remain unconvinced or lose heart if program proposals are presented as "community oriented" even when they are not actually community based, if the people are "allowed to participate" but not to do it themselves.

There may also be instability or undependability in the basic infrastructure, agencies or programs of the larger society that are supposed to support community efforts. For lack of a larger political will and agreement on PHC goals, community initiatives may even appear threatening and bring down professional or official reaction, even brutal military reaction (Heggenhougen 1984). Such violence is band for the people's health and also bad for the people's programs in support of their own health. Continuing to work with the community in the face of powerful

outside forces might seem one of the highest expressions of human health, but in many places today this is not the kind of health activity that increases life expectancy.

We are a long way from achieving the supportive and stable policies at national and international levels that are called for by international advocates for primary health care. There is no more important health provision for the future than the establishment of peace accords with justice – where justice is seen to include "the right and duty to participation individually and collectively in the planning and implementation of health care." (Alma-Alta IV).

GUIDELINES FOR PRIMARY HEALTH CARE FROM THE GUATEMALAN EXPERIENCE

Following is a summary of ground-level practices and findings that have grown up in the course of our cooperation with rural villages to improve, at one and the same time, both community participation and community provisions for health.

- Primary health work begins in dialogue with the people whose health is at issue. They raise the concerns. People everywhere have their own ideas about what should be done with their lives, health and homes. The effective health worker listens, treats people as equals in decision-making and does not force ideas and standards on those served.
- Health has many facets – economic, social, political and cultural – which differ from community to community. Any of these may surface when the epidemiology of a human health problem is being considered. It is less than adequate to depend on outreach programs and service schemes if their guiding policy is not an empowering process, and this means making use of physical, economic, social, political and cultural capacities in addressing problems.

- Proper care of any ailment requires treatment of causes, not merely amelioration of pain. A public health program aimed exclusively at curing the sick will have little effect on the health of the rural poor. A program that includes preventive medicine, nutrition and hygiene will fare somewhat better, but it will fail to do the job. A program expanded by

family planning and increasing crop yields on the family plot will accomplish more. However, a program that fails to deal with the fundamental problem – ownership of land or acquisition of some stakes – will achieve no more than a modest and precarious success.

- The truly successful public health program among the rural poor will tackle problems of both economic and political development. This by no means suggests that program leaders should plunge into controversial national issues or ally themselves with specific political movements. They may, in fact, be required to stand aside from factional politics – if they are to stand with people who are still without broader political power. Yet there are levels below those of national politics where the people can learn to control their own lives through economic and political activity. A cooperative is a good example, since it both responds to economic need and builds local leadership. The cooperative is no panacea, but it is often a practical move in the right direction, laying a foundation for people to gain power in the economics and politics of survival.

- "Health" is perceived differently in different societies. Rural societies, both by circumstance and by choice, have usually depended on natural processes and nontechnical interventions to maintain or restore health. Industrialized societies, by contrast, have viewed health within the context of administered procedures, application of technology and chemically-produced remedies. Whereas rural peoples have stressed dependence on "spirit" and on balanced relationships with fellow human beings and with nature, modern medicine has largely abstracted from these relations to concentrate on causes and techniques amenable to strict application and measurement. When working with the rural poor, one should always be sensitive to their traditions and their felt needs.

- The concept of "development" should be reexamined. Great allotments of time, paper, food, and jet fuel have been expended in development efforts, often with little lasting effect. Clean water and malaria control may help diminish disease but do not in themselves furnish the tools and procedures for building a health promoting society. Genuine development requires creative processes that encourage both self-reliance and a

sharing of available resources. The point is to seek measures that create and activate a community, rather than leave it passive and waiting.

- A program that relies too heavily on outside technical and financial assistance is destines for trouble. Almost any technically trained person, regardless of nationality, is considered an outsider in areas inhabited by the rural poor. There is an enormous difference in outlook between the urbanized technician and the rural poor. The technician is usually assured of a physically comfortable existence, while the poor person struggles to survive from day to day. This discrepancy alone accounts for radical differences of perception. Poor persons are not fools and must be thoroughly convinced that the technocrat's arguments and procedures are value for them before they will risk deviation from age-tested patterns of living, especially if they have to pay for them now or in the future.

- Beware the cry for "higher standards." Professionals are disposed to boost standards, thereby increasing the need for equipment and expertise and driving up costs beyond the reach of a humble community by itself. Quality should never be equated with high cost.

- Local community health committees should be organized and functioning before the first aspirin or dressing is handed out. These committees will then select the people to be trained, supervise them or discipline them. They will also help set the standards of service and the prices to be charged.

- The outside help needed in terms of materials, labor, direction, training and supervision should conform to local customs and traditions. A visiting physician, technician or trainer will prepare local counterparts as quickly as possible.

- Training programs should permits community workers to continue their usual work and maintain their family and community relationships, keeping absences form home to a minimum. Long absences in a different setting can make a return to the community difficult and sometimes impossible.

- Curative training requires the use of clinical teaching with actually patients in a dispensary or hospital. When workers are on the job, frequent consultation is essential, though arrangements will depend on local circumstances. The treatment of ailments should be in accordance with symptoms and should not attempt diagnoses, which are prone to error even by people with sophisticated schoolings. Our experience is that symptom treatment results in relatively low error. Trainees must be clear on what not to treat as well as about what do treat and how. The future of nonprofessional curing depends on this.

- Ideally, program income should cover all ordinary expenses. Dependence on outside finances saps local responsibility and may place the supply of services and materials in jeopardy.

- Progress takes time. Programs formulated by technicians seeking quick, measurable results seldom live up to expectations. Genuine change requires commitment and patience.

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FOR FUTURE MEDICS

FROM AN ADDRESS TO
THE AMERICAN MEDICAL STUDENTS ASSOCIATION (1977)

I will not in this presentation dwell on details of the program that has evolved in highland Guatemala, but rather will deal with basic issues in health care as I have come to see them. It should be remembered that my experience has been largely in communities of rural Guatemala, so these are issues that have been raised for me in that context. However, we *do* have thoughts on health work in what seem more sophisticated communities, like those of the United States.

Medicine is my calling as it is yours. I do not wish to criticize the medical profession as bluntly as do some of its current detractors. But to open our discussion let me present a few manifest considerations.

- Though morbidity and mortality figures have improved during the past century, the largest achievements have come about through engineering, environmental improvements and some simple immunizations.

- Doctors know how to cure and prevent most ailments around the world, yet they direct their energy and skills to a narrow range of curative work for the near-dead at terrible technological and financial costs. More and more energies and resources are dedicate to extending "sick life" (a phase of Ivan Illich), generally for the "haves," while even basic care is not available for the "have nots."

- Nature – not the doctor –cures most human ailments, sometimes in spite of the physician, though professionals like to take credit for nature's work. When we give the impression that doctors are responsible for health we are likely to be miserly with information and tools.

- In modern countries, such as the United States, the preponderance of health problems is society related. Excesses in food, drink and smoking are the primary causes of maladies and morbidities in persons over forty; accidents and violence are the most common causes in persons between five and forty. In the poorer parts of the world simply infectious diseases account for most ill health. In the management of these larger groups of human ailments, social and civil communities play important roles.

- The high costs of medical care are well known and few economies can well afford the disproportionately growing costs of doctors and their new technologies. A tendency to focus on who is to pay the bill rather than on how expenditures can be contained and best used compounds this problem.

- Though doctors are still highly rewarded, there is a steady erosion of public trust in the profession, as is evidenced by an increase in malpractice suits – which sometimes causes us to order additional, costly defensive procedures. This problem is a reflection of diminished communication and relevance on the part of many physicians, and it seems foolish to blame lawyers so long as medicine is slow to straighten up its own house.

This list could go on and all its items are underscored in the world's poorer countries.[i] I repeat these familiar judgments to suggest that our medical house is in need of some revamping, including its educational activities. I am convinced that reforms will come during the next half century, but that these will begin with the next generation – with you.

PATIENTS AS AGENTS

Health has been variously defined and I will not add another definition. Actually, health defies univocal definition since people about the globe have different concepts of health and different ways of describing their health problems. Any definition is likely to be too confining and too inflexible to suggest fully effective responses in actual situations. Health has multiple implications – physical, economic, social, political and cultural – and all these should be taken into account in making fully responsible and human health provisions. If a monopolistic and perhaps self-serving professional group has in recent decades constricted and dominated the

terms of health care, this by no means implies that alternatives are not possible or should not be attempted.

How will new approaches come to pass in this complex life-and-death matter? I wish to suggest that we begin anew with what often seems at the periphery and yet is the most important entity ini the health care scheme: the patient, who is the subject and agent of health. Geography, history and culture differ, but the human subject and the human community are always there. I wish to repeat that the doctor of medicine is *not* the custodian of health; people are responsible for their health, as for their responses to life, suffering and death. To a degree, professionals may even have forfeited their claim to be servants of health by neglecting to use that great equalizer, medicine, as a powerful tool to foster individual human responsibility as well as social development and social change.

The route to health in any medical practice would then begin with a dialogue between people the physicians on equal terms, the former articulating felt needs. A period would follow in which the roles on both sides are brought into proper relation and interaction. Upon establishment of communication, specific objectives would be pursued with a goal of putting knowledge, tools and decision making so far as possible in the hands of the people themselves.

A great deal is being said today about "self-care," but we must recognize that institutional dependencies persist which make this phrase deceptive. Many people have been led to give up their attention to self-experience even when they are well – to say nothing of self-awareness, self-evaluation and self-care when they are ill. This should not detract us from our envisioned goal of putting health care where it property belongs.

When the mystique and power of the doctor are placed in proper perspective and context, the role of the physician will become once again that of a collaborator and teacher – a true health enabling people to respond to themselves and their condition.

COMMUNITY INVOLVEMENT

The way forward with many problems of health care, we have said, is to be found by beginning with what has come to seem peripheral. We should not continually fall into the trap of defining our goals in terms of current methods or of defining problems in terms of present solutions – which, in the case of health, has been disease and death oriented. Let us now think, rather, in terms of health activities on the part of people, who are meant to be useful, functional and even happy. Accordingly, let us ask: What is the manner in which people go about posing and tackling their health problems/

A common phrase for this is "community involvement," which I define as *the active exercise and celebration of self within the context of community and the common good, for which the basic procedure is communication including problem posing, investigation, decision making, action and evaluation*. I take it as given that people have an inalienable right to make decisions affecting arrangements for their own health in their own communities. If this challenges some current economic, political or professional assumptions, so be it.

My personal experience with community involvement, as we have noted, has been in rural Guatemala where, because of a general lack of big systems and institutions, community organization and engagement may be somewhat simpler than in the United States. Here in the states communities are more varied, fragmented and stratified. They are also more strongly influenced by external institutions, including service and reform organizations, all of which have interests of their own. This can deflect attention from consideration of *local* physical, economic, social and cultural realities. Such special complications in North American settings will have to be faced in a straightforward manner. But the general need and projects are similar regardless of geography and culture. Here we might pause to make a simple list of principles and procedures to be affirmed in reclaiming health initiatives for communities.

- Healthy conditions are an integral part of the general goal of justice for all and, like justice, have physical, economic, social, political and cultural dimensions in any actual human setting.

- Expression by individuals and communities of their own health problems and health goals is basic.

- Common reflection on those perceptions by people and health workers together is important, if effectiveness and growth are to occur.

- Sensible planning should follow which includes statements of common goals, problems, priorities, and strategies.

- Along with subsequent community action there should be built-in phases of self-evaluation to stay in touch with realities.

Nothing really fundamental will happen for the sake of health in any community until people think together about their situation and its problems. At the same time, they should be aware of possible alternatives that exist along the road to health. Thus, education of a revised sort seems an important preliminary for both the populace and the physician.

First, lay education that increases awareness of individual capacities and responsibilities for self-care and mutual care. Such education will foster a response for natural processes, for the self and for the community. In actual communities medics could form educational teams with other professionals and community people. These teams, in cooperation with the schools and media, would powerfully communicate personal and community responsibility for health, and set forth the ways of self-healing and mutual healing.

Second, a rededication and restructuring of medical education. More of our medical training will become oriented towards problem solving within a physical and social context, thereby placing the internist with his pills and the surgeon with his knives in proper perspective. A faculty of medicine will see itself as unified in terms of human problem solving, each discipline contributing something toward that function and process. Its graduates will think of teaching and working alongside the farmer, the engineer, the factory worker, the social worker and the minister, to name only a few collaborators.

In communities, both rural and urban, where medical professionals are not available or are unwilling, nurses or local lay healers can be trained for such activities, as well as for symptom recognition and treatment of common health problems. Obviously the selection, training, scope, supervision and continuing education of such primary health care workers deserve careful attention. They need not, however, be defined as physician assistants or paramedics who labor only in the shadow of a doctor. Their work is not "second class" but "appropriate." Experience has taught us that active involvement in a community organization is itself an effective element of supervision.

Personal and interpersonal care will be only a beginning. Major kills stalk human communities for which the hospital is always too late and the community itself is the first line of defense. This suggests the formation of local health committees or centers. Beginning with local experience, local stories and local fears, the people would move with health workers to make epidemiological inquiries and then plan responsible actions of educational, social and environmental sorts. They would also address that profoundest of all causes of disease – poverty – by identifying and seizing local opportunities for economic development. Such health activities should lay claim not only to some of the public responsibilities but also to some of the public funds regularly assigned to health.

PHYSICIANS AS CITIZENS

It may be said, by way of objection, that our special task as doctors is "curing" and that this is more than enough to occupy us. Need we remind ourselves, however, that with the present concentration on curative methods we are not by any means treating all those who need and seek our help, that unnerved populations are growing everywhere even as we speak and that we cannot possible keep up? That our training is much too elaborate, time consuming and costly to prepare a sufficient number of our kind of professionals for all this? Even in the United States, we do not at present afford access to all. What about countries to the south where hundreds of thousands must share a single physician or where none is available at all?

I say to professional critics that they should hold their criticisms until they have done one of two things – either have disproved the value of participation by citizens and lay community workers in addressing many actual health problems or have supplied enough doctors who can and will do the job without adding to already astronomic society-wide health costs.

Until then, a part of the answer by necessity will have to be something less sophisticated. I invited you to visit our modest program in the central highlands of Guatemala where traditional medical service is generally not available but where last year sixty responsible Kaqchikel health workers treated more than 30, 0000 persons who otherwise would not have been served – while at the same time working with community groups on projects for water supply, safety, housing, nutrition, agricultural extension, land acquisition and economic development.

May we look forward to future physicians who will become active leaders of their community in reviewing conditions, programs and policies that beat on the health of all that live there? Is there any profession better qualified than ours to help shape programs and legislation for primary health care and public initiatives for health? By this is by no mean a public concern which raises its head only to lobby for professional interests.

Involvement of the people in making provisions for health will make use of the earth's most creative and most available resources – human beings. It will multiply, both measurable and immeasurably, the quantity and quality of care. Humans, the most sophisticated beings in history, have been bypassed and neglected in approaching public problems of health. As a result, they fail to see themselves as responsible, dignified, violence –free and healing agents. We need not look far to see the massive pathology devolving from this failure.

When the history of medicine is recorded – say around the year 3000 AD – and it is asked what were the great watersheds in medicine, the answer will be founds not merely in the discovery of antibiotics or the introduction of aseptic surgery. One of the great transformations will be traced to a time when basic knowledge and initiatives, tools, decision making and organization passed form a short captivity in the hands of the doctor into the hands of the people.

[i] In a marginal note Behrhorst cited the summary of a film documentary on the work ini Chimaltenango, entitled *Seeds of Health*, produced by the World Council of Churches in 1976. The director, Peter Krieg, generalized form learnings in the Guatemalan highlands: (1) The majority of the peoples in rural areas, where most of humankind still live, are hardly reached by modern medical services, especially in "developing" countries. (2) Where people do have access to medical services, these are often expensive and culturally not adapted. (3) Doctors are expensively trained and are thereby motivated to further the isolation, professionalization and specialization of medicine. (4) Medical knowledge and tools, instead of being spread among the people, are increasingly monopolized in the hands of the medical profession. (5) Emphasis in medicine still is more on curing illnesses than on preventing them; many doctors are not able or willing to address the roots of illness which lie outside medicine in social, political or economic areas. (6) The production of drugs and pharmaceutical information are being concentrated in the hands of multinational drug producers whose economic interest lies in selling as many drugs as possible to as many people as possible. (7) Health knowledge and practices belonging to special cultures apart from Western medicine are often pushed into illegality and obscurity; thus, invaluable knowledge, experience and initiatives are lost. (8) Medicine is often approached as an isolated field, rather than as a part of the general physical, psychological, socio-economic and cultural development of humans. (9) In many "developing" countries self-reliance in health is undermined by the introduction of inappropriate medical technologies and medical training, which increases their dependence on aid and technologies from industrialized countries.