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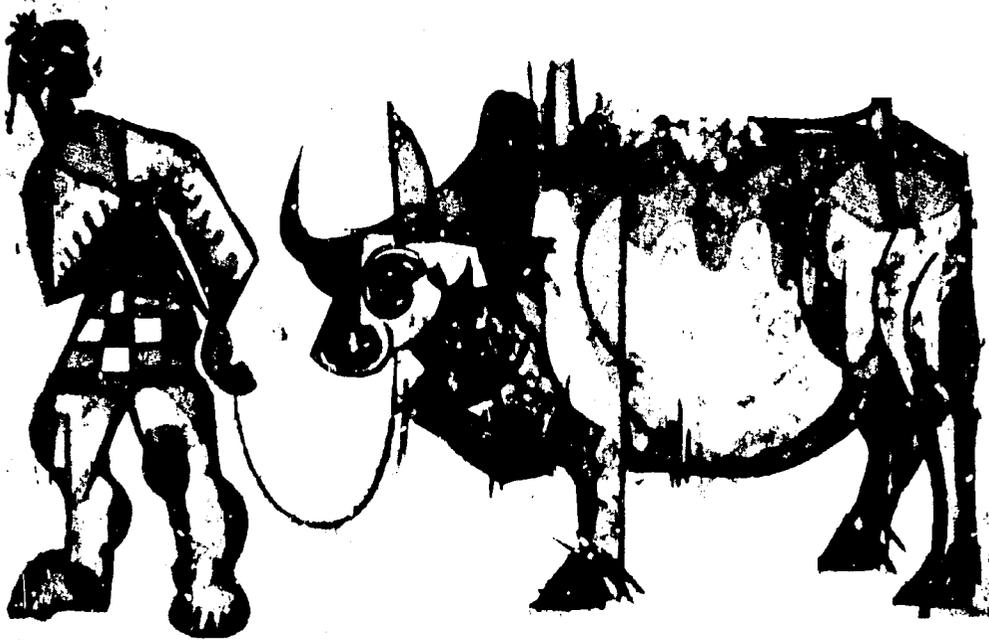
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Special Series on Paraprofessionals

GUATEMALA'S RURAL HEALTH PARAPROFESSIONALS

Forrest D. Colburn

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Forrest D. Colburn

**Rural Development Committee
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Cornell University**

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PREFACE

In cooperation with the U.S. Agency for International Development, the Rural Development Committee of the Center for International Studies at Cornell University has undertaken research on the role of paraprofessionals in rural development. Throughout the world there is increasing interest in using paraprofessionals in various capacities as front-line development workers to provide services which are acceptable and accessible to the rural poor who often have not been reached by development programs. However, there is minimal empirical knowledge on which to draw for program planning and guidance. Our study has sought to remedy this need by analyzing several existing paraprofessional programs to determine which factors affect the paraprofessional's effectiveness. Field studies were conducted of illustrative programs in Guatemala, Bolivia, Senegal, Upper Volta, Sri Lanka and the Philippines. We hope the results of these field studies will provide program planners and administrators, as well as government decision-makers, with well-documented cases of how and why paraprofessionals function in various contexts.

For research purposes the Cornell team decided to define paraprofessionals generally as workers (1) with no more than 12 months of pre-service or technical school training; (2) who have direct service contact with rural dwellers; (3) who play a semi-autonomous role in making day-to-day judgments and decisions; (4) while operating as part of an organized private or public sector agency. The typical paraprofessional is likely to be indigenous to the service area and to have no more than a primary school education.¹

¹R. Colle et. al., Concept Paper: Paraprofessionals in Rural Development, (Ithaca, New York: Rural Development Committee, Cornell University, 1979), p. 9.

An extensive literature search that preceded our field work suggested a number of general propositions: (1) development objectives in the agricultural and health sectors in terms of communication and adoption of improved practices can be achieved efficiently (measured in unit cost and time required) through use of paraprofessionals; (2) the effectiveness of paraprofessional programs depends upon the adoption of appropriate program practices regarding selection, training, supervision, compensation, etc.; and (3) the effectiveness, efficiency and responsiveness of paraprofessionals will vary directly with their success in encouraging local participation, particularly through local organizations.

While the research was guided by these general propositions, our intent was to derive principles of operation and to identify useful operating practices in an area where there is scant knowledge. Consequently, the research effort was designed to be reasonably open-ended and comprehensive to ensure incorporation of many kinds of useful knowledge. Since the paraprofessional cannot be viewed in isolation, it was necessary to focus attention broadly on the relationships among the paraprofessional, the community, and the delivery system.

In accordance with the objectives of the study, it was deemed more appropriate to study in-depth the dynamics of a program in a particular area rather than attempting a summary overview of a program in an entire country. Thus, the major research effort consisted of two months in-depth field work in a limited number of villages within each of the six countries. Including a larger sample of villages would have provided a better basis for generalizations about the program, but the examination of paraprofessional performance would have been more superficial, the quality of data less certain, and the realities of implementing a paraprofessional program less clearly detailed.

To ensure comparability of the results each of the six field studies was guided by a checklist of topics and questions. However, in an effort to obtain frank responses and

empirical detail, the studies employed primarily open-ended interviews and participant observation methods. The field work was supplemented with documents and reports that touch upon experience with the paraprofessionals, and with interviews of officials either directly or indirectly involved in the respective projects.

Royal D. Colle
Milton J. Esman
Norman T. Uphoff

January 6, 1981
Ithaca, New York

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INTRODUCTION

There were several reasons for selecting Guatemala as a site for research into the use of paraprofessionals. First, health paraprofessionals have been used in rural areas extensively in Guatemala by both private voluntary organizations and the Ministry of Health for a number of years. Second, the Guatemalan government has expressed an interest in research on their health paraprofessionals. Also, the government has committed itself to the future use of health paraprofessionals in its rural areas. Other reasons for selecting Guatemala were that its health paraprofessionals work voluntarily or with only token compensation, and that Guatemala has started to use subprofessionals (Rural Health Technicians) trained in rural health care as supervisors for its health paraprofessionals. Thus, Guatemala appeared to be a promising and interesting site for an in-depth study of paraprofessionals.

While there are many private voluntary organizations training and utilizing paraprofessionals in Guatemala, they are by nature small-scale projects which use more resources per capita than are usually available to the government of a LDC. Hence, it was thought more useful to study the efforts of the Guatemalan Ministry of Health in utilizing paraprofessionals. In keeping with the objectives of the project, this study centers on the performance of paraprofessionals in one specific part of Guatemala, described on pages 14 - 37 below (see also map on page viii).

This study employed primarily open-ended interviews with rural villagers, the paraprofessionals themselves and their supervisors. Officials in the Guatemalan Ministry of Health, INCAP (the Institute of Nutrition for Central America and Panama), and USAID were also interviewed. Documents and reports that touched upon experience with paraprofessionals were utilized as well. The fieldwork for the study was done in November and December of 1979.

GUATEMALA

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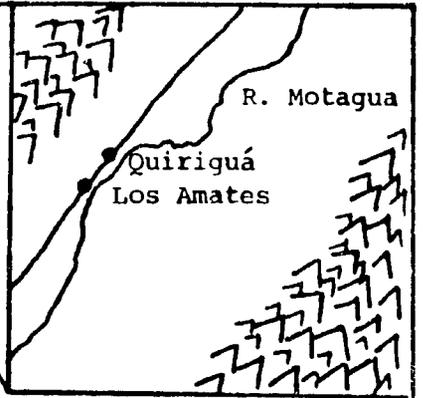
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CHAPTER I: BACKGROUND ON GUATEMALA'S RURAL HEALTH PARAPROFESSIONALS

Guatemalan Development and the Rural Sector

The Republic of Guatemala is situated in the Central American isthmus. It is some 42,000 square miles in area and has a population of about 7.2 million people.¹ Guatemala has a per capita GNP of slightly over U.S. \$800 per year. The growth of the Guatemalan economy has averaged 5.7% per year (2.9% per capita) since 1960, which is about the average for Latin America as a whole. Guatemala's participation in the Central American Common Market has been, and remains, an important stimulus to Guatemala's growth.²

Government budget deficits have been small compared to GDP, and central bank financing has been minimal. This, combined with a relatively liberal trade policy, kept inflation very low from 1960 until the oil crises in 1973. Since then, however, inflation has been about 12%-15% annually. Guatemala's balance of payments has been in good shape, and this coupled with the limited public sector deficits has helped keep external borrowing to a minimum. Guatemala has successfully avoided major economic fluctuations, and the Quetzal was recently chosen by the IMF as one of the world's reserve currencies--a clear indication of its strength.³

Despite this impressive economic performance in recent years, however, social development has lagged. Guatemala has a heritage of two cultures--Spanish (Ladino) and indigenous (Indian). The gap between these two large ethnic groups in terms of per

¹Dr. R. Monzon, Resumen del Diagnostico de Salud (INDAPS: Quirigua, Izabal, Guatemala, 1979), p. 1.

²AID, Country Development Strategy Statement: Guatemala (Department of State, January 1979), p. 75.

³Ibid., p. 16.

capita income, health and education has not been reduced to any significant extent over the past 20 years, in large part because of the very limited role played by the public sector in the nation's development. The indigenous population constitutes over 40% of the population, lives largely in the rural areas and is relatively isolated from the mainstream of modern national life. Socially, it is differentiated by its native culture and languages (the people are frequently monolingual in one of 28 languages of the Maya-Quiche family). The indigenous population is physically isolated from modern national life by the rugged terrain and lack of adequate rural roads in areas where it is concentrated.⁴

Yet while the differences between the "ladino" population and the indigenous population represent a significant duality in Guatemala's development, a more comprehensive dichotomy exists between the standard of living in urban and rural areas. An estimated 64% of the population lives in rural areas.⁵ The rural population is comprised largely of the indigenous population but also contains a sizeable number of "ladinos." The standard of living is not significantly different between the indigenous population and the "ladino" population in the rural areas. This is borne out by the fact that life expectancy figures for the indigenous population and for the rural population in general are the same--45 years. This figure, however, contrasts markedly with the life expectancy figure for the urban population--61 years.⁶

Other standard statistical indicators likewise attest to the dichotomy between urban and rural standards of living. For example, 87% of the population in urban areas

⁴ Ibid., p. 16

⁵ Dr. R. Monzon, op. cit., p. 1.

⁶ Ibid., p. 3, and E. Croft Long and A. Viau, Health Care Extension Using Medical Auxiliaries in Guatemala, private paper, p. 3.

have access to potable water compared to 14% in the rural areas.⁷ Literacy for the population over 18 years is estimated to be 82% in urban areas and only 40% in rural areas.⁸ To be sure, some caution must be used in interpreting such statistics. Taken together, though, they support the conclusion that: "To discuss poverty in Guatemala is to discuss the rural areas."⁹ This is not to say that poverty does not exist in the urban areas--it certainly does. However, the most impoverished conditions are to be found in the rural areas.

Guatemala's Rural Health Care Problems

One of the most pronounced disparities between urban and rural life is in health and health services. Standard health indicators, such as mortality and morbidity rates, show that the people of Guatemala in general endure a very low level of health and health services, and that many rural areas have no access to health services. Guatemala's established health care system has been unable to meet the health care needs of both urban and rural Guatemalans. As a result, it has become clear to many that a new approach to health care is needed.

The following indicators attest to the health care needs of Guatemalans, and of the need for some alternative or supplement to the established health care system. The overall mortality rate is 13 per 1,000 inhabitants. Infant mortality is reported to be 74 deaths per 1,000 live births, though INCAP (Institute of Nutrition in Central America and Panama) estimates that actual infant mortality may be as high as 100 per 1,000 because deaths, especially infant deaths, are under-registered in rural areas.¹⁰

⁷Dr. Monzon, op. cit., p. 8.

⁸E. Croft Long and A. Viau, op. cit., p. 2

⁹AID, op. cit., p. 3.

¹⁰Dr. R. Monzon, op. cit., p. 2.

Needless to say, mortality and morbidity are higher in rural areas than they are in urban areas. For example, the mortality rate is only 9 per 1,000 in the capital city but up to 22 per 1,000 in one rural department.¹¹

Malnutrition is an acute problem in Guatemala. In 1974 INCAP estimated malnutrition levels according to the Gomez classification of malnourishment. The figures indicated that almost 80% of children under 5 years of age could be considered malnourished, with 30% exhibiting severe levels of malnourishment. Furthermore, it is estimated that the poorest 50% of the population has a caloric deficit of approximately 40% of the minimum daily requirement and a protein deficit of 49% of the minimum daily requirements.¹² Again, malnutrition is most severe in the rural areas.

The single most important cause of the low level of health care in the rural sector is the overwhelming poverty of the rural populace. The relationship between poverty and malnutrition is obvious. Less obvious, but equally important, is the impact on health of deficiencies in environmental sanitation measures. In the rural areas a substantial part of total illness can be attributed to the lack of potable water, sewage systems and general sanitation practices. Despite the low level of general health endured by rural Guatemalans the principal causes of disease and mortality are amenable to medical care or preventable by proper health, nutrition and sanitation methodology. The technology of prevention is well established and the facilities are simple and inexpensive when compared to those needed to cure some of those diseases once they occur.¹³

The Guatemalan government has found it difficult to meet the health care needs of rural Guatemalans through the utilization of doctors and hospitals. Dependence on

¹¹ AID, op. cit., p. 6.

¹² Ibid., p. 7.

¹³ AID, Audit: Rural Health Services: Pro Ag 71-35, FY-74, p. 2.

doctors and hospitals has resulted in an urban and curative biased health care system. The scarce resources available for private and public health care are concentrated in the capital city. Of the country's 1,200 physicians, only 20% live outside Guatemala City, while almost 80% of the population is located outside the capital.¹⁴ The Ministry of Public Health and Social Assistance has the task of providing health services to the entire population at no cost. For this it receives an annual budget of between 12% and 15% of the government's total expenditures. Yet, the Ministry's 1977 Operating Budget shows per capita expenditure of \$7.10 in the capital city's department and \$2.40 in the rest of the country.¹⁵ The costly public hospitals in the capital city largely explain this differential. Reliance on doctors and hospitals has led to a further imbalance in that most available resources are absorbed by curative services. An estimated 80% of government resources are devoted to curative services, leaving only 20% for preventive services.¹⁶

This maldistribution of resources is aggravated by logistical support systems which lack sufficient material and manpower resources. Government resources are also impeded by a population growth rate of 2.8%, which stretches public social service resources to the limit in spite of a rapid increase in the GNP in recent years.¹⁷

In summary, the problem of health care delivery in Guatemala lies in four disparities: the disparity between expenditure pattern and needs (curative versus preventive), the geographic disparity between resource distribution and population distribution, the disparity between aggregate resource needs and the resources made

¹⁴ Ibid., p. 2.

¹⁵ Dr. A. Viau and Dr. E. Boostrom, Guatemala's Rural Health Technicians: An Overview, report prepared in August 1978 for the Alma Ata Conference, p. 1.

¹⁶ Ibid., p. 2.

¹⁷ Ibid., p. 2.

available, and the disparity between rate of population growth and the rate at which social services can be extended.¹⁸ Correcting these disparities is made difficult by the physical isolation of much of the rural population. The rural population lives in over 18,000 dispersed communities of 2,000 inhabitants or less. These communities are isolated by either mountainous terrain or jungles, heavy rains, and the lack of roads.¹⁹

Against this background--and in response to it--the Guatemalan government initiated its Program to Strengthen Rural Health Services, with the utilization of subprofessionals and paraprofessionals as its unique and important element.

Guatemala's Plan to Improve Rural Health Care

Early in 1971 the Ministry of Public Health and Social Assistance embarked upon a program intended to bring an improved level of health care to the rural population. A series of studies was undertaken to determine rural health problems and the manner in which they might be best addressed. From these studies a four-level health care delivery plan evolved. This plan envisaged the training and utilization of two new levels of auxiliary personnel--health promoters (promotores) and Rural Health Technicians. The rationale for the creation of these new levels of auxiliary personnel was to meet the lack of trained personnel in general, and to have personnel trained specifically in public preventive health care.²⁰

The envisaged four-level health plan was as follows: at the community level (level 1) health promoters and traditional midwives were to attend to the most basic health needs; at the level of the health posts (level 2)--the simplest physical unit of the health care system--Rural Health Technicians and Auxiliary Nurses were to provide

¹⁸E. Croft Long and A. Viau, op. cit., p. 6.

¹⁹Dr. A. Viau and Dr. E. Boostrom, op. cit., p. 1.

²⁰E. Croft Long and A. Viau, op. cit., p. 8.

outreach health care including preventive, promotive and simplified curative services; the referral and back-up systems (levels 3 and 4) are to provide a more sophisticated degree of medical service, including hospital care in regional hospitals and specialist service in the national referral hospital.²¹

The innovative aspect of this health plan was the creation of the first two new levels of auxiliary personnel. Health promoters had been used for a number of years by various private voluntary organizations working in the country; however, this was the first time the Ministry of Health decided to make widespread use of this low-level health auxiliary. The plan called for communities to provide a volunteer to be trained and subsequently to serve as the local health promoter. The promoters were to receive a one-month training course conducted by a doctor, a nurse and a Rural Health Technician. Limited instruction was also to be given in first aid and treatment of the commonest, most easily diagnosed diseases.²²

At the end of the training period, the promoters were to be given a small kit containing simple medical supplies. The promoters, however, were not to be paid for the month they spent in training, nor were they to receive any form of compensation once they began working. It was expected that they would be willing to volunteer on the average an hour per day to their duties as health promoters. Regular supervision of the health promoters was to be undertaken by the training team.

The other new level of auxiliary personnel was envisaged to be better trained and to work as full-time, salaried employees of the Ministry of Health. Student Rural Health Technicians were to be recruited from the rural areas and given a two-year technical training course. Training was to be in those subjects that the Rural Health Technician was expected to work in: environmental sanitation, basic preventive health

²¹Ibid., p. 8.

²²Ibid., pp. 8-9

care, promotion of appropriate use of available health services, and health education. Although the emphasis of the Rural Health Technician was to be on preventive medicine, they would also be trained in basic clinical skills, so that they could provide basic curative services when necessary and make referrals.²³

After successful completion of the training program, the newly graduated Rural Health Technician was to be assigned to a health post as near as possible to his or her home. With the help of the auxiliary nurse based at the health post, the Rural Health Technician was to attend to the health care needs of an average of 6-10 villages and the surrounding dispersed rural population. The major part of the Rural Health Technician's time was anticipated to be spent traveling through the area in his or her charge, visiting the village health promoters, and providing curative and especially preventive health care.²⁴ Thus, the Rural Health Technician was designed to be an intermediary between the doctor and the village health promoter.

The lowest level of auxiliary personnel, the health promoter, meets our definition of a paraprofessional. The other level of auxiliary personnel, the Rural Health Technician, can be defined as subprofessional on the basis of his or her more extensive technical training. The Rural Health Technicians, however, are of interest to a study of health promoters because they are involved in the training and supervision of health promoters. Also, and equally important, the Rural Health Technicians are using the same strategy--public preventive health care--to improve rural health care.

Implementation of the Paraprofessional Concept

The concept of utilizing paraprofessionals and subprofessionals to extend health care services to the rural majority in Guatemala met with stiff opposition from

²³Dr. A. Viau and Dr. E. Boostrom, *op. cit.*, pp. 2-3.

²⁴E. Croft Long and A. Viau, *op. cit.*, p. 21.

Guatemala's physician-dominated health care community. The health care community argued that non-physicians should not be allowed to deliver health services for reasons of "quality." Physicians were undoubtedly also fearful of competition. Political opposition to the concept was also present. There were laissez-faire objections to increasing government services and fears of promoting community organizations.²⁵

Needless to say, the implementation of the paraprofessional and subprofessional concept has been hampered and restrained by this opposition. Acceptance of the concept was slow in coming. The implementation of the concept was as much a political struggle as anything else. The Association of Municipalities was persuaded to give political support to the program as were leaders of one of the major national political parties. Later the national medical school at the University of San Carlos lent its support to the proposal.²⁶ It was the persistence of a few dedicated individuals and the support of international donor agencies, however, that made the concept a reality.

The Health Promoters. In 1972 the Guatemalan government began training village health promoters with the assistance of UNICEF. Despite the fact that Guatemala now has a number of years experience with its health promoters, there is little information available on the selection, training, performance or supervision of the promoters. Furthermore, the limited information that is available suggests that there has been very little uniformity in either the implementation of the project or in the actual performance of the promoters. Thus, it is very hard to offer generalizations about the promoters, let alone give a detailed account of their training and performance.

The original idea was for promoters to be selected with the participation of the community. However, a government report published in 1978 suggests that while this has sometimes been the case, more often the promoter has been selected by a Rural

²⁵ Dr. A. Viau and Dr. E. Boostrom, op. cit., p. 3.

²⁶ Ibid., p. 3.

Health Technician or by an influential person in his or her community.²⁷ The training of promoters generally has been of six weeks duration although again there appear to be many exceptions. The promoter's training has emphasized preventive medicine but many promoters appear to practice only curative medicine. Others have abandoned their work as promoters altogether. Indeed, it has been estimated that of the nearly 3,000 promoters trained by 1978, only half that number are still working as promoters.

There have been individual successes though. In these instances the promoters have demonstrated that they can be accepted by their communities, provide simple curative care, and promote health care. There are also examples of where promoters have demonstrated a capacity to work successfully with others on specific projects such as potable water supply. The key to these instances of success appears to be appropriate and adequate supervision.

Unfortunately, supervision for promoters has been on the whole very poor and virtually nonexistent for many of them. Evaluation efforts have also been negligible. The lack of supervision and evaluation can be traced to poor planning, lack of commitment at the policy level, absence of trained manpower, and the sheer logistical difficulties involved in reaching many rural communities.

It was soon apparent that supervision of promoters by doctors and nurses was out of the question. Even if funds were available to pay the high salaries of doctors, they as a group were, and remain, unwilling to endure the physical hardships involved in working in the isolated rural areas. The Rural Health Technicians--the other planned component of the supervision team--seem to be, on the other hand, reasonably successful supervisors of the promoters, but their number has been quite limited in relation to Guatemala's needs.

²⁷ Ministerio de Salud Publica y Asistencia Social, Evaluacion del Programa de Formacion de Promotores Rurales de Salud (Guatemala, 1978), pp. 5-9.

The Rural Health Technicians. The creation of this level of auxiliary personnel has closely followed the original plan. A training institute for the Rural Health Technicians was established in a rural area of Guatemala in 1972 with the financial support of AID. The training of Rural Health Technicians has closely followed the original concept. For example, only 15% of their training is devoted to curative care. By the end of 1979, 374 Rural Health Technicians had been trained. The Technicians have a contract to work in the Ministry of Health for four years after completing their training, and most have complied with this requirement. The four years of obligatory service for the first (1973) graduating class expired in December, 1977, and only two of the 32 members of the class have elected to seek employment elsewhere.²⁸

The technicians have been well accepted by the communities they serve. They have also been well accepted by the health promoters. Role conflicts have emerged, however, with other fellow health workers. In particular, conflicts have emerged with auxiliary nurses who had previously worked in relative isolation in peripheral health posts. Unfortunately, supervision of Technicians, especially in isolated health posts, has been infrequent in many cases. Also, there has been a lack of equipment and supplies (e.g., medications) at the health posts. A similar problem, but one which more directly affects the Technicians, is the scarcity of resources for use in projects and activities which the Technicians help communities organize.²⁹

Thus, the general consensus about promoters and Rural Health Technicians is that they have not been as effective as they could be because they have not had adequate support. Promoters have clearly had the least amount of supervision and material support of any health worker in Guatemala. This lack of support can be basically traced to poor planning and lack of commitment at the policy level.

²⁸ Dr. A. Viau and Dr. E. Boostrom, op. cit., p. 6.

²⁹ Ibid., p. 6.

Promoters have demonstrated that they are accepted by the rural communities they serve and that they can at a relatively low cost extend in a limited way the coverage of the Ministry of Health. However, for most public health officials, all conclusions about acceptability, coverage, costs or feasibility are judged meaningless unless some concrete outcome in reduced illness and death is demonstrated.³⁰ To date there is no firm evidence that the efforts of promoters have reduced illness and death in the rural areas of Guatemala.

Future Plans. The consensus of international donor agencies and at least some of the officials in the Ministry of Health is that with proper supervision and support Guatemala's rural health paraprofessionals--its health promoters--could be an important force not only in extending health services to the rural populace, but in reducing illness and death in rural Guatemala. Evidence of this can be seen in the fact that the Ministry of Health recently signed a cooperative agreement with AID to train additional promoters in another area of Guatemala. Increased supervision by Rural Health Technicians and increased material support for promoters is a significant feature of the project. The Ministry of Health has also recently signed an agreement with INCAP to train promoters in another part of the country.³¹ The notable feature here is the increased planning evident throughout the plan. This project--SINAPS as it is named--is a large pilot project with a heavy evaluation component. If the evaluation of the project is favorable, and if the Ministry of Health is willing, a second phase will begin with all of Guatemala being covered by health paraprofessionals.

³⁰ J. Habicht and Working Group on Rural Medical Care, "Delivery of Primary Care by Medical Auxiliaries: Techniques of Use and Analysis of Benefits Achieved in some Rural Villages in Guatemala," PAHO/WHO Scientific Publication #278, Washington, 1978, p. 19.

³¹ A. Lechtig et. al., Sumario del Estado Actual del SINAPS (INCAP, Guatemala, June 6, 1979).

It is generally admitted that efforts to improve the performance of the health promoters are based not only on faith in the potential of paraprofessionals, but also on the lack of any viable alternative to the use of paraprofessionals. If, for example, there is not enough trained manpower available to supervise the health promoters better, then there certainly is not enough more highly trained manpower to replace the health promoters. Likewise, if there is not enough money available to pay the health promoters, then there obviously is not money available to pay the salaries of more highly trained manpower even if they are willing to work in the rural areas.

As mentioned earlier, resources in the health care field are inequitably allocated in Guatemala. There is an over-supply of doctors in the capital city, and large hospitals in the urban areas receive an inordinate share of the funds available for health care. This is by no means unique to Guatemala; in many underdeveloped countries health care receives a low priority, and rural health care the lowest priority of all.

Under the present circumstances the continued employment of promoters--albeit with increased supervision--is the most logical step in the struggle to improve rural health and rural health care in Guatemala. The question arises, though, whether increased supervision and material support will result in an improved and more even performance on the part of Guatemala's paraprofessionals. As one AID official put it, "Supervision is a necessary condition, but one wonders if it is a sufficient condition to improve the performance of the promoters."³² An extensive evaluation of the promoters that INCAP has planned should shed light on this question, as should this report (to a lesser extent, since it was prepared with less time and investment). At the time this investigation started, there was little analysis or evaluation of Guatemala's health paraprofessional experience. We will attempt to provide such knowledge in sufficient detail to assist those interested in learning from that experience.

³²N. Woodruff, AID/Guatemala, in private conversation.

CHAPTER II: EXPERIENCE WITH RURAL HEALTH PARAPROFESSIONALS

Area Chosen for Field Study

In order to learn first hand about the actual working of Guatemala's health paraprofessionals, and to explore the propositions about paraprofessionals stated in the Introduction, field work was undertaken in the area near the training institute for Rural Health Technicians--INDAPS--located at Quirigua. This is a hot, humid, rural area 200 kilometers east of Guatemala City, and lying close to the southern border of the country.

Given the general consensus that the greatest problem confronting Guatemala's health promoters is the lack of adequate supervision, and given the fact that efforts are underway to increase the supervision of the health promoters, it was thought appropriate to study promoters in an area where supervision of promoters was likely to be more extensive than in some other areas. Many of the promoters that were subsequently visited were, in fact, supervised by Rural Health Technicians based at INDAPS. However, promoters were also visited who lived quite a distance from INDAPS and who either were supervised by Rural Health Technicians based elsewhere than at INDAPS or who were not supervised at all.

Research Methods. Eight villages were visited. An effort was made to visit villages in different parts of the area, so as to visit villages where the health promoters had various problems as well as villages where the health promoters were acknowledged to be working fairly successfully. Only two of the eight villages visited were accessible by motorcycle. The others were accessible only by foot or by horseback. Many of the villages visited were a full day's walk or horseback ride from INDAPS. Even with horses travel was difficult. The "roads" were often little more than cowpaths, and in some places were so muddy that the mud would nearly reach the bellies of the horses. This is

especially noteworthy since the villages were being visited during the "dry" season (the difference between the dry and wet season is only that there is more rain in the wet season).

Throughout my stay in the area I was accompanied by a Rural Health Technician or a health promoter. The two Rural Health Technicians and the two health promoters who alternately accompanied me served primarily as guides, but they were also invaluable in gaining the trust of rural villagers. Without their warm introductions it would have been necessary to spend much more time in the field to gain rapport with the health promoters and other rural villagers.

A number of people--including some health promoters--suggested that health promoters, and rural villagers in general, would feel more confident being interviewed by an outsider if nothing was written down during the interview, and if the interview was open-ended. Hence, although the questions asked in the interview were based on a set of questionnaires and checklists that were prepared by our working group at Cornell, no formal written questionnaire was utilized. Also, I refrained from taking any written notes while I was in the villages.

The villages visited ranged in size from about 200 to 600 inhabitants. Many villages--particularly the larger ones--have more than one health promoter. Thus, it was possible to visit and interview seventeen different health promoters in their respective villages. Other rural villagers were also interviewed. Wherever possible members of village self-improvement committees, military commissioners, priests, auxiliary nurses and Rural Health Technicians were interviewed.

Coincidentally, one of the semi-annual reunions that INDAPS organizes for the health promoters in the area was held just prior to my departure. This reunion lasted three days and was attended by many of the health promoters working in the area. The reunion provided an opportunity to meet again with many of the health promoters I had

visited, and to talk with another twenty health promoters. It was also possible for me to sit in on their training sessions and discussions.

Background Information. The area of Guatemala chosen for field work differs from many other rural areas of Guatemala in that there is not an indigenous (Indian) population in the area. Given the cultural differences that exist between the indigenous population and the Ladino population in Guatemala, this is a significant difference. In other respects the area surrounding the town of Quirigua exemplifies much of rural Guatemala. The population lives in dispersed communities of 2,000 inhabitants or less. As noted already, many of these communities are only accessible by foot or by horseback, and for a couple of months during the rainy season many villages are almost completely inaccessible. The population is very poor, and suffers from a low level of education and health. Social services are practically non-existent. These obstacles are, of course, all common problems facing many developing countries in their efforts to provide rural health services.

Quirigua lies on the eastern side of a large plane or valley in the eastern part of Guatemala. Although Quirigua has only 3,000 inhabitants, it and another town of the same size, Los Amates, are the commercial centers of the area. As the map shows, Quirigua and Los Amates lie on the all-weather road that links Guatemala City to the principal Guatemalan port--Puerto Barrios on the Atlantic. East of the highway and Quirigua and Los Amates runs the Motagua River. There isn't a bridge anywhere in the area that crosses this wide river. Ferry service is available, but only by canoes. Thus, the area that lies between the Motagua River and the Honduras border is only accessible by horse or foot. Of course, there are no paved roads.

The United Fruit Company owns and operates a large banana plantation in the valley. Over 5,000 Guatemalans work at the plantation. The company provides medical service to all of its workers and their dependents. Otherwise the land that lies in this

fertile valley is taken up by large cattle ranches which afford little opportunity for employment since the land is not cultivated but only used as pasture. As a result, the bulk of the population in the area live not only east of the river but also in the mountains that rim the southeastern side of this large valley. These mountains stretch well past the Honduras border.

In the mountains are many scattered villages. Agriculture is practically the only form of livelihood. Maize and beans are cultivated in small plots in the occasional meadows and on the sides of the hills and mountains. Although some farmers own the land they work, many are tenant farmers who pay half of their harvests to the land owner. Land is scarce and the holdings of land cultivated barely support the population.

Family and Village Structure. Most families live in simple one-room houses which have sections partitioned off for sleeping quarters. Chickens, cats, dogs and occasionally pigs share the family's living quarters. Houses are constructed of local materials: unhewed poles are strung together for a frame, a reed-like material is used for the walls, and the roof is usually of thatch. Occasionally one encounters a house of adobe construction and/or with a metal roof. Latrines are rare as is any form of planned garbage system. Needless to say, there is no electricity or running water.

Families are quite large by North American standards. The average number of children per family is estimated to be between 6 and 7. Otherwise the family structure is similar to the traditional North American family: the wife attends to the children and the household chores while the husband works in the fields. Generally speaking the wife runs the household on a day-to-day basis, but the husband makes most important decisions that bear on the family. Families are quite atomistic; it is unusual for families, or the men in the families, to work together.

A visitor to the area is struck by the friendliness of the people. Everyone appears to know one another and greetings are always exchanged when villagers pass one

another. However, there is no fixed place--either formal or informal--where people in the village routinely gather to converse and visit with one another. There is also no established manner for bringing up in public an item of broad community interest. Nor is there mail service or access to newspapers although many people do have radios. Thus, formal communication channels within the village are very weak. This is not to say that village news does not get around--it certainly goes. However, news is spread mainly on an individual basis which precludes community discussion.

Given the minimal communication channels, it is not surprising that there is a lack of community organizations. Until the efforts of the promoters began, there were virtually no community organizations in the different villages. There were, and are, individuals with some kind of authority in the village though. These include the military commissioner, the teacher if there is one (there often is not), and the local Catholic and Evangelic priests. While it is not always clear whether to call these persons "leaders," they are usually influential in the village and must be taken into account by anyone--such as the paraprofessional--seeking to work for the community.

Every community--no matter how small--has a military commissioner. This person is usually a middle-aged man of above average economic means. The military commissioner is appointed by the army to serve without compensation as a representative of the army. He is required to send young men to the nearest army base to serve in the army, and to notify the army (personally or by a note sent by messenger) of any disturbances in the village or suspicious activity. These duties do not make the military commissioners very popular. There is no local control over military commissioners and they can act with great independence. As was mentioned earlier, priests and teachers also exert considerable influence in the villages.

Before the activity of the Technicians in Rural Health and the health promoters, all of the medical care in the entire region was concentrated in Quirigua and Los

Amates. There were no health care facilities in the rural villages--not even a traditional "healer." The fact that the area is settled by migran's and not by an indigenous people probably explains the absence of any traditional "healers." Most of the communities were settled between 30 and 50 years ago. There are a few traditional midwives, but their activities have always been limited to assisting women during childbirth. To be sure there are traditional remedies for illnesses, but the people have little to work with. For example, umbilical cords are often cut with a hot machete.

The health care facilities in Quirigua and Los Amates are too inaccessible for most people in the mountains to reach--particularly when they are ill. Traditional wisdom has it that if a really sick person tries to make it to Quirigua or Los Amates, he or she will just die on the way. Given the distance and the atrocious roads it is held to be best just to die at home.

Community Attitudes Towards Health Care

The poverty of the communities and the lack of nearby health care facilities to work with are obvious difficulties facing the health promoters. Community attitudes toward health, change and community organization also pose a number of obstacles to the health promoters--or to anyone else seeking to improve rural health care. A further problem is the differences among villagers.

Discussions with rural villagers, and to a lesser extent with health promoters, suggest that the lack of health education poses a problem not only because villagers are ignorant of basic health care principles, but also because they hold to beliefs which impede efforts to educate them in health care. No one ever has a blank mind on a question as important as health. The problem in the area surrounding Quirigua is not that there is a belief in magic or magical forces. Instead, there is the problem of people believing that--at least in the field of health--things are fine the way they are,

or that everything--including illness--is ordained by God, and that all one needs is faith in God.

These attitudes are an especially serious problem when health promoters attempt to provide preventive health education or care. For example, a health promoter attempting to convince people to build and use latrines is liable to be told such things as, "I'm fifty years old and I haven't been sick for years. Why do I suddenly need a latrine?" A health promoter attempting to organize a garbage disposal system recalled being told, "Look at how the pigs live and how fat they get." These comments reveal an attitude of passivity or acceptance that is all too common. This attitude is not in such evidence when there is a need for curative care.

A slightly less common attitude is the belief that everything is the way it is because it is the will of God. Many villagers who were queried about their feelings toward health care answered that they had faith in God and that was all they felt they needed. A few villagers were even encountered who refused to use medicines or other curative care because they felt it was against the will of God. This religious fatalism is especially common among members of the Evangelic church; however, this attitude is by no means limited to members of this church.

Impact of Village Stratification. A further difficulty facing health promoters is that while everyone in a village may appear similar and in equal circumstances to the outsider, that is simply not the case. Villages are not one big happy family. Villagers do not necessarily share a consensus of opinion and are not necessarily willing to help one another. Some villagers are better off economically than others and set themselves apart from others. Some villagers wish to change village life while others do not. Consequently, villagers differ in their opinions as to what their village needs, and how these needs should be satisfied. Thus, it is no surprise that in any given village some villagers will enthusiastically support the activities of the health promoters, others will

be indifferent, and some will actually be opposed to the activities of the paraprofessionals.

Another noted aspect of the rural villages surrounding Quirigua is the fear villagers have of participating in any sort of community organization or activity--even if such activity is only for improving the health of villagers. The villages have suffered greatly in the past from the activities of guerrillas and the Guatemalan army; as a result of the violence, there is a general fear of anything that resembles politics.

A certain apprehensiveness of some village authorities stems from lack of understanding of what the health promoters are and what they are doing. There is, however, also some fear that the community's working together to improve the level of health in the village may lead to group concern for issues such as the distribution of land. Curative practices, in contrast to preventive health care, are not thought to be threatening since they are practiced on an individual basis and the patient plays a passive role.

Attitudes Towards the Paraprofessionals. The literature on paraprofessionals often makes the assertion that one of the advantages of using paraprofessionals is that villagers who enjoy the confidence of their peers can be recruited to serve in their own communities. Villagers are perceived as being more receptive to accepting social services if provided by one of their peers. The experience of using health promoters in the area investigated suggests that this is a misleading simplification. Discussions with villagers suggest that villagers trust a local health promoter more than they would a health promoter or other type of health worker who was a stranger to the village. However, villagers expect very little from someone who is from the same village; he or she is perceived to have no special knowledge or resource. A commonly cited Biblical proverb in Guatemala that the health promoters use to describe their predicament translates as, "no one is a prophet in his own land." This is not to say that health

workers who were strangers would not have problems of their own--they certainly would. But being from the community does not solve problems of acceptance.

Summary of Community Attitudes. Reviewing the statistics available on the health problems in rural Guatemala, and considering the limited facilities that have been historically available in the rural areas, has led many to support the use of health paraprofessionals. Interviews with people who live in an isolated area which is served by the health paraprofessionals did not refute the evidence that suggests paraprofessionals are necessary. However, the interviews also indicated that there are a number of obstacles in the rural communities that confront the paraprofessionals from the start. These obstacles are normally not recognized in the literature on paraprofessionals.

At least initially communities are bound to be interested in only curative medicine. Preventive medicine is much more difficult to practice. For many preventive practices the health promoter needs to bring at least part of the community together into a working group. Concomitantly, before or after, he or she must persuade them to take an interest in preventive medicine. Only after these two steps can the health promoters begin "promoting health." The experience of health promoters in the area surrounding Quirigua suggests that these first two steps are just as difficult as the third step.

Selection of the Health Promoters

The selection of health promoters in the area surrounding Quirigua mirrors the selection of health promoters throughout the country. The original plan called for health promoters to be elected by their respective communities. Many promoters have, in fact, been selected in this manner. Usually a Technician in Rural Health will invite all villagers to a meeting which will be held at a church or in front of someone's house.

In order to insure that everyone can attend, the meetings are inevitably held on Sunday or are held by candlelight at night. The Technician in Rural Health will explain to those gathered what a health promoter does. The village will then be asked to elect a candidate for training, making sure, of course, that the candidate elected is willing to serve as a health promoter.

The only stated requirement for being a health promoter is being literate. Since messages are often sent to and from health promoters, and because of the necessity of reading labels on medical supplies, it has been deemed important for health promoters to have at least minimum reading and writing skills. Of course, training is also facilitated if health promoters are literate. The literacy requirement certainly excludes many people from serving as health promoters, but it does not exclude a whole segment of poor rural villagers from serving as health promoters. Nearly all of the health promoters interviewed were as poor as the people they served, and did not own the land they cultivated. Yet, they--like some other rural villagers--had one or two years of schooling, were self-taught, or had learned to read and write in the army.

Community Participation in the Selection Process. In the area surrounding Quirigua, roughly three-quarters of the health promoters have been selected in the above fashion. In the other instances, a Technician in Rural Health merely picked someone whom he or she thought would be a suitable candidate and who was willing to serve as a health promoter. The opinion of villagers, health promoters and Technicians in Rural Health who were interviewed suggested that it is preferable for communities to participate in the selection of their health promoters, and that consequently Technicians in Rural Health should not be allowed to select candidates without community participation.

Communities have more knowledge, interest and confidence in their local health promoter when they have participated in the selection process. Interviews in the

villages visited revealed that health promoters were both better and more widely known if villagers had participated in the selection process. Second, if communities participate in the selection process of health promoters it is more certain that health promoters will be selected who have those characteristics and qualities that are esteemed by villagers. This will be true not only with regard to personal qualities but also with such characteristics as sex and age. This point was sharply brought out by the tendency of communities to elect middle-aged men to serve as health promoters. Technicians in Rural Health, on the other hand, tend to select people in their late teens to serve as health promoters, but even the young health promoters admitted that their efforts were hampered by their youth.

When questioned about this, the director of INDAPS (the training center for Rural Health Technicians), Dr. Monzon, said that he had suspected that health promoters who were selected without community participation were not as effective as those selected with it. He did point out, however, that it is much more difficult to train older candidates than it is to train younger candidates. He did not feel that this was so important a consideration, however, and agreed that in the future all health promoters should, without exception, be selected with the participation of their community.

Very few women serve as health promoters. Given the different roles men and women have in the family and the village, it appears easier for men to serve as health promoters. However, even male health promoters admit that it is difficult for them to talk with women about birth control, pregnancy and to a lesser extent child raising. Women, on the other hand, report difficulties in talking to men about certain subjects. AID/Guatemala, which has recognized this dilemma, has come up with an idea for dealing with this: the health bureau is proposing to use husband/wife teams as health promoters. Villagers and health promoters were queried of their opinion of the idea. Not surprisingly, everyone was enthusiastic about the proposal.

Training. The training of most of the health promoters interviewed took place at INDAPS. The training period lasted for one month during which INDAPS provided room and board for the health promoters. The promoters, however, did not receive any salary during the training period. Training was done primarily by Rural Health Technicians with occasional help from the teaching staff of INDAPS and the staff of the health post at Quirigua. A wide variety of subjects was covered--community organization, health education, nutrition, preventive public health care, curative health care and even agriculture. Simple medical kits supplied by UNICEF are given to graduates of the training program when the kits are available (lately they have not been available).

Health promoters appeared very satisfied with their training. They were content with both the organization and the content of their training. There was no consensus on what area of study they felt they most needed further training in. To be sure it was difficult for them to spend a month away from their families and work; however, INDAPS wisely selects months of the year for the training of health promoters when there is very little work in the fields. Otherwise it would be impossible for the health promoters to attend the training program. The health promoters who had been trained at INDAPS liked having their training in one complete month. They felt that for that month they could concentrate exclusively on their studies, and were spared the hassle of traveling to and from the training center as they would have to do if, for example, their training was only given on weekends.

Some health promoters interviewed, however, had not been trained at INDAPS or another training center for one month's period. These health promoters received three or four days of training every two weeks for a number of months. They felt their particular training system was best because they did not have to spend long periods of time away from their family, and they had an opportunity to practice what they learned as they were being trained. There was no evidence that graduates of one training

center were any better than graduates of the other centers. The only conclusion that can be drawn is that each system of training has its advantages and disadvantages, but that each is nonetheless satisfactory. Other than the scheduling of the training period, the various training programs in the area did not seem to differ appreciably.

In-Service Training. There is very little opportunity for in-service training. Nearly all of the health promoters interviewed expressed a desire for some sort of in-service training. Interest was expressed in learning more about everything from curative medicine to community organization. The health promoters frequently ask their supervisors questions and are, hence, potentially able to learn from their supervisors. However, as will be discussed shortly, there is a lack of supervision for the health promoters.

All of the health promoters in the area around Quirigua are invited to INDAPS roughly twice a year for a reunion. For the few days that they meet--usually a long weekend--there is the opportunity to learn from one another, and to receive additional training in areas of interest. The health promoters participate in both the selection of topics to be covered and often also in the actual presentation of the material. Although attendance is reasonably good at these semi-annual reunions, the health promoters do not have the time to attend monthly reunions.

The health promoters do have another way of obtaining some sort of in-service training. With the financial support and supervision of INDAPS, the health promoters publish a small newspaper or newsletter every couple of months under the title, "Voz Campesina." With only rare exceptions all of the articles are written by health promoters. Usually there will be articles that contribute to the knowledge of the promoters. The paper also lets promoters keep in touch with what other health promoters are doing and is thus valuable for the morale of the health promoters. Since there is no mail service to the villages where health promoters are working, copies of

the newspaper are given to people who happen to be going to the different villages. Often the newspapers do not arrive, but when they do they are eagerly read and shared. A recent issue is included in an appendix to this paper.

Performance of the Health Promoter

It was apparent from the information already available on health promoters that they perform a wide variety of tasks but that the level of service is very uneven. Our study supports this view. Health promoters around Quirigua do quite a variety of tasks: some provide only curative medicine, a few only participate in government vaccination campaigns, some work on educational and preventive health care projects, others do a little bit of everything, and still others admitted to doing nothing at all.

The various tasks that the health promoters in the area surrounding Quirigua have undertaken are as follows:

- 1) Provide basic curative service (e.g., emergency first aid, taking care of cuts and scrapes, and dealing with infectious diseases);
- 2) Assist others who provide curative service;
- 3) Refer patients to the nearest health post when necessary;
- 4) Participate in government vaccination campaigns (both for human beings and animals);
- 5) Promote local organization in their communities;
- 6) Educate villagers about basic nutrition, health care and sanitation, either at group meetings or by house visits; and
- 7) Initiate and coordinate projects aimed at providing potable water, constructing latrines or establishing a garbage system.

Not all health promoters undertake all of the above activities. Indeed, many have limited their activities to two or three of the above tasks. Most health promoters estimate that they spend an hour a day on the average working in this role. Since they

work in their fields during the day, they work as health promoters in the late afternoon or early evening.

Curative Medicine. Why there should be such variation in the activities and performance of the health paraprofessionals is the most perplexing and important question surrounding their use in Guatemala. While it is admittedly difficult to make generalizations, it is clear that there is one activity that tends to be undertaken most often--the practice of curative medicine. Given the nature of community attitudes towards health care, it is very easy for health promoters to concentrate their efforts on curative medicine. The health promoter can acquire prestige by helping people in the village who are ill. On the other hand, however, villagers are inclined to be uninterested in something like building latrines. Also, the need for curative care is much more urgent--a garbage disposal system can wait, a dying baby can't. Thus, it is not surprising that the most widely practiced activity of the health promoters is curative medicine.

Health promoters commonly provide emergency first aid. They also take care of simple cuts and bruises, and common infectious diseases. Two of the most common--and difficult--problems that health promoters have to deal with are cases of diarrhea in infants and young children, and intestinal parasites. Both of these problems point to the need for public preventive health care to break the vicious circle of poverty and ignorance that makes such diseases so common, and so difficult to treat.

Many health promoters buy medicine with their own money in Quirigua or Los Amates. They all claimed that they subsequently marked up the price of the medicine only so that they could continuously increase their supply of medicine. In a few villages, health promoters have even built their own health posts with the help of people in their communities. There is little doubt that they sometimes make mistakes and that occasionally there is little they can do for patients, since often they are called upon to

do things that go beyond their limited training. For example, one health promoter recalled having to sew up deep machete wounds. The health promoters and the rural populace they serve are aware of their medical limitations but as is often said, "They are better than nothing."

The health promoters in Guatemala are sometimes deprecated by policy makers for devoting too much time to practicing curative health care, rather than working on public preventive health care. There is some justification for this complaint; however, it overlooks a number of considerations. First, as mentioned earlier, many villages are without any access to curative care, and perceive having some form of curative care as their most serious need. Second, even when health promoters are seemingly only practicing curative care they can also be educating villagers on how diseases are contacted and spread, and how diseases can be avoided in the future. Health promoters in such a situation are not practicing only curative care. Third, given the felt needs of the villagers, providing some sort of basic curative care enables the health promoters to gain the interest and respect of villagers. Health promoters can, if they are so motivated, draw upon this interest and respect to teach villagers the value of preventive public health care.

There simply are not enough trained Rural Health Technicians. Visits to those villages that have supervised health promoters, though, do suggest that there is a strong correlation between the success of health promoters in practicing public preventive health care and the availability of supervision. This point is explored further in the section on supervision.

Another factor that is important in insuring the success of the health promoters is community participation. One of the first things health promoters are taught to do (and helped with if they are supervised) is to create a village self-improvement committee. This committee has the task of improving village life, and it works both directly with

the health promoter (or promoters) and tries to enlist village cooperation for the activities of the health promoters(s). Members of the committee are elected by villagers in the same fashion that health promoters are elected. Committees tend to consist of middle-aged men of average economic means. Interestingly enough, no committee was encountered that contained a village authority figure (such as a school teacher or priest). The seriousness with which these committees are taken is exemplified by the fact that in one village visited, the committee was reorganized by villagers three times in an attempt to secure an energetic and effective committee. As could be expected, some committees are more active than others. On the whole, though, the committees appear to work reasonably well, and to aid the health promoters a great deal.

The committee members solicit the participation of other villagers. Community participation is sought for three distinct reasons. First, it is thought to be "democratic" and "fair." Villagers, even if impoverished and illiterate, do place some value on public involvement. Second, it is believed that villagers will have more interest in the activities of the health promoter and the village committee if they participate in the selection and discussion of the activities to be undertaken. Of course, it is also easier subsequently to persuade villagers to contribute their time and energy to a project if they have participated in its selection. The third reason why community participation is sought is that many projects simply cannot be undertaken without the assistance of community members. For example, a single health promoter cannot build a health post even if he has the time and inclination. If other villagers are willing to pitch in, though, it is a feasible project. Thus, community participation is seen as being both desirable and necessary.

Committee meetings are open to the public to encourage community participation. In many villages committee members will individually visit households to

announce upcoming meetings. Such efforts usually secure a good turnout. However, there are always some villagers who simply will not participate. This illustrates one of the clearest findings of the study: The greatest difficulty in the area investigated is not finding someone to devote a good deal of time to serve as a health promoter, or to find a group of people who will volunteer some of their time to serve on a village self-improvement committee. Instead, the greatest difficulty is attracting and sustaining broad community participation.

As reported earlier, in every village there are some who are interested in working to improve village life and some who are indifferent. There may even be a few who are opposed to the efforts of the health promoter. Often--though not always--those in the village who are economically above average are indifferent or opposed to the activities of the health promoter. Usually, though, there is seemingly little economic difference between the households who support the health promoter and those households that are indifferent to his or her activities. Health promoters explain this difference as being just part of human nature. A good deal of their efforts, and the efforts of the Rural Health Technicians and the village committees, goes into trying to persuade those villagers who are indifferent to take a more active role in village affairs.

Although village authorities do not serve on the village self-improvement committees, obtaining their support seems to be the key to attaining greater community participation. As was mentioned before, these authorities consist of the military commissioner, priests and the local teacher (if there is one). Just why the village authorities are not members of the village self-improvement committees is not really clear, although it appears that village authorities are not interested in such activities. However, the issue may well be more complicated than this. Although it is not necessary for village authorities actually to be members of the local committee, their support of the health promoter(s) and the committee is very important.

Much has been said and written of patron-client relationships in Latin America. Although one should be wary of extending the analysis too far, it appears that even at the village level elements of such a relationship are in existence. Some health promoters are acutely aware of this and try to obtain the support of village leaders before approaching the village at large. One health promoter reported that it is more important for him to talk to the priests of the two churches (Catholic and Evangelic) than to talk with the congregations of the churches. If the priests give their approval, the congregations will go along with the promoter. The support, or at least the silent approval, of the local military commissioner is also important for the health promoter.

Of course, just because the village priests and the local military commissioner offer their blessing to the activities of the health promoter does not mean that the village will therefore enthusiastically support the health promoter. Conversely, even with the opposition of the village authorities some health promoters have been able to organize their communities and carry forth in their duties. Still, it is infinitely easier for health promoters to elicit broader community support and participation in their activities if they have the support of the authorities in their particular village.

It is difficult to generalize about the success of the health promoters in eliciting participation, since there is considerable variation in the amount of community participation from one village to the next. Most of the villages visited had some kind of active community participation. Exceptions were in villages where the health promoters only practiced curative medicine. There one finds less participation as this kind of service does not require an organizational effort. Aside from these cases, most villages had enough participation for the health promoter to accomplish some projects, but not enough participation to accomplish other more ambitious projects.

One area that villagers do not participate in is in evaluation of their health promoters. The notion of periodic evaluation is not commonly held by villagers, and

there is no provision for formal evaluation of the health promoters at the village level. One might expect that the existence of a village committee and participation by at least some villagers in the activities of the health promoter would provide at least some sort of informal means of local evaluation of the health promoters. No evidence was encountered that confirmed this however.

The other two factors that help explain the performance and the activities of different health promoters are the particular characteristics of the village in question and the individual differences among the paraprofessionals. The remoteness of curative medical services can help explain why some health promoters devote their time to curative health care and why others devote their time to health education or public preventive health care. Differences in villages can also explain which--if any--public preventive health care projects will be undertaken. For example, in one particular village visited, the women had to walk for over an hour for water that was often unclean. Not surprisingly, there was a great deal of interest on the part of the health promoters and other villagers in constructing a well that would supply potable water.

Individual difference between paraprofessionals also explain differences in performance. This is important at least partly because the health promoters do not receive any sort of material compensation for their work. They say they work as health promoters to "serve their community." They certainly would not have agreed to work as health promoters if they were not interested in doing volunteer work; nonetheless, altruism is limited. Furthermore, the altruism of health promoters--like everyone else--can be expected to vary. Also, the amount of free time that health promoters can devote to their duties varies from promoter to promoter.

Compensation. The fact that Guatemala's rural health paraprofessionals work without any sort of material compensation is amazing in itself. With only rare exceptions the health promoters are as poor as the people they serve. The health

promoters interviewed did feel that they had increased status in the village as a result of being health promoters; however, this did not appear to be that important to them. There is a rather high dropout rate for the health promoters, but it is very difficult to estimate just how high it is. Many of the health promoters interviewed admitted to having occasional thoughts of quitting their work as health promoters altogether. Not surprisingly all of the health promoters expressed a desire for a salary, and believed that with a salary they as a group would be much more effective. They believe, though, that any salary should come from the government, and not their own villages which they feel are too poor to pay for their services.

It does seem that the health promoters could be more effective if they were compensated for their efforts. Still, on the whole they are willing to do quite a bit as volunteers. Most of them have no interest whatsoever in national politics, but are interested in improving life in their villages. They are willing to make sacrifices to do this, principally through donating their time, but also by doing such things as buying translated copies of the book, Where There is No Doctor, with money from their own pockets.

Supervision of the Health Promoters

Supervision of the health promoters is by Rural Health Technicians. Despite their youth (most are in their early twenties), they are generally very well accepted by the health promoters and the rural villagers. They are respected for their education. Sometimes it takes the Rural Health Technicians a while to become known and trusted, but this is seldom a serious problem. It is especially important for the Rural Health Technicians to gain the acceptance of the village authorities, in particular the local military commissioner.

The Rural Health Technicians work very well with the health promoters. Both the Rural Health Technicians and the health promoters have the same orientation toward rural health and public preventive health care. Though supervision is usually thought to be important for purposes of control, that is the least important function of the Rural Health Technicians. Instead, supervisors of the health promoters help them in the following ways:

- 1) They give the health promoters direction and guidance.
- 2) They give prestige to the health promoters in the eyes of villagers.
- 3) They offer training in specific tasks.
- 4) Occasionally they supply needed resources.
- 5) They give the health promoters valued social contact.

All of the above functions of the supervisors are reasonably clear with the possible exception of the second function.

As mentioned earlier, villagers trust the health promoters as persons but tend to believe that someone from their own village can not really change village life. If, however, health promoters can give villagers the impression that they have access to outside "experts" and/or resources, they can command greater respect in their villages. Supervisors help to establish the legitimacy and authority of the health promoters in their villages, and health promoters are keenly aware of this. For this reason, health promoters like to be seen in their villages with their supervisors. The Rural Health Technicians frequently end up speaking with a number of people in the villages they visit.

Given the assistance that the Rural Health Technicians can offer to the health promoters, it is unfortunate that many health promoters receive inadequate supervision. There simply are not enough trained Rural Health Technicians to supervise all of the

health promoters. Some Rural Health Technicians have as many as twenty villages to supervise. Thus, even when there is supervision it is likely to be infrequent despite the best intentions of everyone concerned.

Although the frequency of supervision is uneven, the quality seems very good under the circumstances. The Rural Health Technicians have an informal and friendly relationship with the health promoters, and the health promoters feel free to ask questions about how to handle particular problems and for any resources that might be available. In one village visited, the health promoters had asked their supervisor to talk with the recently formed village self-improvement committee about how to conduct meetings and how to begin working on village problems. On the arranged day the supervisor presented a lecture on the topic with the help of a blackboard borrowed from this village school. He then answered questions from the villagers.

The attitude of health promoters towards their supervisors attests to the important and harmonious role that the supervisors play in aiding the health promoters. Some health promoters refer to their supervisors by the title "Don" or "Professor" although they clearly do not have to do this. Supervisors never carry food with them because the health promoters are so hospitable. Health promoters often ask their supervisors to visit them more frequently. Also, those health promoters visited who were not supervised asked us whether or not they could receive supervision in the near future. At the reunion for local health promoters held in December, 1979, the director of the training center asked what the health promoters felt they most needed. The answer was: "We need more supervision."

Since villages were visited in which the health promoters did not receive supervision as well as villages that did receive supervision, it was possible to see what difference supervision made. The difference was clear-cut and striking. Those health promoters that were supervised had better morale, were more active, and more likely

to engage in public preventive health care projects as opposed to just providing curative medical care. Although the differences were not readily measurable, the magnitude of the differences is suggested by the fact that supervised health promoters appeared to be twice as active as those health promoters who were not supervised, and four times as likely to engage in public preventive health care projects. Furthermore, the consensus at INDAPS was that the drop-out of health promoters was two to three times higher among those health promoters who were not supervised.

Apart from being themselves in short supply, supervisors lack resources to assist promoters in their duties and to share with them. Educational materials are practically non-existent. Many potential projects are thwarted by a lack of resources. For example, there is virtually no way of obtaining materials for a potable water system. To be sure, there are some things that can be done without outside resources. Still, the shortage of logistical support and supplies is a major constraint on the activities of both the health promoters and the Rural Health Technicians.

CHAPTER III: FINDINGS OF THE STUDY

Specific Conclusions and Policy Implications

The use of health paraprofessionals in the area studied cannot be said to be a great success, but it has registered some success. It is difficult to quantify many of the activities of the health promoters, and even more difficult to separate the work of health promoters from the work of Rural Health Technicians. However, a few statistics are available that attest to the success of both the health promoters and the Rural Health Technicians in the area studied between the years 1977 and 1979.¹

Before 1977 there were no health care facilities in the area surrounding Quirigua and Los Amates. At the close of 1979, one health post had been established in the mountains and staffed by an auxiliary nurse and a Technician in Rural Health. The local health promoters and other villagers raised money to buy materials for construction of the necessary facilities and subsequently constructed the building with their own labor. In addition, five other health posts have been established that provide basic services only. These are staffed entirely by health promoters. Again, the health promoters organized their communities so that funds could be collected and labor obtained to build simple facilities. Many individual health promoters are also now providing limited medical care. These health posts and health promoters are now providing health care in areas where there was previously no access to health care.

During the same period, three projects were completed that provide potable water to villages. Twenty-three other projects led to an improvement in the water supply available to villages. Sixty-two projects were carried out that improved the local

¹All of the statistics are from V. Racancoj, Memories 1977-1979, Area Comunitaria INDAPS (INDAPS: Quirigua, Izabal, Guatemala, 1979), pp. 4-6.

disposal of garbage. Before 1977, only an estimated 5 percent of the families in the area had latrines; by 1979, 11 percent of the families had latrines. Educational programs of various sorts have been carried out. Finally, thousands of animals have been vaccinated to prevent the costly death of animal.

If it is difficult to obtain measures of the outputs of the health paraprofessionals in Guatemala, then it is impossible to obtain statistical indicators of the net outcome of their efforts. Just how their efforts have affected morbidity and mortality rates, for example, is not known. Still, it is difficult to believe that rural Guatemalans are not better off as a result of their efforts. Many villagers have access to some kind of medical care for the first time in their life and now have at least a limited knowledge of preventive health care. Also, many villages now have a village improvement committee and the experience of using local resources to improve village life. Many people have participated in projects aimed at offering them and their neighbors a better life.

The efforts of the health promoters are impressive when one considers the difficulties that they face. Some of these difficulties--such as rural attitudes to health care--are unavoidable. Other difficulties the health promoters presently struggle against could be alleviated with the assistance of policy makers. There is little doubt that a greater commitment at the policy level to allocating funds to rural health would enable Guatemala's health paraprofessionals to be both more active and effective.

Three useful policy steps would be as follows:

- 1) Increase the supervision of the health promoters by training more Rural Health Technicians.
- 2) Increase the amount of resources that are provided or made available to promoters.
- 3) Improve the level of cooperation between employees--paid or not--of the Ministry of Health, the Ministry of Defense and the Ministry of Education.

Each of these suggestions merits further discussion.

Given the dramatic difference that exists among those health promoters who receive supervision and those that do not, one of the easiest ways to improve the performance of health promoters in general would be by training more Rural Health Technicians so that all health promoters could receive at least some supervision. Increasing the availability of supervision would not only improve the overall level of performance of health promoters, but also would result in a more even and uniform level of service to rural Guatemalans. As we have seen, supervision improves the performance of health promoters not by providing control, but by providing encouragement and guidance that not only increases the morale of the health promoter, but also increases his or her standing in the eyes of other villagers. Supervisors can also help health promoters resolve problems that impede the efforts of the health promoters.

Increasing the amount of resources that are provided or made available to health promoters would also increase the success of health promoters in much the same way that increasing supervision would. Access to outside resources improves the morale of health promoters and concomitantly improve his or her standing in the village. For example, it is very difficult for a health promoter offering curative care to maintain the confidence of his or her village if he or she does not have adequate medical supplies. However, if medical supplies are provided regularly, then the health promoter not only has something tangible to offer the villagers, but also has a heightened sense of confidence because someone outside the village thinks enough of the health promoter to provide him or her with medical supplies.

Of course, resources also directly facilitate--or make possible--the undertaking of certain activities and projects. A village may have some resources, such as labor, but the absence of other needed inputs can severely constrain the activities of health promoters and Rural Health Technicians. Health promoters expressed a need for more

medical supplies and educational materials and for equipment used in preventive health care projects (for example, pumps for potable water projects). The supply of these resources can provide the incentive for health promoters to organize their communities and jointly carry out projects that improve the level of health in rural villages.

The third policy suggestion is to improve the level of cooperation between representatives in the villages of the different branches of the government. Given the influence that village authorities have in rural Guatemala, their cooperation is very important. Changing attitudes towards health and health care is a very difficult job. When there is not a consensus among those with authority in the village that the activities of the health promoter are worthwhile, then the job of the health promoter becomes much more difficult. This is particularly true because the health promoter's claim to authority and professional skill is weak. Indeed, it may very well be that paraprofessionals in general are more dependent upon the support of others with authority than are professionals who can base their authority on their expertise.

Improving the level of cooperation between employees of the different Ministries that have representatives in rural villages can, and should, be undertaken at two levels: the national level and the local level. For example, the Minister of Health should secure the support of the Minister of Education for the activities of the health promoters. Teachers could then be instructed to publicize and support the activities of local health promoter(s). At the local level each health promoter should make an effort to explain his or her activities to village authorities, and to encourage their participation in the activities. The government could also do other things to publicize the activities of the health promoters, and to increase their legitimacy in the eyes of rural villagers. One possibility would be to have radio stations periodically broadcast short announcements about the activities of health promoters. Although a majority of rural villagers are illiterate, many of them do have radios.

Another possible policy change that would probably improve the performance of health promoters would be to pay them a salary. Unfortunately this does not seem to be likely for the health promoters. The cost of paying the health promoters would be high. Also, there is another disadvantage to paying health promoters: if health promoters were paid a salary, it would be difficult to determine which candidates for the job were really interested in working and which were only interested in the salary. However, if health promoters are not paid a salary, it must be recognized that the health promoters can devote only a limited amount of time to their duties. Also it is necessary to be continuously training promoters since the drop-out rate is quite high.

Although the policy suggestions would probably greatly aid the health promoters if implemented, it must be recognized that there are some constraints on the effectiveness of the health promoters that cannot be eliminated through mere changes in policy. Community attitudes towards health care have already been mentioned as a strong obstacle. Certainly community attitudes cannot be readily changed by government efforts. A more serious obstacle for health promoters is the poverty of their villages. The health promoters were nearly unanimous in stating that the poverty of the rural populace was their most serious problem. Again and again it thwarts their efforts. For example, one health promoter stated that he can lecture his village on what foods they should eat in order to have a nutritious diet, but he himself (as well as others in the village) cannot afford to buy these foods. Likewise the health promoters can treat sick people, but if their patients return to the same conditions that produced the illness, then they are bound to get sick yet again. Thus, it must be remembered that even if the Guatemalan government were to increase its support of the rural health paraprofessionals, they would still have a very difficult job.

On the positive side, the decision to have communities elect their health promoter was found to contribute to the knowledge, interest and confidence that communities

have in their health promoters. Likewise, the timing and content of the health promoter's training was seen as being appropriate. The importance of this is exemplified by the fact that all of the health promoters said that if the training had been given in any other months than when it was provided, they simply could not have left their fields to receive training. In this case, the administration was aware of farmers' situation and could take it into consideration in its planning and decision-making. This type of sensitivity in planning makes a crucial difference.

There have been inadequacies in program practice though. Most of these can be traced not to poor planning and administration, but to a lack of resources. The Ministry of Health clearly operated under budgetary constraints. Needed resources have not been allocated to the health promoters and Rural Health Technicians. This lack of support is one of the health promoters' greatest problems.

Our final proposition about the use of paraprofessionals was that the effectiveness, efficiency and responsiveness of paraprofessionals will vary directly with their success in encouraging local participation, particularly through local organizations. As reported earlier, local participation has proven invaluable to the health promoters but occasionally difficult to obtain. Before the efforts of the health promoters and the Rural Health Technicians were initiated, it was rare for villages to have any sort of local self-help organization. The first activity of recently trained health promoters and Rural Health Technicians is invariably the establishment of village self-improvement committees. These committees have proven essential for enlisting the interest, confidence and support of villages in the activities of the health promoters.

Community participation in general is clearly desirable. Health promoters who are elected by their local villages are more likely to be trusted by villagers, and to have those qualities that are valued by villagers, than health promoters who are selected

without community participation. Villages frequently participate in the decision on which village problems will be tackled and how. They also help health promoters carry out projects. Indeed, without some minimum of community participation, only certain kinds of projects (e.g., purely curative activities) could even get started.

One difficulty for the kind of rural health program intended is the importance assigned by the rural populace to curative medical care, while program designers believe that the priority need of rural people is preventive public health measures. Emphasizing local participation is likely to slacken. How is it to be decided who is right? The easiest solution is to provide both curative and preventive health care whenever possible. Despite these difficulties, there is little doubt that participation has been important to the success so far achieved by health paraprofessionals.

In addition to these conclusions, several others emerged that are of possible interest. If the only limitation on using medical professionals is their high cost, paraprofessionals can be employed and professionals then utilized as their trainers and supervisors. However, if, as is the case in Guatemala, the constraint on using professionals is not only their high cost, but also their unwillingness to work in rural areas, and their having a professional orientation not suited to the prevailing health problems, then a country would be well advised to follow Guatemala's example and train subprofessionals to supervise paraprofessionals. If established professionals are unwilling to practice their profession in the rural areas, then they probably will not be willing to work there as supervisors either, and it would be unwise to plan a program that was dependent upon them. Also, Guatemala's experience suggests that established professionals may very well be hostile initially to the use of paraprofessionals, and hence unwilling to work with them. Subprofessionals, like Guatemala's Rural Health Technicians, can be recruited from areas where they will eventually work, trained to deal with rural problems, and employed specifically to work with paraprofessionals.

Guatemala's experience with paraprofessionals has cast doubt on two common assumptions about paraprofessionals. The first is that paraprofessionals from the community have the advantage of being more easily accepted than outsiders seeking to perform the same duties. It seems this consideration is oversimplified and misleading. As reported already, rural villagers trust the health promoters more than they would outsiders, but they have low expectations of what someone who is from their village can accomplish. This attitude is an obstacle for health promoters though it can be overcome with the status conferred by outside supervision and logistical support.

Another common assumption is that there is a great deal rural villagers can do for themselves if they are organized. Villagers should participate in development efforts designed to serve them, and this participation is more easily attained if there is some community organization. However, there is a definite limit on what a rural village can do for itself. A village may have some resources (such as labor), but a shortage of other necessary inputs. Villages need some outside assistance. This suggests that the use of paraprofessionals should be thought of more as a "compliment" to professionals and social service delivery systems rather than as an "alternative." From this it follows that the active support of the government, and to a lesser extent the established health care system, is necessary for the success of a health paraprofessional program.

APPENDIX



VOZ Campesina

PROMOTORES RURALES DE SALUD QUIRIGUA. LOS AMATES, IZABAL SEPTIEMBRE 1979 N°4

*¿Cómo te sientes
con tus vecinos
contento y sin
enfermedad
eso es Salud*

EDITORIAL

Comunidad, comités y promotores reunidos. Gran importancia para nuestras comunidades pobres, sin tierra y con mucha enfermedad del municipio de Los Amates fueron las actividades realizadas en la primera semana de Septiembre en el INDAPS, Quiriguá.

Activamente participaron miembros de organizaciones de diferentes comunidades en la segunda etapa del cursillo de orientación a comités.

También se logró intercambiar experiencias entre promotores en función y de la IV Promoción que pronto inician su actividad como Promotores de Salud.

Pero mayor fué nuestra satisfacción cuando por primera vez estuvieron reunidos comités y Promotores de Salud discutiendo nuestros problemas, y se logró dar a conocer,

qué aprende, cuál es la función, que a hecho y qué problemas tiene el Promotor en Salud Rural; para esta actividad fueron invitados con tiempo anticipado y por escrito las autoridades militares y civiles del municipio, pero lamentablemente no asistieron, ni sabemos por qué, pues no nos notificaron, ¿Será porque somos pobres y sencillos? aunque era importante su presencia, nuestros logros fueron buenos.

Alegría nos causó también ver a cientos de nuestros vecinos de diferentes comunidades que vinieron para participar en la clausura de la IV Promoción de Promotores, primer cursillo de orientación a comités y segundo encuentro de Promotores en función.

El sábado 8 de Septiembre, pudimos personalmente escuchar comentarios y deseos por seguir trabajando unidos para cambiar la situación de pobres de nuestra comunidad.

Estas actividades fueron el inicio de una mayor comunicación, creemos que se deben de seguir fomentando, para recorrer unidos, el camino hacia una mejor salud, y en ello una mejor vida para nosotros los campesinos pobres.

EL DIRECTORIO

... Y así, toda la nos insulta.

... de Jaime Coronroy.

... con el esfuerzo de la comunidad y la ayuda del Ministerio de Obras Públicas se construyó en la aldea La Libertad una escuela y vivienda para el profesor.

Al terminar la construcción de la obra, CORRARON 500 BLOCS Y MADERA. Por lo que el Comité Pro-Mejoramiento decidieron SOLICITAR al ingeniero encargado de la obra PARA LA CONSTRUCCION DE UN PUESTO DE TRABAJO, para que respondiera que pedíamos usarlo. Pero resulta que EL PROFESOR QUIERE VENDER ESE MATERIAL, PERO nosotros los del Comité, Alcaldes, un Horno, Promotores y la comunidad nos hemos opuesto a la venta. Es por eso que el profesor está enojado y el día 15 de Septiembre estando yo en la casa de un mi vecino, me trató con palabras pesadas y me dijo que eramos unos COMUNISTAS, gracias a unos señores que intervinieron no siguió insultándome. Pero eso que nos dijo no nos aflige y estamos dispuestos a trabajar por los intereses de la comunidad.



DIRECTORIO VOZ CAMPESINA.

- Amilcar González
- José Luis Cerna
- Antonio Rodríguez
- Domingo Recinos.

LOS HABITANTES DE LA REPUBLICA TIENEN DERECHO DE ASOCIARSE LIBREMENTE PARA LOS DISTINTOS FINES DE LA VIDA HUMANA CON EL OBJETO DE PROMOVER, EJERCER Y PROTEGER SUS DERECHOS E INTERESES ESPECIALMENTE LOS QUE ESTABLECE LA CONSTITUCION.

Artículo 64 Constitución, Guatemala.

SEMINOLA EN MARCHA.

Seminola es una aldea situada más o menos a 20 Kms. de la cabecera municipal de Los Amates, se cultiva maiz, frijol, arroz, plátano, yuca, banano, tomate, piña, cocos, aguacates, etc.

Hasta el momento solo 100 personas tienen cada quien una parcelita de 5 manzanas cada una, el terreno donde vivimos es privado. Por el momento tiene dos vías de acceso la más antigua por la finca privada Patzún (Bandegua).

La otra es la carretera nueva que acaba de introducirse a la altura del Km. 212 de la ruta al atlántico, está nueva, tiene una extensión aproximada de 7 Kms. y medio, carretera balastrada.

Para la construcción de esta carretera naturalmente se precisó del abundante recurso humano de toda la comunidad organizada, así como la ayuda económica de la misma y de instituciones internacionales.

En otra oportunidad daremos a conocer otra faceta de nuestra bella y progresista comunidad.

COMITE PRO-MEJORAMIENTO SEMINOLA.

INDAFES DE PROTECCION AL

COMBUSTIVO.

Por: Domingo Rivas.

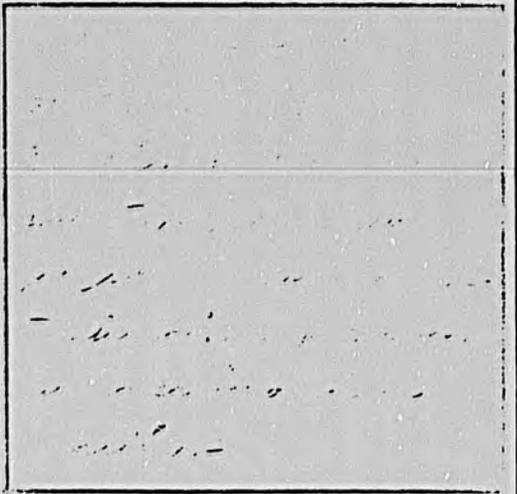
En 1974 el MINISTERIO DE SALUD PUBLICA Y ASISTENCIA SOCIAL creó un nuevo centro de capacitación para personal en Salud.

En el edificio que nosotros conocemos como Hospital de Quirigua se transformó en el ahora llamado INDAFES. Su principal objetivo es formar TECNICOS EN SALUD RURAL Y AUXILIARES DE SALUD COMUNITARIA.

Para el personal como buenas guatemaltecas, no conformes con sus actividades pasadas en trabajos de HUMILDES Y PROMOCIONES COMUNITARIAS por primera vez podemos ser capacitados.

En agosto de 1977 INDAFES inicia la capacitación de PROMOCIONISTAS EN SALUD RURAL de las aldeas, a la letra como 76 PROMOCIONISTAS capacitados en 4 Promociones. Es necesario mencionar el esfuerzo y dedicación del T.S.R., Víctor M. Racancoj y de la A.E.C., Gladys A. Gabriel y todo el personal del Puesto de Salud de Quirigua así como el apoyo del Dr. Roderico Rosado Arroyo, Director del INDAFES.

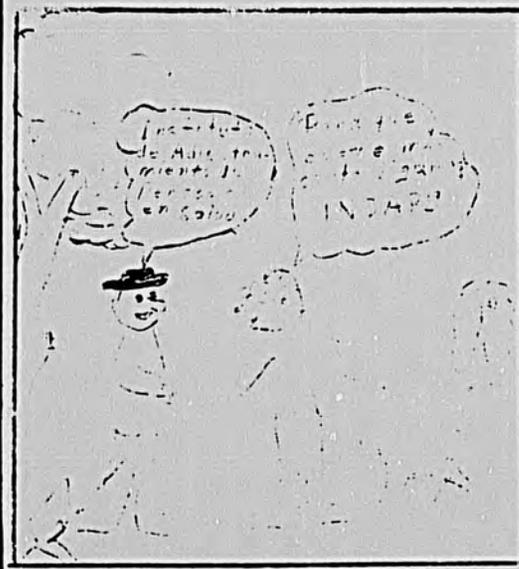
Finalizo diciendo que sigamos de PRENE en el PROGRAMA DE GUATEMALA.



HISTORIA DE UNA DEBATA

Por: Mario Galdamez.

Los campesinos de la aldea Mixco, Izabal, se reunieron en Mayo de 1970 en el rancho de la escuela con el propósito de afiliarse al Movimiento Campesino "Independiente" para que por medio de esta organización obtener la "adquisición legal" de nuestras tierras en El Corosito, desde esa fecha se empezó hacer solicitudes al llamado Instituto de Transformación Agraria I.N.T.A., pero el tiempo iba transcurriendo y los resultados no eran nada seguros y así pasaron 7 años sin ninguna resolución favorable, los campesinos se cansaron de tanto aportar dinero y decidieron ya no continuar, pues nos dimos cuenta que esa organización trataba de defalcarnos nuestra comunidad, habiendose llevado el dirigente del M.C.I. La cantidad de Q. 4,000.00. Este fracaso nos dejó como experiencia que todo campesino debe preguntar cuáles son los objetivos de las organizaciones que se realicen en nuestra comunidad y participar cautelosamente.



AUTORIDADES SANITARIAS PROBLEMAS,

Dr. Samuel Ramírez.

En el tercer turno de la casa de salud de San Mateo, los doctores, especialmente recibidos las autoridades de atención de enfermos, poner inyecciones. Allí se refieren a su casa cuando es necesario, cuando emergencias. El tema más importante es la vacunación.

Esto se refiere en toda la comunidad, pero estas autoridades las van a hacer para ganar un poco de dinero. Es difícil que a pesar de tener que traer el agua para el sustento diario y el trabajo de la familia, al ser todo de la comunidad voluntariamente. Pero las autoridades militares ya han dicho antes que no agarrarán para el servicio militar, la primera vez iba a la reunión importantísima de promoción y no agarraron en la zona Trincheras, ya no tuvo nada de la reunión de San Mateo, los narrativamente a trabajar como todo buen hombre, me agarraron en los Amates y me llevaron hasta Puerto Barrios, para dos días de tanto portador (gallo) en el departamento militar.

¡Qué que estas autoridades nos comprendan y ayuden, pues nuestra actividad es de más importancia para nuestra gente.

SOCIALES

Alegremente el 7 de Septiembre celebró su cumpleaños MARIA ETHEL VINA FERRE, en la comunidad Sembrada. Otro año más cumplió BENSERNADO GREGORIO, el 28 de Septiembre en Comunidad La Unión. El grupo de PROMOTORAS DE SALUD a través de VOZ CAMPESINA, desea a los compañeros muchos años más de vida y lucha a la par de sus vecinos FELICIDADES Y ABELANTE COMPANEROS.

DECISIONES DE LA COMUNITARIA.

El Comité de Bañabero tolerado tiene varios problemas debido a que la comunidad es muy pobre. Se debe pagar el agua, pero desde hace unos años que se están formando no pagan y no pagan nada, pues tardan unos veinte o treinta días, no pagan el agua, por eso mismo los comunitarios ya no creen en nosotros, piensan que igual vamos a pagar. Entre los campesinos, integrados al grupo promotoras de Bañabero. Como esto estamos decididos a combatir que el agua a trabajar y lograr traer agua potable a nuestra comunidad por el bien de desarrollo.

Dr. Comité Promotoras.



Gracias por
HERVIR
EL AGUA
que bebo

CONSEJOS DE UN PROMOTOR.

Para: Reginaldo López Cruz. Hervir el agua antes de beberla. Lávate las manos antes de comer. Construye una letrina para tu familia. Quemar o enterrar las basuras. Mantén limpia tu casita por muy sencilla que sea y enterra las basuras. No dejes entrar ni dormir gallinas ni perros donde tú duermas y comes.

Haciendo esto ayudarás a proteger a tu familia de muchas enfermedades.

Y también te recordamos que la enfermedad, desnutrición, analfabetismo, carencia de trabajo, poca producción y falta de tierras; tienen solución.

TRABAJANDO ORGANIZADOS.

Presta atención y pon en práctica los consejos del Promotor en Salud de tu zona. Hacia Nº4

DESHIDRATACION Y FRIJOLEZ DEL CUERPO,

LA MAYORIA DE NIÑOS QUE MUESTRAN DE DIARREA, MUESTRAN TAMBIEN FRIJOLEZ EN SU CUERPO LIQUIDO EN SUS CUERPOS.

ESTA CONDICION SE LLAMA DESHIDRATACION.

DESHIDRATACION RESULTA CUANDO EL CUERPO PERDE MAS LIQUIDO DEL QUE TOMA. ESTO PUEDE PASAR EN

casos de diarrea fuerte (aunque no siempre hay mucha frecuencia) y en varias enfermedades graves. Personas de cualquier edad pueden padecer de deshidratación, pero es peligroso para los niños pequeños. Es importante reconocer las señales para saber como combatirla.



Voz Campesina Oriental

TOMAR NIÑOS PARA LA DEHIDRATACION.

Una persona deshidratada debe tomar mucho líquido: agua, té, refrescos, etc. Si la persona está muy deshidratada, se le prepararle y darle suero PARA TOMAR. A la persona deshidratada, dale tragos de suero para tomar cada 5 minutos hasta que empiece a orinar normalmente. Una persona grande necesita 1 litro de suero cada 2 horas; un niño pequeño necesita por lo menos un litro de suero. Si el enfermo no puede tomar

suficiente suero para combatir la deshidratación, o si comienza a vomitar lo que toma, no se puede controlar los síntomas, busque un puesto de salud. Si una persona deshidratada tiene síntomas que no se pueden controlar, pero no tiene diarrea, puede ponerle suero TRES VECES DE SUERO PARA TOMAR muy despacio. Hay que poner el líquido muy lentamente para evitar que los absorba y evitar los ataques. ENFERMO DIFÍCIL, ARTES PRÁCTICAS DEL TRABAJO.

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