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Health Promoters, Political Struggle and Social Transformation: Framework for Systematizing the Experience of a Popular Health Education Project in Chile

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HEALTH PROMOTERS, POLITICAL STRUGGLE AND SOCIAL TRANSFORMATION

A Framework for Systematizing the Experience of a Popular Health Education Project in Chile

A

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> ...the point is that if poor health is a political problem it will need a political not a technical solution. The answer is not more health care workers. The answer is health care workers who can mobilize their own communities to improve their own health.
>
> Susan Rifkin

I. INTRODUCTION

In September 1978, representatives from 134 nations met at Alma Ata, USSR, for a major United Nations Conference jointly sponsored by the World Health Organization (WHO) and UNICEF to discuss primary health care and to pledge their support to the world wide effort of "Health for All by the Year 2000". In the wake of the conference, the emphasis in international health shifted conceptually and practically from high technology and expensive professional training to a focus on primary health care (PHC). Programs emerged all over the world centered on the eight essential components of PHC: health education; promotion of food supply and proper nutrition; adequate supply of safe water and basic sanitation; maternal and child health; immunization; prevention and control of endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs (Morley, et al, 1983, p.x). According to this approach, the successful implementation of the PHC strategy

depended on the training, supervision and practice of the community health worker (CHW) or barefoot doctor to provide the critical link between the community and the formal health system.

While appearing to be a simple concept, turning primary health care policy into effective practice has proven to be a difficult task. The concept of PHC enthusiastically adopted at Alma Ata was so broad that public health officials and national governments from countries with diverse social and political regimes could wholeheartedly support it. No sooner had the concept of primary health care been embraced by the vast majority of countries in the world, when the debates, polemics and confusion began. Technocratic or overly-romanticized notions cloaked diverse and contradictory conceptions of health care, community participation and community health workers.

My interest in this topic stems from having worked in primary health care projects in India, Chile and in a remote Native American village in the Sioux Lookout Zone, Canada over the past fourteen years. My own frustration with clinic-based experiences led me to research and initiate a project designed to train CHWs in urban shantytowns in Chile. In 1982, I founded EPES (Educacion Popular en Salud), a popular health education program. Since its inception, our primary objective has been to improve the health of the

poor through the organized participation of the people themselves. Using a popular education framework we train, support and supervise community health workers in urban shantytowns and squatter's settlements. In our eight years of existence, we have trained over 150 CHWs in ten different shantytowns in Santiago and Concepcion, two major Chilean cities.

Purpose and Significance of this Project

In 1987, the EPES staff set itself the goal of acquiring the information and theoretical background necessary to design and lead a process of collective theorization on our experience which would actively incorporate the 150 community health workers trained thus far.

The purpose of this Master's project is to contribute to meeting that goal by achieving a twofold objective: first, to explore some of the major issues, assessments, limitations and recommendations that appear in the literature regarding community health workers (CHWs); second, to define the concept of "systematization" and outline the major dimensions which such a process must consider. The paper is divided into two sections and a bibliography:

1) The first section contains a review of the current literature on CHWs with a particular emphasis on: a) contrasting the various conceptions of CHWs; b)

assessments and critiques of the CHW experience to date; c) the major limitations of CHW programs as identified by international health experts.

2) The second section focuses on the process of systematization and reviews: a) the development of NGOs in Chile and the need for systematization, emphasizing the EPES experience and; b) the concept as it appears in the literature coming out of Latin America, tracing its origins and importance for the Latin American popular education movement.

Any effort to democratize the health services in Chile, must include the analyses, inputs and innovations of the hundreds of community health workers who have been in the front line of primary health care efforts during these past sixteen years. Fair and accurate appraisal of the CHW's efforts to date requires more than just additional data collected from a wider variety of case studies. The thrust of this paper is to argue that the discussion needs to be broadened to include the more ideological dimensions of the debate, and more analysis and input should come from the CHWs themselves. There is a need for participatory research and collective systematization of the grassroots experience in order to provide vehicles for the voices of those commonly excluded or marginated from the theoretical debates. This project is significant because it responds to those needs.

Rationale for this Project

EPES' experience of training CHWs collides with much of the literature on the subject. In a country devastated by sixteen years of military dictatorship, the dismantling of the public health service, and the collapse of the traditional clientelism of the State, the training of CHWs is necessarily inserted in the larger social and political struggle for "work, bread and liberty" and cannot be reduced to the technocratic approaches so often found in the literature.

The literature suggests that trainers turn to an organized, homogeneous, and amicable community to select CHWS, but in our practice such a community does not exist. In the Chilean reality, this is a community divided politically, economically, socially, and sometimes, even culturally. In this context, clearly, the health of the poor is a highly political matter. During military raids, CHWs have had their manuals, medications and teaching materials confiscated as subversive matter. They have been arrested and harassed. Providing a link to the government's public health centers, as the PHC strategy suggests, is impossible in this setting.

Over the last years, CHWs have created an important role for themselves and have emerged as an organized political force with a rich and diverse practice. Their experience has much to offer other social organizations and policymakers both in

and outside Chile. The role of CHWs will be crucial as the Pinochet regime is replaced in early 1990 by an elected civilian government that has promised to democratize Chilean society and address the severe health situation that has developed since the 1973 military coup.

My eight years of experience training and working with the CHWs in the shantytowns and squatter's settlements of Chile, indicates that they play a much broader role than what the official PHC strategy assigns them. Moreover, it is precisely this broadened, more political role which is the key to their success.

II. LITERATURE REVIEW

An introduction to "Health for All": Origins and Concerns

By the early 1970s, frustrations with clinic-based rural health services in developing countries was growing. Clinic-based services failed to reach their target populations, were expensive, and focussed primarily on treating symptoms rather than addressing the underlying causes of mortality and ill health (Berman, et al, 1987, p. 444). Reports of numerous successful small-scale CHW experiences and the dramatic improvements in China due to the barefoot doctors provided much of the initial impetus for the CHW movement. Finally, the support and legitimization provided by the Alma Ata declaration created the conditions for the proliferation of CHW programs all over the Third World.

But while everyone from World Bank bureaucrats to peasants from grassroots health projects shouted their allegiance to this strategy of "Health for All by the Year 2000," a few worried about the naivete inherent in the Alma Ata document and its failure to address the historical causes of poverty (Zaida, 1988, p. 119). Perhaps the most astute critique came from Vicente Navarro (1986) who saw the declaration as the deceptive depoliticizing of health--an approach perfectly consistent with the interests and ideologies of the dominant "development establishment." Others questioned whether

primary health care efforts would be allowed to succeed given that in many repressive environments the logical outcome of PHC strategies would be activities considered subversive and therefore dangerous by those in power (Heggenhougen, 1984).

In many countries, primary health care has been reduced to the recruitment and training of CHWs instead of being one aspect of a multifaceted plan and effort to reach health for all. Despite ample evidence showing that the mass production of community health workers is not effective, WHO member governments continue to push this strategy (Matomora, 1989; Werner, 1980). Studies have also shown high attrition rates of CHWS from a wide variety of programs (Walt, et al, 1989; Matomora, 1989).

Over a decade after Alma Ata, assessments on the achievements and effectiveness of CHWs report varied findings. There are differences of opinion in the international health community as to whether CHWs are a critical link in efforts to reach health care for all, or whether they are part of a flawed attempt to resolve more fundamental problems (Berman, et al, 1987). One problem is that few programs have conducted careful monitoring and evaluation over significant periods of time (Li, et al, 1983-84), but the real issue is that what people are evaluating depends on their own ideological assumptions and political frameworks. At least part

of this debate stems from the different--and many times conflicting--conceptions of community health workers.

Conflicting Conceptions of CHWs and Political Implications

After 1978, the World Health Organization began promoting the concept of CHWs internationally as a wise use of para-medical personnel and a realistic way to meet the health needs of the world's poorest sectors.

In general terms, the CHW was described as someone who lives in the community and understands local needs; someone who is selected by the community and has the confidence of the people; someone who can be trained to carry out specific low-cost tasks in a relatively short period of time; and someone able to establish a link between the community and the national health service (Stark, 1983, p, 230; Matomora, 1989, p, 1084).

While this understanding of the CHW was certainly a step in the right direction, it missed the main idea of the Chinese experience which it attempted to emulate. As Rifkin (1978) and Navarro (1986) have pointed out, the Chinese experience was essentially a political act designed to break the elite medical hegemony over health care.

> Many either glossed over, or missed completely the fact that barefoot doctors are a political rather than technical creation--in China, a tool to break the power of the medical profes-

> sionals, give the people a part in providing their own health care, and distribute health resources more equitably (Rifkin, 1978, p.34)

The appropriation and implementation of barefoot doctors by the development establishment required depoliticizing this conception and replacing it with a more technocratic notion of CHWs. Navarro sees this depolitization as typical of the WHO apparatus. "In all their discourse (WHO), there is a "depoliticization" of political interventions,recycling them into technological ones" (1986, p.221).

Embedded in the conception of community health worker are different understandings of health and different notions about the relationship between the poor and the state. In sharpening our own understanding of CHWs, it is necessary to review the main types of CHWs that appear in the literature where there are reports of a wide variation in the selection, training, remuneration, supervision, management and evaluation of CHW programs (Li, et al, 1983-84).

A Critical Link With Many Different Names

A vast and confusing array of titles is used in the literature to refer to the local health worker: community health volunteer (Maru, 1983); village health worker (Bender & Pitkin, 1987; Heggenhougen, 1984); barefoot doctor (Sidel, 1975), community health worker (Berman, et al, 1987; Vaughn, 1980); primary health care workers (Stark, 1983), village medical helpers (Bennett, 1979), community health aides

(Cumper and Vaughn, 1985), and so on. In much of the literature, different kinds of primary health care workers are fused and titles are used interchangeably although they represent fundamentally different understandings of the role and function of the CHW (Vaughn, 1980).

Some see the existence of so many different titles as unimportant because they all refer to essentially the same type of CHW whose main task is to be a bridge between the formal health system and the community (Bender & Pitkin, 1989). Others argue that it is crucial to recognize the difference between CHWs who are "lackeys" and those who are "liberators" (Werner, 1981). Rifkin warns that if we do not recognize this political dimension, CHWs will only serve to further entrench a "health system which denies adequate medical care to most of the world's population" (1978, p.34).

In much of the literature on primary health care and CHWs, the political implications are simply not considered (Stark, 1983). This depoliticizing is, as Navarro (1986) says, in and of itself, political. CHWs are not neutral agents of health care but must be recognized as political actors operating within specific socio-political contexts. The notion of neutrality of medicine leads to the reproduction of class and power relations within medicine and beyond medicine (Navarro, 1983, p.196).

It is essential, therefore, to examine the ideological dimensions of community participation, PHC and CHWs. Any assessment of the CHW experience which does not make explicit the paradigm from which it is operating, will only serve to mask the real issues.

For the purposes of clarifying the different kinds of health workers, it is helpful to turn to definitions found in Vaughn (1980), Sanders (1985) and Hevia (1989). These authors seem to me to be the most helpful in at least attempting an initial analysis of the different kinds of CHW.

Vaughn distinguishes two main kinds of CHWs:

Community health worker (CHW): a local person trained in basic primary care and responsible to the community; often assumes tasks related to general development and political functions; free of professional influence and control.

Village health worker (VHW): a local person trained as auxiliary or extension of formal health service; subordinate to medical professionals

Sanders compares the more traditional auxiliary health worker to the VHW suggesting that while the VHW performs many of the same tasks as the auxiliary, their roles are

decidedly different in their relationship with social change efforts (1985, p.185). They are different in the following respects. The VHW:

1) Should be selected by the people from among themselves and should be responsible primarily to them, not to the health professionals
2) Should work part-time as a VHW and perform agricultural or other work, possibly receiving a subsidy from either the local community or the national health service.
3) May be someone who has already been a traditional healer or birth attendant and should preferably be trained in the community in not only curative but also preventive and promotive functions (Sanders, 1980, p.185)

While Sanders and Vaughn differentiate the two types of health workers in essentially the same way it is important to note the contradiction in the nomenclature. What Vaughn describes as the CHW Sanders calls a VHW and Vaughn's definition of a VHW is exactly the opposite of Sanders. The lack of clear definitions adds to the confusion in this field. There is a need for a broader framework that both recognizes the different conceptualizations of CHWs and provides a framework for analysis.

In attempting to differentiate the types of CHWs, it is important to recognize other approaches to community participation in PHC. The overemphasis on CHWs and CHW training programs has overshadowed other major experiences of community mobilization for health. From the Latin American experience, Hevia identifies three significant modes of community participation in health:

1) Community health volunteers: These are be called: leaders, delegates, monitors, promoters, responsibles or auxiliary volunteers depending on the country or region. In general, they receive local technical training and perform minimal health tasks under the supervision of the institutional staff.

2) Local health committees: These also have different names, the most common in Latin America being Health Committee, Community or Local Committee, etc. Generally, they are organizations with a character of consultation or support located at the community level or in a health agency, and they are composed of community members or representatives of local health personnel, the community and local health authorities.

3) Brigades and brigadistas: many times these are workers or students of public or private institutions who carry out sanitary campaigns. When the community is effectively integrated they constitute innovative

forms of participation (Hevia, 1989, p.29; my translation).

In sum, Vaughn's taxonomy focuses primarily on the degree of subordination of the CHW to the formal health sector, Saunder's focuses on the range of tasks performed and Hevia looks at modes of community participation in PHC. While all suggest that the CHWs are different in relationship to political functions or role in social change, none of them explicitly discusses those differences.

Without linkage to a political theory, the conceptualizations of CHWs fall short in their social analysis. Health is a profoundly political issue and as health workers we must be committed to dealing with the political, as well as the pathological, dimensions of illness (Labonte, 1989).

Assessments of CHW performance

Today, eleven years after Alma Ata and less than a decade away from the year 2000, there is growing concern over the state of primary health care and the emphasis that has been placed on the training of CHWs. A review of the literature suggests that the CHW strategy has met with limited success (Madan, 1987). Some state that the majority of CHW schemes have failed (Sanders, 1985), while others have found that there is ample evidence of the success of small-scale projects but the problem lies in trying to develop large-

scale, national programs (Berman, et al, 1987; Werner, 1980; Vaughn, 1980; Walt, et al, 1989). There is general agreement that assessments from either a pro or con perspective are rarely demonstrated with "scientifically" valid studies (Berman, et al, 1987; Li, et al, 1983-84; Norren, et al, 1989). Despite their limitations, there are a number of studies attempting to evaluate the success of the CHW approach in different settings.

Berman, Gwatkin and Burger (1987) examined large-scale community-based worker programs in China, Indonesia, India, Peru, Thailand and Jamaica and concluded that the strategy has succeeded in some objectives and not in others, and that any assessment will depend on the specific objectives each program is attempting to achieve. Their conclusions are summarized in five points:

1) CHWs have reached more people than clinic-based services, especially the poorest sectors of the population.
2) CHW services generally have a lower average cost than comparable clinic-based services.
3) CHWs are capable of providing highly efficacious interventions directed at major causes of population mortality.
4) The quality of care of the CHW activities is poor.
5) As of this study, they could find no substantive

evidence of large-scale health impact of CHW programs.
(Berman, et al, 1987, p. 456-7)

Overall, they conclude that CHWs do in fact represent a head start towards health for all, specifically in small-scale programs. Large-scale programs, they found, are still fraught with problems and are not as effective as they should be.

In another study, Bender and Pitkin (1987, p.527) examined primary health care and CHW schemes in Nicaragua, Costa Rica and Colombia and concluded that CHWs have been essential in extending health services to the underserved in these countries, and that CHWs are the best way to achieve community participation. The most important factor they cite in the successful implementation of PHC is a national commitment to primary health care and the concomitant resources necessary to reach health for all.

Since 1977 the Indian government has supported a national plan of primary health care. Based on a national evaluation of a CHW scheme as well as micro-level research in one of the largest Indian states, Maru (who participated in both studies) also concludes that despite limitations in being able to mobilize the village communities for public health tasks, the CHWs have in fact succeeded nationally in bringing primary curative care to the people (1983). In

contrast, Jobert studied the health policy in India and concluded that the CHW program was not a "first step towards radical transformation of health institutions, nor is it the beginning of active popular participation (1985, p.25)." He asserts that the government policies essentially stripped PHC of its political significance--CHWs became mini-doctors and the program served as a means for reinforcing the dominant political apparatus (Jobert, 1985, p.25).

In yet another assessment of CHWs working with voluntary agencies in Indian villages, the workers were found to be poorly trained, isolated from supporting structures and more project-oriented than community-oriented (Ramprasad, 1988). Despite this rather bleak appraisal, Ramprasad concludes from his study that by correcting some of the problems, CHWs can become an important force in their communities.

Studies done in Sri Lanka (Walt, et al, 1989) on national programs also found that large scale efforts suffer from high attrition rates and low activity. They found a gap between the rhetoric of CHWs and their practical reality. For example, in most national programs CHWs are not selected by the community as the literature suggests, and often the community members have little idea what the volunteers are supposed to do (Walt, et al. The assumption that communities would be willing to support their CHWs was [illegible] of the communities in

this study were unable or unwilling to sustain payment of the CHWs over long periods of time.

David Werner, one of the strongest critics of the depoliticizing of the role of the CHW and author of two of the most widely used health manuals, visited forty rural health programs throughout Latin America and found the majority of large-scale programs to be ineffective and in fact "community-oppressive" (1980). He found that health policies or programs fell along a continuum between two diametrically opposing poles:

Community-supportive programs: those that favorably influence the long-range welfare of the community and help it stand on its own feet encouraging responsibility, initiative, decision-making, self-reliance, etc.

Community-oppressive programs: those that give lip-service to community participation but which are basically authoritarian, paternalistic and encourage dependency.

(Werner, 1980, p.5)

Unfortunately, in some places where CHWs have been community-supportive they have been perceived as a threat by the government. Heggenhougen (1984, p.219) described the case of CHWs in the Chimaltenango program in Guatemala, many of whom were killed during the Lucas regime of 1978-82. The

program focused on training and supporting health promoters who were involved in health care in their villages as well as in agricultural improvements, water development schemes, cooperatives, etc. The program helped the Indian people become conscious of their situation and work together with other communities in the search for collective solutions to their problems. By the early 1980s, sectors of those in power became increasingly threatened by these efforts for change and unleashed brutal violence against the Indian population. CHWs were particularly targeted for repression. Those who were not killed were forced into hiding or exile.

From this and similar cases in Chile and Bangladesh, Heggenhougen (1984, p.222) concludes that the powerful in many countries will **not allow** CHWs to succeed. Efforts to achieve the goals pronounced in the Alma Ata Declaration will be met with opposition and resistance by those who see fundamental social change as a threat to their interests.

In sum, it is clear from the experiences to date, that training armies of CHWs is not in and of itself the answer to the dramatic health problems facing the world's poor. Matomora (1989, p.1084) observes that, "by isolating and concentrating on mainly VHW training the PHC strategy has been robbed of its spirit and power.." The political dimension cannot be ignored. As Rifkin states, poor health

is a political problem and not a technical one, and therefore what is needed is not just more CHWs but rather CHWs and organized communities that can defend their right to health and improve their own health (1978, p.34). But also, as the Guatemalan case so dramatically illustrates, CHWs who can organize their communities to defend their rights and improve their health, will be seen as a threat in many environments. Each situation will require careful analysis and appropriate strategies.

Eight Major Limitations in CHW Experiences

Most authors agree that despite the limitations, CHWs have in fact been effective in many settings. Future programs and efforts related to the training of CHWs can learn from the limitations and recommendations growing out of these ongoing experiences around the world.

In reviewing the literature, I examined the main articles and studies dealing directly with the CHW experience and found eight limitations that came up repeatedly. Some of them are related to more operational issues like training and supervision, while others reflect problems involving political issues and power struggles.

1) Lack of adequate supervision

In many cases, the CHWs were put in situations of responsibility without adequate supervision.

Supervision often tends to be sporadic and punitive rather than supportive and ongoing.(Heggenbougen 1984; Jancloes, 1985; WHO, 1985; Madan, 1987; Berman, et al, 1987; and Skeet 1984.)

2) Caught by conflicting expectations

CHWs are overburdened. They are caught between the expectations of the professional health team and the community which are both unrealistic. They are local people, but once they are trained they often enter into conflict with more traditional beliefs and customs and consequently with the community. Often there is a gap between what they are trained to do and what they actually do. Bond (1985) expresses this well when she says that CHWs are resources without cultural or historical tradition--they are new actors in the health scene. (Matomora, 1989; Berman, et al, 1987; Skeet, 1984; Madan, 1987; Jancloes, 1985; and, Bond, 1985.)

3) Inadequate training

The training has been called amateurish and inappropriate. There is too much focus on theoretical training and curative care rather than on problem-solving, leadership training and organizational skills development. There is a lack of appropriate learning materials which are relevant to the

socio-cultural environment in which they are used in. David Werner suggests that CHWs need to be trained in a wider range of skills that is consistent with what goes on in their communities.
(Ramprasad, 1988; WHO, 1987; Jancloes, 1984; Madan, 1987; Skeet, 1984; and Werner, 1980; Hoff, 1981-82).

4) Isolation

It is clear that CHWs cannot work in a vacuum. Lack of links to the national health service or to some health service was identified as a major weakness in many programs (Hevia, 1989; Heggenhougen, 1984; WHO, 1987; and Skeet, 1984.)

5) Opposition from the medical profession

A key limitation to the success of the CHWs in some areas is medical bias. The medical profession is not always willing to break down the mystification that has allowed them such a sacrosanct position in society. Physicians can be obstacles to the effective functioning of the CHW in overt or covert ways.
(Ramprasad, 1988; Werner, 1980; and, Madan, 1987.)

6) Political limitations

Lack of popular democratic control is a major limitation of the majority of CHWs projects.
In many countries, unless there is broader

socio-economic and political change, the CHW who tries to promote health by identifying and attacking the structural causes of bad health, will be seen as a subversive and harassed or assassinated. (Sanders, 1985; Skeet, 1984; Werner, 1980; Stark, 1983; and, Heggenhougen, 1984.)

7) Lack of resources

Inadequate supply of materials and medicines is a serious limitation in many programs (Heggenhougen, 1984; Sanders, 1985; and, Madan 1987.)

8) Cooptation

Many of the other above-cited limitations are related to the cooptation of the CHW into bureaucratic structures. If CHWs are unsupported, poorly trained, isolated, overburdened, etc., they are easily appropriated by the health bureaucracy (Sanders 1985; Madan, 1987.)

Recommendations for future CHW practice

Related to the above limitations, and growing out of the evaluation of successful programs, there are also many recommendations for future programs.

David Werner summarizes a few ways that health care programs can become more genuinely **community-supportive** including such actions as: decentralization, promoting greater

self-sufficiency at the community level; open-ended planning; allowance for variation and growth; planned obsolescence of outside input; deprofessionalization and deinstitutionalization; more curative medicine; increased feedback between doctors and health workers; earlier orientation of medical students; greater appreciation and respect for villager's traditions, skills, intelligence and potential and that the directors and key personnel in a program be people who are human (1980, pp.9-10).

Lydia Bond (1985, p.450) studied CHWs in Colombia and called for the following: better process of selection of CHWs; broader educational approaches to include more popular education; adequate training of supervisors; more opportunities for ongoing education and advanced training; promotion of more exchange and communication among the CHWs themselves; establishment of a system of evaluation of health personnel that looks at their capacity to promote and increase participation, health education and creation of resources for the community.

Vital aspects of community-based health care which Matomora (1989) identified are:

1) Full community mobilization, power sharing and empowerment of communities
2) Clearly defined roles for CHWs by community itself
3) Evident community participation in local and social

organization

Vaughn (1980) identifies five criteria of successful projects: they are relatively small and in areas where government services are poor; they do not pose a powerful threat to the medical establishment or those in power; they have exceptionally capable and committed leadership; they are small scale efforts with minimal or no bureaucracy; and they have hidden support mechanisms.

From Berman, Gwatkin and Burger's (1987) study of six large-scale programs came the following recommendations:

1) CHWs must be adequately supported;
2) CHWs cannot be seen as marginal; they need to be an integral and effective component of the health service
3) Quality of care and tasks are directly related to the training, program management and supervision.

Conclusions

While the debates on the success and limitations of the community health worker experience will undoubtedly continue, there is agreement on the lack of research. The literature is full of unanswered questions like: Who are the CHWs accountable to? Who should supervise them? Are CHWs accepted by the community? Should CHWs be paid or should they be strictly volunteer? What is the role of CHW? Are CHWS community-based? Little is known about the

characteristics of the CHWs. Even basic, fundamental questions regarding the social and demographic features of the CHWs come up repeatedly in the literature (Matomora, 1989; Garfield & Frieden, 1987; Ramprasa, 1988; and Vaughn, 1980).

The answer to these questions will not be found in the literature, but rather will grow out of the day-to-day practice of thousands of CHWs around the world. To understand and argue for the political dimension of the CHW's role, it is essential to help systematize their experience and the role of popular education in primary health care projects. This systematization is essential if the CHWs themselves are to become theoreticians and add their knowledge to the evolving conceptualizations of PHC and CHWs.

III. SYSTEMATIZATION

This section provides a brief overview of the proliferation of nongovernmental organizations (NGOs) in Chile after the 1973 military coup, and discusses the need for theory-building and systematization that has emerged from the NGOs' diverse and extensive grassroots practice. The concept and process of systematization are also outlined below.

NGOs and the need for systematization

Since 1973 and the military coup, Chile's economy has undergone one of the most dramatic restructuring in its history. Under the leadership of General Augusto Pinochet, the neoliberal monetarist model of the Chicago Boys replaced the previous strategy of import substitution industrialization which had characterized capitalist development in Chile since the 1930s (Leiva & Petras, 1986). For Pinochet, the Chilean bourgeoisie and their transnational allies, the allegiance to free-market doctrine was more than mere economic policy. Rather, it was the implementation of a whole new mode of domination through the application of a new economic structure; a new mode of accumulation and new values (Bitar, 1980). The Doctrine of National Security formed the ideological foundation for this project and counterinsurgency the tactics of implementation.

In this context, nongovernmental organizations (NGOs) began to play a significant role in filling the gap left by defunct State welfare programs (Downs & Solimano, 1988). Three main factors stimulated the creation of hundreds of nongovernmental organizations (NGOs) after the coup: the collapse of the traditional delivery systems due to the neoliberal policies and privatization of public services; the expulsion of many professionals from State agencies; and, the brutal repression unleashed against the population causing many people to seek medical, legal, material and psychological help outside the traditional State apparatus. In the early post-coup years many programs provided direct assistance to people with immediate needs--soup kitchens, clinics, legal aid. Gradually, as socio-economic and political conditions changed, the majority of NGOs evolved to include participatory research, coordinating efforts, popular education, political mobilization and training in structural analysis. The traditional clientelism that had characterized the relationship between the State and the popular sectors began to be replaced by the more advocacy model employed by the NGOS. Civil society began to take on more and more of the responsibilities that had previously been assumed by the State apparatus, thus helping to lay the groundwork for future democratic development in Chile (Downs & Solimano, 1988).

The magnitude of people's needs, the difficulties of working under a dictatorial regime and with popular organizations under the constant threat of military repression, the lack of adequate theoretical background for theorizing about their practice along with the deeply embedded conceptions that theory is the property of experts and those formally trained, forced NGOs to confront and deal with the internal obstacles and fears which were preventing them to systematize a rich and multifaceted experience.

Educacion Popular en Salud (EPES): Overcoming Fears

In 1987, as the EPES staff gathered for our yearly evaluation and planning meeting, we discussed the need to systematize our experience. We had carried out extensive, participatory evaluations. We had registered absolutely every training session or workshop we had ever run, but we had done almost no traditional research and writing about our work. Lack of time was one serious limitation, but-- almost more important--we were apprehensive about the political implications of putting things in print.

This fear had various dimensions. First, we had seen time and time again how the shantytown organizations felt "ripped off" by the professionals who were supposedly working with them and in their interests. Professionals had the tendency and intellectual justification to appropriate the people's experience in the name of advancing knowledge through

documentation and research. In one case, members of a soup kitchen actually went into the office of an NGO that had worked with them on a research project related to hunger and "stole" (reappropriated) a case of books that contained the results of the study. They sold them and used the money to buy food for their soup kitchen. (The NGO would not give them more than one or two complimentary copies of the booklet). Obviously, we did not want to "steal" the people's experience, but rather we aimed to search for a way to work together with the health promoters to analyze and recount the experience.

Another fear had to do with the safety of the people we worked with. We didn't know how to write about our experience in a way that would be meaningful without revealing information that might put people in danger. As mentioned earlier, the whole idea of CHWs was seen as subversive in the government's eyes. On the other hand, to write yet another depoliticized "ABCs" training manual seemed totally irrelevant. Finally, we were held back by the fear of cooptation. After we published our series of health games, we were constantly fighting the idea that popular education can be reduced to methods and games (we see the games as instruments that have very little meaning if they are not linked to a process of ongoing conscientization and political practice; others buy our games, play them with a

shantytown organization once and celebrate their arrival to popular education!)

In 1987, however, we decided that it was time to confront our fears and explore ways to begin a process of systematizing our experience. We decided that two of us would go back to school to gain the necessary skills to help design a process of participatory systematization and to then carry it out. I am one of those two people--thus, this project. The following section attempts to glean an understanding of systematization from the scarce literature available on the subject.

Systematization: A Process in Search of Definition

I could find virtually nothing written on systematization in English. (It is interesting and important to ask why there is nothing in English on the subject, but it is beyond the scope of this paper to address that issue here). The concept, which grows out of the Latin American social action and popular education experience, is essentially a concept in evolution. Systematization grew out of the practical and political needs of the action-reflection-action cycle of popular education.

According to Chateau (1982), the idea behind the concept is to explain an experience in at least two ways:

1) To permit an ordering in a way that allows the different persons involved to obtain conclusions about the meaning of the project
2) To transcend that which is unique and day-to-day about the experience to be able to capture the significance it has in a broader social context (my translation,p.11)

Systematization is related to evaluation but it is also different in several important aspects. While evaluation tends to be a process of formulating a **judgment** about a project often initiated by funders (Chateau, 1982), systematization is a process of collective **theorizing** about practice that responds to the needs of the central protagonists of a project or experience.

Pierola (1985, 5) identifies seven common reasons for systematization:

1) The need to communicate and disseminate popular education and social action experiences.
2) The need to evaluate the achievements and mistakes made in the development of a project in order to avoid repeating mistakes and to recreate or consolidate successes.
3) The need to recover experiences in order to reflect on them and consequently generate propositions for change.
4) The necessity to respond to the different questions

that emerge in the development or implementation of actions--like the need to modify or adapt the methodology, to measure creativity, advances, problems, search for work efficiency, etc.

5) The need to locate the experiences in the broader universe to understand the meaning the project has in an overall social process.

6) The need to order the actions taken and the overall framework of the project (plans, objectives, methods, goals, policies).

7) The need to deepen one's understanding of the reality in which the project takes place. (my translation)

There are various schools of thought about systematization reflecting the diversity of reasons and realities which generate the concept and practice itself. In general, the conceptualizations share the attempt to deepen the development of a project through analysis and reflection (Pierola, 1985).

In an excellent summary of the theory and practice of systematization, Pierola (1985) outlines the definitions put forward by the major writers in the field:

Marcela Gajardo defines systematization as:

> A synthesis of empirical and conceptual antecedents that allow one to explain the scope and significance

> of the practice of popular education emphasizing the relationship between theory and practice.
> (p.7, my translation)

Eduardo Pino states that:

> Systematization is the conscious effort to capture the significance of actions and their effects.
> (p.7 my translation)

And Oscar Jara, a major theoretician of popular education defines systematization as:

> A holistic process in which the participants of a concrete social action can achieve a conceptual framework, a formulation of knowledge and at the same time assimilate and appropriate new elements that can contribute to a critical vision of the reality at its specific-concrete level and at the broader global-contextual level.
> (p.8, my translation)

Jara differentiates phases in the educational process as diagnosis, planning, execution, synthesis, evaluation, systematization and reproduction (Pierola, 1985, p.7). He considers synthesis and evaluation as necessary preliminary steps to systematization. Systematization, for Jara, implies an initial theorizing about practice that is inserted in a specific context. According to Pierola (1985), Jara's is one of the most accepted and shared definitions in Latin America.

Finally, Eduardo Garcia Huidobro offers perhaps the most political definition of systematization clearly articulating the essential role of the popular organizations and participants in the process. He states:

> The tactic and strategy of the projects are within the framework of a broader popular project (proyecto popular) and therefore systematization--along with considering the factors of reflection, ideological identification, evaluation of the project, and inter-relationship with society--has to look for the decided participation of the people themselves, clarifying their role as protagonists and historical subjects of the project for a new society.
> (Pierola, 1985, p.8, my translation).

The Process of Systematization

Pierola outlines a process of systematization that unites the major elements of different Latin American schools of thought. This is not the only methodology to systematize but it can provide a good overview and starting point to be adapted according to the specific context. My translation of the main components as she discusses them is contained in table 1.

The systematization of a project aims to generate new knowledge about social reality and the interplay of actions and historical processes as an integral part of popular education itself. In Gramscian terms, it is a process helping to transform "common sense" into "good sense."

SCHEMA TO SYSTEMATIZE POPULAR EDUCATION EXPERIENCES

I. THE SOCIO-POLITICAL, CULTURAL AND ECONOMIC CONTEXT OF THE AREA OF WORK AND ITS SIGNIFICANCE

(in local, regional and national reality)

1.1 Zonal-regional social formation

1.2 Social classes and sectors (forms of domination - subordination or relations of exploitation)

1.3 Popular movement
- a) its situation
- b) its organization (history, composition, propositions, influence, relationships)
- c) its perspectives, allies, enemies, and its future, taking into consideration the current situation

1.4 The role of the State, the churches, other institutions, and the matrices of the organizations in the zone

1.5 The social dynamic or historical process

II. THE CONCRETE PROBLEM THAT NEEDS TO BE CONFRONTED

2.1 The principal problems that the program-project detects

2.2 Obstacles and elements that facilitate action

2.3 Concretization of the beneficiaries

III. THE PROJECT OR PROGRAM

3.1 Strategy: Ideological principles, goals general objectives, policies, characterization of the reality (R1), of the reality that needs to be reproduced (R2), and the reality that is hoped for (R3).

3.2 Tactics: specific objectives, priorities, actions, lines of work, hypothesis of action, methods, techniques, material resources, organization, staff, time framework.

3.3 Relationship and insertion to larger institution, consistency with institutional policy, coordination with other programs, function in the institution.

3.4 Inter-relationship with organizations (level of insertion, coordination and participation).

IV. EVALUATION

4.1 Achievements and difficulties

4.2 Activities or aspects with the most impact

4.3 Level of realization of the tactics and strategy (consistency of methods, objectives, line, organization, resources, etc)

4.4 How to overcome or consolidate level of realization of project

4.5 Needs and future tasks and projections

Aspects to take into consideration: Reflection on practice
Permanent process
Participatory methods

Source: Pierola, V. (1985) Avances sobre sistematization. La Paz: Centro Boliviano de Investigacion y accion educativas. Pages 13-15.

V. CONCLUSION

In conclusion we see that in the community health worker theory and practice a diversity of definitions, assessments, limitations and recommendations exists depending on different entry points or medical-ideological conceptions of the authors. Rather than attempting to determine which one is true or correct, it is my contention that we should recognize the diversity and analyze the impact that each approach has had, is having, and can have in the ongoing struggle to make health for all a reality by the year 2000.

If we recognize the social, political and economic determinants of health, then it is impossible to isolate the training and activity of the CHW from the larger social struggle for better quality of life. We need to sharpen the debates on PHC, community participation and CHWs by clarifying our terms and politicizing our practice. Community health workers with all of the characteristics described in the WHO literature will mean nothing if the structural causes of poverty, injustice and oppression remain untouched. Noble words and concepts cannot replace real change in the lives of the poor.

The Alma Ata Declaration is not a recipe for primary health care. Each context has its own specific historical, cultural, social, political and economic dimensions which must be

considered in the development and assessment of health programs and CHW schemes. In Chile, community health workers have a vast and rich history and experience that needs to be shared with others. Adequate theorization on that experience must include the CHWs--participatory methods need to be employed so that the central protagonists of primary health care can contribute their critical knowledge to the design and implementation of effective strategies.

Systematization is an important process that can contribute to the popular movements and struggles in Chile, Latin America or wherever they are taking place. It is a concept that challenges those involved in popular education and social action projects to build theory out of their widespread experience in a way that is consistent with that experience. It accepts and recognizes the richness and diversity of perspectives involved in social action programs and popular education efforts. And as such, it is a rupture with the traditional positivist approaches to evaluation that understand reality as one fixed entity waiting to be measured and judged (Martinic, 1984).

To bridge the gap between the theory and reality, the process of systematization cannot be divorced from the overall construction of a "proyecto popular", a people's political project for liberation. This means that the systematization of the EPES experience in training CHWs

cannot be self-referential, but must also explore the impact that CHWs, individually and collectively have had in promoting the social and political organization of the poor. Both dimensions of CHW activity--health and organizing--are crucial to their success in achieving the right to health for all. For as Werner says:

> In the world today, it has become increasingly clear that the struggles for health, development and social justice, even in a remote village of slum, are inseparable from the global struggle for a more just world economic and social order. Poor people in a single village will not gain control over the factors that determine their health and lives, until they join together with many others to bring about transformations at the national level (1988, p.9).

Much of the literature ignores or pays little attention to the political dimensions of CHW activity. A more glaring limitation is its failure to call for the active participation of the CHWs themselves in the process of reflection of the successes, failures and challenges after Alma Ata. If the theorization of the eight years of experience accumulated by EPES is to contribute, these two shortcomings must be addressed in the design and implementation of the systematization of our experience.

This Master's Project does not end with this final paragraph, but represents the deepening of a collective effort initiated in 1987 by the EPES staff. Its real value will be seen if these ideas, resources and insights are translated into concrete actions that bring us one step closer to health for all.

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