

'We know a better way...'

Photos by Neill McKee
Story by Bob Stanley



The people, the language and the climate are different, but the problem is essentially the same: how to bring basic health care to people in isolated rural communities that are too small to support a resident doctor — even if one could be persuaded to live there. It is also a problem that points up the dangers of attaching labels like “developed” and “developing” to countries, since the two programs illustrated here are serving rural peoples in Canada and in Iran.

Charles ‘Skip’ Brooks is the Regional Health Educator for the Province of Saskatchewan in the heart of Canada’s prairies. He describes how the Community Health Auxiliary Program came into being in 1964 after a group of Indian leaders met with health officials and told them: “We know a better way to do more than just health care — that is education.”

The initiative was welcomed by the health professionals, he says, because for years they had been unable, for cultural and linguistic reasons, to deliver either health education or effective treatment to Canada’s native peoples on the reserves.

One of the first community health representatives (CHRs) to be trained under the program was Eugénie Lavallée, a Cree Indian and mother of six living on the Piapôt Indian Reserve north of the provincial capital of Regina. Says Brooks: “Somebody like Eugénie comes along and we teach her what we know about health, but the ingredient she adds is the concern for the people and the ability to move amongst them.”

Although Eugénie retired last year from her CHR role, she is still an important community figure, he adds. “The health spectrum is so broad that she got into everything. Politics is very important — she is a councillor now (the first woman to be elected to the council) and she influences the thinking of the people making decisions about development on the reserve.”

While the historical and cultural background of Canada’s native people may be unique, the CHR program has a broad enough application that it has attracted attention from outside the country, including Iran, where an experimental village health worker (VHW) program was begun three years ago with the support of the IDRC. The program’s director, Dr. Houssain Ronaghy, Head of the Department of Community Medicine at Pahlavi University, has had considerable correspondence with Mr. Brooks and his colleagues, and both groups have gained from the resulting exchange of information and ideas.

About two-thirds of Iran’s 33 million people live in some 60,000 villages, most of which are far too small to support a resident health professional. Iran has only about 12,000 trained physicians, most of whom practice in the large population centres, but, says Dr. Ronaghy, “Even if we had enough physicians, they would not be suitable for that kind of community, so there would be no choice but to create a kind of manpower socially, economically and mentally suited to village life.”

Iran’s VHWs receive six months training in both preventive and curative health care, and are then assigned to a village to provide basic health services. Like their counterparts in Canada, they refer the more serious cases to a physician or a middle-level health professional, and they also receive a small salary for their services.

It is too early yet to assess the full impact of the program, the second phase of which is now fully supported by the Iranian government, but Dr. Ronaghy is optimistic. A preliminary survey shows that in the villages with a VHW, infant mortality has been cut by 50 percent compared with the national average for rural areas. And, almost as important says Dr. Ronaghy, the VHWs are “very much accepted” by the villagers themselves.

Or, as Eugénie Lavallée puts it: “Your people come to learn to trust you.”

Eugénie Lavallée — “Before I started training I had to visit every home on the reserve and question people about their health needs. I had lived on this reserve many, many years, and yet until then I did not know half of what was going on. I was too busy raising six children.

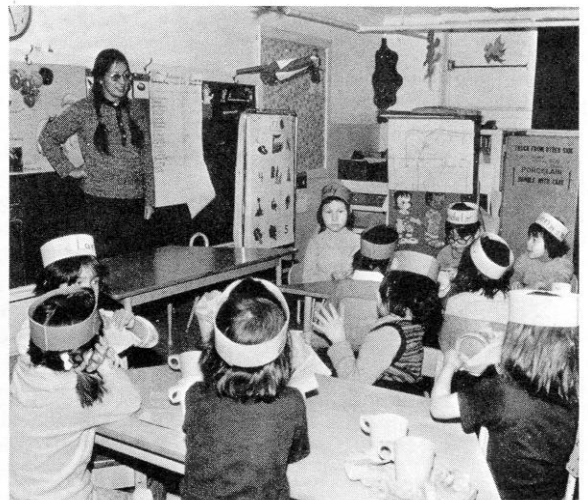
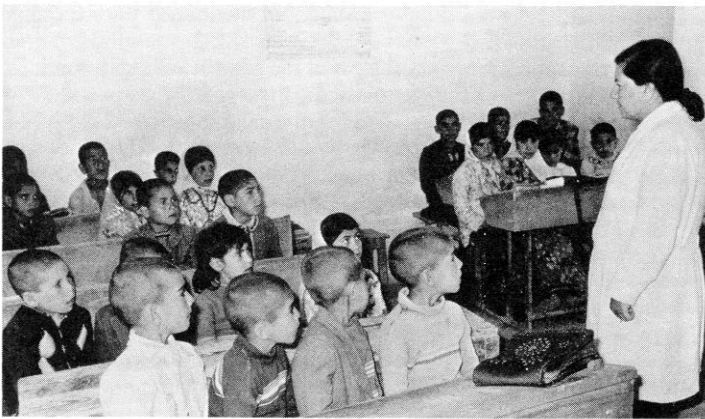
“I was always interested in people, I think that was the main reason I got involved. At first I was afraid of what kind of response I was going to get from the people, but I had a good field nurse, and by the time she left I was even getting gardens going, and had started a women’s club. I also had pre-natal classes, immunization and x-ray programs, spring clean-ups, and always home visits.

“Your people come to learn to trust you. Many years ago in Lone Lake, after our first meeting when I told the people in their own language why I was there, one old man said to me: ‘You know this is the first time somebody ever comes here that we understand’. They don’t usually tell me to my face, but by their actions. And today my people here have respect for me. They still come to me.

“I retired last year at age 65, not rich at all, but with a lot of friends. I always wished I could have been younger when this program came on, because there was a lot of things I felt I hadn’t fully accomplished.”



Iranian boy and Canadian girl: the health of the children is one of the community health worker's primary concerns.



In school the children learn from the community health worker about basic hygiene and nutrition. Classrooms in Iran (left) and Canada (above right).



Out of school activities are much the same for rural children anywhere. Watering cattle in the Canadian winter (left) and herding sheep in Iran (above).

The following article is based on a paper presented by Hermes Marroquín, the Guatemalan delegate to a meeting of national groups carrying out low-cost housing studies held in Costa Rica last April. The meeting was sponsored by the IDRC and SIAP (the Inter-American Planning Board). The paper, prepared by the Institute for Economic and Social Growth of Central America, is a preliminary report prepared three weeks after the disastrous Guatemalan earthquake. On the opposite page Michelle Hibler reports on preventive measures being taken to prevent similar disaster in Ethiopia.

EARTHQUAKE!

Guatemala counts the cost

The violent earthquake that shook Guatemala on February 4 of this year affected almost every phase of national life. At first sight, of course, the most shocking fact was the sheer destructive power of the quake, seen in the loss of lives, housing, communications and public services. But there is something equally horrifying — the social aspect of the earthquake's ravages.

The quake, with an intensity of 7.5 on the Richter Scale and a duration of 35 seconds, was caused by a shift of the tectonic layers in contact along the Montagua Fault. Its effects were felt by 57.4 percent of the country's population living in 16 of the 22 provinces. Seven provinces suffered catastrophic ravagement. The total death toll was more than 22,000, with 75,000 injured.

The area has a long history of earthquakes. Testimonies to such movements are found in Mayan texts and in colonial literature. Geomorphically, the earth's faulted structure undergoes permanent tectonic activity. Earthquakes in the area, obviously, are no novelty.

In such a situation experience should have produced preventive measures — including anti-earthquake housing design and construction. But such standards are too costly for the poor people, and as a result the majority of all the low-cost housing in Guatemala was destroyed, while some wealthy residential areas in identical terrain were relatively undamaged. In other words the earthquake did not affect all sectors equally.

Little damage was suffered by large industry, but small and medium sized industries, especially urban and rural handicrafts, suffered greatly, since in these small operations a considerable part of the capital is invested in the building itself. For these small industries, relocation, cultivation of new clientele and the replacement of equipment will be a long and painful job.

Similarly, the large scale agricultural sector was not greatly affected, largely because it was outside the range of the quake. But in the highlands 65,000 small farmers lost their housing, and 11,000 their lives.

In the commercial sector, as in the

other sectors, large installations did not suffer great damage, and were able to absorb what losses they did suffer. But for the small businessman the loss of existing stock is a significant part of his investment. Furthermore, the small businesses were mainly in the hardest hit areas, where the population has had to restrict its consumption, and the influx of external aid in the form of food and goods has reduced consumer demand even more. The traditional small marketplace has completely disappeared, at least for the present.

All the social and economic activities of the country have been affected by the condition of communications. Blocked highways have brought transportation almost to a standstill. The major port of Puerto Barrios lost one of its piers and several of its other facilities are paralyzed. And while power was restored to the capital and other major centres within five days after the quake, some towns and villages are still without it.

Health service installations suffered heavy damage. Fifteen hospitals and 55 health centres were affected, representing 4,700 beds — or 60 percent of the country's hospital capacity. With the aid of other countries, however, the health service was quickly restored to almost the total capacity required in an emergency. In hospitals, clinics and health stations in the affected area some 75,000 people have been treated for injuries — a statistic that illustrates not only the dimensions of the tragedy, but also the efficiency of the social security organization and the Ministry of Health.

The earthquake's ravages have also

been felt in the cultural wealth of the country. Some historical ruins and buildings of great architectural value were damaged or destroyed, and libraries and important art collections were also damaged.

Some 250,000 students will be affected this year by the complete or partial destruction of school buildings. Again rural schools and those in poor urban areas are most affected.

In regard to handicrafts, the means of subsistence of many of the country's Indian people, the quake has hit their already precarious economy hard. Weavers, woodworkers and potters have lost their work materials. Their value, and the time it will take them to recover, are incalculable costs.

The earthquake destroyed 222,024 homes — or 34 percent of the houses in the affected area, representing 20 percent of all the housing in the country. But the number of homeless families is even greater. In the capital the 60,000 homes destroyed are mostly those of the poor. According to a poll taken by the SIAP project many of these homes house two or more families. This leaves approximately 90,000 families homeless in the Guatemalan metropolitan area alone.

The social costs of such a disaster are high, especially since the monetary cost of rebuilding the houses is usually beyond the reach of the affected families. In other words, the material bases of daily living — work and buying power — have been radically affected. The tragic consequences are obvious: rural migration to urban areas, squatters, misery and new slums. □



Photo: J. Valle-Riestra