Solutions That Empower the Poor: Examples of Equity-Oriented Initiatives
INTRODUCTION TO PART 4

In advocating Primary Health Care, the Alma Ata Declaration affirms that health is determined mainly by factors outside the domain of medical or public health services. In the five examples of countries that achieved good health at low cost—Sri Lanka, Kerala, China, Costa Rica, and Cuba—we saw that a key to widespread improvement in health is strong political commitment to equity in meeting all people’s basic needs. The Alma Ata statement warns, however, that powerful interest groups both within and outside the health sector are inclined to steer health and development initiatives in directions contrary to the best interests of all, especially those of poor and vulnerable groups. To make sure that the design and implementation of Primary Health Care correspond to the concerns and abilities of local people, the Declaration called for active community participation. This was not to be the weak participation of compliance (as in many top-down programs) but rather strong participation of leadership and control, involving community members in analysis of needs and in the planning, evaluation and redesign of health actions according to popular demand. In short, Primary Health Care should be an emancipatory process. Unfortunately, there are too few examples of health initiatives that have put these Alma Ata ideals into effective, sustainable action. And most that have tried have confronted major obstacles.

The final part of this book begins, in Chapter 16, by exploring the process of confidence building, critical analysis, and enablement (or empowerment) necessary for people to stand up for their rights and take a decisive part in decisions that affect their health and their lives.

Chapters 17 to 20 look at four quite different community health initiatives which, to varying degrees, have been introduced in enabling or empowering ways. These range from a small nongovernmental initiative—as seen in Project Piaxtla in Mexico—to a nationwide mass mobilization for health, as part of Nicaragua’s unending struggle for liberation. While one of these four examples—the community-run oral rehydration program in Mozambique—might be considered to be narrow-focused or selective, we will see that it actually responded to health-influencing factors far outside the health sector. It attempted to make schooling more relevant to children’s daily lives by helping them to gain problem-solving skills for meeting health needs in their homes and communities. Through participatory epidemiology it helped prepare children as critical thinkers and advocates for health-promoting change. Likewise, the example from Zimbabwe, although essentially a government-sponsored program for supplementary feeding, helps to bring poor families together in defining a spectrum of health-related problems and taking cooperative action to solve them.

In all four of these initiatives, attempts were made to put into practice the democratic, participatory principles of Alma Ata. However, sooner or later, each of these programs ran into obstacles created by the existing power structure, not just locally or even nationally, but at an international level. Currently, global forces are dictating development and health policies. It is becoming harder for disadvantaged communities and countries to follow local alternatives that are empowering and democratic, equitable, and thereby sustainable. In view of these globalized obstacles to health, the closing chapter of this book explores the growing need for globally coordinated people-oriented solutions to help make the promise of Alma Ata—health for all—a real possibility.