# Helping Health Workers Learn

A book of methods, aids, and ideas for community health education

**David Werner and Bill Bower**

drawings by

David Werner
Regina Faul-Jansen
Pablo Chavez
Marie Ducruy

hesperian
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**THIS BOOK CAN BE IMPROVED WITH YOUR HELP.**

If you are a community health worker, doctor, parent, or anyone with ideas or suggestions for ways this book could be changed to better meet the needs of your community, please write to Hesperian at the above address or email us at hesperian@hesperian.org. Thank you for your help.

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*This book is dedicated to the village health team of Ajoya, Mexico, from whom we have learned a great deal...*

*and to health workers everywhere who side with the poor.*

REQUEST FOR YOUR COMMENTS, CRITICISMS, AND IDEAS:

This book is only a beginning. We want to improve it—with your help.

If you have any ideas, teaching methods, visual aids, or ways of exploring or learning that you feel might be put into this book, please send them to us. We are especially interested to hear how you are using newer technologies that were not available when the book was first written such as computers and mobile phones.

Also let us know which parts of the book you find most useful, and which parts you find least useful, confusing, or incorrect.

As much as possible, we try to incorporate your suggestions, update the contact information for other organizations and materials, and make sure the book continues to be a useful companion to ***Where There Is No Doctor.***

Please write to:

Hesperian Health Guides
2860 Telegraph Avenue
Oakland, California 94609 U.S.A.
hesperian@hesperian.org

Thank you!

# THANKS

The creation of this book has been a long, cooperative effort. We have borrowed ideas from many sources. Included in these pages are methods and suggestions from health and development programs in 35 countries on 5 continents. Often we mention the programs or countries from which particular ideas have come as we discuss them in the text. Here, however, we give our warm thanks to all programs, groups, and persons whose ideas, suggestions, and financial assistance have contributed to this book.

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We would also like to renew our thanks to the dedicated persons who helped put the first edition of this book together back in 1982: Myra Polinger, Lynn Gordon, Mary Klein, Michael Blake, Hal Lockwood, Christine Taylor, Richard Friedman, Susan Klein, Andy Browne, Ken Tull of World Neighbors, Meg Granito, and Emily Goldfarb. Trude Bock generously provided her home and all-round assistance during the three years it took to give birth to this book.

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Early drafts of ***Helping Health Workers Learn*** were field tested in Latin America, Africa, and the Philippines. From these various field trials we received many helpful ideas and suggestions. We are deeply thankful to all those health workers, instructors, volunteers, and health officers who contributed.

For many years our books were packaged and mailed by a dedicated group of volunteers who contributed their labor to support Hesperian's efforts to make health information available. Without their commitment, far fewer copies of our publications would now be available to people throughout the world. Our thanks to Barbara and Herb Hultgren, Tom Beckett, Paul Chandler, Bob and Kay Schauer, Marge West, and Betsy Wallace.

Over the years we have received financial assistance from many sources for the development and distribution of this book. We are grateful to the Ella Lyman Cabot Trust, the Public Welfare Foundation, Brot für die Welt, OXFAM England, the Sunflower Foundation, Misereor, Helmut and Brigitte Gollwitzer, and Reinhart Freudenberg. We also thank the Carnegie Corporation of New York for funding gratis distribution of this, and other Hesperian publications, in Africa. We wish to thank the many generous friends of Hesperian who have donated their time and resources to support the struggle for better health and a better world.

# CONTENTS

# INTRODUCTION FROM FIRST EDITION, 1982

*Health for all by the year 2000* has become the goal of the World Health Organization (WHO) and most countries around the earth.

Such a world-wide goal is very worthy. But in some ways it is dangerous. For there is a risk of trying to reach that goal in ways that become so standardized, so impersonal, so controlled by those in power, that many of the human qualities essential to health—and to health care—are lost.

There is already evidence of this happening. In the last 10 or 15 years, a great many attempts have been made to bring basic health care to poor communities. Billions have been spent on large national or regional programs planned by highly-trained experts. But the results have often been disappointing. In most countries, the number of persons suffering from preventable or easily-curable illness continues to grow.

On the other hand, certain community health programs have been more or less successful in helping the poor meet their health-related needs. Studies by independent observers* have shown that **programs generally recognized as successful, whether large or small, often have the following things in common:**

1. **Small, local beginnings and slow, decentralized growth**. Even the more successful large programs usually have begun as small projects that gradually developed and evolved in response to the needs of particular communities. As these programs have grown, they have remained decentralized. This means that important planning and decision making still take place at the village or neighborhood level.

2. **Involvement of local people—especially the poor—in each phase of the program.** Effective programs recognize and try to deal with the conflicts of interest that often exist between the strong and the weak, even in a small community. Not just local leaders, but the most disadvantaged members of society, play a leading role in selecting their own health workers and determining program priorities. A conscious aim of such programs is to help strengthen the position and bargaining power of the poor.

3. **An approach that views planning as a learning process.** The planning of program content and health worker training does not follow a predetermined "blueprint." Instead, planning goes on continually as a part of a learning process. Participants at every level (instructors, health workers-in-training, and members of the community) are invited to help shape, change, and criticize the plans. This allows the program to constantly evolve and adapt, so as to better meet people's changing needs. Planning is both local and flexible.

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*For example, see *Community Organization and Rural Development: A Learning Process Approach, Public Administration Review,* 1980

4. **Leaders whose first responsibility is to the poor.** Programs recognized as effective usually have leaders who are strongly committed to a just society. Often they have had intense personal experience working with the poor in community efforts to help solve critical needs. Even as their programs have grown and expanded, these program leaders have kept up their close relations with the poor working people in individual communities.

5. **A recognition that good health can only be attained through helping the poor improve the entire situation in which they live.** Successful programs link health activities with other aspects of social development. Health is seen as a state of wholeness and well-being in which persons are able to work together to meet their needs in a self-reliant, responsible way. This means that to become fully healthy, each person needs a clear understanding of himself or herself in relation to others and to the factors that influence all people's well-being. In many of the most effective health programs, activities that help people to develop a more critical awareness have become a key part of training and community work.

In view of these features common to success, the failure of many national and regional community health programs is not surprising. Most are carried out in quite the opposite way. Although their top planners speak proudly of "decision making by the community," seldom do the people have much say about what their health workers are taught and told to do. "Community participation" too often has come to mean "getting ***those people*** to do what ***we*** decide." Rather than helping the poor become more self-reliant, many national health and development programs end up increasing poor people's dependency on outside services, aid, and authority.

One of the biggest obstacles to "health by the people" has been the unwillingness of experts, professionals, and health authorities to let go of their control. As a result, community health workers are made to feel that their first responsibility is to the health system rather than to the poor. Usually they are taught only a very limited range of skills. They become the servants or "auxiliaries" to visiting doctors and nurses, rather than spirited leaders for change. They learn to follow orders and fill out forms, instead of to take initiative or to help people solve their problems on their own terms. Such health workers win little respect and have almost no influence on overall community health. Many of them get discouraged, grow careless, become corrupt, or quit. Results have been so disappointing that some experts, even within WHO, have begun to feel that the goal of "health for all through community involvement" is like the pot of gold at the end of the rainbow—a dream that has been tried, but failed.

In spite of the failure of most large, centrally controlled programs to achieve effective community participation, in many countries there are outstanding examples of enthusiastic community involvement in health. This is especially true in small, non-government programs that take what we call a ***people-centered*** or ***community-strengthening*** approach to health care.

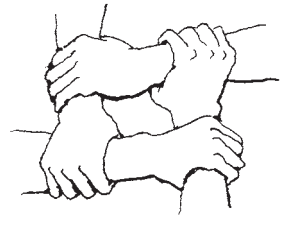
Within these community-based programs, there is a wealth of variety in terms of innovation and adaptation to local conditions. But at the same time, there is a striking similarity in their social and political objectives in many parts of the world—Pakistan, India, Mozambique, the Philippines, Mexico, Nicaragua, Honduras, El Salvador, and Guatemala.

In these community-based programs, a new kind of health worker has begun to play a leading role. These health workers speak out for the "voiceless" poor. Their goal is health for all—but health that is founded on human dignity, loving care, and fairer distribution of land, wealth, and power.

To us, one of the most exciting aspects of this new world-wide community-based movement, decentralized and uncoordinated as it may be, is that it goes far beyond any rigid religious or political doctrine. Most of the leaders in these programs recognize the dangers to ordinary people in any large, centrally controlled system, be it capitalist or communist. They have far greater faith in small, self-directed groups of working people. Rather than accept any established dogma, they are asking searching questions. They welcome criticism, and encourage others to observe for themselves and form their own conclusions. They believe in helping the powerless to gain strength through a greater understanding of the factors that shape their health and their lives.

Around this practical human vision has gradually grown a whole new approach to the training, role, and responsibilities of community health workers. Ideas and methods are being shared and further developed through a series of informal networks around the world.

Many of the ideas in this book have been gathered from these networks of community-based health programs, and especially from Project Piaxtla, a small, villager-run program based in Ajoya, Sinaloa, Mexico.



# WARNING

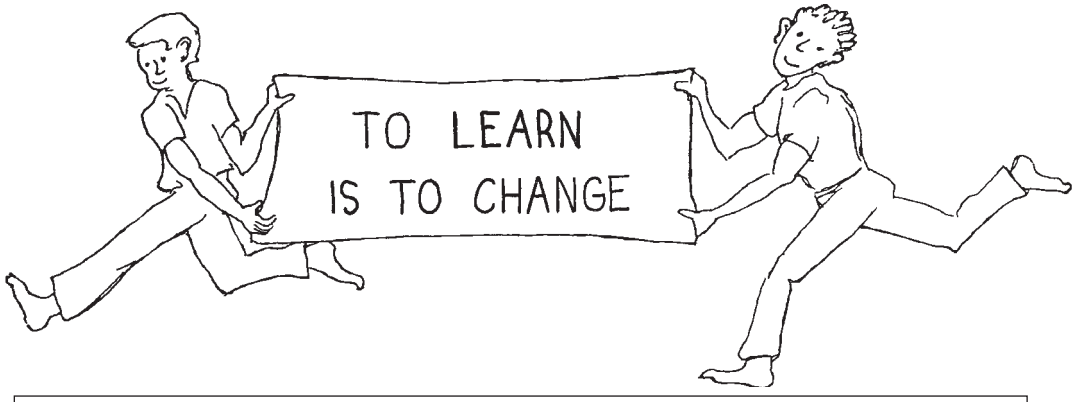
**This is not a "recipe book"** of how to plan and conduct a training course for health workers. Experience has taught us that such a book could easily do more harm than good. Instead, this is a collection of examples and ideas, of group experiences and outrageous opinions, of "triggers to the imagination." It is an invitation to adventure and discovery.

Part of the value and excitement of learning is in finding out "how to do it" for yourself and with others. It lies in looking at the ways things have been done before, then improving and adapting them to suit your own circumstances. This sort of open-ended, creative learning process is as important for instructors of health workers as for the health workers themselves. After all, finding ways to do things better is the key to improving health. The instructor can set the example.

**To be fully alive and meaningful, a training course cannot be either prepackaged or replicable** (able to be copied). It needs to be redesigned not only for each area and set of conditions where it is taught, but each time it is taught.

**A training program, like a person, ceases to be interesting when it ceases to grow or be unique!**

So rather than being a "blueprint" on how to build a training program, this book is a kit of nuts and bolts and tools. Many of the methods and suggestions come from our personal experience, which has been mostly in Latin America. So pick and choose from them critically. Use and adapt what you can, in order to create—and continually re-create—your own very special, unique, and always-new program. Try to make planning a continuous learning process for everyone concerned: instructors, students, and members of the community.




Many of the ideas and suggestions in this book are controversial and will not apply to all areas. We do not ask anyone simply to accept and use them. Instead, we ask you to challenge them, adapt them, criticize them—and use only what makes sense for the people and needs in your own area.

**We ask you to consider—and urge you to doubt and question—everything we say.**

# WHY THIS BOOK IS SO POLITICAL

Doctors, health workers, and health educators often do not look far beyond the immediate and physical causes of illness—such as lack of access to clean water, healthy food, and medicines—when working to improve people's health. They are often not trained to look for the social causes of suffering and ill health in communities, including poverty and human greed.

The health problems in most communities will not be solved by medicines or clean water or nutrition centers or birth control alone (although improving access to these may help). What people really need to stay healthy and thrive is a fair chance to live from their own labor, and a fair share of what the earth provides. We can see this in the following story about Chelo and his family in Ajoya, Mexico.

Chelo lived in a rural village in Mexico and had advanced tuberculosis. Before the villager-run health center was started in his village, he received no treatment. He knew he had tuberculosis. He wanted treatment. But he could not afford the medicines. (Basic tuberculosis medicines are not expensive to produce. But in Mexican pharmacies, they are sold at up to ten times their generic price in the United States and other developed countries.) Although the government's tuberculosis control program gave free medication, it required patients to travel often to one of its city health centers for tests and medication. For Chelo, this would have meant 250 kilometers of travel every 2 weeks. He simply could not afford it.

For years, Chelo had worked for the richest landholder in the village. The landholder was an unhappy, overweight man who, apart from his enormous landholdings, owned thousands of cattle. When Chelo began to grow weak from his illness and could not work as hard as before, the landholder fired him, and told him to move out of the house he had been lending him.

Chelo, his wife, Soledad, and his stepson, Raul,* built a mud-brick hut and moved into it. By that time Chelo was coughing blood.

Around the same time, the community-based health program was getting started in the area, but no health worker had yet been trained in Chelo's village. So a visiting health worker taught Chelo's 11-year-old stepson, Raul, to inject him with streptomycin. Raul also learned to keep records to be sure Chelo took his other medicines correctly. The boy did a good job, and soon was giving medicines and doing follow-up for several persons with tuberculosis in the village. By age 13, Raul had become one of the central team of health workers in the area. At the same time, he was still attending school.

Meanwhile, Chelo's family had cleaned up a small weed patch and garbage area at the lower edge of town. With much hard work they had constructed a simple irrigation system using ditches and grooved logs. At last they had a successful vegetable plot, which brought in a small income. Chelo's health had improved, but he would never be strong. Treatment had begun too late.

*These are real persons, but we have changed their names,

Economically, Chelo had one setback after another. Just when he was beginning to get out of debt to the storekeepers and landholders, he fell ill with appendicitis. He needed surgery, so health workers and neighbors carried him 23 kilometers on a stretcher to the road, and from there took him to a hospital in the city by truck. The surgery (in spite of the fact that the doctor lowered his fee) cost as much as the average farmworker earns in a year. The family was reduced to begging.

The only valuable possession the family had was a donkey. When Chelo returned from the hospital, his donkey had disappeared. Two months later, a neighbor spotted it in the grazing area of one of the wealthier families. A new brand—still fresh—had been put right on top of Chelo's old one.

Chelo went to the village authorities, who investigated. They decided in favor of the wealthy thief, and fined Chelo. Chelo did not even seem angry—just sad. He laughed weakly and shrugged, as if to say. "That's life. Nothing can be done."

His stepson, Raul, however, took all these abuses very hard. He had been a gentle and caring child, but stubborn, with an enormous need for love. As he got older, he seemed to grow angrier. His anger was often not directed at anything in particular.

An incident with the school was the last straw. Raul had worked very hard to complete secondary school in a neighboring town. Shortly before he was to graduate, the headmaster told him in front of the class that he could not be given a certificate since he was an illegitimate child—unless his parents got married. (This happened at a time when the national government had decided to improve its statistics. The president's wife had launched a campaign to have all unwed couples with children get married. The headmaster's refusal to give graduation certificates to children of unwed parents was one of the pressures used.) Chelo and his wife did get married—which cost more money—and Raul did get his certificate. But the damage to his pride remained.

Young Raul began to drink. When he was sober, he could usually control himself. But he had a hard time working with the local health team because he look even the friendliest criticism as a personal attack. When he was drunk, his anger often exploded. He managed to get hold of a high-powered pistol, which he would shoot into the air when he was drinking. One night he got so drunk that he fell down unconscious on the street. Some of the young toughs in town, who also had been drinking, took his pistol and his pants, cut off his hair, and left him naked in the street. Chelo heard about it and carried Raul home.

After this, Raul hid in shame for 2 weeks. For a while he did not even visit his friends at the health post. He was afraid they would laugh. They did not. But Raul had sworn revenge—he was never quite sure against whom. A few months later, when drunk, he shot and killed a young man who had just arrived from another village. The two had never seen each other before.

Raul was fighting forces bigger than himself. As a boy of 12, he had taken on the responsibilities of a man. He had shown care and concern for other people. He had always had a quick temper, but he was a good person.

Who, then, is to blame? Again, perhaps no one. Or perhaps all of us. Something needs to be changed.

After the shooting, Raul fled. That night, the State Police came looking for him. They burst into Chelo's home and demanded to know where Raul was. Chelo said Raul had gone. He didn't know where. The police dragged Chelo into a field outside town and beat him with their pistols and rifles. Later, his wife found him still lying on the ground, coughing blood and struggling to breathe.

It was more than a year before Chelo recovered enough to work much in his garden. His tuberculosis had started up again after the beating by the police. Raul was gone and could not help with the work. The family was so poor that, again, they had to go begging. Often they went hungry.

After a few months, Chelo's wife, Soledad, also developed signs of tuberculosis and started treatment at the village health post. The local health workers did not charge for her treatment or Chelo's, even though the health post had economic difficulties of its own. However, Chelo's wife helped out when she could by washing the health post linens at the river. (This work may not have been the best thing for her TB, but it did wonders for her dignity. She felt good about giving something in return.)

Then, 5 years later, a new problem arose. The landholder for whom Chelo had worked before he became ill decided to take away the small plot of land where Chelo grew his vegetables. When the land had been a useless weed patch and garbage dump, Chelo had been granted the rights to it by the village authorities. Now that the parcel had been developed into a fertile and irrigated vegetable plot, the landholder wanted it for himself. He applied to the village authorities, who wrote a document granting the rights to him. Of course, this was unlawful because the rights had already been given to Chelo.

Chelo took the matter over the heads of the village authorities to the Municipal Presidency, located in a neighboring town. He did not manage to see the President, but the President's spokesman told Chelo, in no uncertain terms, that he should stop trying to cause trouble. Chelo returned to his village in despair.

Chelo would have lost his land, which was his one means of survival, if the village health team had not then taken action. The health workers had struggled too many times—often at the cost of their own earnings—to pull Chelo through and keep him alive. They knew what the loss of his land would mean to him.

At an all-village meeting, the health workers explained to the people about the threat to Chelo's land, and what losing it would mean to his health. They produced proof that the town authorities had given the land rights to Chelo first, and they asked for justice. Although the poor farm people usually remain silent in village meetings, and never vote against the wishes of the village authorities, this time they spoke up and decided in Chelo's favor.

The village authorities were furious, and so was the landholder.

The health team had taken what could be called political action. But the health workers did not think of themselves as "political." Nor did they consider themselves capitalists, communists, or even socialists. (Such terms had little meaning for them.) They simply thought of themselves as village health workers—but in the larger sense. They saw the health, and indeed the life, of a helpless person threatened by the unfairness of those in positions of power. And they had the courage to speak out, to take action in his defense.

Through this and many similar experiences, the village health team came to realize that the health of the poor often depends on questions of social justice. They found that the changes that are most needed are not likely to come from those who hold more than their share of land, wealth, or authority. Instead, they come through cooperative effort by those who earn their bread by the sweat of their brows.

More and more, the village team in Ajoya looked for ways to get their fellow villagers thinking and talking about their situation, and taking group action to deal with some of the underlying causes of poor health.

Some of the methods they developed and community actions they led are described in several parts of this book. For example, three of the village theater skits described in Chapter 27 show ways in which the health team helped the poor look at their needs and organize to meet them.

These 3 skits are:

SMALL FARMERS JOIN TOGETHER TO OVERCOME EXPLOITATION (page **27**-27),

USELESS MEDICINES THAT SOMETIMES KILL (page **27**-14), and

THE WOMEN JOIN TOGETHER TO OVERCOME DRUNKENNESS (page **27**-19).

These popular theater skits had a marked social influence. Villagers participated with new pride in the cooperative maize bank set up to overcome high interest on loans. Women organized to prevent the opening of a public bar. And storekeepers stopped carrying some of the expensive and dangerous medicines that they sold before. In general, people seemed more alert about things they had simply accepted.

On the other hand, new difficulties arose. Some of the health workers were thrown out of their rented homes. Others were arrested on false charges. Threats were made to close down the villager-run program.

But in spite of the obstacles, the health team and the people stood their ground. The village team knew their road would not be easy. They also knew to be careful and alert. Yet they chose to stand by their people, by the poor and the powerless.

They had the courage to look the whole problem in the eye—and to look for a whole answer.