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Health: The Human Factor
Contact Special Series No. 3

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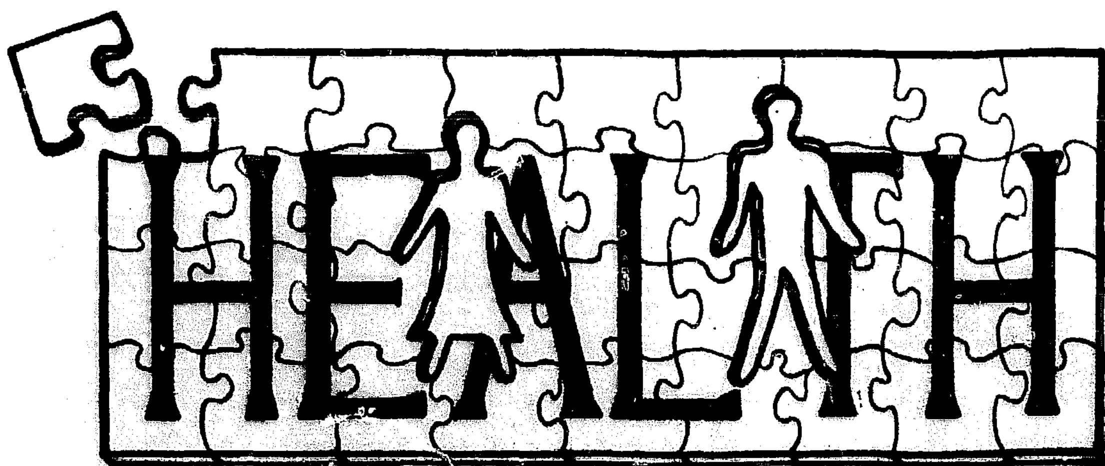

READINGS IN HEALTH, DEVELOPMENT AND COMMUNITY PARTICIPATION

Guest Editor: Susan B. Rifkin

CONTACT Special Series is an occasional publication of the Christian Medical Commission. Each issue is designed to gather under one cover a collection of articles dealing with a single theme. This is the third of this monograph series.

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The Principles and Practice of Primary Health Care

CONTACT Special Series Number 2 – June 1979
In Search of Wholeness...Healing and Caring

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CONTACT SPECIAL SERIES

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HEALTH: THE HUMAN FACTOR

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June 1980

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CONTACT EDITOR'S NOTE

In both our regular CONTACT publications and in this Special Series, we are trying to promote the continuing debate on the basic issues in primary health care. Long recognized as crucial among these basic issues, the factor of *community participation* is still one of the least understood of them all. It is crucial because the effective realization of justice in health care and development cannot take place if true participation is denied. Self-reliance will never characterize a programme that fails to provide for participation of the people at all stages of planning and implementation. Sustaining commitment and support for any programme can only emerge from those who believe that the programme is in their hands.

We are pleased, therefore, to present this issue of CONTACT Special Series devoted to this important theme. Out Guest Editor for this issue, Ms Susan Rifkin, has gathered an illuminating series of articles which treat the several levels and dimensions of participation. The articles emerge out of a wide variety of ideological positions and experiences. The opinions expressed must be understood as those of the authors, and in any given case do not necessarily represent the view of the Christian Medical Commission or the World Council of Churches. However, they are presented, both individually and collectively, as worthy contributions to the dialogue on these issues.

Once again, we would like to invite your participation in the continuing dialogue and debate, and we would be pleased to hear your comments and views. Please write to us at the address on the front cover.

ABOUT OUR GUEST EDITOR

Susan Rifkin, at present, is a researcher on community health for the Hong Kong Christian Council and is an associate of the Center for Asian Studies at the University of Hong Kong. Her current research concerns a study of three community-based, church-related health programmes in South-east Asia, in the Philippines, Indonesia and Hong Kong. The purpose of the study is to define and explore issues which concern community health programmes generally, and to see the problems and potentials in dealing with these issues by examining three case studies.

Prior to this present assignment, Ms Rifkin spent two years as the health consultant for the Christian Conference of Asia, where her work carried her throughout the region looking at church-related community health programmes. Ms Rifkin has worked as a health education officer for the Republic of Zambia and was a Research Fellow at the University of Sussex where she studied the health care system of the People's Republic of China. She has been a Visiting Fellow at the Institute of Development Studies at the University of Sussex and a Consultant to the World Bank.

Her publications include: *Health Care in China: an Introduction,* published by the Christian Medical Commission and articles in *Journal of Development Studies, Social Science and Medicine* and *Lancet.* She also occasionally writes for the *Far Eastern Economic Review.*

INDEX

		Page
Acknowledgements		VII
Preface		IX
Introduction		
Chapter I	Community Participation, A Planner's Approach Susan B. Rifkin	1
PART I Community Participation: An Overview		9
Chapter II	Towards Another Development in Health Göran Sterky	11
Chapter III	Community Participation, the Heart of Primary Health Care Manzoor Ahmed	19
PART II Community Participation: A Strategy		29
Chapter IV	Rural Health Problems in Developing Countries: The Need for a Comprehensive Community Approach Marie-Thérèse Feuerstein	31
Chapter V	People Power: Community Participation in the Planning of Human Settlements Mary Racelis Hollnsteiner	43
Chapter VI	Formulating an Alternative Health Care Scheme for India D. Banerji	53
Chapter VII	On the Limitations of Community Health Programmes Maria das Merces G. Somarriba	61
Chapter VIII	Development Campaigns in Rural Tanzania Budd Hall	69
PART III Community Participation: A Process		77
Chapter IX	From Extension Talk to Community Therapy Andreas Fuglesang	79
Chapter X	Health Care and Human Dignity David Werner	91
PART IV Community Participation: An Illustration		107
Chapter XI	Development of a Community Health Programme Mary Johnston	109
Conclusions		119
About the Contributors		123

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"Formulating an Alternative Health Care Scheme for India", Dr. D. Banerji. *Community Health in Asia,* Christian Conference of Asia, 1977. Singapore.

"Development Campaigns in Rural Tanzania", Bud Hall. *Rural Africana,* 1975.

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"Some Questions Concerning Methods of Leadership", Mao Tse Tung; *Selected Works of Mao Tse Tung,* Vol. III, Foreign Language Press, 1965, Peking, People's Republic of China.

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The editor wishes to thank Maria das Merces G. Somarriba and David Werner for their original contributions.

The guest editor also wishes to thank all the authors and publishers for waiving the reprint fees in order that the production costs could be reduced and the volume could be sold at a lower price.

PREFACE

At an intensive four-week health planning seminar last year, an Indonesian friend came to talk with me during a tea break. She told me that, while she felt many of the ideas presented at the meetings were indeed interesting and useful, she also felt that their presentation was very technical and dry. She said, "The problem with you in the West is that you think development is about increased production and rational economic planning. We in the developing countries know it is about people".

Her reflections are shared by many who are looking for ways to rapidly and radically alter the impoverished living conditions in which the majority of the world's people still live. Health is one area of focus for this concern. Adequate health care is still denied a majority of people in the developing world because the Western/curative/urban-based health care delivery system has proved both inappropriate and limited for meeting the needs of these people. In addition, people lack care because health has too long been seen as the result of medical technology rather than a response to human endeavour.

In recent years, the human element in development has been of increasing importance to the United Nations (UN). In the area of health, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have been instrumental in focusing this concern through a series of studies and conferences and their evolving concept of "Primary Health Care". A key element in this new view of health care is community participation, in which those who are affected by health policy take part in formulating that policy.

This new area for examination and action — community participation in health — still lacks a significant body of literature. While some case studies have been written about the personal experiences of the authors, few have been able to abstract from specific to general issues in programme planning. Those articles that are the most comprehensive and analytical are often singularly difficult to obtain.

This book of readings is a beginning to correcting the deficiency in this area. It does not seek to provide the answers to how to plan a community-based health programme. Instead, it seeks to abstract, delineate, clarify and classify some of the basic questions. In bringing together some of the most well thought out and provocative essays in one volume, it allows for comparison of issues in different countries and for an identification of areas of concern common to all programmes. Hopefully, it will challenge planners, be they government officials, medical professionals or community workers, to look at their assumptions about community health and to apply revised ideas to their own programmes.

The selections in this volume are all written by people who have lived and worked for a number of years in the developing world. Several are nationals of the countries about which they write. Reflecting on health care as a part of the socio-economic-cultural environment rather than solely as the delivery of a scientific and modern service, these essays probe the various dimensions of involving the community in taking responsibility for its own health and highlight the necessity of emphasizing, building and protecting the human element in development programmes. This volume does not deal with the best known component of community-based health programmes: the community health worker. This is a subject of a separate volume. Nor does it contain an extensive bibliography, due to both the lack of information on this subject and the difficulty for most readers in obtaining many of the pieces.

This book was compiled as one part of a study which I am undertaking for the Hong Kong Christian Council on community-based health care programmes in Southeast Asia. The study is funded

by Bread for the World of the Diakonische Arbeitsgemeinschaft Evangelischer Kirchen in Deutschland. Funds were also contributed by the Department of Social Work at the Hong Kong University.

I am most thankful to a number of people for their assistance. David Morley and Huw Jones encouraged me to undertake this volume. The Health Group at the Institute of Development Studies of the University of Sussex provided much intellectual stimulus during my stay there in the summer of 1978. I especially owe thanks to Alastair White and Alanagh Raikes for our never-ending discussions about community participation in health. In Hong Kong, Margret Carter and Mona Lo helped me to think out various issues. John Anderson, Paul Morris and R. Maru patiently read and commented on many of the drafts. And I particularly owe thanks to Jerry Stromberg in Geneva who gave me advice and insight to help with this work.

Susan B. Rifkin
Hong Kong
March, 1979

COMMUNITY PARTICIPATION IN HEALTH: A PLANNER'S APPROACH

Susan B. Rifkin

"In the past few years, we have seen a flowering of new conceptions of the development process. Perhaps the most far-reaching is the acceptance by many countries and international organizations of the importance of the human factor — as distinct from the purely physical or material." Henry R. Labouisse, Executive Director, United Nations Children's Fund (as quoted in *Assignment Children* no. 42, UNICEF, Geneva, April-June, 1978)

In recent years, there has been evidence to suggest that, particularly in the developing nations, health and medical services have not achieved the remarkable improvement for the majority of the people that they did in the industrial nations in the late 19th and early 20th century.[1] This fact has led to the observation that: "In the absence of dramatic breakthroughs in medical science, the greatest potential for improving health is through changes in what people do and do not do to and for themselves".[2] For this reason, the idea of community participation has created a great deal of interest among both planners and field workers implementing health care activities. Community participation is seen by many as the key to rapid and radical health improvements for the poor and the majority of the world's people.

A major reason for the emphasis on community participation in health care is a new understanding of the concept of health. The traditional Webster dictionary definition, "freedom from physical disease or pain", has virtually been replaced by the World Health Organization's (WHO) definition, "the state of complete physical, mental and social well-being of the individual". This more positive concept has emerged as those who are involved with, and responsible for, health care delivery systems see health as being more concerned with people and less concerned with medical science and its concommitant technology. A brief review of this changing focus helps us to understand the relationship of community participation to health.

A BRIEF HISTORY

The view that health was the absence of disease, which could be realized through the delivery of medical services, emerged as a dominant idea in the mid-nineteenth century. This view was due in great part to the remarkable scientific achievements in clinical medicine of that period and of the following one hundred years. Because scientists discovered how to control and cure disease with penicillin, vaccinations and sterile techniques, they also defined development in health care. The result was that not only the curative as well as preventive and rehabilitative practices found their roots in the clinical laboratories, but also the values and ethos of the modern medical culture reflected Western scientific beliefs. Priority was placed on complicated scientific research and specialized clinical education, regardless of cost. This meant the growth of the importance of institutional, individual care, the predominance of the "bio-science" aspect of medical education and large allocations for sophisticated medical technologies, teaching hospitals for research and training and increasing emphasis on scientific progress.

A change in this narrow medical focus took place in England in the 1830's with the publication of the Reform Acts. Recognizing that disease could be reduced by the introduction of public health measures such as good sanitation, and clean water supplies, the government enacted laws which provided some measure of prevention and some concern for large groups of people rather than strictly clinical, curative, individual work. Eventually, an argument was accepted that scientific medicine should not make the division between prevention and cure and the individual and the community. However, the preventive, community aspects of health still remained in the hands of the medical professionals who regarded these aspects as part of a medical delivery system — a system which was fundamentally based on the ability to cure disease.

The concentration of health concerns in a highly-trained scientific group meant that this group continued to dominate views about health in both practical and policy terms. Their orientation often defined national governments' ideas about national health policy. This situation had two rather serious

consequences. The first was that, often, the national policy reflected the interest of the medical profession rather than the needs of the majority of the country's population. New hospitals, for instance, took precedence over expanded public health activities. The rural poor and the urban shanty dwellers, especially in the developing countries, often were only spectators of new medical and health improvements. Secondly, the medical profession maintained a monopoly on knowledge about medicine, health and the human body. It created a mystique around people who had been trained in, and certified by, formal medical institutions. Thus, not only were the poor deprived of health resources, they also were denied the opportunity to learn to use what few resources they might have in their own communities.[3]

Professor Rex Fendall, Professor of Tropical Community Health at Liverpool School of Tropical Medicine has stated:

> *"If I were to compose an epitaph on medecine through the 20th century, it would read: brilliant in its discoveries, superb in its technological breakthroughs, but woefully inept in its application to those most in need. Medicine will be judged not on its vast and rapid accumulation of knowledge per se, but on its trusteeship of that knowledge. We are now experienced, and all that remains is the problem of translating what is common knowledge and routine medicine, and hence practice, to the other two-thirds of the world. The implementation gap must be closed."*[4]

Fendall's words reflect the fact that an era of scientific medicine which realized the potential of control and eradication of many of the world's most devastating diseases by the mid-20th century still had not produced a radical improvement in the health of the majority of the world's population. The Western scientific approach to health could not direct people's attitudes towards, and beliefs about, disease. It had, in reality, produced a view of health and a system of health care delivery which was acceptable and available to a minority of people and often only to those who had financial resources to afford doctors, drugs and a healthy environment.

Fendall's observation was one which has caused health planners a great deal of concern over the past twenty years. One might argue that it was Gunnar Myrdal's *Asian Drama*[5] that was a catalyst for planners, both in and outside the medical profession, to begin to turn the tide of health and medical priorities from individual, curative, clinical expenditures to programmes which would affect large numbers of people. As an economist, Myrdal argued that health was not a "bottomless pit" into which a benign government poured health care resources as a gesture of concern for its people. Rather, he said that health was an "investment in man" which, if improved, could add to the productive capacity of a nation because it would increase man-hours available for work. This argument not only dramatically questioned the rationale of existing health and medical policy but also brought the policy into the fast-growing "development debate".

The last fifteen years has produced a body of literature concerning the role of health in development.[6] It is an area too vast even to sufficiently summarize in this short essay. Suffice it to say that the growth of general development theory which included ideas about the priorities of investment in urban or rural areas, to agricultural or industrial production and capital- or labour-intensive investment strategies, influenced the changing definition of health. In practical terms, one result was that many doctors who had experience in developing countries began to question the wisdom of existing health care allocations in these countries.[7] They argued that the existing policies which supported a capital-intensive medical care system with its large teaching hospitals, its advanced medical technologies and research and its preoccupation with training fully-qualified doctors, were both too expensive and too limited to improve the health of the majority of the people. Armed with the support of some members of the medical field, economic planners began to look at the basis of all health care allocation of resources in the Third World.[8] Emerging from the work of these people was sufficient experience and analysis, if not to introduce the community potential in health, at least to question the existing health and medical priorities.

In the 1960's, those concerned with health care also became increasingly concerned about who received health resources. Evidence was produced to show that most resources for health and medicine in the developing countries were going to large urban curative medical institutions where the majority of a nation's doctors served, making them available, in the absence of national health insurance schemes, only to the wealthy. In addition, the data showed that the serious health problems were among the rural poor, i.e., the majority of the population, whose priority health problems could be met by preventive services delivered by paramedicals at a health centre. James McGilvray, then Director of the Christian Medical Commission (CMC) of the World Council of Churches (WCC), in his speech to the American Medical Association (AMA) in 1969 very well summed up the thinking about health and medicine in the decade of the 1960's. The problems were, McGilvray said:[9]

1. the high cost of medical treatment in relation to the amount of existing resources and the lack of availability of this treatment to most of the people;

2. the limited effectiveness of the highly- and expensively-trained doctor to deal with the most prevalent diseases among the majority of poor rural people;

3. the dilemma of having knowledge about how to control and treat disease and having little success in transferring that knowledge to radically improve the health status of the masses; and

4. the competition in resource and time allocations between individual, clinical care, and community health care.

This concern, by the early 1970's, led to the search for solutions. Major efforts were made to identify alternative health care systems where health resources were being used to respond to the needs of the majority of the people. For a number of historical and political reasons, one area of this research focused on health care in the People's Republic of China. With the general relaxing of the strict isolationist policies of the Cultural Revolution, China invited several groups of prominent scientists to visit. Those who went as members of medical delegations confirmed reports of the impressive advancements China had made in the areas of control of communicable diseases, in decentralization of health care units, in use of paramedics and village people who had no formal medical education and in mobilization of its 800 million people to engage in health activities.[10] Many began to argue that China had much to teach the world about good health care delivery.

The Chinese experience emphasized two aspects of health care which now moved into the forefront of current thinking. One was that health care was not, as previously argued in influential circles, an apolitical entity subject only to change by scientific advances. It was a reflection of existing social, political and economic conditions. Secondly, health improvement did not depend solely on science and professionals. Great changes could be brought about by mobilizing people to take part in health care activities. This fact was supported by evidence that, by 1956, China had virtually eradicated smallpox and cholera and had drastically reduced typhoid, typhus, scarlet fever and diphtheria. This was at a time when the nation was recovering from civil war and was virtually depleted of resources to build more hospitals or dramatically increase its 10,000 Western-trained doctors.[11]

Another source of experiences in alternative health care programmes were the small voluntary-agencies' pilot programmes in various poor communities in Asia, Africa and Latin America. These programmes were usually begun by a doctor or nurse, often Christian, who early discovered that health services were not making an impact on improving the health of the community. Learning through experience that food, clothing and housing were seen by the people as priorities over health needs, these health professionals began to develop programmes where health services were but one element, though possibly the entry point, in a number of community development programmes which included agriculture, education and handicraft work. These experiences confirmed the link between poverty and poor health, and the need to tackle the whole range of development problems and not just the lack of medical services. They also confirmed the fact that getting communities involved in health and health-related activities could radically and rapidly improve the health status of the people.[12]

THE UN CONCERN

These experiences began to focus on a heretofore neglected aspect of health — the potential and necessity of having people in local communities define and act upon their own health needs. The UN concern did not suggest that people had never been involved in their own health care. Each society has always had a history of involvement in traditional cures and approaches. What the UN did was to clearly articulate the necessity of recognizing this involvement. As early as 1973, a WHO Executive Board study emphasized the need to find ways of more systematically developing people's participation in their own health care. This document stated in part:

> *"...the health services must really be accepted by the persons they serve. It is not difficult to understand why health services have developed as a system imposed upon populations — something that comes into a town or village from the outside. Medical literature and project proposals are filled with terms such as 'acceptors', 'refusal rates', 'problem families', 'under-utilization', which show clearly that the problem is seen as a failure on the part of the people, rather than as a failure of the health services. What is necessary now is to solicit community identification with, and participation in, the development of health services. This will require innovative approaches."*[13]

This recommendation was followed by further studies which considered in some detail these recommendations. Among them were the study on "Alternative Approaches to Meeting Basic Health Needs in Developing Countries" (1975), the book edited by K. Newell, *Health By the People* (1975) and the study of "Community Involvement in Primary Health Care" (1977).[14] One result of these studies was the evolution of a concept of Primary Health Care (PHC) which is defined by the UN as "essential health care based on appropriate and acceptable methods and technology made universally accessible to individuals and families in the

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Two newly-trained health promoters in the community of Pihal, 50 km from Quito, Ecuador, hold a clinic session for villagers.

community through their full participation and at a cost that the community and country can afford to maintain in the spirit of self-eliance".[15]

PHC has explicitly challenged many of the fundamental concepts of health and medical care which have dominated health policy for the past 150 years. So that constituent members could confront this new challenge, WHO and UNICEF convened a conference in September, 1978 at Alma-Ata, USSR.[15] The conference documents detail the principles which must be considered to establish PHC in order to provide, in the words of WHO, "health care for all by the year 2000". Among these principles are:

1. health care is political;
2. Western medical care is not the only efficacious type of health care;
3. medical professionals are not the only people capable of giving medical advice and treatment;
4. health cannot be isolated from other development policies and agencies;
5. the most sophisticated technology does not necessarily provide the best care;
6. the doctor/patient ratio does not necessarily indicate the quality of care available; and
7. decentralized health planning and institutions are better able to respond to local health problems.[16]

Today, health is no longer defined as "mere absence of disease", made possible by medical science and medical professionals. It is, in addition, increasingly being seen as a human right, a part of the socioeconomic development of a country, and a reflection of political will. It is less about scientific advances than it is about people's needs. In other words, it is a human condition[17] which cannot be changed solely by the provision of services. Its improvement also becomes the responsibility of individuals, communities and governments.

ASPECTS OF COMMUNITY PARTICIPATION

One direct result of this new understanding of health is the increasing interest in the concept of community participation. Arguments for community participation in health are many and varied. The first and perhaps the strongest is that, in most communities, health resources are scarce and community inputs, for instance community health workers, are needed to increase resources at minimal cost. A second argument suggests that health resources are better mobilized and utilized when the community helps to formulate its own health plans. A third position is that community participation is a key to mobilization of community resources and a means of educating the community to accept health goals established by the medical profession. A fourth position sees community participation as a process which has as its aim to question and redefine health goals with the view of having health policy determined by the community itself.[18] These differing views raise the question of whether community participation in health care is a means or an end in itself.[19] They also point to the fact that the role of community participation in planning is not an easy one to define. To be able to assess its potentials and problems, it is perhaps best to make some observations about the nature of community participation.

The first observation we can make is that, to consider community participation, it is necessary to consider the nature of "community". A dictionary definition of community which says it is "a body of people having common organization or interest, or living in the same place under the same laws" might

be acceptable for a theoretical view of community participation. However, in terms of policy and programmes, those with experience recognize that, in reality, communities consist of various social, political and economic groups. These groups can have different cultural backgrounds and different values. Often they do not share the same goals and same objectives at the same time.

These elements of the diversity of communities in community participation efforts have been documented from the experiences of the 1950's and 1960's. The community development movement of this period sought ways of encouraging people to improve their own lives by relying on their own initiatives and on their own resources. Using agriculture in many cases as the focal point, these programmes' achievements were disappointing. Their failure resulted from, among other things, conflicting interests within certain communities, the institutionalization of the programmes at governmental level, problems with creating new structures to support these programmes and the unclearly-defined duties of government officials who had to carry out the programmes in mainly rural communities. The lessons from this period are worth studying for those who are now engaged in community health programmes.

Another important observation is that community participation is essentially a political concept. In making this observation, we can note, firstly, that the way a community "participates" depends on the socio-economic-political system. A major factor is the type of system which rules the nation. There is a basic difference in the organization and objectives of communities in socialist systems like China and Cuba from those in non-socialist, capitalist societies. In the former, the collectives are the basic units of production and, therefore, the community shares basic economic objectives. It is essential that commune members participate not only in community work but also in decisions about how the work will be carried out. In the latter, where there is a high incentive for individual production, objectives are often shared when people see actual short-term individual gains. Thus, consensus on many activities might be difficult to obtain.

In countries where there has not been an attempt at the national level to restructure the society, other determinants of participation are the existing cultural values and social structures. In countries under the colonial influence of the Western democracies, for instance, the idea of participation often means one man, one vote. However, in many rural villages where this belief has had little influence, the agreement of the village chief represents the agreement of the entire community. In developing ideas about community participation, it is necessary to examine the existing traditions and the structures which support these traditions. Short of social revolution in which these structures are totally destroyed, it will be necessary to take account of, modify and/or change them in order to make participation viable.

Further, we should understand that participation is essentially a concept which means that the community, rather than the government or outside professionals, has control over health resources and has the power to decide how these resources will be used. This highlights the distinction between community "participation" and "contribution". The former means control by the community. The latter means that people outside the community, most often the government, create activities and provide resources for these activities in which community people are encouraged to join but over which they have virtually no control. In commenting on this aspect, Kenneth Newell, former Director of the Division of Strengthening of Health Services, WHO, states that it is not enough for people to enter a partnership with those who have control over the existing health system, but that the people will have to "... take the system over as a supporting segment of their own health concerns or (if this is not possible) to design a new one".[20] This call for, in WHO's terminology, "health *by* the people" plainly spells out the political nature of community participation.

A STRATEGY AND A PROCESS

With these observations in mind, and on the basis of the experiences of those who have been working in community-based health programmes, of which some of the more interesting are compiled in this book, it is possible to make some observations about community participation in health care planning. What is most important to note is that community participation cannot be considered a component of a health care delivery system. It is not something which can be compartmentalized, confined to a series of inputs or costed out. Rather, in terms of health planning, it must be seen as a strategy and a process. By strategy is meant that community participation is the context in which a health care programme develops. Because this context confronts the traditional view that health can be delivered and acknowledges that health is a human condition which everyone — the individual, the community, the government and not only the professionals — acts upon, the goal of having the community take responsibility for its own health care must be carefully developed and supported. A community participation strategy is one which can be characterized in some of the following ways.

It emphasizes people rather than technology. Traditional health planning has sought to spread Western medicine and its concommitant technology as the basis of health care delivery. As we have noted, this policy has not necessarily improved health status or health situations, particularly in

rural areas. A community participation strategy recognizes the limits of modern technology and instead emphasizes ways in which communities might be motivated to change bad health behaviour and improve their living conditions. The emphasis on people stresses their ability to choose to improve their conditions rather than their passive acceptance of either government or voluntary-agency handouts.

It emphasizes community motivation rather than service coverage. It recognizes that health services are often under-utilized and/or utilized improperly because people have little or no incentive to maximize the services that are provided. A prime task of a community participation strategy is to help the community understand what health care services can and cannot provide and to utilize the scarce health care resources for the maximum benefit.

It emphasizes a bottom-up rather than a top-down approach to health planning. In most health policy planning, the government and/or voluntary-agency officials are the ones who define the programme and give the directives to the community. The community which receives the programme is rarely involved in the planning and, therefore, is given little incentive or commitment to implement these decisions. Service delivery reflects the thinking of bureaucrats and/or professionals rather than the needs of those who get the service. Top-down, and planning from the centre, from which most of the resources are allocated, does little to encourage good use of resources and often does much to create blocks to improving the health of the community. A community participation strategy is one in which outside planners work with community leaders to develop services and communication links which are responsive to community needs. The outside planners serve as a resource base for community programmes.

Community participation is also a process. In this context, process means the various ways in which people in communities first recognize, and slowly begin to act upon, their own health problems. A first step in this process is to enable community leaders and, eventually, all members of the community, to begin to understand that health and health services should not be equated, and thus that the community should not rely solely upon the medical profession for health improvements. Activities which aid this process may include the formation of health committees and the selection of, and responsibility for, community health workers. This process develops in different ways, at different times in each different community. Some key features of this process are as follows.

The process emphasizes flexibility rather than rigid replicability. It is a process whereby the policies which are formulated as much as possible allow local officials and local people to meet local needs and encourage programmes which reflect solutions to problems that are peculiar to the specific area. This process, however, operates under constraints in the government different to those under which it operates in the voluntary sector. For a national government which must appear to be distributing resources in a fair and logical manner, programmes with community participation must represent some kind of replicability. The process, therefore, must be designed to follow general guidelines while maintaining the ability to meet local requirements. This need argues for government policies which promote decentralization for decision making.

In programmes developed by voluntary agencies, in the actual development of the process, it is easier to ensure flexibility. These programmes usually have responsibility for the health care of a relatively small area. In addition, they often have access to sums of money from overseas donors which allows much latitude to including experiments in the programme. Even in programmes where self-reliance is a goal, there is the flexibility to experiment because of the lack of financial problems. However, the voluntary agencies also operate under some restraints. A major one is that most governments insist on some type of coordination/cooperation. If the programme does not accept government relationships, then its area of operations can be severely restricted. If it does, government often attempts to impose its objective of replicability. Despite the barriers in both the government and the voluntary sectors, flexibility is a mainstay of the process of community participation.

The process begins at the policy level. This means that those who are committed to implement a community participation strategy should be able to give it support at either the government and/or voluntary-agency level, where decisions for programming are made. In addition, this process must involve, and have the commitment of, those who have the responsibility to initiate health programmes with community participation. Because there is little experience in developing community participation strategies, the process must start with the planners. Firstly, it must help planners examine this new approach to health care, to criticize and revamp the existing planning system and to define the specific steps which might be taken to begin to get the community involved. Because most present planning systems are hierarchical in nature and are not given to encourage participation of lower levels of personnel, many planners have no experience in their changing role in decision making. For this reason, the initial step in the process must help planners realize the participation potential of those who are at the lower level in the hierarchy and help them to free themselves from the traditional relationships with their own staff, other officials and with the community.

Finally, the process must be seen in terms of long-range goals rather than short-term achievements. It is often necessary to sacrifice what might seem a radical improvement in health status, for a period of education in which people unfamiliar with medical terminology and technology may learn to put these ideas into their own context. All too often, campaigns for vaccinations, for instance, get high results when first introduced. However, if second or third injections are needed, the number of people who reappear is very much reduced. Time is necessary for communities, particularly rural communities, to internalize unfamiliar ideas. If the process moves too quickly and does not become part of the new conceptualization of community people, then it is questionable whether improvement in health status, let alone community participation, has really materialized.

The readings in this volume explore in some detail the issues in the strategy and process of (what is now accepted terminology) community-based health programmes. Based on the long experience of the various authors, these essays delineate potentials and problems in this new approach to realizing health for the majority of the world's people. Although they reflect views of people from different backgrounds, cultures and countries, each essay contains two important points of reference. The first is that large-scale improvements in health will come as a result of actions by the people. The second is that these improvements must, therefore, take people rather than technology as the focus of planning activities. The challenge for development planners today is essentially how to allow the human factor to realize its potential. These essays, hopefully, will provide a deeper understanding about how this challenge can be met.

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COMMUNITY PARTICIPATION: AN OVERVIEW

In the theoretical debate about community participation in health, two distinct views have emerged. One, which reflects the traditional view of health planners, is that community participation is a means by which to deliver better health services. The other is that community participation is a means by which to change the existing social, political and economic structures that presently deny access of the poor to health care.

Both views share a number of common points. Firstly, they both believe that health services and opportunities for health improvement should be available to all members of society but, at this time in history, especially to the poorest members. Secondly, they both accept the idea that the people who benefit from health care must take an active part in planning that care. Thirdly, they acknowledge that plans for improved services and health opportunities must not only be supported by the national government but also must have contributions of local resources at the local level to make health plans adaptable to community needs. Fourthly, they accept that health plans must also reflect the ability of the government and the communities to support programmes and must not rely on technologies or activities which are neither appropriate to local conditions nor possible to support from indigenous resources. Finally, they agree that community participation is not an end in itself but a means to improve the entire life circumstances which, at present, are unacceptable for the majority of people in the Third World.

The two views, however, diverge in various respects, for example, on the *means* by which health can be improved. The first approach is based on the belief that the health of the community can be improved if health budgets are increased, the existing health system is extended and the community is encouraged to participate in health activities. The second approach argues that none of the above activities will have a noticeable effect on the health of the majority of the people without change in the social, political and economic structures which, at present, keep most people in most developing countries in a state of poor health.

Secondly, they differ in objectives. A major objective of the first approach is to find ways of providing health services to those who have little or no access to these services at present. A major objective of the second is to begin a community building process whereby the potential capacity of the local population to contribute to their own health improvements may be tapped.

Finally, it can be said that the first approach is a community development approach which focuses on providing assistance to help the community improve their standard of living. The second approach emphasizes the need to recognize and confront the political process whereby the poor can grasp the power to ensure that the community can secure and maintain control over the resources to bring about these improvements.

Göran Sterky, in the following article, develops the argument which considers community participation as a means by which health can be used to change existing structures which deny equality to the poor. In confronting the traditional view of community participation as a component of health care delivery, he challenges the dominant role of the doctor in health care decision making and argues that power must rest in the people who benefit, or, at present, don't benefit, from medical and health services. He analyzes health in terms of the Dag Hammerskjold Foundation's "Another Development" and raises some fundamental questions which must be explored if health, in its new context of a right and a human condition, is to have real meaning.

Sterky's article delineates some basic issues which Manzoor Ahmed explores in his piece on com-

munity participation in Primary Health Care (Chapter III). Recognizing that the reality in most developing countries is that existing structures are not likely to rapidly change, he tackles the problem of how to modify the existing system to work toward the "health *by* the people" objective. Ahmed has identified areas of concern common to all community participation programmes regardless of country, culture and values. His piece gives some general but very practical ideas about how to begin a strategy and a process to bring the human factor into health care.

CHAPTER II

TOWARDS ANOTHER DEVELOPMENT IN HEALTH

Göran Sterky

"Another Development" is totally people-centred. As defined and elaborated in the 1975 Dag Hammarskjold Report *(What Now)*, it means that Another Development is:

Need-oriented — being geared to the satisfaction of the individual's needs, both material and non-material.

Endogenous — stemming from the heart of each society, which defines in sovereignty its values and the vision of its future.

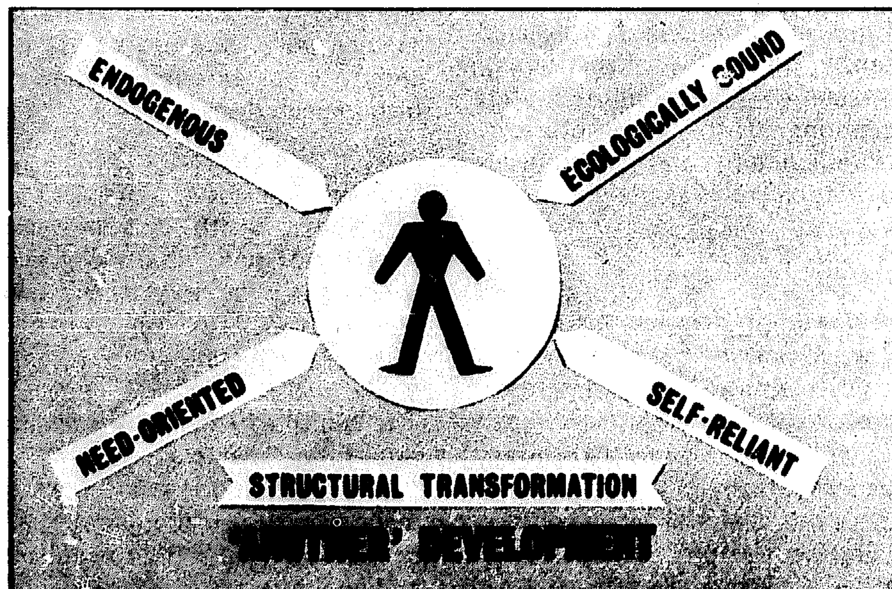
Self-reliant — relying on the strength and resources of the society which pursues it, rooted at the local level in the practice of each community.

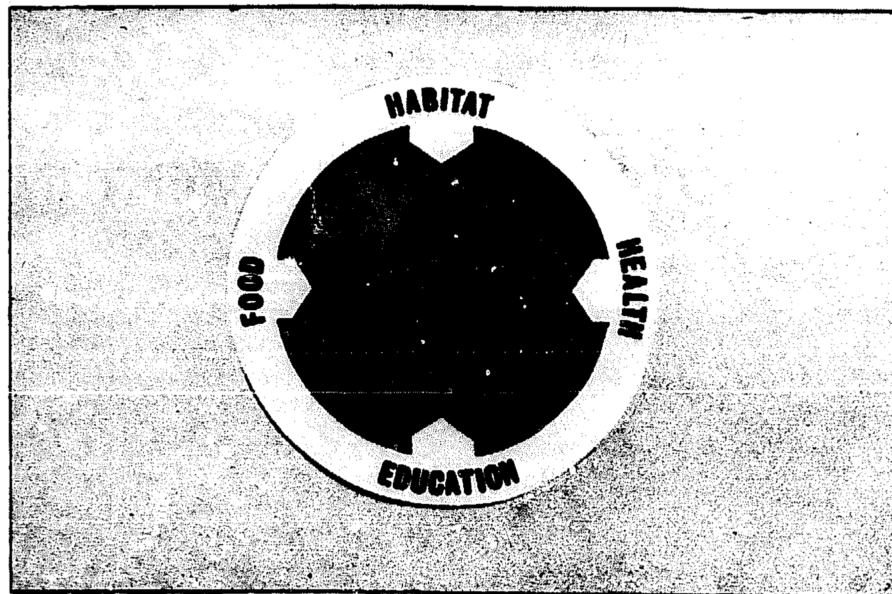
Ecologically sound — utilizing rationally available resources in a harmonious relation with the environment.

Based on structural transformations — originating in the realization of the conditions for self-management and participation in decision making by all.

These general statements are not meant to provide specific information on which action can be based, but rather to serve as guidelines. The question now is: how can we make Another Development operational?

In characterizing the need-oriented nature of Another Development it should be emphasized that, though human needs are both material and non-material, the basic needs of food, habitat, health and education should be satisfied on a priority basis. But — whether in food, habitat, health or education — it is not the absolute scarcity of resources which explains the sub-satisfaction of needs; it is rather the distribution of resources, since traditional mechanisms fostering inequality have been aggravated by the indiscriminate imitation of the economic growth model. This poses the problem and shows the necessity of structural change.





Having accepted the primacy of the *satisfaction of man's needs* in implementing Another Development, one is led to recognize the importance of finding a way to measure the quality of human life. We can take purposeful action only on specific information: how much is too little, how much is enough and how much is too much? Where is the floor and where is the ceiling?

Another Development may already be at the cross-roads: will it just amplify the rhetoric of current social-development planning or will it become operational and change and intensify the development process?

Maybe this is the challenge, and it is an exceedingly tough one. After 25 years of developmental activities by the United Nations' multiple agencies, with so many plans of action, programmes, strategies and declarations, the painful fact remains that a satisfactory range of development indicators still does not exist; and those which do exist are largely without relevance to policies and practices. The so-called social indicators have always received only cursory treatment in the shadow of economics. The system has thereby not promoted, but distorted, our perceptions of the very nature of development and has left nations and communities without the necessary tools to evaluate their own social-development efforts.

Concentrating, as we are doing here, on the role of health in Another Development, it should first be pointed out that health has, for a long time, been the exclusive preserve of a professional class – the medical profession – and that this has had certain unfortunate consequences. Thus, unlike other policy issues, health issues have not been the active concern of the community and no comprehensive view of health problems has been formulated. The inferior position usually assigned to health ministries by governments and the almost total absence of health issues in the national and international development debate is, in fact, a result of the splendid isolation in which the medical profession has preferred to perform its work.

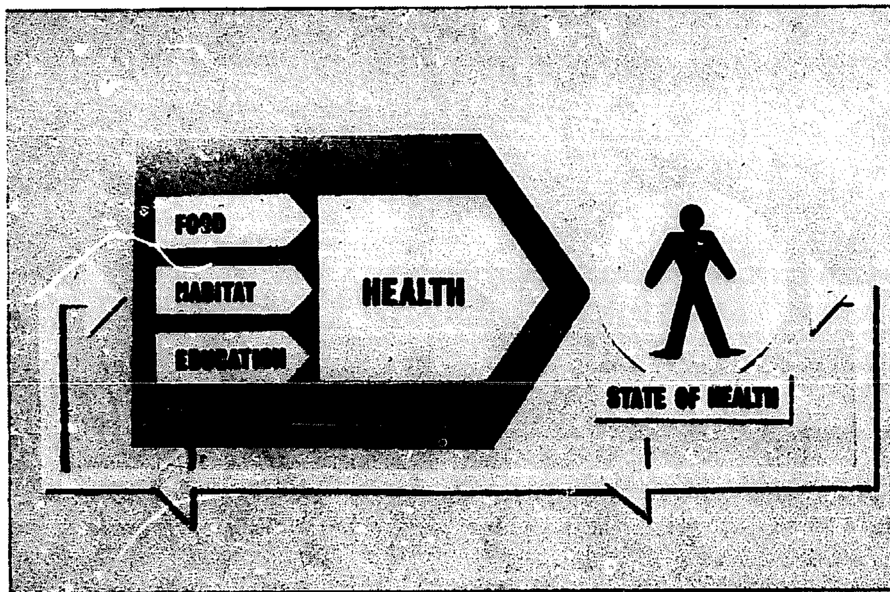
Our practical problem today is to break down the barriers created by the medical profession and willingly accepted by society and to put health in the centre of the debate and make it a real political issue.

May it be that health, in an expanded and refined definition, can be fruitfully used as an indicator of quality of life? And may it be that health promotion itself can become, as Halfdan Mahler, Director-General of WHO, has said, the very lever for development? If that is the case, our model becomes, almost by a stroke of magic, pointed, goal-oriented and dynamic.

But is our concept of health well enough defined and able to channel a massive development effort? Furthermore, how do our health services function and to what extent can they meet these new and high expectations?

Let us first look more carefully at the current concept of health. It is both strange and disturbing that, colloquially, the word health appears to have meaning for us only as the negation of a state of illness. It has no real content of its own, it has become just a state of no-disease.

The health service system, which is so often turned into a medical supermarket, displays the disease problem so predominantly that we are incapable of seeing the health problem. What exists, then, in our perception is the disease episode of the individual and not the state of health of the community.



May it be simply that our concept of health is undeveloped?

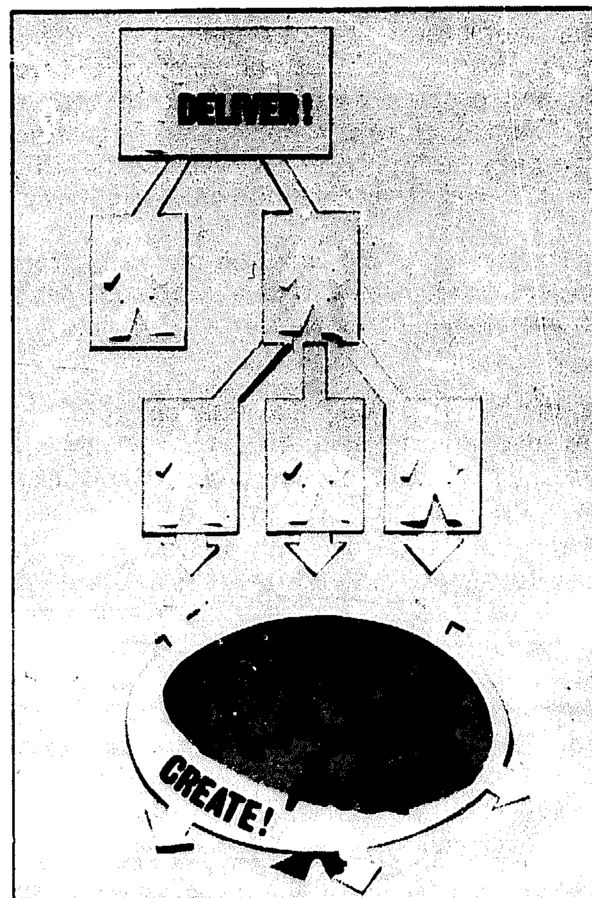
The Western doctor basically diagnoses and treats an isolated individual. He or she habitually makes individualistic assumptions about the "case" and society. Patients and human beings are mostly viewed as inherently separated from one another and from their surroundings. What do the Western health professionals know about the *concept* of health in other cultures?

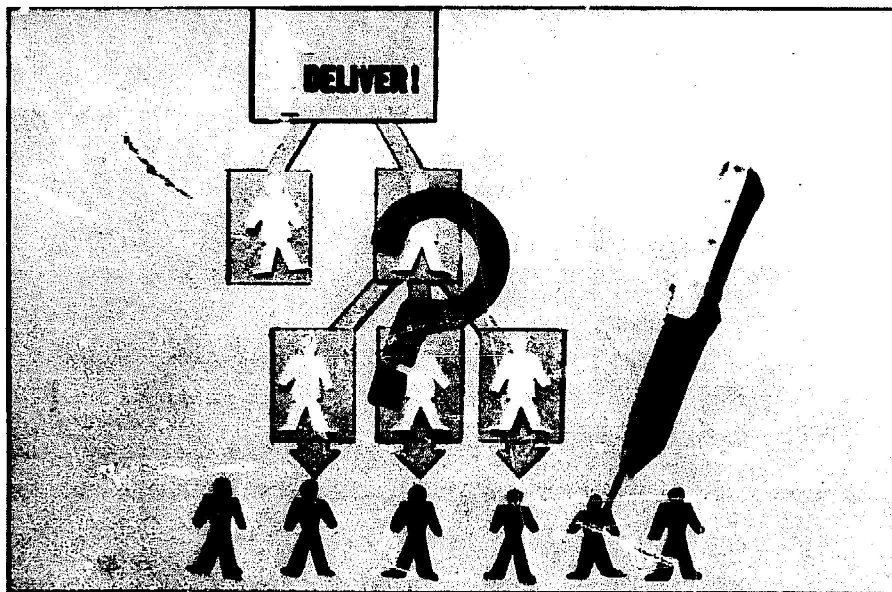
In the Zulu concept *ukuzilungiza* — health — is not a state but a continuous activity, an endeavour to restore order where there has been disorder. *Isifo* — disease — covers not only bodily ailments, but also misfortunes and vulnerability to misfortune, and even repulsiveness, the condition of people who feel they are unpopular and possible repugnant to others.

Good health is therefore not just a matter of your body being in good working order, but rather of the whole world about you, with you in it, being actively kept in a well-ordered and harmonious condition. If there is something wrong with a person, it may be in his/her body, but it may also be in the social setting or the physical environment. Good health is an expansive concept in this culture: it also comprises the community and the ecology.

Societies which, supposedly, are "ridden by witchcraft" may be closer to an understanding of what makes for a truly healthy life-style than those who patronize the world with medical technology. No wonder that the Western attempts at community medicine have always been failures. We have shown gross disrespect for the people's own health culture. Another Development in Health must begin with a redefinition of our concept of health.

Studies indicate that the diagnostician fails to note that the experience of symptoms — and the consequent decision to consult a doctor or another health worker — is as much a function of people's ability to cope with, and adapt to, their life situation as it is a biological phenomenon. What turns symptoms into medical problems are massive failures on the part of individuals to manage the stress that accompanies these symptoms. Should we start recognizing that there is not only a medical but also a sociocultural concept of health?





Valentina Borremans says: "Health is the autonomous coping with the environment". A quotation from Katherine Mansfield is also appropriate: "By health I mean the power to live a full, adult, living, breathing life in close contact with what I love — I want to be all I am capable of becoming".

The definition of health as laid down in the constitution of WHO* has been widely used, but it is not possible to apply it in its general formulation. In practice, it transfers to the physician the exclusive right to determine what constitutes sickness and lets medical technology and professional satisfaction erode people's self-confidence. There is a glaring contradiction in WHO's policy when, at the same time, it promotes the notion of Primary Health Care, based on community involvement and people's own capabilities to cope with their health problems. A sociocultural redefinition of the basic health concept is needed if health is to become the very lever for Another Development.

Our problem is to turn health care from a *professionalized service* into a *self-reliant personal care,* exercised in collective forms.

And this we must do in a situation where major health development institutions are still obsessively promoting, in their recommendations and declarations, the notion of distributing, delivering, providing or boosting health services. WHO in its work programme 1978-83 says: "If health development is an integral part of social development it would seem reasonable to *provide* (my italics) health care...". The Swedish International Development Authority (SIDA) makes the following recommendation: "The Ministry of Health needs to take extraordinary action to boost health *services* (my italics) ...". Those are examples of what we say internationally while at the same time proclaiming our belief in Primary Health Care.

This is what leads to the "landrover syndrome" which adds more to the pile of scrap iron than it contributes to the development of Primary Health Care.

We should seriously question whether our present health development institutions are suitable tools for the tasks ahead. In other words, will the technicalities of the professional bodies kill what Primary Health Care is all about?

The hospitals are isolated from the people's health problems. Ivan Illich may be right; the system has to a certain extent become counterproductive. The *delivery* of more cures and more medicines tends to make people more sick. And even worse: the "medical-service ideology" has deprived the people of their creative potential, their precious ability to act as a competent community upon solvable health problems.

The ideology of service delivery is still a strong force and one is led to ask: what did the medical system *actually deliver* to the Third World?

Does not the experience of the last generations indicate that improved hygiene and nutrition were necessary conditions for the substantial decline in mortality and the consequent growth of population? WHO now seems to have concluded that it is questionable whether infectious diseases (with the exception of smallpox) can be controlled by vaccination in a malnourished population. The impact of the syringe, the symbol of our professional potency, has been small in comparison with other factors.

Health as a lever for Another Development should be viewed in the light of the probability that the

* "Health is a state of complete physical, mental and social well-being and not merely absence of disease and illness."

determinants of health in the future and in all countries, sooner or later, will be behavioural, environmental and nutritional.

This has drastic consequences for the setting of priorities in medical research. Such research should primarily concentrate on solving health problems by the identification of behavioural and environmental factors. If we gear the research to our real needs, epidemiological and sociological methods become more important than laboratory work. The contradiction is brought out by the fact that some of the greatest successes of clinical medicine are in the treatment of conditions such as accidents, which ideally should not occur. Who shall decide the research priorities: the doctor, or society itself?

The doctor as the natural leader of the health team is no longer unchallenged. The community will eventually take over. It is not easy for doctors to accept that medicine is not vitally concerned with the major determinants of health. But let us watch out. From the belief that medicine can do everything, public opinion is in danger of swinging to the equally untenable conclusion that medicine can do nothing. Let it be said clearly, therefore, that, even if it is on a *primus interpares* basis, successful development of environmental and community health cannot be undertaken without a strong medical contribution.

But, before that can happen, the medical profession must get its own house in order.

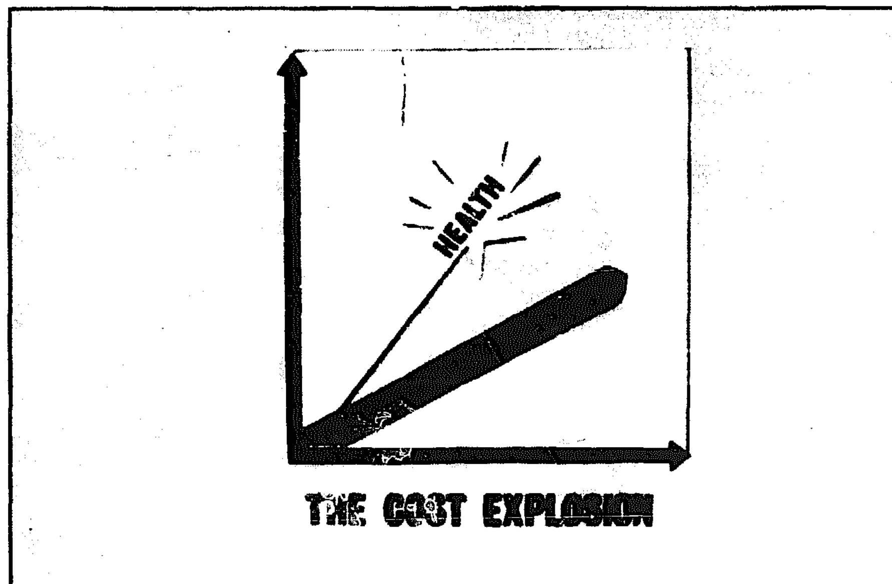
The outlook for all countries, sooner or later is that the expenditure on health services is growing faster – in Sweden now twice as fast – than the gross national product; with the growing demand for health services, their weakness is laid open.

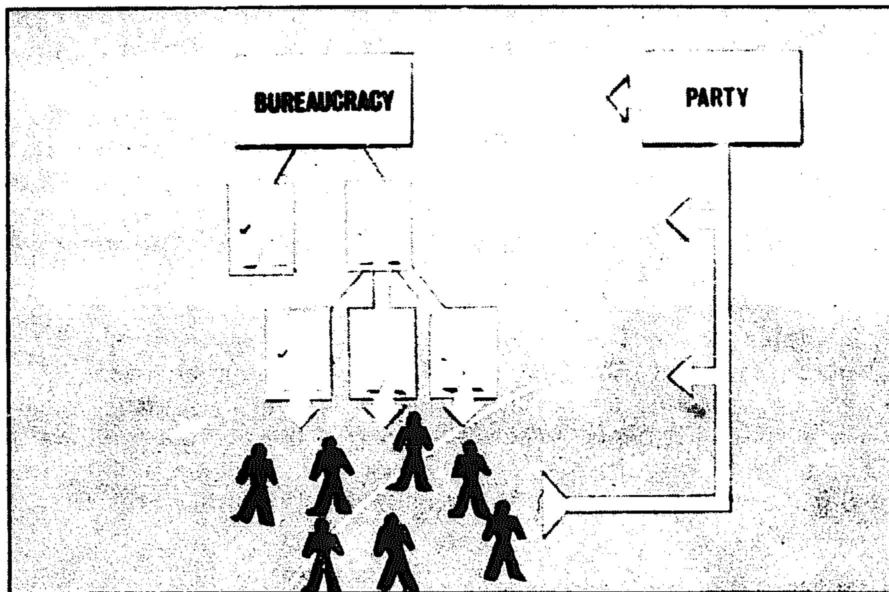
But let us recognize that "getting the house in order" does not mean a superficial attempt at increased cost-effectiveness, introducing new cost control systems, new personnel training systems or new technologies. It means a drastic restructuring of budgetary priorities with a reallocation of resources from the high-technology central hospitals to local PHC programmes. The strength of the health care system will have to be mobilized in support of the primary health workers.

How can the associations of doctors and other health workers be made to comply? Maybe the power of the doctors could be better geared to the needs of the people if there was one single labour union for all health workers?

One attempt at health house cleaning well worthy of attention was made in Canada in 1974 by the then Minister for Health, Marc Lalonde. His working document *A New Perspective on the Health of Canadians* elaborates a "Health Field Concept", which is dynamic and action-oriented. It projects with clarity the social and environmental determinants of health: Life-styles and Environment in interaction with Human Biology and Health Care Organization. But, in my opinion, it stops short of the final goal: *people's involvement.* The model remains a model for service delivery. Defining – as Lalonde does – categories of "populations at risk" in this mode of social marketing is synonymous with defining consumer target groups in commercial marketing. It is based on the notion of the passive recipient. Converted into action, it will tend to become manipulative.

Lalonde perceives the perspective and raises the doubt: "The ultimate philosophical issue raised by the Health Field Concept is whether, and to what





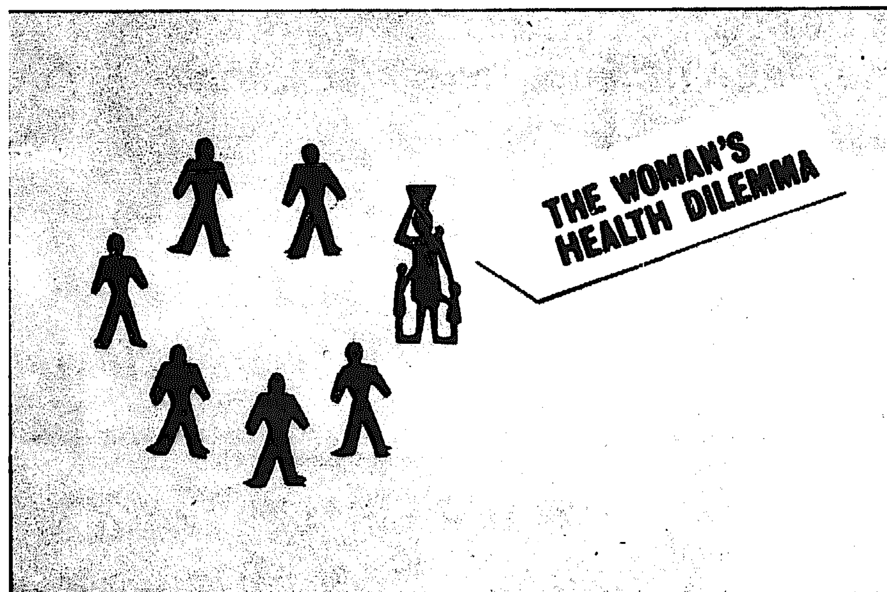
extent, Government can get into the business of modifying human behaviour".

What now about all our declarations and recommendations on Primary Health Care? Could it be that they still are stuck in the old frame of reference? In view of the empirical evidence of the failure of our health delivery systems, WHO *prescribes* a new cure: Primary Health Care, an intramuscular injection to give the old system new vitality.

Could it be that we really think that Primary Health Care can be injected into the system from outside? What shall be useful for the system must germinate and mature inside the system!

The need for community involvement is reiterated in the declarations, but in an abstract and generalized way. This is the sad result of the fact that health professionals seldom discuss social objectives.

Experience from countries which have tried Primary Health Care on a national scale shows that it cannot be implemented if the vested interests of the medical establishment are allowed to dominate. Spokesmen for these countries would insist that a plan of operation for health must include a strong party organization, controlled by the people and committed to continuous PHC action programmes, ranging from the digging of pit latrines to the promotion of breast feeding. The health bureaucracy provides technical guidance, but it needs both the motivation and the supervision of an independent political machinery. How far are health professionals willing to accept this kind of political involvement?



The role of the woman in the PHC situation is of particular significance. In the countries of the Third World, she carries, because of frequent childbirths, the burden of a mortality which is relatively much higher than the man's. Her workload is excruciating, in gardening, weeding the fields, collecting water, other household duties, and the rearing of children. In this situation of overwhelming demands on her labour, primary health and community involvement lay further claims on her. She has a key role in any programme. It seems to me, therefore, that a more equitable division of labour in society is a prerequisite for successful primary health development.

Through my experience, both in the Third World and in my own country, Sweden, I have come to the conclusion that what characterizes our health development problems and their solutions, although seemingly so different in nature, is that they have so much in common. For me, the central problem — and the solution — is people's participation, the creation of a relationship of trust, which subordinates health work to the needs of the people and thus marks an important step not only towards Another Development in health but towards Another Development of society.

CHAPTER III

COMMUNITY PARTICIPATION, THE HEART OF PRIMARY HEALTH CARE

Manzoor Ahmed

THE PRIMARY HEALTH CARE APPROACH AND COMMUNITY PARTICIPATION

Several essential features of the Primary Health Care (PHC) approach, as it is generally understood, define the nature and scope of community participation in PHC programmes.

A health system directed towards the grassroots

First, the PHC approach requires that health-related activities be shaped and carried out in conformity with the life pattern, needs, priorities and capabilities of each community. This contrasts with a mere downward extension of the standard national health service practices which, in any event, has proved to be difficult and ineffective for a large majority of people in the developing countries. The organizational structure of the health service will have to make a shift from drawing clients to a hierarchy of central service locations (thus limiting the numbers served and kinds of needs addressed) to an organization that, essentially, supports and provides back-up for services organized and performed in the communities. With this perspective of the health service structure, the centre-periphery analogy becomes not only inappropriate, but smacks of a relic from conventional ideas of the past (even when more services at the "periphery" are advocated). The basic thrust of the PHC approach is that the centre of gravity of the health system should shift from central urban locations to local communities.

Community input, a crucial element

Secondly, communities, according to their capacity, need to mobilize human, financial, and material resources to supplement the resources provided by the national government and other extra-community sources in order to effectively carry out local health improvement efforts. Selected community members with a minimum of training, fully or partially supported by their respective community, are the frontline workers at the point of contact with the beneficiaries.

Primary role of local people

Thirdly, in the preventive and promotive aspects of Primary Health Care, the community people are the main actors, with the health service and extra-community agencies playing only a supportive role. Collective and individual decisions and actions by community members, with appropriate assistance and input from the government, determine the effectiveness of the efforts in respect to sanitation, nutrition, environmental hygiene, supply and use of pure water, precautions against communicable diseases, and family planning.

Community coordination of concerted effort towards better health

Finally, the PHC approach recognizes that the health status of a community is affected by many non-health factors, including access to such essential goods and services as food, clean water, shelter, clothing, and basic education. These factors together have more influence on the health and overall welfare of the people than all the measures that could be taken by the health service. Health care provisions constitute a necessary, but not sufficient, condition for improving the people's welfare. The integration and coordination of the different sectorial activities necessary for making an adequate and sustained impact on health can be brought about effectively only at the community level through community action and organization.

It is evident that popular participation in health-related activities is the essence of the PHC approach, and that it implies much more than passively benefiting from the government health service.

DIMENSIONS OF COMMUNITY PARTICIPATION

A community, for the purpose of organizing a PHC programme or other development programmes requiring strong community involvement, may be defined as a group of people which has a sense of belonging to the same entity, has a common perception of collective needs and priorities, and can assume collective responsibility for community decisions. The collective participation of communities in Primary Health Care assumes different forms and varies in effectiveness and intensity.

The major dimensions of community participation include at least the following:

The organization of services on a community basis, with wide and easy access to the services. This may range from rudimentary services and a mere intention of eventual community-wide coverage, to adequate provisions for basic health needs and truly universal coverage of all community people.

The contribution by the community to the operation and maintenance of the services varying from small voluntary contributions in cash and in kind to supplement government and other external resources, to almost full coverage of costs through the systematic allocation of communal resources and individual payment.

The participation of the community in the planning and management of the services within the community, which may consist of only an informal and occasional consultation by health service workers with a few villagers, or the assumption of full responsibility for the programme by a representative community body.

A community input into the overall strategies, policies, and workplan of the programme, which may range from unsystematic efforts by well-intentioned government officials to understand varying community situations, to a systematic arrangement for the participation of community people in policy making and planning at regional and national levels, and for regular feedback of pertinent programme information from communities into the decision-making processes at different levels.

The overcoming of factionalism and interest conflicts in the community in order to achieve a broadly-based participation, particularly on the part of disadvantaged groups. The situations in this respect may vary from attempts to serve various subgroups as equitably as possible, recognizing the reality of interest conflicts within the community, to the emergence of cohesive communities capable of engaging in cooperative efforts for the benefit of all.

DISCERNIBLE PATTERNS IN EFFECTIVE PROGRAMMES

The work of the joint review committee of the WHO and UNICEF Secretariats and other recent studies of community participation in rural development efforts, including Primary Health Care, have made it possible to discern broad patterns of predisposing conditions in the larger society and factors internal to the operation of the programme which enhance effective community participation.[1]

A national commitment to meeting the people's needs

It has been possible to make substantial progress towards adopting and implementing the PHC approach on a national scale with a high level of community involvement in situations where the national political structure has made it possible to mitigate the effects of the system of privileges and the unequal social and economic relationships within rural communities, and to commit national resources to the basic needs of the common people. In the absence of such an overriding national commitment, genuine community involvement can be generally found only in small-scale programmes in specific locations, guided by highly dedicated individuals with charismatic leadership qualities.

A strong national commitment, reflected in clear and forceful central government priorities, policies, programme objectives, and general programme decisions in favour of Primary Health Care and other basic needs can go hand in hand with a high degree of decentralization of planning, management, and operational decisions to the regional and community levels. UNICEF/WHO studies describe examples of strong community involvement with decentralized management within the framework of unified national programmes in the People's Republic of China, the Socialist Republic of Viet Nam, Cuba, Tanzania, and Yugoslavia.

Primary allegiance of health workers to the community

In relatively effective examples of community participation, as in the UNICEF/WHO studies, the frontline health workers — trained for specific, essential, and widely-needed tasks, and given continuous support by a hierarchy of paraprofessional and professional health workers — belong to the community they serve, are chosen by it, and are fully or partially supported by it. In an effective programme, the health worker is accountable to the community, and his/her primary allegiance is to it rather than to a government department.

In many programmes, it is the traditional birth attendants and healers who have become the frontline workers. Examples of traditional birth attendants with some training and supervision being

utilized for family planning services and maternal and child health care are found in many countries, though not always in the context of a comprehensive PHC programme.[2]

Mobilization of the community's resources

Substantial financial and human resources can be mobilized from the community, some of which may otherwise remain unused, such as the enthusiasm and energy of youth and women for community action. Communities with institutional structures such as a local government council, a cooperative society, or a commune, which have a degree of control over the community's productive assets, can mobilize resources for community purposes more easily than those relying on voluntary and individual contributions. In underdeveloped rural communities, what they can mobilize can be only supplementary to resources provided by the national government and other external sources. *The primary health care strategy is not a means for reducing the share of national health care allocations for rural areas, but a way of utilizing effectively the resources a nation can afford for health care.*

The Chinese and Vietnamese communes, for instance, shoulder most of the local health care costs out of their own resources. In voluntary projects in Bangladesh, India, and Guatemala, for example, small regular contributions by rural families subscribing to a kind of "group health insurance scheme" cover up to one-half of the total costs for Primary Health Care in the community.[3] The remaining half or less can be more than covered if a portion of the per capita national government expenditure for health is redeployed to the PHC programme. The result can be a radical improvement in the quality and coverage of health care for the rural people.

Strong local institutions and cross-sectorial activities

Community participation in its various dimensions is more likely to be found in situations where local organizations — an area development agency, a local government body, a voluntary society, or a commune — have wider development responsibilities than just one or more aspects of health care, although special local committees or groups may be formed for health-related activities under the aegis of the parent organization. Since the interests and needs of people transcend sectorial jurisdictions, genuine community participation on the basis of people's interests and needs calls for integrated, cross-sectorial development efforts, at least at the community-level.

It is interesting to note that many of the small-scale non-government programmes included in recent case studies started with only a health focus, but soon attempted to expand their scope of activities into agricultural production, basic education, women's programmes, etc., as the interrelationship between health and other basic needs became obvious. While voluntary programmes can cut across sectorial boundaries, depending on their resources and concept of development, integration and coordination of government programmes, with their necessary jurisdictional limits, call for strong local government structures or other local institutions capable of overseeing various sectorial activities at the local level.

Problems in multiplying the impact of small-scale projects

In many developing countries, non-governmental voluntary organizations have played an important role in introducing participatory processes and forming participatory institutions in the context of their own health care and rural development programmes. However, their impact has often been limited in the absence of political and economic structures sufficiently conducive to a vigorous national effort to pursue the PHC strategy in conjunction with a basic needs-oriented national development policy.

Dedicated and able local leadership has almost invariably been vital in the success of the voluntary programmes. These small-scale programmes with positive experience in community participation appear to share the problem of how to transfer the lessons of their own experience to large-scale public programmes and how to multiply the impact of their efforts. Collectively, however, the small-scale programmes have made an international impact in heightening the awareness and demonstrating the possibilities of the community-based primary health care approach.

OBSTACLES TO COMMUNITY PARTICIPATION

The recent studies of PHC programmes as well as the historical review of broader community development efforts point to many obstacles in the way of cooperative community action for self-help and the growth of the participatory process:

Diversity of interests and priorities due to social stratification

One basic problem is that the group cohesion and similarity of interests and perception necessary for a collection of people to behave like a community are far from universal phenomena. The rural areas of developing countries are often characterized by a highly uneven access to productive resources such as land, water, and capital; traditional social stratification and separation based on castes, ethnic origin, religion, and sex; and political and economic institutions and practices that reinforce the existing structure of privileges and create new privileged groups.

The "quack" medical practitioner, the usurious money lender and the large landowner may be the same person in the village; or if different persons, they will have a common interest in maintaining the status quo that preserves the system of privileges contrary to the interest of the rest of the villagers. Even such a seemingly innocuous change as the introduction of community-selected health workers may pose a threat to the existing village power structure and open a floodgate of social change, especially if the innovation calls for the democratic participation of all the village people, unless, of course, the whole process can be sufficiently controlled by the village "notables". The interests, priorities, and perceptions of problems of the different interest groups in the village may not be similar at all; in fact they may be in serious conflict.

The unhappy reality in many developing countries is that, unless the structure of privileges and highly unequal social and economic relationships among the people are swept away by prior change in the national political structure, the creation of a community spirit, the articulation of community aspirations, and the people's participation in the planning and management of community programmes can progress only falteringly and in limited ways.

Projects are often cited as examples of community participation in situations where the national political system has not yet established the basis for cohesive communities and has not removed the barriers to community participation; however, sometimes a closer examination reveals that, even in these projects, community participation merely means giving a voice in local decisions to the local influential people, rather than to the most needy and the deprived who may constitute the majority. It may also be found that a disproportionately small share of the services and benefits go to the neediest. In other instances, community participation means seeking the local people's compliance with predetermined central plans and programmes and extracting financial and other contributions from them, rather than a genuine partnership between the government agency and the people.

Administrative resistance to decentralization and redistribution of benefits

Even when the general principles and objectives of Primary Health Care and community participation are accepted in terms of overall national policies and goals, the tradition and attitudes prevailing in the governmental bureaucratic machinery often stand in the way of their translation into concrete action. This tradition is reflected in the unwillingness to decentralize the administrative structure, to entrust authority and responsibility to community people, and to make government programmes and personnel accountable and answerable to the people they are supposed to serve. This tradition, of course, is supported and maintained by the stratified social structure that separates the rural masses and the educated, urban, and relatively privileged people who staff the government system, including the health services. It may be argued that the bureaucratic inertia and the inability to translate rhetoric into action are indications of less than full national commitment to a PHC strategy with community participation; and of an unwillingness to probe, understand, and accept the full implications of such a commitment.

Failure to reorient entire health service to Primary Health Care

The PHC approach can be undermined and communities can become victims of cynicism and despair, if the nominal adoption of the PHC strategy leads to a dichotomy in the health service structure: "barefoot doctors" and "self-help" for rural people and the poor, and hospitals and medical specialists for town dwellers. It is not always easy for the health establishment and national decision makers to accept that the whole health service has to be reoriented to the demands of Primary Health Care and that PHC needs must have the first call on national health resources. The surest way to discredit the PHC approach and dampen community enthusiasm for it is not to provide adequate support to community-level activities in the form of supervision, training, essential supplies and an efficient referral arrangement.

Difficulty in mobilizing previously uninvolved populations

In situations where there is no tradition of community involvement in development efforts, and adequate local government structures or other local organizations do not exist, it is a difficult and slow process to create the mechanism and motivation for community participation only in respect to health care. It becomes a pioneering effort, and to sustain the momentum and motivation, the organizers of the health programme must make an effort to extend community participation to other spheres of development.

The dilemma, however, is that the absence of local participatory institutions in the first place can be usually traced back to a national political and economic system that does not encourage decentralization of governmental responsibilities and does not offer the climate for active community roles in local development.

ELEMENTS OF A STRATEGY FOR COMMUNITY PARTICIPATION

Assuming that there is a general acceptance at the national level of the PHC strategy and the importance of community participation, and that

there is a willingness to reorient existing policies and programmes accordingly, a process can be initiated and a number of practical steps can be taken to enhance community participation in a PHC programme.

1. Reorientation of the health service structure and personnel

One essential step is the evaluation of the capacity and limitations of the existing structure for delivering Primary Health Care, the adoption of appropriate remedial measures, and the instilling among the health service personnel of attitudes and perspectives in conformity with the principles of community participation and the new role of the health service. The most difficult task is not identifying the shortcomings of the present health service, or the changes needed in its organizational structure, but changing the attitude and values of the personnel who have to implement the new mandate for the national health service.

An approach that should prove effective in bringing about the necessary change of outlook among the health personnel and, at the same time, in introducing the necessary reforms in the health service, is to engage the health personnel themselves – from the top planners and managers in the ministry of health to the lower-echelon medical professionals in the field – in a process of self-appraisal and self-education. Small mixed teams of health personnel from the national and regional offices can go out to representative rural areas in the country to investigate the health status of the people, the performance of the government health service in relation to their basic service needs, the functioning of the traditional health system, the amount that villagers spend (or misspend) for health care, the opportunities for mobilizing financial and other resources in the village for health care, existing village institutions as possible underpinnings for village-based and -managed health programmes, and so on. Personnel from individual health institutions such as the hospitals, research centres, training institutions, and departments and units of the health service can examine and analyze what they can do to reorganize themselves, to redefine their functions and goals, and to produce the needed manpower for implementing a PHC strategy with community participation. The results of the investigation and appraisal can be compared and analyzed to identify and formulate the plan of action at different levels and for different parts of the national health service. It would be as much a process of discovering the facts about the health service and preparing plans for the system's reform, as of reeducating the personnel.

Encouraged and prodded by the minister of health, with the support of other top government and political leaders, and with appropriate guidance regarding the crucial health issues and the direction of change, the process of self-appraisal can become a kind of national movement from which can emerge a workable plan for a community-based PHC system, as well as the necessary health service personnel willing and able to guide the plan's implementation.

2. Diagnosis of the situation in individual communities

Following the national appraisal and the formulation of a national strategy, an early necessary step is a diagnostic exercise to identify and assess pertinent factors that affect community participation in particular localities.

The essential elements of the assessment are:

– *Study of the various groups within the community.* The basis for selecting the aggregation of population that can effectively organize itself for community participation can then be determined. Prevailing administrative units, natural geographical boundaries, and cultural affinity are important considerations in this respect. While existing social divisions need not be reinforced, factors which help generate a sense of community should be taken advantage of.

– *Survey of the community's resources and constraints.* Its general socioeconomic situation, the productive resources and potentials, the status of the social services and institutions, the condition of the poor and disadvantaged segments of the population, and the community's social structure need to be studied. These factors will determine the environment of cooperative development efforts in the community, the nature of prospective community involvement in development activities, and the potentiality for mobilizing the community's resources.

– *Survey of the community's health status and health care needs.* Basic objective information about the health situation – disease pattern, age-specific mortality, birthrate, sanitation and water supply, nutrition status, the nature and extent of available indigenous medical care – needs to be supplemented by the population's subjective perceptions about the most serious health problems and the most urgent health care needs. This information provides the basis for deciding on priorities for the community's health care programme and for organizing appropriate motivational and educational action.

– *Examination of the adjustments needed in the nationwide strategy* for Primary Health Care. A rigid nationwide uniformity of approach is neither practical nor in conformity with the principle of community participation. The diagnostic exercise should provide the basis for responding to the variations in the circumstances

Salgado/Christian Aid

A new health promoter at his post in the community of Alaspongo, Ecuador.

of the local communities within a framework of national objectives and performance criteria.

Basic diagnostic tools: self-appraisal and dialogue

This diagnostic exercise should not become an elaborate social science research project costly in time, money, and expertise, and beyond the means of local communities or even many national governments. At the initial stage, however, the health service personnel and other concerned agencies have to develop and learn a diagnostic methodology by engaging in a "learning-by-doing" process. The self-appraisal project mentioned above will provide useful experience for this exercise. Social scientists from universities and research organizations, with special interest in rural and community development, can be of assistance.

Eventually, the diagnostic exercise should become a fairly simplified, quick, and relatively standard process, carried out under the guidance of a local administrator who is responsible for supervising the community health workers. This simplified diagnostic method can be applied to all communities as the community-based health care system expands nationwide.

True to the spirit of community participation, local people should be extensively involved in the diagnostic process through formal and informal dialogue and discussions, and the findings and conclusions of the exercise should be validated and verified through this interaction.

3. Devising and improving modes and mechanisms of participation

In situations where a community is a political and economic unit with wide jurisdiction over local government and productive activities, or where a strong representative local government body has substantial authority and responsibility for local affairs, the institutional structure for community participation in respect to health care already exists. In these situations, the main concern would be extending the benefits of the programme equitably, making the participatory bodies truly representative, coordinating the health activities with other development efforts, and improving the overall quality of health care; in other words, improving the functioning of the existing participatory institutions.

Where the institutional structure does not exist or the local government body is without substantial authority, an appropriate participatory mechanism has to be devised or existing weak ones have to be rejuvenated. On the basis of a national appraisal and the local diagnosis, it has to be determined to what

extent traditional and existing institutions, whether formally or informally constituted, such as village councils, neighbourhood associations, youth and women's groups, can serve the purpose; what modifications may be needed in existing institutions to ensure effective and fair participation; or whether new mechanisms are required. When new institutions need to be devised, initially, at least, the scope of participation will be narrow and limited to the health programme. Eventually, these new institutions may evolve into multisectorial participatory organizations, provided the communities so desire and the government policies support such a move.

Balance between local responsibility and government protection of the weakest

In all situations, opportunities and the right conditions must be created for a free expression of views and genuine dialogue. It may be necessary for the health service and the community representatives to jointly set some guiding principles and criteria regarding democratic community representation and equitable sharing of responsibilities, obligations, and benefits. These criteria should not lead to frequent bureaucratic interventions in local programme activities and the stifling of local initiatives. However, the health service or appropriate national government agency must ensure that the vital interests and rights of the weak and the needy in the communities are not violated by local decisions.

4. Use of the educational process

– *in conscientizing the community.* In addition to the usual health education activities, and distinct from the training and retraining of different types of health workers in the community, a continuous and vigorous educational effort is needed to get across to the people — accustomed, on the one hand, to the bureaucratic neglect of their plight and, on the other hand, to a paternalistic handout approach in government services — the premises of the PHC approach, the obligations and responsibilities of the government and the local people, the principle of accountability of the programme and its workers to the community, the tenets of democratic participation and sharing of obligations and benefits, and the need for the community people to organize and prepare themselves for greater self-management of community affairs.

  This educational process does not necessarily require special "educational" activities; rather, an educational approach needs to permeate all the activities of the programme. The participatory process itself through the opportunities for dialogue, discussion, and involvement in planning and decision making becomes an educational process, creating a critical awareness among the people of the roots of their problems and of approaches to tackling them. All the workers of the programme must become educational workers as well, and the educational dimensions of all programme activities must be identified and given recognition in the planning and implementation phases.

– *in preparing the workers.* The educational process, obviously, is not a one-way street. The programme workers and organizers at the local level and above also have to learn to understand the local environment and the socioeconomic structure, the ways of promoting and supporting local initiatives, and effective approaches for communication and education. The training and preparation of the community-level workers and their supervisors have to take into account not only their technical tasks, but also their educational responsibilities. The workers have to be made aware of their educational role, and encouragement and opportunities given to play that role. Together the community and the programme personnel must learn to work effectively to improve the people's health and welfare.

– *in conveying health-promoting information.* The educational approach for the enhancement of community participation, to have any substance, must be accompanied by a strong emphasis on the health education component in the local health programme. The community-based health workers themselves have to be convinced of the environmental origin of the common diseases; designated health education tasks have to be identified and made part of the normal routine of health workers at the community level and above; and the health workers have to be ready to take advantage of all local organizational media such as women's and youth groups, adult education groups, and primary schools to disseminate health information and to discuss actions the community people can take collectively and individually to improve their health situation.

5. Cooperating with voluntary organizations

– *in organizing innovative projects.* The special characteristics of small-scale non-government projects run by voluntary and non-governmental organizations make them good instruments for testing and developing innovative community participation approaches that might be difficult and costly to try in large-scale public programmes. A practical way of facilitating the application of the lessons from these experiences to government programmes would be to embark on a "joint venture" by the government and the voluntary organization. Pilot projects can be organized in one or more specific locations once the viability of an idea has been demonstrated in small-scale projects, and some basic criteria of

viability and feasibility (such as compatibility of objectives between the private projects and a national programme, the cost structure, etc.) for their large-scale expansion appear likely to be met.

– *in ensuring the participation of the disadvantaged.* Besides being the testing ground for innovative techniques, voluntary organizations can also serve as an institutional mechanism for promoting the participation of the disadvantaged and the weak segments of the population in the local government structure and other local planning and decision-making bodies. Local voluntary organizations, through their conscientizing actions and efforts to organize homogeneous interest groups among the poor and the deprived for collective self-help activities, can prevent the local decision-making bodies from being captured by the powerful minority. The voluntary organizations can serve as complementary primary organizations and, to a degree, as the countervailing force for community-level and regional planning and decision-making institutions.

6. Experimentation and phasing of development to the community

The implementation of a PHC approach with effective community participation has to be viewed as an evolving process. While it is important to adopt appropriate national policies and objectives and to demonstrate national commitment by launching a nationwide programme, it may not be possible to totally reorient all at once the existing health service, to solve myriad operational problems, and to make the right choices in many novel situations. It may be advisable to introduce the different dimensions and levels of community participation in phases as both the community people and the health service personnel learn from experience and grow in skills and confidence.

Even in a nationwide programme, selected representative localities may be designated as experimental zones where the operation of the programme may be closely monitored, variations in certain practices tried out, and the impact of the programme analyzed, the results of which then can be used to improve the whole national programme. The experimental zones may be the testing ground for such questions as the interrelationship between the health-oriented participatory institutions in the community and other development needs, the degree and nature of local management responsibility, the health-related problems in the community which can and should come under the purview of the health programme, the amount and kind of resources which can be mobilized locally, the education and training strategies, the role of the voluntary organizations, the maintenance and improvement of the quality of service, and the collection and feedback of pertinent service and evaluative information.

A high-level task force or unit at the national level (or at the regional level in a large country) has to be entrusted with the responsibility for determining the experimentable issues, planning and guiding the experiments in collaboration with the regular health personnel in the zones, monitoring and assessing the results, and examining their policy implications.

7. International action in support of PHC

International, bilateral, and other external assistance agencies supporting the adoption and implementation of the PHC approach in developing countries can enhance the effectiveness of community participation in various ways.

– *Consideration of the needs of the poorest in project aid.* The issues and concerns related to community participation, including access of the poorest in the community to the health programme and the democratic representation of all segments of the population in the participatory process, can be raised and explored in considering all assistance projects.

– *Encouragement of experimentation to improve PHC.* International assistance should encourage and support activities with multiplier effects on the quality of community participation in expanding PHC programmes. Such activities would be the management of experimental zones as mentioned above, cooperative pilot projects by government and voluntary organizations, development of means to improve the skills and understanding of health administrators and workers in promoting community participation, and establishment of diagnostic and planning techniques for community programmes.

– *Support for international and regional information networks.* International support should be provided for activities which require international and regional cooperation, which are not easy to undertake for individual governments. Such activities may be the regional and international exchange of ideas and experiences through workshops, seminars, study tours, and the exchange of training materials and other documents; the identification, monitoring, and evaluation of significant experiences for the benefit of all struggling with comparable problems; and the comparative review and analysis of regional and international experience in health care and community participation.

– *Self-evaluation in terms of effectiveness in promoting community participation.* International and other external agencies need to examine critically their own responses to need for

assistance and their effectiveness in promoting community participation in health care programmes. They need to examine their own organizational arrangements, institutional practices, and personnel capabilities, and consider ways of equipping themselves to face the mounting challenge of ensuring adequate Primary Health Care for every community.

– *Collaboration among UN and bilateral agencies.* WHO and UNICEF, having taken the lead in promoting the PHC approach and drawing attention to the role of community participation in this approach, should explore ways of cooperating with other UN and bilateral agencies in promoting the concept and practice of community participation for development.

MAKING PARTICIPATION MORE THAN EMPTY RITUAL

It must nonetheless be remembered that community participation is not an end in itself. The ultimate aim is to deliver better health care and to increase people's welfare. This is the ultimate test that has to be applied in judging the value and effectiveness of participatory activities. Unless it contributes to the improved health and welfare of the community, the participatory process becomes empty ritual and token gestures.

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3. International Council for Educational Development, "Case studies of BRAC and Savar Projects in Bangladesh, and Social Work and Research Centre Project in Tilonia, Rajasthan, India" (Drafts); K.W. Newell (ed.), *Health by the people,* WHO, Geneva, 1975.

COMMUNITY PARTICIPATION: A STRATEGY

Much has been written about the reasons for the need to include community participation in health care planning. Among these reasons are the need to increase scarce health resources by utilizing community resources such as local personnel and traditional medical treatments which heretofore have been ignored; the commitment of a community to carry out health plans in whose formulation it has been involved; the value of using local people to teach their neighbours about good health behaviour and the motivation of these people to stay and serve in their communities rather than moving up the ladder of professional advancement. All these reasons are valid whether community participation is viewed as a component or the context of health service delivery.

The difference in the two approaches is whether the community is the subject or object of health care planning. It is not a matter of the degree of participation, that is, whether the community leaders are asked their opinion about health care or work with the planner to formulate activities. It is basically a question of whether the community actively takes part and makes choices about resource allocations or remains passive only to be consulted by the experts. A strategy for the former, as we have already noted, develops in a completely different context than the latter.

This section looks at specific strategies for community participation. The first two selections present the broad framework in which the other three health-related case studies might be viewed. Marie-Thérèse Feuerstein discusses the links between community development and health care programmes. Using the framework of community development which grew out of the Anglo-American experiences in the first half of the 20th century and became adopted by the UN in the 1950's, this piece explores the relevance of the community development principles to rural health work. By looking at this strategy, Feuerstein places health work in a new context. It is a context which sees health improvements more as a learning process than a transfer of technology; more as a result of community motivation than of increased numbers of trained medical personnel.

Mary Racelis Hollnsteiner looks at the power relationships of a strategy for community participation. Analyzing six modes of participation from peripheral involvement of the community to grassroots decision making, she discusses various policy implications for planners who are going to develop this type of strategy. In doing so, she presents a typology of degrees of community involvement. This article assesses participation in human settlements rather than health, but the framework remains relevant to health planners.

The remaining three selections document strategies specific to health care in three different countries in three different parts of the world. From Asia, D. Banerji discusses a possible alternative health care system for India. Within the framework of political economy, he surveys the history of health service development in India and notes its failure to improve the health status or health (a distinction which he develops) of India's poor rural majorities. He explores the alternatives and suggests important immediate actions which particularly concern use and deployment of personnel.

Merces Somarriba's article explores the problems and potentials of a community participation strategy which emerges from a traditional, capitalist, medically-oriented society when one of the government units takes seriously the dictum of health *by* the people. By examining the effectiveness and efficiency of health care, she develops a conflict model of decision making in community participation that emerges from a situation where government and communities do not share the same objectives. The study, an original piece based on

Somarriba's PhD thesis, highlights points of tension likely to develop in any country where the existing socioeconomic political structures impede the realization of the goal of community participation.

To gain a perspective of a strategy for community participation in a strict interpretation when shared and promoted by a national government, Budd Hall describes the mass campaigns for health improvement in Tanzania. Referring to the Chinese experience, he discusses how sharing the Chinese view of the potential of people at the grassroots, the Tanzanians attempt to develop an educational process to bring out this potential. Although mass campaigns have had a history of use for disease control in various countries, they have not been seen as a strategy to change the people's views of their society and themselves. Hall's study analyzes the direct relationship between health care and social change.

RURAL HEALTH PROBLEMS IN DEVELOPING COUNTRIES: THE NEED FOR A COMPREHENSIVE COMMUNITY APPROACH

Marie-Thérèse Feuerstein

A Multitude of Definitions

The term "community approach" is much used at present among those attempting to confront the problems of rural health in developing countries. But interpretation of the term varies widely.

There is, for example, an increasing tendency to regard a community as the "patient", amenable to "community diagnosis" with treatment "prescribed" accordingly. This is regarded as one type of community approach.

A further type is where a vaccination campaign attempts, as an initial step, to gain public approval and cooperation. There appear to be few attempts to formally define the term and it is generally presumed to be understood, albeit in a vague manner.

However, the term "community development" or CD is *not* always understood by those engaged in rural health activities. CD is a specific approach, a pattern of well-established practices emanating from certain basic principles, attitudes and objectives. And, although often in operation in close proximity to rural health activities, health personnel are frequently unfamiliar with its implications.

CD and Health – Some Links

In 1954, the WHO Report on Health Education (TRS89)[1] did *not* emphasize the need for any special knowledge of the CD approach. However, by 1958, a further report in the series (TRS 156)[2] pointed out that training in health education should be made available to workers in other fields including CD and that health workers had the responsibility to assist with CD programmes. Thus in 4 years, CD had not only been recognized, but special training in this field was felt to be an essential part of the training of all health workers.

In some developing countries, the CD approach has, in fact, been used in rural health improvement activities, as for example well and latrine construction projects. But it has not been used extensively and *never* in its most comprehensive sense. Rather, a few techniques have been "borrowed" in order to achieve certain health objectives. There is evidence to suggest that today, where CD *does* form a part of rural health activities, it is usually regarded as being distinct from them and slightly oblique to the health activities. For example, in a Korean rural health project, "a community development effort (was envisaged) to encourage the local residents to participate in cooperatives and other self-help projects".[3] And from a Nicaraguan rural health project, "The community development workers will try to create an awareness of the possibility of progress to replace the apathy which is at present a brake to development."[4]

In the main, rural health activities (both curative and preventive) have often been "prescribed" without any trace of popular consultation or participation.

"There are far too many examples of social indifference and even arrogance on the part of the health professionals towards the consumers... this is one of the root causes of the under-, or improper, utilization of health services... It is most important that the consumer's social preferences, needs, interests, aspirations, goals and values should be identified... and that these aspects are allocated a carefully considered and reasonable weight in the planning and implementation of health care..."[5]

The Search for New Approaches

In Nigeria, a cholera prevention programme attempted to influence the members of one rural community individually – in the traditional manner – while in another, it aimed at securing community approval. It was subsequently found that, in the first community, 45% of the population reported for vaccination, while in the latter, 73% of the community responded.[6]

Controversy continues today as to which particular "community" approach is the most feasible, preferable or desirable.

At a symposium in 1970, Professor Maurice King enjoined health personnel to "peer over the top of the accepted and look round the edges of the conventional... our predecessors used their microscopes well; our challenge is to use the instruments of our time with equal determination and with equal vision".[7]

While many health personnel are by no means reluctant to consider "peering over the top of the accepted" in the search for new and more effective approaches to the problems of rural health, the very magnitude and complexity of those problems appears to weigh the scales heavily against them.

Rural Health Problems – The Context in Which They Occur

The young mother of five children was carried into a rural dispensary, after many hours journey on a makeshift stretcher. Having been in labour for two days, she was unable to give birth to her twins. The personnel and facilities of the dispensary could not provide the caesarian operation that she needed. By the time she was carried into the nearest health centre, both she and the twins were dead.

The factors of poverty, isolation, and lack of adequate basic health facilities conspired to produce this tragedy, based on fact.

Other factors which continue to characterize rural life in tropical and sub-tropical developing areas and have a special bearing on health include the continuing heavy reliance on agriculture and employment of people rather than machines, which influences nutrition, economic resources and expenditure of human energy; continuance of the extended family system; large family size and frequently crowded living conditions; the "low" status of women which still often prevents them playing a fuller role in health activities; early marriage and frequent childbearing; high illiteracy rate and low educational attendance; firmly-established and conservative leadership; high incidence of alcoholism; and the existence of an intricate socioreligious system which affects the interpretation and treatment of disease.

There is often a continuing reliance on hunting, fishing and food gathering, indicating a food supply unguaranteed in quality and quantity; the introduction of processed foodstuffs such as powdered milk used in infant feeding, and atrophy of the arts of food preservation. Little actual money may exist in the economy, goods being exchanged instead. Western medicaments, where available, are expensive, and crippling debts may be incurred by a family in pursuit of cure.

The major "killing" diseases in rural developing areas include pneumonia, diarrhoeal diseases, tuberculosis, parasitic diseases, infections of the newborn and measles. Then there are the so-called "silent" diseases, "concerning which, people often prefer to be silent, such as veneral diseases and leprosy. Other prevalent conditions include trachoma (in some areas more than 10% of the adults are totally blind), infectious hepatitis and worm infestations which cause a great deal of debility, but which do not kill many people".[8] "Bilharzia", yaws and hookworm are responsible for widespread chronic disability and suffering.

Infant mortality and maternal mortality are generally high; life expectancy is low; children, (constituting often 20% of the population) may account for 50% of the deaths; standards of domestic sanitation and hygiene are low and there is continuing reliance on indigenous and often inadequate health practices and practitioners.

Reappraisal of the Status Quo

In the face of daunting odds then, health planners continue to attempt to grapple with rural health problems. But certain questions recur with increasing emphasis. Why, for example, do communities so often continue to receive only the fringe benefits of such efforts? Should only the health needs of those who seek treatment be catered for? What of the needs of those who do not attend at all? Is the local health centre catering only to the needs of those who live near it? What responsibility should the community itself have for the provision and maintenance of its own health care? How far are health personnel being trained to regard the patient as part of his community? Which are the factors within the social and political structures of a country which continually undermine health progress?

"We must not assume that health is being cared for simply because a system of health care exists. We must learn to recognize the right issues, find out what are the right tools and put them in the right hands. It may require developing approaches to health care that are entirely new."[9]

In many quarters, this entirely new approach is increasingly being connected with a "community" approach.

There are indeed many types of community approach currently being employed in various countries. But personnel involved in such projects are increasingly encountering the need to explore a really comprehensive approach.

What follows is an attempt to outline the characteristics that such an approach would need to have. However, it should be noted that nowhere, to

the author's knowledge, is such an approach in operation at present *in toto*.

THE COMPREHENSIVE COMMUNITY APPROACH TO HEALTH PROBLEMS IN RURAL DEVELOPING AREAS

This approach is one by which individuals and communities are helped to perceive, within the context of the national health plans, their health needs, (that is, the need to change belief and/or behaviour in order to increase the incidence of good health) and aided to remedy them by the utilization of internal and external resources. The long-term aim is improved rural health conditions and services, the responsibility for whose organization and maintenance rests largely with rural communities themselves.

ELEVEN CHARACTERISTICS OF THE COMPREHENSIVE COMMUNITY APPROACH

It is wholistic.

1. Health activities occur within the context of planned national development.

Historically, many rural health activities have occurred independently of planned national development or, more specifically, of the national health plan. Practitioners of traditional medicine, for example, have, with some major exceptions such as China and India, generally functioned independently. And until recently, the activities of philanthropic and religious organizations who established hospitals and dispensaries in rural areas have been little coordinated with national ones.

Where health activities have taken place in insolation from the nationally planned ones, overlap, duplication and conflict have occurred. For example, without a coordinating policy, an agricultural rural development agency engaged in stimulating increased egg production for cash return found itself in direct conflict with a nutrition programme in the same area which was encouraging the increased production of eggs for home consumption.

Without coordination on the one hand, activities are pursued which are unrelated to nationally selected priorities, and on the other, national health planners are often unaware of all the resources available for rural health activities.

Today, coordinating bodies do exist in some countries. Coordination itself is far from easy as the health activities of, for example, religious organizations have emphasized curative rather than preventive or educative care, both of which may be priorities of the national health plan. And an unresolved question remains: how far is effective liaison really possible between religiously-oriented bodies who are in competition on the theological level?

However, there are many examples of cooperation, such as the missionary doctors of Zambia, who have played a significant role in training medical auxiliaries.

A comprehensive community approach is a wholistic one, and the process of its adoption is rendered more difficult due to the "fragmented" nature of present rural health activities.

It has Long-term Community Objectives

2. Long-term objectives include the evolution of rural communities into healthy citizens, capable of fully participating in their own lives, that of their communities and nation, and assuming where possible a greater share of responsibility for the delivery and maintenance of rural health activities.

The objectives of health personnel are often far from clear to rural communities, and this has resulted, on occasion, in resentment and conflict. A South American study revealed that a community found its health centre staff lacking in tact and good manners: the staff considered themselves as being of a higher socioeconomic group and therefore "superior" to the rural population. For the community, long periods of waiting preceded attention, and most seriously, the centre did not treat sick children. (The centre saw its role as preventive and was not fully equipped for curative treatment.). To the community, prevention was unnecessary; one only needed treatment when something went wrong. What they desired was treatment for their children. They felt their primary desires were being disregarded so there was little confidence in, and cooperation with, the centre.

In the South Pacific, an assessment of a latrine-building programme concluded that, too often, "latrines were built only to satisfy the desire of administrative personnel, and unused they stood there, mute symbols of the willingness of people to cooperate".[10] The community's objectives then did not include the acquisition of latrines.

Only a good communications system can ensure that health policy makers are really familiar with the objectives of rural communities, and vice versa. When national resources are limited, it is important for communities to understand the reasons for decisions about their allocation. And local health personnel may have little idea as to the overall national policies and, therefore, become easily frustrated by seemingly inexplicable plans, shortages and objectives. Communities also need to be aware of the problems of health personnel. During an Indian rural health project, the communities were asked to listen to the physician's problems. Lack of roads was a constant hindrance. Eventually, the

villagers constructed a 7-mile road themselves and a local minister paved a further 50 miles of road.[11]

A criticism levelled at previous health activities is that long-term objectives have often been obscure, if not totally lacking. Statistical evidence of large-scale vaccination has very often been regarded as a hallmark of "success" with little attention given as to whether deep-rooted popular attitudes and beliefs have been changed or "merely" disrupted.

It has coordinated programmes and uses appropriate technology and staff

3. Each country evolves a specific pattern of health development consistent with its own traditions, circumstances and aspirations. Special emphasis is placed on the concepts of integrated development, appropriate technology and the employment of new categories of health personnel.

Until recently in many countries, the trend was to adopt, and not always to adapt, patterns of health activities formulated largely in other countries of widely different socioeconomic and climatic situation. Today, the selection of a national health pattern is, to a greater extent, influenced by economic and political issues.

Countries with the greatest health problems tend to have the least to spend on them. For example, some countries provide health care with an annual per capita expenditure of under one American dollar, one hospital bed for 1000 of the population, and one doctor and nurse for from 1000-28,000 people.[12] (A ratio of one physician to 10,000 people is considered operationally feasible).

Curative care continues to be allotted the largest "slice" of available resources, and in some countries, 80-90% of total health budget is spent in services in the larger population centres where only 10-20% of the population live.

In rural areas, who in fact does receive the care that is available? In many instances a "cafeteria" approach has evolved where it is "first come, first served". Those who do not come, or are unable to come, receive no care. But there is also the danger of spreading health resources so thinly that they become ineffectual.

Large hospitals traditionally absorbed large resources, but smaller hospitals and health centres are now being increasingly employed. "Auxiliary-staffed health centres represent a substantial return in human welfare for comparatively little expenditure of money and skill".[13]

Integrated Development

In the past, there have been specialized divisions in rural development, each pursuing a particular problem, e.g., education, agriculture, or a specific disease eradication target, and each with its own programme, personnel and resources. Coordination has been the exception rather than the rule. This "fragmentation" has, on occasion, detracted from the overall success of such activities. Rural communities, not regarding their own lives as compartmentalized, have been bemused by the influx of various agencies, each concerned with just one compartment of their lives.

There is a pressing need to view health problems in their totality. Health is a social as much as a medical problem. If, for example, the problem identified is infantile malnutrition, then more than just improved nutrition classes are needed. For the problem also embraces socioeconomic conditions, education, domestic hygiene, agriculture and food technology. For the realistic confrontation of this problem, then, an integrated viewpoint is necessary. The aim for, example, of an Indian rural health project was "complete integration of curative, preventive and promotional work so that there was no category such as public health nurse or any other worker in one specialized field alone ... In a small rural health clinic, it is important that each professional knows more than his own skill".[14]

Appropriate Technology

In most developing countries, there are limited resources for the purchase of the usually imported technological tools and hardware of modern health care. While some items such as instruments and certain medicaments may continue to require importation, improvization and adaptation of locally-available resources like wood and cloth for trolleys and dressings, have proved both more economical and appropriate.

Employment of Personnel

A central problem in the provision of basic health care concerns the changing role of health personnel. For example, "the physician must fill a role in which he manages limited resources to meet the comprehensive health needs of large numbers of people, rather than serving as personal physician for a few".[15]

A further problem is the frequent reluctance of health personnel to work in rural areas. In a central American country, trained health personnel from urban areas, according to the coordinator of a rural health project, are "not only reluctant to work in the isolated, culturally distinct (project area); they actually refuse to work there. In some government agencies, it is regarded as a punishment when one is assigned to this area".[18]

Rural areas tend to lack the sociocultural and educational opportunities to which personnel and their families are accustomed. And lack of health

facilities often hampers a high standard of health care.

Even where a part of medical education occurs in rural areas or where postgraduate rural service is compulsory, these measures are unlikely to provide the long-term answers to the problem.

And the role of the nurse continues largely to be associated with hospitals and health centres. The nurse *from* and *in* the community is a relatively new concept. "The nurse has a contribution to make to the total concept of health care that goes beyond clinical activity and techniques, to encompass such things as education ... nutrition and other elements that ultimately affect the health of people".[17]

The role of the nurse, however, varies according to circumstances. In Malawi, for example, an auxiliary nurse will often run a rural dispensary alone. "To many patients, auxiliaries mean more than doctors, they work long hours in lonely places".[18]

Auxiliaries are increasingly being regarded not as "stop-gap" measures until more highly-trained personnel become available, but more as a new category of worker in their own right. In an Indian rural health project, auxiliary-organized community care was planned in the villages in the form of Under-fives clinics, antenatal care, immunization programmes, detection of chronic illness such as TB or leprosy, school health programmes, basic sanitation and family planning. Indigenous practioners, teachers and other leaders aided them.[19]

A survey in 1971 of a Ghanaian rural health project revealed that almost all diseases encountered were readily diagnosed and treated by auxiliaries using relatively few drugs.

Problems surround their role and status, remuneration, availability of further training opportunities and supervision. (Professionals are seldom trained for this supervisory role).

The use of auxiliaries is increasingly seen as not only holding a possible key to the problem of personnel shortage, but also to the total effectiveness of rural health care delivery.

It is related to the Community Culture

4. An appreciation of the sociocultural context in which health activities occur is considered essential.

"The success or failure of medical programmes depends on many cultural factors besides competence of doctors and quality of services".[20] Lack of cultural understanding has robbed many health activities of their effectiveness.

In rural India, for example, a well- and latrine-building programme was initiated. The wells were successful. But the unused latrines fell into disrepair. It transpired that, in order to properly flush the latrine, at least a quart of water was required after each use. So, the larger the family, the more intolerable had been the water-carrying burden on the women. In Ghana on the other hand, the pouring of "libation" drinks and water on the ground (the traditionally-prescribed ceremonial) marked the inauguration of the Danfa rural health project, and initiated the health activities in a fashion comprehensible to the community.

It has been asserted that medicines often work effectively, despite total ignorance of a patient's culture. While this may often be true, it is yet a narrow point of view. While a child may be cured of malnutrition, unless his/her sociocultural and economic background is effectively considered, recurrence is almost inevitable and treatment is poured into a vacuum with limited effectiveness.

Health personnel are increasingly enjoined to become aware of the health beliefs and practices of a community, the reasons for their existence, how customs are linked to one another and how new health habits often cannot be introduced by merely "adding" them to a preexisting sequence, or old habits merely "subtracted".

Culture must be understood as it relates to health. Why, for example, when children are malnourished, will a community not use the readily-available protein source of eggs? Why is there a prohibition on eating eggs? These and similar questions can only be answered with a knowledge of the context in which they occur.

5. There is an appreciation of the fact that communities have distinct, valued and time-tested beliefs and practices related to health and disease.

Some years ago, a revolutionary new method for the rapid healing of fractured bones was found to be the very same technique as one that had been used for centuries by certain South Pacific Islanders. And in Africa, long before the advent of modern vaccination, people had been rendered immune from smallpox by vaccination with the scab exudate from mildly-infected persons.

Some systems of indigenous medicine are well developed, such as those of China, where the system is practised concurrently, and also synthesized with, Western medicine, and the Indian Ayurvedic system, which is practised alongside Western medicine.

One of the most significant contributions that indigenous medicine has made to mankind is knowledge of the natural remedies such as opium, cocaine and eucalyptus, and "mind-influencing"

medicines which were used centuries before the development of modern psychotherapeutics.

After a study of Mexican Americans, Margaret Clark concluded that "the causes of illness and mortality and curative procedures are understandable and logical in the light of (indigenous) beliefs . . . only to be understood in terms of the total culture".[21]

In indigenous medicine, the patient's physical, psychological and spiritual needs are considered *in toto.* Health care is rendered within the context of the family, who represent a force to envelop and protect the patient, help the practioner, remember directions given and guarantee financial support. In a Western context, this would be done by a receptionist, lawyer, nurse, orderly, secretary and bondsman.[22]

In Western medicine, belief in disease causation often ranges from the microbial to excesses. Missing is the notion of an external agency such as a malevolent spirit or person. Also missing in Western medical care is the reassurance of recovery (even where it is common knowledge that recovery is not possible) which is often considered, in indigenous terms, essential to adequate treatment. Also considered essential is dietary advice, and a multiplicity of remedies may be applied as opposed to a single one.

As Western medicine is regarded as having its failings, so too does indigenous medicine have its own. These include inability of patients to seek alternative treatment due to prohibition, fear, or undue conservatism, and the vulnerability of individuals or communities in the face of powerful or unscrupulous practitioners. And some practices have been proved to be harmful.

Many rural communities consider certain diseases amenable to Western treatment and seek relief of symptoms. But causation continues to be sought from indigenous sources which often offer a complex and detailed categorization.

Traditionally, Western medicine has mostly held indigenous medicine in low esteem. Many of the direct links between them have occurred only when patients were brought to receive Western treatment after indigenous methods had failed.

Today, indigenous health systems mostly exist alongside Western ones or are "filtered out" as direct conflict of belief results in their rejection. Or, they are synthesized with it in such a way that their beneficial aspects may be retained to enrich the evolution of modern health care.

It attends to a Broad Health Education

6. Communities are helped to identify their health needs; and to select those which are likely to bring the greatest communal benefit synonymous with balanced local and national development.

Very often, the health needs of the community that appear most obvious to health personnel are not perceived at all by the community: they are "unfelt needs". In rural India, for example, health personnel found that, "in certain villages, they just did not feel there was any need for medical care and were quite happy with what they had . . . the issue uppermost in the minds of the villagers was not health but food and water".[23]

The issue of compatibility of rural felt needs with national or agency plans sometimes continues to defy a satisfactory solution. Do communities, it is argued, ever *really* identify their needs? Or is there often a "charade" of need identification and a "rubber stamp" of approval obtained for previously selected health plans? Often, then, few resources are left for the longer-term aspects of improved health care. And do the time and resources exist anyway to attend to strongly-felt needs first?

The process of need identification following just one public meeting and a democratic "show of hands" is considered a poor substitute for the slower pace of systematic discussion. It has been found that rural communities in the latter case are more likely to choose a simple health post, than a multistoreyed hospital.

But guidance is needed in order for communities to perceive that to confront a single problem may involve attending to various needs. For example, improving the health of "under-fives" may require the provision of safe water, improved agricultural techniques, nutrition education, food storage techniques and fertility control.

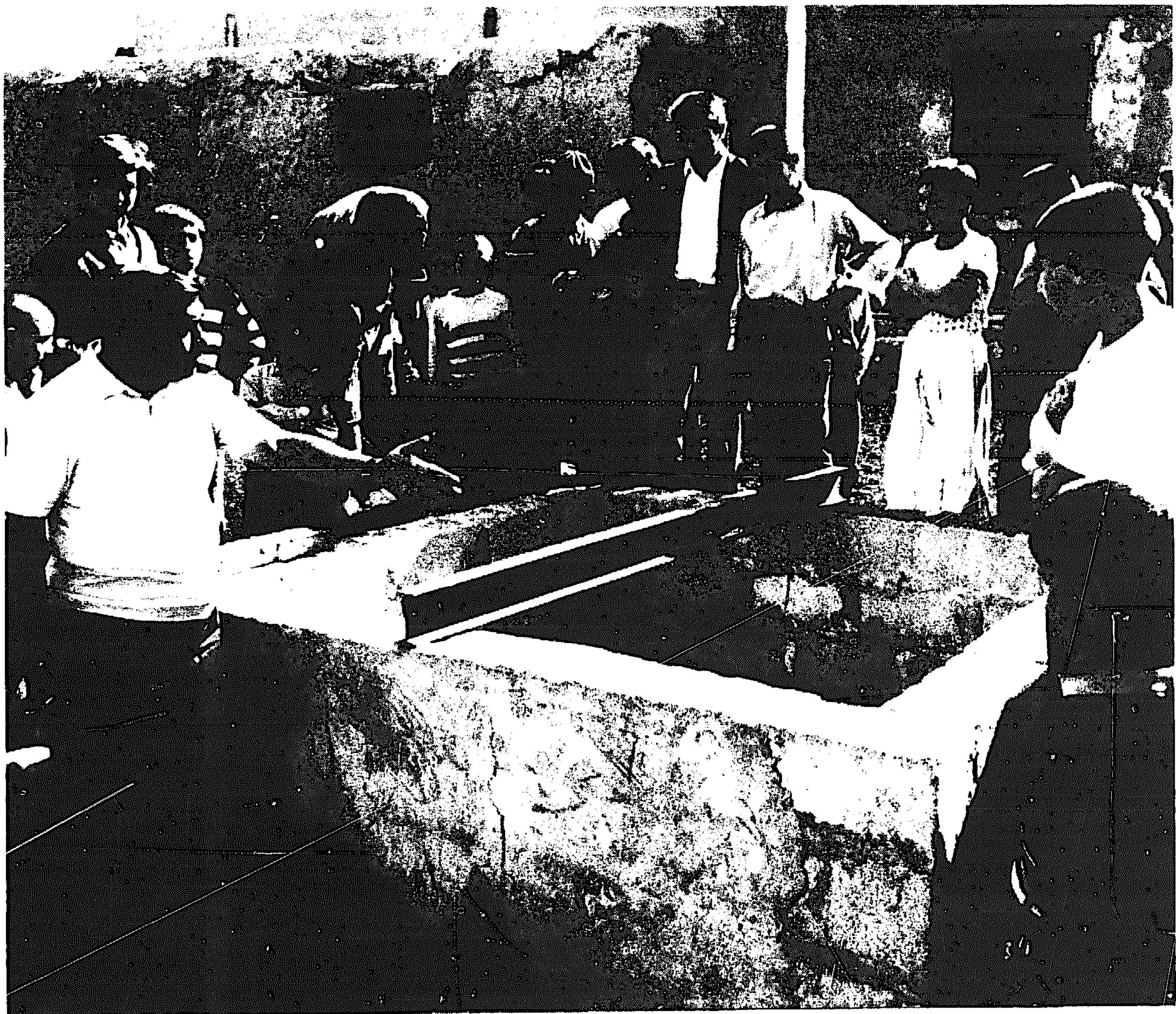
Guidance is also needed with regard to costing the desired health improvements and explanation of the national health priorities and resources.

To achieve the necessary balance between curative and preventive health care is hazardous because the demands for curative care always seem to be more pressing.

It encourages Self-help

7. By a process of self-help, communities are enabled to contribute resources and skills in pursuit of chosen objectives. Use is also made of voluntary organizations and technical assistance at local, national and international level.

There is much that a rural community, however impoverished, can provide in the way of resources for health activities, for example, human resources for labour and leadership (especially where cultivators are only seasonally employed), inside knowl-



WHO photo D. Derias

In an Iranian village, instructions are being given by a health worker on how to cover a well to protect the water from contamination.

edge of the community itself, and materials such as stone, wood, pottery and weaving. At the same time, self-help may not be a particularly cheap or easy method of improving health conditions. Indeed, it may be more costly in terms of economy and time. During an African rural health centre construction project, many problems intervened: disputes over the token wages, deaths necessitating mourning, heavy rainfall, traditional rivalries, etc. During the last stages of construction, the whole labour force was engaged by the project.[24]

But there is evidence to suggest that self-help is often more effective in the long-term as it affects many aspects of community life, guards against over-reliance on outside assistance, mobilizes community support, is an educational process and is related both to self-respect and self-determination.

In the Philippines, a free medical clinic for the poor evolved into a medical cooperative. Locally-selected community leaders had met the medical staff and formulated a plan whereby the treatment costs were related to peoples' ability to pay and the cost of the medicines involved. Then, "the people came to the clinic with clean clothes and scrubbed bodies. The end of the dole-out phase saw the commencement of a new pride among the people in themselves and in their medical cooperative".[25]

Outside assistance should encourage self-help, not take its place. For when aid is poured in from outside, the undertaking is no demonstration of what communities themselves can do. And, in the past, aid has been tied to projects acceptable to donor agencies. Hospitals, on occasion, have been constructed where there were no personnel or resources to run them.

The pace of self-help may appear too slow where visible results are required by an external agency. But haste undermines real self-help in that it seldom allows adequate time for the attitude changes fundamental to long-term health improvement.

It encourages Community Leadership

8. Various types of community leadership are identified and individuals approved by the community are selected to receive leadership training.

Rural leadership is often a vital factor in the success of health activities. Where community leaders have perceived that these activities pose no threat to their own status, they have proved invaluable allies.

The identification and selection of leadership for rural health activities remains more an art than a science. Part of this art often consists of identifying certain personality characteristics allied to mental aptitude and certain job-related skills. Those who have initially "rallied to the cause" have, on occasion, proved to be ineffectual leaders for health purposes, perhaps being self-ambitious or malcontents, with little community standing and limited enthusiasm. However, the more retiring "informal" or "opinion" leaders, such as the middle-aged mother of a large family to whom others automatically turn for help, or the elderly respected religious leader, have proved to be of greater effectiveness.

One aim, then, of a comprehensive approach in rural health is to promote action by groups within the community, led by the community's own leaders.

In Nicaragua, an objective of a rural development programme was to train village health leaders: "someone chosen by his own village with efficient education to be able to distribute common medicaments in accord with his judgement of common diseases and be able to administer injections for vaccination and TB programmes, in far-distant areas".[26]

These leaders were supported by a medical committee comprised of villagers who supervised the ordering of medicines, payment of the leader, and cooperated with government programmes. This type of leader is the precursor of the "Village Health Worker" or "VHW" recommended by WHO.

It minimizes damaging Side-effects of Health Programmes

9. The simultaneous involvement of all or many sections of the community at each phase of the approach is seen as contributing to its long-term effectiveness and minimizing the disruptive effects of change.

In a community, few, if any, changes occur in isolation. Rather, they affect the whole community to some degree. Within this whirlpool of change, health activities take place. If the interrelatedness of rural life is ignored, their impact may be minimal and their effect disruptive.

If, for example, a clean water supply is installed but disposal means are lacking, mud holes will appear and breed diseases; without trained personnel, the machinery will fail . . . violence will be done to many social customs; women will be deprived of their social opportunities over wash tubs or youths may be deprived of courting opportunities at village wells.[27] The "simple" supplying of clean water is, in reality, a complex innovation.

In practice, then, "simultaneous involvement" includes recognition of, for example, the fact that individuals and groups are part of kinship networks; that identification with one group often automatically incurs the opposition of rival groups who may then refuse participation; that older people, while resisting change for themselves, may well accept it for their children (who are often more highly-educated than their parents); that the use of friendship groups carries with it the extra safeguard of friendship against the possible disruptive effects of the change.

In many health activities, there is still a continuing tendency to regard change as good per se. In the light of experience past and present, that assumption can no longer stand. For it has been seen that, where disruptive change occurs, it often provided a legacy of emotional and psychological disorders. In the process, then, of attempting to bring healing and health to the "body" of the community, much harm may inadvertently be done to its "mind".

It gives special Emphasis to Women's Health and their Contribution to Family Health

10. Special emphasis is placed on the involvement of women due to their influence on family health and role in community health.

In most developing countries, children under the age of 15 years and women in the childbearing age (15-44 years) form over 60% of the total population.[28]

If women are even to begin to play their full role in rural health activities, they first require to be in adequate health themselves. But many factors conspire to prevent this. These may include anaemia, parasitism, malnutrition, chronic ill-health, early marriage and constant childbearing, poverty, heavy manual labour, illiteracy, and lack of basic health care and fertility control opportunites.

Lack of adequate care during pregnancy, childbirth, and up until the next pregnancy – usually in the following two years – is often a central factor in the state of health of a rural woman. Usually, she receives care during pregnancy and delivery, both from her kinswomen and from a "traditional birth attendant", who is often an elderly woman of considerable community prestige, skilled to varying

degrees in the art of birth attendance. In some countries, inclusion of these attendants in health programmes has proved to be beneficial both to themselves and to their patients.

One approach to the problem of basic health care for rural women is the African-style "maternity village". This is situated near a hospital or health centre, and a woman, following outpatient antenatal care, arrives prior to her confinement with her relatives who remain nearby to cook and care for her. Delivery and postnatal care is usually provided by supervised auxiliaries. Correct infant feeding and the care of children under five are emphasized in the educational measures in which the mother and her relatives participate.

The Nigerian-style "under-fives" clinic is a further, particularly sensitive, approach to the realities of the role of rural women.

"A whole day wasted waiting in the (average) clinic can ill be spared by the African mother who is a busy woman . . . with a large family, food to grow, a husband to cook for and, only too often, her own living to earn . . . if she keeps her own child's record card, she need not waste time waiting for the clerk to find it . . . nor need she wait at the dispensary if the nurses keep medicines on their tables".[29]

In their role as wives and mothers, the influence of women on family health is critical. They frequently have the power to reinforce – or sabotage – measures designed to improve community health. For example, the maintenance of latrines and wells often falls to them, and without their comprehension and support of these innovations, the unkept latrines and polluted wells instead become health hazards.

In a comprehensive community approach, the role of women in rural health is not seen as one merely of passive enlightenment and mute support of others. Rather, in the industrious round of domestic and communal activities, a new more dynamic role emerges. (A minority will eventually assume more technical and bureaucratic roles). What is sought is the self-development of rural women. But the low status of women is seen in some quarters as a hindrance to the attainment of this new role. However, estimates of status must be appreciated within their cultural context. The rural woman has many traditional and prestigious responsibilities both inside and outside her home, and weeding, pounding and water carrying are not merely manual labour. In some societies, women's status has altered as sociocultural change has occurred as, for example, in Zulu society, where the absence of the menfolk as migrant labourers necessitated the caring for cattle, traditionally a strictly male pursuit, by the womenfolk.

The task of communicating with rural women is complicated by their often "enclosed" status which may necessitate making the first contact via their husbands or mothers-in-law. Once trained for health activities, women have been found to be particularly beneficial frontline workers in any pattern of basic health services. Their advice is readily acceptable in the community and they can easily adapt their approach to the local social, religious and cultural attitudes.[30] They are also more "rooted" in the community, often for domestic reasons, and less likely to leave in pursuit of better employment.

It incorporates ongoing Research and Evaluation

11. Research and evaluation are considered an integral part of the approach. The importance of education is emphasized, and changes in attitude are considered as of similar and, on occasion, of greater significance than material changes.

A physician engaged in rural health in the Philippines called research "a basic tool to reorient and reformulate community medicine to meet the needs of the people".[31] The treatment of the community patient can be monitored, treatment modified accordingly and the information gained used to enrich future treatment.

The value of research during or following health activities is commoner than that prior to their commencement. "There is usually a greater demand for data after a project comes to an end ... headquarters and supporting organizations want to know what they got for their money".[32] But "baseline" and "pilot" studies may well be crucial to eventual success. For example, if research had been carried out prior to the inauguration of an unsuccessful health insurance scheme for rural families, it would have emerged that the modest premium required was even then too large for the impoverished families to pay.

Much research of value for health lies strewn throughout many other fields, such as, for example, agriculture, education, anthropology and nutrition. Much data of importance for health deals with private thoughts, behaviour and attitudes. These things are hard to elicit and even harder to quantify. Research in community health is particularly difficult in that it often requires a range of skill and personnel which reach beyond those of health personnel.

Past research has often been based on personal observation or isolated small-scale studies from which it is hard to generalize. One problem is that research among those who attend as patients is not representative of the whole community, many of whom do not attend at all. In the words of a physician in a part of rural India: "There must have been 4000 deliveries each year, but we were taking care of only 300 of them. What happened to the

remaining 3700 deliveries? For every patient that came for care, 20 remained in the village."[33]

For over-worked health personnel, research often represents an output of time and energy which they find themselves unable, and often unwilling, to give. Some countries have enlisted the help of auxiliaries in various research procedures such as the compilation of statistics. But statistics and tables can tell only a part of the story of development. The self-respect and self-reliance that village people gain cannot easily be measured. But these changes are what make future progress possible.[34] Evaluation procedures, to be effective, should be determined at the planning stages of health activities and proceed during their duration.

The evaluation of health personnel themselves is not usually carried out. Reasons for the success or failure of particular workers and projects are not always evaluated. In the past, "preoccupation with keeping services going often prevented an evaluation of *where* one was going".[35]

Research and evaluation of health activities is crucial in most countries. Appraisal includes whether objectives are being achieved at lowest possible cost and whether the benefits accruing are recognized as being greater than the cost.[36]

Summary

From the common thread of past and present experiences in rural health activities has evolved the concept and methodology of a "comprehensive community approach". This approach is particularly economical in that it emphasizes the use of existing community resources, auxiliary personnel and appropriate technology.

Where it has been employed, albeit partially, this type of approach has emerged as particularly effective with regard to the achievement of both short- and long-term objectives, integrated development, the avoidance of community disruption and in promoting the self-development of individuals.

For, in the past, where communities have succeeded in attaining improved health, little self-growth has occurred. They have neither increased in self-knowledge nor in ability for self-organization. Today, where a community approach does form part of the training curriculum of health personnel, too often it consists only of a few lectures, i.e., a fragment of the whole potential approach. To be effective, the principles and methodology of the approach require to suffuse the whole training of health personnel and allied workers, of all categories.

"Despite current emphasis on community health and the need for training sub-professional personnel in developing areas, there still exists a feeling among some doctors and nurses that public health is secondary to hospital medical care, and training professionals is more important than training sub-professional health leaders . . . (These attitudes) are as difficult to change as traditional health beliefs because of their cultural and psychological aspects".[37]

And the traditional physician is warned against the temptations of tacking "a little public health on to his traditional medicines. This can quiet any haunting concern that he may not be doing enough, and still allow him to continue pretty much as he was".[38]

In the words of the same director of a Korean rural health project "there should be a way to deliver the fruits of Western medicine without the burden of its frills".

In view of the fact that present approaches to rural health problems do not appear to be adequate, a comprehensive community approach perhaps poses an economic and effective alternative.

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CHAPTER V

PEOPLE POWER: COMMUNITY PARTICIPATION IN THE PLANNING OF HUMAN SETTLEMENTS

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(This is an edited version of the original)

PREORDAINED DESIGNS TO SATISFY NEEDS AND ASPIRATIONS?

Although people's participation in affairs governing their lives dates back to the beginnings of human society, the concept has taken on a new significance as societies have grown in size and complexity. This is partly because the governance or management of large groups has become more and more a specialized enterprise, an area for "technocrats", trained bureaucrats, and well-educated political leaders to handle.

Catering simultaneously to general and specific vested interests, these "modernistic" elites seize the initiative to plan policy and implement programmes for society. Although they verbally advocate people's participation, in practice they bring them into the picture only after the major decisions have been made. Hence they often leave the ordinary citizen, the grassroots population, the man in the street, the proletariat, the masses – all equivalent definitions of "people" as used here – to follow their predetermined paths. If a path is crooked where it should be straight, or straight where it should be crooked, the people have little recourse. They must accommodate to the preordained design. Even if the blueprint is inappropriate to their needs and aspirations, they are expected to conform. The results range from submissive apathy to violent resistance.

It is this perceived discrepancy between the more universalistically oriented actions of planners and administrators, on the one hand, and the particularistic preferences of ordinary people in complex large-scale societies, on the other, that has led to the emergence of people's participation as a controversial sociopolitical issue. From there, it is but one more step to confronting the issue of power and where it is lodged.

TWO VIEWS ON THE PEOPLE POWER ISSUE

One need not look too hard to realize that differential access to economic resources generally parallels power-holding disparities. Those persons strongly imbued with this awareness diverge nonetheless in preferred strategies for redressing the imbalance.

One group focuses on immediate gains and advocates open confrontation of the powerful by the powerless through a multitude of tactics and strategies. This is accomplished by the latter's banding together and, in so doing, generating collective power through mass action. This militant approach forces negotiation on an equal bargaining basis and promotes immediate, specific gains for the poor and powerless.

A second group dismisses such an approach as merely palliative, seeing even hard-won gains as temporary delusions that lull the powerless into continuing acceptance of distorted social structures. In reality, argues this group, these partial victories only deter the powerless from facing the real and ultimate issue, namely, the need to overturn and revamp societal structures totally and completely, violently if necessary, so that the distinction between powerful and powerless is forever eradicated.

This article addresses people power from the first group's point of view, avoiding judgements on the validity of the second. It deliberately selects from among the many possibilities for enhancing the poor majority's participation in developing societies. The particular aspect of people's involvement in the planning and implementation of human settlements, specifically housing and community management makes up the focus of this paper.

THE IMPORTANCE OF PEOPLE'S PARTICIPATION

The rationale behind people's helping to formulate the kinds of homes and communities in which they will live goes beyond a simple reference to democratic ideology. Involving people in the decisions that affect their own lives is significant for several reasons.

A sense of responsibility through direct involvement

First, programme results are more successful if the intended beneficiaries take part in their design and implementation.

Moreover, if people like living in their community, they will more readily take care of it and express their interest in action. If uncollected garbage draws flies, o. canals become clogged and overflow, or if dirt pathways become ankle-deep mud sloughs in the rainy season, they will likely do something to remedy the situation, from complaining to the Department of Sanitation to dredging canals and filling in the rutted, muddy pathways themselves. If a sense of friendly neighbouring has emerged, they will help a needy neighbour out with the children when she is sick, or go out of their way to tell her husband to follow up a promising job opening. By getting people involved in a neighbourhood building or renewal project before actual work starts, the administrators ensure a better fit between people and community.

Rectification of planners' misconceptions

A second reason for people's participation is the reeducation it gives architects, planners, and administrators directly involved in the project. By showing them another perspective on the matter under study, low-income groups can give their middle- and upper-class counterparts new insights into the ways of their clientele. The product of years of technical training — the specialist — has probably lost his capacity to empathize with lower-income people's viewpoints. Not only was he never a member of the lower class; school curricula, especially if he comes from a developing society, have probably further alienated him from them. Nor has he ever taken a behavioural science course that might make him more sensitive to people's values or social patterns.

This combination of circumstances, therefore, has probably left him with little appreciation for lower-class people's outlooks.

People's participation thus rectifies planning errors by making it possible for clients to point out to technicians/managers what will work and what will not. It is a wise listener who takes these points seriously and revises plans and programmes accordingly.

General increase in community's self-reliance

A third benefit of people's participation derives from the very process itself. For if it is genuinely mass-based, it builds up the self-enabling character and cooperative spirit of the community. Facing common problems as a group in solidarity and finding solutions collectively leads to greater self-assurance and pride in the group's ability to act productively. Consciousness of a larger whole whose welfare is every individual's concern is more likely to evolve in organized participating groups. While conflict within is also unavoidable, it can, if handled properly, be turned into a strengthening device and yield effective results.

Further, when people learn to operate and even manipulate the institutions of modern urban society, to interact as peers with its technicians, managers, and government officials, and to grapple with technological problems and complex bureaucratic structures, they grow as individuals and learn to cope with modern urban life. Successful adaptation depends in large measure on one's belief that one *can* manage one's environment, and on the evidence that proves that one is indeed doing so.

Finally, people's participation springs from guarantees cited in most national constitutions of the world. The right of citizens to express their views and share especially in decisions that affect them is the mark of a modern society. That ordinary people are poor and often powerless does not mean they need be voiceless. Since most nations espouse the republican principle leaving sovereignty vested in the people, it should not be difficult for private and public authorities to give the people their just due.

OBSTACLES TO PEOPLE POWER

Considering the number of valid reasons that can be advanced for fostering people's participation in the formulation, implementation, and management of human settlements, why are people not brought into the picture as often as they might be? Or, put another way, why is popular participation often resisted by or even denied by the planner administrator/manager? One can suggest several reasons.

Conviction that the elite specialist knows best

Perhaps the major one is that the elite specialist believes that, where technical information is concerned, he knows best. In his view, a professional education and degree equip and entitle him to make the decisions. It is only a small step from "knowing best" to "knowing what is best for them", especially when "them" represents barely literate people who cannot tell a building blueprint from a flow chart. In less-developed countries especially, where advanced

education is at a premium, specialists are so accustomed to telling others less trained then they what to do, that they find it virtually impossible to accept as valid the practice of listening seriously to the views of lower-status persons, particularly contrary views. The fact of the people's being the end users and having ideas based on practical realities carries little weight. Education, status and income differences evidently authorize a dual approach.

The higher-status "experts" thus set the framework of the discussion and carry it through in categories meaningful to themselves but often incomprehensible to ordinary lay people, poor and lowly-educated as they are. Even if the latter should, by some chance, have access to the neighbourhood plan for comment, their non-participation in earlier phases renders it extremely difficult for them to understand the conceptualization, much less to argue on an equal plane in favour of any divergent view. Generally embarrassed by lack of education before such prestigious personages, lower-status citizens lapse into silent acquiescence. If their suggestions or arguments are demolished by the specialists, their demoralization is complete. The paternalistic or even superior attitude of the specialist towards ordinary people serves to convince the specialist that *he* must talk while *they* must listen. No genuine participation is possible under such circumstances.

Apathy after years of powerlessness

Yet the reluctance or outright refusal of elites to encourage meaningful people's involvement cannot be blamed wholly on any particular elite group's actions. Part of the problem lies in the people themselves. Years, indeed centuries in some cases, of being planned *for* have rendered them apathetic about taking a hand in matters beyond their immediate family domain. On the other hand, a pattern of community participation does exist, but it revolves around the observance of traditional rituals such as religious festivals or wedding celebrations. Redirecting people's efforts to the level and type of active secular participation that housing and settlements' development requires, poses a special problem. It entails defining a new role for them in the daily round of life.

Often outsiders, such as social workers or community organizers, help people delineate the issues that need organization and action. Alternatively, people can be forced into a position of aroused consciousness through a recalcitrant housing manager. High-handedness, arrogance, or sheer inefficiency on his part can do the trick better than any earnest social worker can. For the most part, however, people forfeit any claims to participation by apathetically letting the specialists decide for them. Experience has not led them to believe that anything else is possible or feasible.

Government resistance due to fear of delays and of subversion

While apathy about self-help in the context of human settlements' management probably characterizes the majority of prospective residents in developing countries, there are a number of militantly organized people's groups who not only take the initiative to define their wants, but actually demand participation. The organized shanty-dwellers who invade unoccupied lands and turn them into dwelling sites in various Latin American countries provide such an example. Often at a loss to counteract such moves, some governments have simply conceded to their *de facto* occupancy and have subsequently provided sites and services components. A similar case in Tondo, Manila, provides a counterpart Asian experience. One can predict that, given the conscious articulation by government agencies and others of people's participation as a new ideal, more and more people's groups will find a legitimization of their conviction that, when other conciliatory mechanisms have failed, open confrontation and a demand for negotiation is the only avenue left to them.

Herein lies an inherent contradiction in governmental espousal of people's participation, for once grassroots awareness is aroused and people demand a say in housing and community actions, government may eventually find itself sending out police to control angry demonstrators. Charges of subversion may be levied and gaol terms meted out to offenders who go beyond the government's definition of legitimate participation. Unfortunately, the designation of the legitimacy/non-legitimacy line remains an ambivalent product of differential outlooks where government and militant people's groups are concerned. Even if this extreme level of violence is not reached, planners/administrators/managers approach people's participation with some reluctance. They fear it will lead to delays in implementation because an array of contradictory recommendations will have to be reconciled.

MODES OF PARTICIPATION

A number of modes exist whereby people may join with planners/administrators/managers in the developing of housing and housing estates. Six are delineated here. They are by no means the only ones, but they do constitute some major types. One can assess them in terms of: 1. the type of participation; 2. its functions; and 3. the locus of power. The closer people come to controlling their own life situations, the more fully participatory they may be adjudged.

1. Unofficial representation by a "solid citizen" group which endorses outside-planned programmes

The first mode involves the educated "solid-citizen"

group as the key actors. They bear the brunt of representing the people in dealing with government or private development agencies. As prominent people in the district or in the community undergoing change, their own educated backgrounds render them acceptable to officials, as they tend to share the same outlook and categories of thought. Further, they possess a certain amount of influence in their own right and can rally support for projects needing it. Generally enthusiastic and sincere in their commitment to improving neighbourhood life, they take the position of speaking *for* the people in the community and planning *for* them, whether the people have given them that mandate or not. They sit on the community council as symbols of civic consciousness. Correspondingly, the ordinary people are organized into associations where they serve as followers to these upper- or middle-class leaders, leaving to the latter the responsibilities of dealing with outsiders, of raising funds, and initiating action. Success is reckoned in terms of the number of meetings held, projects launched in the community, and material benefits resulting from them. Since the leadership is of a voluntary nature, these leaders must exert a great deal of energy and personal magnetism in order to get people to provide a mass base of support.

This mode of participation, so typical of Filipino towns, has the function of legitimizing outside-planned programmes by having prominent local elites endorse the activities offered and play key roles in them. An assessment in terms of grassroots participation would have to conclude that, under this mode, the locus of power remains at local elite levels. The grassroots sector plays only a minor, if any, role in decision making; the function allocated to them is to follow and to serve as a population needing help.

2. Appointment of local leaders to positions in government bureaucracy

The second mode of participation embodies appointed local leaders in the government bureaucracy as representatives of the people. They may consist of ward leaders, or community relations officers, or neighbourhood chairmen. As local residents, they take the lead in bringing government and civic agency programmes down to the grassroots level, interpreting for the people what is to be done and how it should be done. Their acquaintance with bureaucratic procedures and prominent people enables them to accomplish activities requiring agency assistance and influence. At the same time, their authority enables them to mobilize groups of people for all sorts of events: to march in civic parades and wave flags on national holidays, to serve as audiences for political leaders or other speech makers, or to join work brigades for widening streets or cleaning canals.

These officially or semi-officially appointed bureaucrats serve to legitimize programmes drawn up outside the community, be it a cleanliness drive, a rice distribution scheme, or a lottery to determine the choice of dwellings. Moreover, their authority allows them to direct neighbourhood activities and perform as spokesmen to higher authorities. With the locus of power residing in these lower-level bureaucrats, grassroots citizens find themselves far removed from decision making even if they participate by choice or otherwise in the community activities designed for them. Direct sharing on the part of the population in the plan formulation and management remains virtually nil, even though a kind of participation evolves through their followership roles.

3. Community's choice of final plan from among predetermined options

The third mode entails *ex post facto* consultation by development personnel with the people at the community level. The classic situation occurs where a development agency is upgrading or renewing a low-income neighbourhood or building a new relocation site to house a specific evicted population. Here architects, economists, engineers, and the like spend months drawing up plans for community layouts and job creation. When the plans, or one phase of them, are completed, these technocrats then call a meeting with the community to explain the plans and solicit its views.

In terms of people's participation, this mode comes closer to the mark than the first two since the grassroots population actively enters into the picture, making up the majority of participants. Moreover, people do have a say in telling the planners whether or not they like the designs or job creation schemes or neighbourhood rules laid out for them. Full-scale participation is nonetheless wanting in this situation since the options have already been predetermined by others. Nor are the assumptions behind the scheme always clear to the people, since they did not go through the same process as the designers/planners in considering a wide range of possibilities and rejecting some in favour of others. Consequently, the people are offered Plan A, Plan B, and Plan C, and asked to choose among them. This is accompanied by the presentation of maps, charts, and diagrams in confusing succession. Plan A and C usually turn out to be mere variations of Plan B. As a people's planner once remarked, "Belive me, it's always Plan B that bureaucracy planners want people to 'choose'." Since Plan A approximates the people's interests more closely and Plan C is the technocrats' ideal, Plan B usually wins the day because it represents the compromise that presupposes harmony and cooperation from then on. Thus, the *ex post facto* mode of participation does see people participating in community decisions, but on a

token basis more than on a real one. For the plans have been devised long before the first consultation. The people are merely expected to endorse them or suggest minor revisions without changing the basic outlines of the scheme.

4. Ongoing consultation starting with plan formulation

A significant breakthrough comes about in the fourth mode of participation, namely, consultation between people and planners right from the beginning of the plan formulation. The very conceptualization of the scheme occurs with ordinary people sitting in and expressing their opinions. To facilitate discussion, their elected or chosen leaders meet with planners more frequently and regularly, with community assemblies held every so often for wider dissemination of information and discussion. These sporadic meetings allow a two-way communication process; the people are kept abreast of developments to date, and at the same time check the directions their leaders are taking in representing their interests. Since no community is homogeneous, the varying views and interests of the population emerge in such gatherings, dramatizing a range of sometimes conflicting interests which the chosen leaders must reconcile.

Early involvement in the planning process not only leads to a more suitable outcome for those who are most affected; it also gives people an appreciation of the complexity of the process and an awareness that issues are rarely simple and clear-cut.

5. People's representation on decision-making boards

The fifth and sixth modes of participation have people's chosen representatives actually serving on decision-making boards. In the first case, the people of a housing community, for example, have one or two representatives sitting on the board to express their interests and viewpoints; in the second, the board is, in effect a people's board because the majority of members on it come from the grassroots sector.

6. Community control over expenditure of funds

The sixth mode marks the triumph of people's participation in that the grassroots elements dominate the membership of the decision-making board. The expenditure of funds falls completely under their control, meaning that they allocate it according to a scheme suited to the people's wishes. Even here, of course, their independence is not total, since the funds come to them from higher levels of government or from international agencies. Hence, negotiations with

Weekend work by families in low-cost housing reconstruction project at Sakerty, on the fringe of Guatemala City.

Salgado/Christian Aid

these entities remain necessary, but usually on a peer basis. For the aim of people's participation is not to divorce people's groups from the state or decision-making centres of society as a whole. Rather, in human settlements' development, it is to give the ordinary residents a significant voice in that development.

BASIC ASSUMPTIONS UNDERLYING THE SIX MODES

A summary presentation of the six modes described here appears in the following paradigm. One must remember that some overlapping of modes may occur at different community levels.

Modes of People's Participation in the Planning and Management of Human Settlements

	Identity of participants	Locus of power	Functions	Assessment in terms of direct exercise of power by the people
1	"Solid citizen" educated group appointed by outside authorities	Planners and local elites	Legitimizes outside-planned programmes through endorsement and implementation via local elites	People are minimally involved, if at all, in decision making
2	Appointed local leaders in the government bureaucracy	Planners and local elites	Legitimizes outside-planned programmes through endorsement and implementation via local elites; facilitates implementation of outside programmes, since local elites have authority from above	People are minimally involved in decision making, although the official character of leaders' authority encourages people to join in programme activities as followers or recipients of the benefits entailed
3	Planners in *ex post facto* consultation with people's groups	Planners; people to a slight degree	Legitimizes outside-planned programmes by having people feel they have a say in matters affecting them; allows some feedback from people on their views about plans	People's involvement in discussion of plans after they have been formulated allows few genuine options; participation exists but only in token fashion
4	Planners in consultation with people's groups from the beginning of plan formulation	Planners and people, but planners have more authority than the people	Allows a meeting of minds and views between planners and people; gives people a more realistic understanding of planning process and need to establish priorities	People's involvement in the formulation of plans and in the manner of their implementation gives them a sigificant share in decision making; however, planners still control the process
5	People have one or two minority representatives on a decision-making board	Planners/administrators and people, but planners/ administrators have major decision-making power as the majority membership	Legitimizes the concept of people formally having a voice in local affairs through direct participation and representative vote; also legitimizes boards with outside elite in control	People's participation is significant because they share in decision making by having an official vote on a local governing board
6	People have the majority representation on a decision-making board	People and planners/ administrators, but people have major decision-making power as the majority membership	Legitimizes the concept of people's having the dominant voice in local affairs through direct participation, control of votes, selection of technicians/planners to assist them as advocates	People have attained full participation in controlling the actions of the official decision-making body

Further, the strength of a community is likely to be greater, the more closely it approximates those modes nearer number 6 than number 1.

It is evident from the discussion summarized by the paradigm that the six modes of participation reflect three basic approaches, namely:

a) local elite decision making (modes 1 and 2);

b) people acting in an advisory capacity to elites in authority (modes 3 and 4);

c) people sharing in, or controlling, local political decisions affecting their lives (modes 5 and 6).

Two divergent orientations to the causes of poverty apply to the choice of any particular mode. Where poverty is believed to be the product of individual disadvantages or deficiencies, action programmes focus on changing people so they can function more effectively in society. Hence, providing them with improved social services is deemed to be the solution to helping them compete more effectively in the larger society. Having obtained these benefits, they presumably can cast aside their poverty and achieve a decent level of living.[1]

Here lies the rationale behind modes 1 and 2, namely, the emphasis on providing assistance and benefits to enable people to live better lives. It is the basis of the community development approach espoused by private and public welfare-oriented agencies in which harmonious cooperation is the dominant ethic. Self-help, it is believed, will arise out of people's raising their incomes through joining personnel training programmes or making available limited amounts of credit for small-scale enterpreneurial operations. Their common welfare will grow out of community councils organized by social workers to channel the flow of goods and services from the larger society into the community. These arrangements may indeed lead to somewhat more prosperous communities, but they do not challenge the basic structure. Instead they accept the prevailing principle of elite control.

The second orientation explains poverty as a product of social and economic systems that remain intact precisely because of the "powerlessness of the poor and the dominance of the wealthy power-holders". In this view, only as the poor acquire political power can they negotiate as peers with their wealthier counterparts and themselves change community policies and conditions inimical to their state. Modes 5 and 6 best express this policy-making orientation.

The transitional situation represented by modes 3 and 4 combines the two extremes in espousing the community development approach with incipient versions of the grassroots-policy-making one. While often difficult for elites to accept, it nonetheless represents the position currently taken by more progressive agencies. The object of far greater resistance among authorities the world over is the political power orientation advocated by a few militantly organized people's groups. For, aside from being a nuisance or a downright threat to beleaguered groups in authority, they give rise to a controversy over whether the government or established private agencies can or should subsidize with funds or otherwise support citizen groups apparently in open opposition to duly constituted authority. From the people power point of view, however, this confrontation stance has proven to be the only really effective means of jolting slow-moving bureaucracies out of their lethargy and forcing them to take seriously conditions adversely affecting the everyday well-being of the people. Since the role of government is to serve the people, they say, these active grassroots groups and their supporters feel their conflict strategies and political goals need no further justification.

THE INTERPLAY OF PEOPLE AND TECHNOCRATS

When people and planners/administrators/managers deal with one another, each set uses a range of strategies to achieve its objectives. If a particular people's strategy works, and the other party accepts it, the users come away satisfied; a period of relative quiet and perhaps even harmony prevails. If it does not work, either apathy or a stronger approach is mounted on the people's part. The development personnel, on the other hand, may opt for motivational approaches, bureaucratic inertia, or more authoritarian tactics.

The issues, then, come down to how far organized people power and its strategy of confrontation can be tolerated by government, and to what extent forms of people's participation may be accepted as legitimate by law enforcers. Where is the line to be drawn between legitimate representation by people of their collective desires, on the one hand, and outright defiance of government authority, on the other? Certainly, most people and government officials seek and prefer peaceful means of attaining their own ends. But each set can be pushed only so far before it turns to more violent responses deemed justifiable under the circumstances.

ENCOURAGING COMMUNITY PARTICIPATION

People can participate effectively in the management of their own surroundings only if they have developed a sense of community and have organized themselves into associations. This explains why a grouping of new residents who did not know one

another previously proves difficult to organize. It takes time for people to feel at ease with one another and to accumulate the experience of interaction that allows some assessment of what the others are like.

Creating opportunities for contact

The process of breaking down barriers and establishing a modicum of trust can be accelerated, however, by creating opportunities for people to come into contact with one another. Recreational programmes geared to the children will often bring out even the most aloof householder. Mothers' classes in nutrition or income-raising activities, carpentry seminars, or, in rural settlements, farmers' meetings for the men, help cement new-found friendships even as they communicate useful knowledge to the participants.

Given the dearth of formal associations in settlements composed of residents who moved in almost simultaneously or in waves some months apart, it may be necessary to have professional social workers or community organizers deliberately set about forming the people into organizations, usually on a block basis. Yet one should also be aware that evidence from rural and urban settings the world over suggests that grassroots organizations founded and nurtured by the government rarely succeed in becoming effective means for people to express themselves. Privately-organized spontaneous efforts do much better. In view of this, it would be well for the above-mentioned social workers to phase themselves out as soon as possible.

In older communities which are being upgraded, one can reasonably assume that a wide variety of formal and informal groupings already exists. These can become the basis of a larger umbrella organization made up of groups who formally file an application to join. If representation on a block basis is also necessary, the existing organizations may plan out the new structure. Whatever the final composition of the community grouping, its existence as a truly representative body is crucial for effective people's participation in the management of their settlement.

An organized community group performs several important functions. They may plan and implement numerous projects, especially if they have access to funds. They make it easier for outside agencies to help community programmes as they provide a formal organization with which an agency can deal directly. Thirdly, they can hire and direct technicians to carry out their own plans. All these functions have great potential for the independent action of the community group.

TRAINING NEEDS FOR PEOPLE'S PARTICIPATION IN HOUSING AND NEIGHBOURHOOD MANAGEMENT

Too often, it is assumed that the training component of a housing and neighbourhood settlement falls completely on the residents. Yet, because of the often wide gulf between the people of low-income communities, and elite managers, the latter need just as much of an education, but of a different sort.

Educating management personnel :

1. A better understanding of the conditions and life-style of the urban poor.

The greatest deficiency found in management personnel is their general lack of understanding of low-income people's life-styles, outlooks, and aspirations. They tend to censure the residents basically for not being or thinking like themselves. The precariousness of the household economy among the poor is something most middle-class specialists cannot sufficiently appreciate. They will thus deplore, for example, a family's turning to scavenging and littering its immediate surroundings with discarded paper, plastic, metal, and glass bottles. The filth and disarray offend their aesthetic sensibilities, even as they assume that the ragpickers see nothing disturbing about being dirty. A recent Manila study has shown, however, that scavengers do not enjoy their situation any more than anyone else and would gladly leave that occupation if any other viable opportunities turned up.[2] Since chances are limited, the scavenger accepts this form of income generation as tolerable; it is after all better than theft or outright unemployment.

2. A service rather than a control orientation.

Attitude change on the part of the manager who looks down on his customers is also called for. It is difficult to inculcate a service orientation instead of the control orientation towards tenants among long-time bureaucrats, used to taking a superior attitude towards their clients. Appreciation of the rights of people, regardless of their lowly social status in society, is a view that often needs conscious learning among elites. Better rapport with the people needs conscious reinforcement as well. So too must an understanding be cultivated of conflict strategy in people's organizations and the possibility of negotiating with them as peers.

3. An awareness of the social implications of policy decisions.

Finally, an awareness of, and concern for, the larger social implications of policy decisions needs to be developed. Thus, the manager who believes

he is doing the community a favour by banning street vendors or hawkers in the interests of order and sanitation may find that his decision eliminates the incomes of 100 local breadwinners, and therefore the source of livelihood for 600 people, mostly children. Hunger, malnourishment, and sickness come in its wake, and he may be forced to initiate costly welfare programmes to enable this group to survive.

4. Training seminars and refresher courses for managers.

How are these reformulations to be communicated to the manager ? A training seminar would be a good start, Here, sociologists and anthropologists who have done research in comparable neighourhoods can describe and analyze the subculture of poverty. Psychologists can help the managers understand the roots of their own attitudes and conduct laboratory exercises in group dynamics, role playing, simulation, and conflict-cooperation games for behaviour change. Panel discussions by the more articulate poor residents focusing on their reactions to life in the area under those particular circumstances can communicate something about the rationality of their outlooks. Tours of other communities which have fairly successful people participation in housing decisions, and discussions with their managers and people's organization leaders, can further drive home the message as no amount of lecturing can. Refresher courses with other estate managers every few years enhance the good beginning already made in learning the more progressive approaches utilized by their advanced colleagues. For those seeking genuine empathy with the people they are to serve, actual residence in the community proves to be a particularly enriching, if difficult, experience.

Educating the residents:

1. Training grassroots leaders in communication and urban planning.

Residents also profit from various kinds of educational programmes. Community assemblies that try to convey the ideas of the manager in a consultative rather than commanding tone generate interest and understanding on the part of the community. Training local grassroots leaders usually proves a wise decision. Their ability to run meetings so that everyone who wants it has a say, without prolonging the gathering unnecessarily or letting it get out of hand, is a necessary skill. Further, if they learn some of the rudiments of urban planning, management principles, and architectural design, they can better appreciate the constraints under which professionals in these areas operate. Their all too obvious disadvantage at meetings with these specialists becomes less pronounced and their sense of inferiority or defensiveness diminishes as their command of the subject matter increases. Thus, later discussions with the managers will be conducted on a more egalitarian basis, an experience which will stand them in good stead should they actually take over control of the housing estate and have to hire their own supervisory and working personnel.

2. Training in technical skills for neighbourhood improvement.

Training of the people involves not only instruction in decision-making procedures, but also in the technical service needs of the community. Ideally, residents should be given hiring preference for local jobs.

PEOPLE'S NEEDS VERSUS TECHNOCRATIC MODELS

It should by now be amply clear that if people do not participate in the planning and management of their immediate surroundings, the chances of their environment's improving, not deteriorating, drop correspondingly. The areas of housing and estate management offer natural incentives for encouraging people to act in their own and their neighbours' interests. After all, home and family come closest to a householder's heart everywhere in the world.

Unfortunately, educated elites make people's involvement difficult. They have been "experts" too long to allow their pronouncements to be challenged by near-illiterate, simple people. Their values have been nurtured on middle- and upper-class preferences for beauty, order, symmetry, and reliance on a fat pocketbook for realizing their desires. Little understanding the constraints ordinary rural or urban dwellers face in choosing their life-styles and residential locations, the technocrats draw plans with a grand sweep but a myopic one *vis-à-vis* the interests of the poorer population.

Perhaps this technocratic approach has recently served to generate people's participation. For it ranks technical efficiency, abstract design, and high-level cost-benefit analyses, based on economic assumptions often alien to the people's real situation, above basic human concerns. The latter can include kinsmen wanting to be located near one another despite a site-raffling plan, fear of losing customers owing to the required transfer of a household industry into a centrally-located manufacturing site, a resistance to sharing newly-built toilet facilities with one's neighbours, or insisting on lot ownership even if leasehold constitutes the experts' preference.

Peattie has observed that, when politicians held sway in less technologically complex times, people could express their views on a more egalitarian basis

and expect some kind of sympathetic response from their non-technical vote-hungry leaders.[3] But in the age of the technocrat, ordinary mortals cannot really meet him on his own terms. His knowledge is too specialized for them to contradict on a scientific or technical basis. Not even the politician-bureaucrat can compete with his judgements. Thus, a growing conviction emerges among ordinary people that the only way to make the technocrat acknowledge other factors to which he has given little recognition thus far is to smoke him out of his air-conditioned office and force him to see reality as it is lived. If he balks – and he usually does at first since no one of lower education has ever challenged him before – an organized people's group can restore the balance his expertise has tilted in his favour. The more autocratic he becomes about having his way, the more militant an opposing people's group is likely to become. The reaction of unorganized groups, on the other hand, is an increased apathy.

FROM PARTICIPATION TO PEOPLE POWER

In the long run, people's participation cannot be separated from people's power. For, through constant involvement in community affairs, they begin to learn what organization and united action can accomplish. It will not take them much longer to discover that, so long as basic institutions of society and the existing power distribution do not change, their situation is not likely to improve qualitatively, only quantitatively at best. Thus, more donations of free medicines will come to their children, more lower-level jobs will be opened to them, water will be piped into the houses, parks and playgrounds will be improved – the list goes on and on. Yet they remain at the bottom of the social heap, moving up in small increments perhaps, but always overshadowed by the ever-increasing affluence of their countrymen higher up on the scale. Those who move up are, of course, the more fortunate ones. The great majority remain right were they are, beyond the reach of the trickle-down process. When the total social structure undergoes a drastic reformulation – which presumably can be evolutionary rather than revolutionary – and development policy is assessed in terms of its human costs, especially for the bottom half of the population, only then can a just society emerge.

SOME FINAL REFLECTIONS

How should governments view direct people's participation in their own world? Here lies a dilemma. The housing manager may genuinely seek the views of occupants; but if basic differences become irreconcilable, he cannot condone more violent action on the people's part. At what point does he evict "undesirables" and "trouble makers" who are arousing the population against him in a hotly-debated issue over the installation of hallway bulbs in a tenement, or the revocation of a bus franchise to an outsider? At what point does he call in the police if a sit-in or passive resistance tactic has gone on too long, disrupting ongoing activities? Who are "the people" in the first place? Which of the competing groups in the community should he recognize, if any, as legitimate spokesmen?

It is easier to pose these question than to answer them, partly because the world's experience with people power and participation remains limited. The elusive happy medium between apathetic people and paternalistic authorities, on the one hand, and militant people coupled with repressive authorities, on the other, is still being sought in country after country. The more laudable models provide too few examples. But the search must continue, for the age of the comon man and the common woman is upon us. They will not tolerate for long always taking the follower role that poverty has heretofore thrust upon them, not when the development ethic trumpets loudly its aim of enhancing the lot of the masses and encouraging self-reliance.

So long as resources and power continue to be lodged in a few in this otherwise enlightened age, the potential for effective grassroots movements looms ever greater. Since elites seem loath to surrender or even share their decision-making capacities with their poorer brothers and sisters, it is safe to conclude that the struggle for people power will dominate the close of the twentieth century.

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CHAPTER VI

FORMULATING AN ALTERNATIVE RURAL HEALTH CARE SCHEME FOR INDIA

D. Banerji

I. POLITICAL DIMENSIONS OF THE HEALTH STATUS AND THE HEALTH SERVICES OF A COMMUNITY

Health services are one of the many factors that influence the health status of a population. Health of a population is also influenced, sometimes even more significantly, by such social and economic factors as nutrition, water supply, waste disposal, housing, education, income and its distribution, employment, communication and transport and the social structure. Secondly, like the other factors influencing health status, the health services of a community are usually a function of its political system. Political forces play a dominant role in the shaping of the health services of a community, through decisions on resource allocation, manpower policy, choice of technology and the degree to which the health services are to be available and accessible to the population, for instance.

These political dimensions of health services – political economy of health – are brought into a sharp focus by the cases described in the World Health Organization publication, *Health by the People*.[1] In countries such as China and Cuba, where very positive efforts have been made to involve the entire population in the process of decision making as a part of a nation-wide political movement for bringing about a radical social change, an alternative perspective for rural development and, as one of its components, an alternative health care system developed as its logical corollary. In these countries, the very process of bringing about democratization of the political system had led to serious questioning of the technological, social and economic bases of the health care system which was prevailing earlier.

In the case of Tanzania, where serious attempts are being made to promote democratization at the grassroots, the earlier health care system, which was inherited from the colonial rulers, is being subjected to a close scrutiny. This scrutiny has already led to a shift in the allocation of resources from the urban to the rural, from the curative to the preventive and from the privileged class orientation of the services to those which are oriented to the underprivileged classes.

In all these three instances, all the sections of the community, particularly the weaker sections, have been actively involved in the shaping of an alternative primary health care service and in its implementation.

Significantly, in countries where the process of democratization has not made deeper inroads, there is considerable hesitation and often confusion in the formulation of alternative health care systems. The WHO publication describes two categories of cases. One category is exemplified by two oil-rich countries. In both these countries, the political system has not allowed any change in the highly sophisticated, state-subsidized curative services in urban areas which are accessible mostly to the privileged classes. However, both these countries happen to have very dedicated Health Ministers. Even within the very stifling political constraints, they have been able to make significant innovations in the rural health services of their countries. However, it is still to be seen whether, within the existing political climate, the alternatives promoted by these workers will turn out to be viable ones.

Guatemala, Indonesia and India are in the other category of country. In all these three countries, not only has the process of democratization not reached the underprivileged and the deprived sections of the population to any extent, but there has also been a conspicuous lack of leadership in the field of health care. This might explain why, in all these cases, inspiration for alternatives had been sought from the experiences of Christian missionary organizations. These experiences are derived from programmes

which had available to them disproportionately large amounts of resources (when compared to the very small population served by them). Further, they had workers who worked with a missionary zeal. These certainly are not reproducible and they cannot be considered as alternative health care systems for the rural populations of these countries.

II. ALTERNATIVES IN HEALTH SERVICES UNDER DIFFERENT POLITICAL SYSTEMS

Formation of alternatives is thus essentially a political question. A crucial determinant of the nature of an alternative is whether there is a political system which continues to encourage a country to be ruled by an oligarchy or whether it actively promotes a change in the social system which enables the masses, particularly the underprivileged and the underserved, to actively participate and to have their say in the affairs of their country.

Under a political system which sustains the status quo which perpetuates an oligarchy, alternative systems are formulated either to find more effective approaches to serve the ruling oligarchy or, much worse, to provide on aura of legitimacy to an obviously unjust social system by arousing false hopes among the underprivileged and the underserved.

Development of super-specialities to provide services which are mostly accessible to the privileged classes can be cited as an instance of an alternative health care system within a political framework which perpetuates an oligarchy. Establishment in poor countries of Rotary Club-supported cancer hospitals, setting up of units for cardiothoracic surgery and neurosurgery and other such super-specialities and opening of elaborate intensive care units, form the medical care components of alternatives under such political systems. Campaigns for cancer control, development of genetic counselling services and control of noise pollution are examples of components of preventive services of such alternatives. Imposition of compulsory sterilization on the weaker sections of the population, without making available to them even the most elementary health care services and economic security provides another facet of an alternative within this political framework.

Efforts to cover up such obviously unjust and inequitous distribution of community health resources in poor countries by projecting manifestly unreplicable measures as miracle solutions of the health problems of the masses in these countries form an even more pernicious category of alternatives within political systems that are dominated by an oligarchy. Work by a highly respected clinician to develop "voluntary" health services in a periurban population of a few thousand with the help of heavy state subsidy, heavily subsidized health insurance schemes to cover some villages and state-subsidized health cooperatives to cover the medical needs of the "middle" classes are instances of this category of "alternatives".[2] In recent years, a number of Christian missionary institutions, which have extended their "charitable" medical work from the hospital to the community, have been projected with the help of a well-orchestrated propaganda campaign as alternative health care systems.[2] Here, again, adequate consideration has not been given to their replicability in the rural population at large.

In their eagerness to find alternatives within the existing political framework, unwittingly, or otherwise, research workers have lost sight of a most glaring sociological characteristic of rural populations of the poorer countries : the acute stratification of such populations into a small but all-powerful oligarchy which has a stranglehold on the vast masses of the dispossessed and the deprived population. It has been assumed that such a "community" can select its own health functionary, its own "barefoot doctor", and thus, it will be possible to have an alternative of "health *by* the people" as opposed to the earlier approach of "health *to* the people".

In a political system where there is a commitment to extend the process of democratization and involve the entire population in decision making, the circumstances for formulating an alternative health care system are basically different. In the first place, in such situations, there is considerable enthusiasm among the people to actively participate in the shaping of their health services system and in actually running it. Secondly, the very process of democratization ensures that those working at the technological levels are impelled to evolve an alternative technological framework which is more meaningful to the entire population, particularly to the weaker sections.

No doubt, more often than not, this commitment to democratization is used as a mere facade to perpetuate the old, unjust, social relations. It is also very likely that, under such political conditions, formulation of an alternative system, however scientific and relevant, becomes at best a mere academic exercise. Nonetheless, even an academic exercise can become a useful instrument for putting some pressure to bring about the desired political change by offering concrete, well-thought-out alternatives. It can, in any case, serve as a blueprint for action when the political changes finally take place.

III. DEVELOPMENTS IN THE HEALTH SERVICES IN INDIA

Truly conforming to what Gunnar Myrdal has called

the "soft state" character of the Indian political system, the political leadership of independent India, while solemnly promising to make available benefits of the health services to the masses, particularly to the weaker sections, not only perpetuated the old colonial tradition of having an urban, curative and privileged class orientation of the health services. It also actively promoted such a colonial outlook by making available disproportionately more hospital beds for urban populations, by setting up more extensive facilities for super-specialities which are accessible mostly to the urban population, by very rapidly expanding facilities for Western-oriented medical education and by abolishing the old licentiate medical course.

Recommendations by the Bhore Committee (Health Survey and Develcpment Committee),[3] which was set up by the colonial government of India in 1946, provided an almost revolutionary alternative to the then existing health care system of British India. Apparently inspired by the Soviet Union and by the welfare measures recommended by the Beveridge Committee of the United Kingdom, the Bhore Committee adopted the following as the guiding principles for its recommendations:

(i) no individual should fail to secure adequate medical care because of inability to pay for it;

(ii) health programmes must, from the beginning, lay special emphasis on preventive work;

(iii) the need is urgent for providing as much medical and preventive care as possible to the vast rural population of the country because they received medical attention of most meagre description although they pay the heaviest toll when the famine and pestilence sweeps through the land; and,

(iv) the doctor of the future should be a social physician attracting the people and guiding them to healthier and happier life.

Significantly, way back in the thirties, the leadership of the freedom movement in India had also accepted similar guidelines for developing health services for independent India.[4] The Report of the Bhore Committee, which was submitted just on the eve of Independence, should have provided a very valuable draft blueprint for a new approach to health services in India. In fact, the government of independent India readily accepted the recommendations of the Bhore Committee. However, apparently because of the political orientation of the leadership, the key recommendations of the Bhore Committee got considerably diluted and there was considerable delay in actually putting on the ground even those diluted versions of the recommendations. Ironically enough, the same political forces invoked the Bhore Committee Report and the urgent health needs of the "people of India" to perpetuate and actively promote the colonial tradition of the urban, curative and privileged class character of the health services system of the country.

Only after 20 years of independence was it possible to cover the rural population of the country by a type of primary health centre which is manifestly rudimentary and grossly inadequate, both in terms of the quality of the services as well as coverage of the population.[5] These primary health centres are a very far cry from what was suggested by the Bhore Committee: they did not have even a fourth of the "irreducible minimum requirements of the staff" recommended by the Bhore Committee (and that too as a short-term measure). During the same period spectacular progress was made in expanding the medical education system of the country, with expansion of hospital facilities in urban areas, both qualitatively as well as quantitatively.

Subsequently, some more efforts were made to develop alernative health care systems for rural populations. In 1963, a Government of India committee[6] recommended that rural populations be provided integrated health and family planning services through male and female multipurpose workers. But the clash of interests of malaria and family planning campaigns soon led to the reversion to unipurpose workers. In 1973, yet another committee[7] revived the idea of providing integrated health and family planning services through multipurpose workers. This time also, the prospect of effective implementation of the scheme did not appear to be very bright. Earlier, there had been at least two more efforts, both similarly abortive, to develop alternative health strategies. One, the so-called "Master Plan of Health Services" envisaged, (in 1970) more incentives to physicians, establishment of 25-bed hospitals and use of mobile dispensaries for remote and difficult rural areas.[8] The other,[9] apparently inspired by the institution of the "barefoot doctors" of China, was to mobilize an estimated 2,000,000 registered medical practitioners of different systems of medicine as "peasant physicians" to serve as rural health workers.

Because of this long neglect of health care needs of the masses, even today as many as four-fifths of the population of the country does not have access even to most elementary health care services.

The same "soft state" approach governed the formation of alternatives in medical education. The need to radically reorientate medical education to suit the conditions prevailing in India was recognized way back in the early fifties. Since then, numerous committees, seminars, conferences and workshops have dutifully reiterated the need for such reorientation. Yet the system of medical education remains heavily oriented to the conditions of the highly industrialized countries, with emphasis on highly sophisticated, curative practices, along

with all their paraphernalia of mystification, professionalization and total submission to the dictates of the drug industry.

IV. A PERSPECTIVE FOR FORMULATING AN ALTERNATIVE HEALTH CARE SYSTEM FOR INDIA

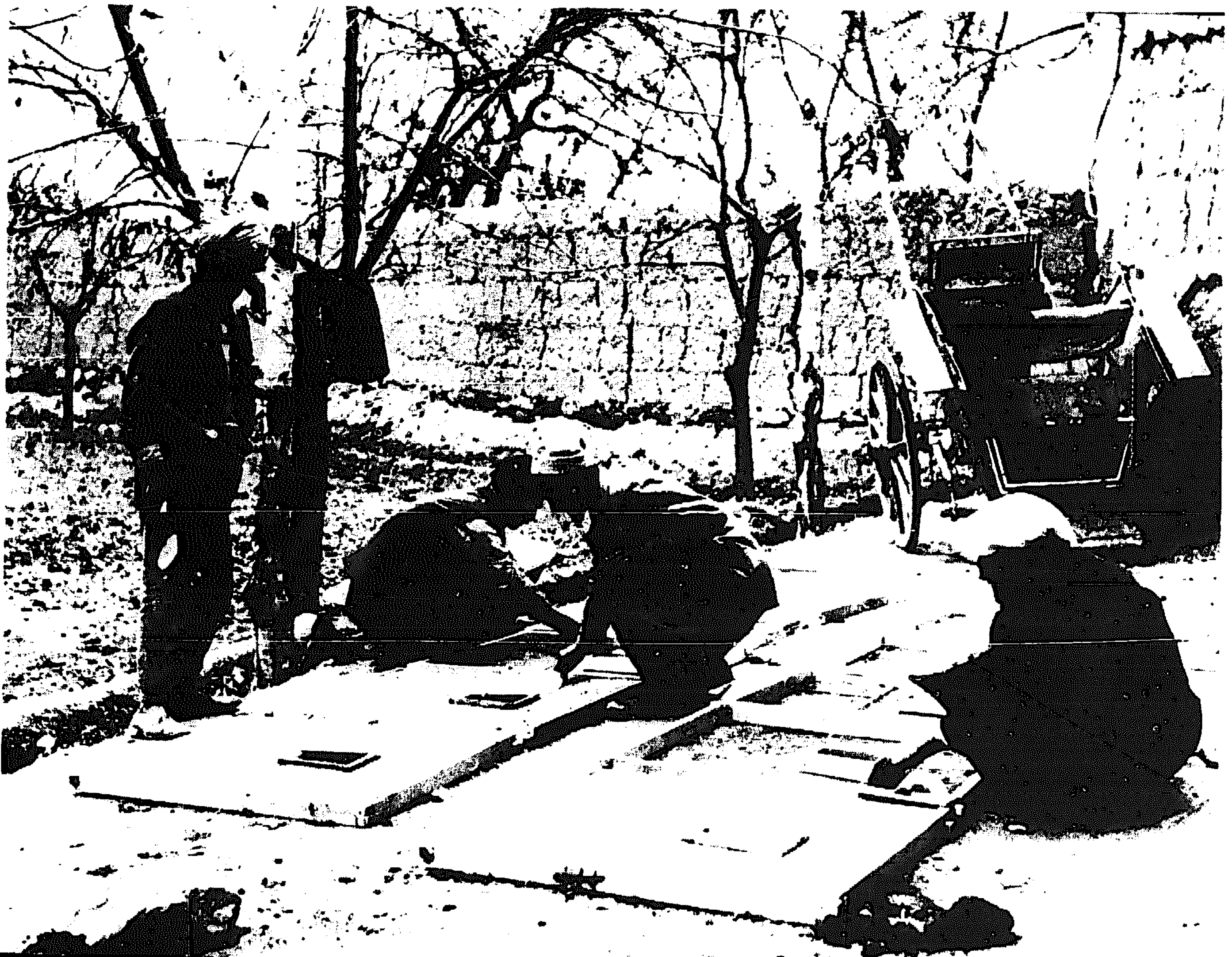
A political system that actively encourages a change process which promotes involvement of all segments of the population in the development of health services and in their implementation as a part of their involvement in the larger sphere of services in the social and economic fields, is an essential prerequisite for setting up any meaningful alternative health care system for India. Such democratization is not possible in a stratified society where a small privileged class controls the social and economic life of vast masses of the people. A campaign for active promotion of a people-oriented alternative health care system thus, in fact, becomes a potent tool for pressing for change in the political system.

As a result of democratization, medical technology is subordinated to the interests of the community: the health services system is demystified, deprofessionalized, debureaucratized and decommercialized to provide better services to the masses. Such a subordination of the medical technology to the community needs should lead to basic changes in the entire "culture" of the health services system: changes in the value orientation of the personnel within the services, changes in the institutions for education and training of health workers and changes in the approach to research.

Under such changed circumstances, the challenge in the field of research will be to develop a wholistic research perspective which covers the entire health system. Attempts thus far have been to see, in an arbitrary manner, often without using any research methodology whatsoever, only fragments of the whole, in the form of mass campaigns, basic health workers, multipurpose workers, difficult areas and peasant physicians and practice of the indigenous systems of medicine. Indeed, many of these fragments will acquire an entirely different relevance when they are seen from a wholistic perspective.

Active community involvement in building for a health project : villagers making cement slabs for latrines in Afghanistan.

UNICEF photo by J. Ling



Four major categories of variables which are obviously relevant for acquiring such a wholistic perspective for rural health services are:

1. *Variables related to the different dimensions of the various community health problems, including the ecological, cultural, social and economic factors which determine these dimensions of the problems.* For exemple, in the field of tuberculosis, epidemiological surveys provide vital information concerning the size, extent, distribution and time trends of the disease; assessment of tuberculosis as a problem of physical suffering and economic suffering and the response of the victims to such suffering provide information which is of critical importance for formulation of an alternative. Similarly, analysis of ecological factors, e.g., the resistance of the host, mediating factors in the environment and the virulence of the agent, provide critical insights for developing a more rational strategy for dealing with the problem.

2. *Variables related to identification of an appropriate medical technology.* It is essential that technology for dealing with a health problem is not considered in isolation from other factors which are relevant to the provision of health care to a community. A technology for a given health problem should be a part of a package of technologies for dealing with the health problems of the community as a whole; and that package has to be shaped to fit in not only with the agency for delivering the package but also with the acceptance of the package by the community, its applicability in terms of the resource constraints and its epidemiological relevance. There is thus an intimate and often very intricate interconnection, not only amongst various alternative technologies for a group of health problems, but also between such a package of technology with the epidemiological character of the health problems, available resources, agency for delivery, and above all, with the community or the consumer.

3. *Variables related to the agency for the delivery of health care.* Here, again, the community is the pivot. Social and cultural data are basic to identification of a network of personnel which will deliver the health services needed by the community. Such supportive factors as supplies, transport, referral system and the entire supervisory echelon are also included under this category of variables; and,

4. *Variables related to education and training of health workers of different categories, research, planning and evaluation.*

Consideration of the numerous variables under the above four, and other, categories requires adoption of a wholistic approach to formulation of alternatives. A health care system is an organized complexity in which its several components are in complex interaction with one another. As it is not always possible to take into account all the variables of such a system, it becomes necessary to identify at least the key variables within the system which are of decisive relevance. Data on the key variables are then used to formulate a number of alternative ways of providing health care. Making of forecasts (with or without the aid of mathematical models) concerning the relative effectiveness of the formulated alternatives helps in identifying one or more of them which is (or are) likely to be most effective. As the data that have been used for making such forecasts are not always very precise or even very reliable, and as the forecasts themselves have often to be made on the basis of some hunches rather then on well-established quantitative behaviour of the key variables, it is particularly important to subject the data and the postulates or hunches which led to the choices of the solution to practical test under live conditions. The choices should be test run, which either confirms the forecasts or, if not confirmed, provides a framework for making alternative choices. Once the choice is well tested, it is recommended for implementation on a community-wide scale.

Techniques such as operational research, systems analysis and linear programming are very relevant for studying such complex systems. By the use of such techniques, data concerning the different components of a system, which are derived from concepts and methods of a variety of disciplines, are processed and synthesized with a view to formulating an alternative system which is more effective; these techniques are used in an attempt to "optimize" the use of the available resources. These techniques also provide a framework for identifying the direction of research that is to be carried out in the laboratories, in the hospital wards and in the community at large in order to make the system as a whole more and more effective. It is particularly noteworthy that, in following such approaches to research, priorities for research in specialized areas are determined by the overall requirements of the health care system. Research in health care systems thus does not preclude research activities in highly sophisticated fields. It only ensures that, as long as the central focus is the community, the distribution of resources for research should be determined by the requirements of community health research, rather than by the personal preferences or biases of individual research workers.

V. SCOPE FOR IMMEDIATE ACTION TO IMPROVE THE HEALTH CARE SYSTEM IN INDIA

As has been pointed out earlier, increasing

democratization of the political system, through a change in the "culture" of the health care system, will stimulate research work which is specifically directed towards making more effective use of the resources for providing health care services to the people, particularly to those who were earlier neglected. This, however, does not imply that action will have to wait till findings from complex, time-consuming researches are made available. In fact, while such researches go on, the same political forces will actively press decision makers and research workers to come out with specific alternative programmes for immediate action that can be formulated by making judicious use of all available data and, where required, supplement the data with intelligent hunches. A built-in feedback system and ongoing research on the alternatives will ensure that the suggested alternative for immediate action is constantly monitored and its performance improved.

An obvious framework for suggesting an alternative to the existing approach of "selling" some technology to the people will be to start with the people. This will ensure that technology is harnessed to the requirements of the people, as seen by the people themselves, i.e., technology is subordinated to the people. This alternative enjoins that technology should be taken with the people, rather than people taken with technology, by "educating" them.

Based on their way of life, i.e., on their culture, people in different communities have evolved their own way of dealing with their health problems. This concept forms the starting point, indeed, the very foundation of the suggested alternative for immediate action. People, on their own, seek out measures to deal with their health problems. Meeting the felt needs of the people, which also happen to be epidemiologically assessed needs, receives the top priority in such a framework for an alternative. People should not be "educated" to discard the measures that they have been adopting unless a convincing case is made to show that, taking into account their own perspective of the problems and under the existing conditions of resource constraints, it is possible to have an alternative technology which will yield significantly greater benefits to people in terms of alleviation of the suffering than is caused by a health problem.

As is the way of life, health behaviour of a community is a dynamic phenomenon; it changes with changes in the epidemiology of the health problems, available knowledge relating to such problems, availability of resources and other such considerations. Therefore, to be based on such a dynamic phenomenon, the alternative for immediate action is required to be correspondingly accommodative.

More detailed suggestions for immediate action concerning the major components of the alternative framework which is based on the above concept are as follows:

Medical Care

Community members may be encouraged to make maximum use of self-care procedures through continued use of various home remedial measures. The services of locally available practitioners of various systems of medicine should be used as a supplement. Another supplementary community resource can be created by providing training to community-selected primary health workers, who are specifically drawn from among the weaker sections, who can make available home remedies and remedies from the indigenous and Western systems of medicine for meeting the medical care needs. Services of full-time health auxiliaries may be used only to tackle more complicated cases and those which need more specialized care.

Maternal and Child Health Services

Here also, the key workers are those who have, thus far, been providing services to the community: the family members assisting in childbirth and child rearing and the traditional birth attendants. The birth attendant or any other community-selected member can be trained as a primary health worker to work with the members of the community to improve the work that is already being carried out there and to provide assistance when called for. They, in turn, are backstopped by the full-time auxiliary health workers and by the primary health managerial physician and other referral services.

Findings concerning oral rehydration of children with severe diarrhoea provides a very valuable technological device which can be used by the mothers themselves when their children suffer from diarrhoea, with birth attendants, primary health workers and other full-time employees providing support to these mothers. Primary health workers, similarly, can be valuable agents for providing nutritional supplements, while the mother is trained to monitor weight gain of her child. The primary health worker, again, can organize the community resources to provide some form of a crèche to the children of the mothers who have to go out to work in the field.

Control of Communicable Diseases

Even with existing strategies which were mostly developed to deal with many communicable diseases as "vertical" programmes, PHC workers and other community-level personnel can take over many of the duties that are at present being carried out by specialized unipurpose health workers. Surveillance of malaria and smallpox, treatment of cases of leprosy, filaria and trachoma, spraying of houses

with insecticides and water management, including vector control, are some of the duties that can be taken over by the community. Demystification of diagnosis and treatment of tuberculosis patients has made it possible to bring about a shift in the work from trained professionals to workers at the community level and at the level of auxiliary workers at the health centre. Similar studies concerning other communicable diseases can also lead to demystification and simplification of technologies so that they could be made use of by the community itself or by auxiliaries with limited training.

Fertility Regulation Programme

The PHC approach, particularly when it is a component or a rural development programme, is likely to have a profound influence on the fertility regulation measures. Education of women, opening up of employment opportunities for them, their participation in community activities, greater social justice and fall in the maternal and child mortality and morbidity in particular, and of the mortality and morbidity rate of the total population in general, are likely to materially change the level of motivation for a small family norm in the community. Rise in the age at marriage of men and women is expected to have a direct demographic impact. Even within the limited framework of primary health care, methods such as the use of condoms and other "conventional" contraception, coitus interruptus, the rhythm method and the contraceptive pill may acquire much greater significance with the people.

Community health workers will be most appropriate persons to support such community activities by providing the needed contraceptives. They also can be a vital link for the community to make use of other methods such as male and female sterilization, induced abortion and IUD insertion at the health centre.

Environmental Sanitation Programme

Thus far, progress in this field has been very sluggish due to heavy cost and lack of community participation. Community involvement in environmental sanitation programmes through efforts of community health workers and interdisciplinary research efforts to develop technologies that are appropriate to the specific conditions in different rural communities will contribute significantly in increasing the cost-effectiveness of the programme.

Integration of Primary Health Centre with the National Health Services

It is essential that the principles underlying primary health care are fully accepted and assimilated at all levels of the health service organization, most particularly at the highest level of decision making. Specifically, among other considerations, this will involve adequate support at the levels of:

- Supervision: providing technical support, guidance and encouragement to workers at health centres and at the village level;
- Logistics: in the form of drugs, equipment, other supplies, transport, etc.; linking primary health care with regionalized health care services at the national level: by ensuring to and fro exchange of patients, personnel and facilities and developing a to and fro communication system;
- Community orientation of education and training of health workers: this is a most vital element for promotion of primary health care. It is essential for suitable socialization of community health workers. Concepts of organization and management of PHC are so articulated that they form the content of curricula for providing education and training of all categories of health workers, from the most sophisticated to the most elementary health worker;
- Research and evaluation: primary health care is a dynamic concept which needs constant monitoring and research input to improve its cost-effectiveness. The premises, the problems, require an entirely different approach to planning. Correspondingly, constant research efforts are required to keep on readjusting and reinforcing the programme to keep it in tune with changing conditions;
- Planning: principles of PHC require an entirely different approach to planning; it is planning for health and not for health services, with the understanding that such planning for health is a component of the overall socioeconomic planning. Secondly, even within the limited framework of planning for primary health care, emphasis on starting from the people requires an entirely different approach to planning, i.e., planning from below.

VI. SUMMARY

Formation of the alternative is essentially a political question. Health services and other social services and economic considerations that influence the health status of a community are considerably influenced by the nature of the political system of a community. In political systems which perpetuate domination by an oligarchy, alternative systems are formulated either to find more effective approaches to serve the ruling oligarchy or to provide an aura of legitimacy to an obviously unjust social system by arousing false hopes among the masses. A social structure manifesting acute polarization between the haves and the have-nots is inimical to the development of an alternative health care system for meeting the needs of the entire population.

Democratization of the political system is the key to the formation of an alternative.

In the case of India, where the process of democratization has not yet reached the underprivileged and the underserved to any significant extent, the health service system continues to nurture the colonial tradition of having a curative, urban and a privileged class orientation. The ruling classes have actively promoted those alternatives which served their interests. Expansion of Western-oriented medical education and establishment of more facilities for curative services, often of very sophisticated nature, in urban areas, are instances of such actions. Search for an alternative health service system to cover the entire population has been half-hearted. Even the few promising lines of action that were developed under such unfavourable conditions were not implemented effectively enough. A political system that actively encourages involvement of the entire population in the development of the health services and in their implementation is an essential prerequisite for setting up any meaningful alternative health care system for India. Democratization of the political system will subordinate medical technology to the interests of the community: it will be demystified, deprofessionalized, debureaucratized and decommercialized. It will bring about a change in the entire "culture" of the health service system.

The challenge in the field of research to form an alternative health care system will be to develop a wholistic research perspective for the health system in its entirety. Four major categories of variables which are obviously relevant for acquiring such a wholistic perspective are:

(i) variables related to the different dimensions of the various community health problems;

(ii) variables related to identification of appropriate medical technology;

(iii) variables related to the agency for the delivery of health care; and,

(iv) variables related to education and training of health workers, research, planning and evaluation.

While such researches go on, it is possible to single out specific alternative programmes for immediate action by making judicious use of all available data and supplementing them with intelligent hunches. These specific suggestions for immediate action cover the fields of medical care, maternal and child health services, control or eradication of communicable diseases, programmes for fertility regulation, environmental sanitation and integration of primary health care with the national health services.

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ON THE LIMITATIONS OF COMMUNITY HEALTH PROGRAMMES

Maria das Merces G. Somarriba

I. EFFICIENCY AND EFFECTIVENESS IN THE HEALTH SECTOR

The concept of the distinction between the efficiency and the effectiveness of a given organization seems quite appropriate to the analysis of the performance of health institutions. This is so because, as argued in the sociological literature on formal organizations, often the over-concern with efficiency (production of units of output) limits the scope of activities of an organization, while its effectiveness (degree to which it realizes its goals) might require a large variety of activities and a large amount of time.[1] And, more than in any other sector, there is a clear distinction in the health field between the quantitative production of services and the achievement of improvements in health conditions. Such improvements clearly are a relevant aspect of any health institution's goals, and they are, in the final analysis, the definition of the institution's level of effectiveness. By showing a concern for the distinction between the two concepts, we do not imply that they are independent when applied to the health field. Here too, as in any other sector, effectiveness presupposes efficiency. Why, then, is that distinction so important?

In the first place, health status is dependent on wider socioenvironmental factors. To this extent, the effectiveness of most medical interventions will be heavily dependent on factors which lie in fields beyond medical control.

Secondly, for complex reasons linked to social class interests in past and present times, current medical practice has been directed mainly at the extension of the concerns of clinical medicine. Meanwhile, the notion that most diseases are caused by socioenvironmental factors has been neglected. As a result, there is a contrast between the current efforts which stress new technical developments in medicine, and the decreasing returns to health brought about by ever-increasing investments in complex and expensive medical technology.[2]

The lack of correlation between investments in medical technology and health improvements is even higher among the people who have no protection against the harshness of the environment. In this context, the distinction between efficiency and effectiveness becomes crucial. In other words, the current medical approach, which lays stress on the production of health services, tends to be ineffective amongst the poor.

The distinction between efficiency and effectiveness in the health field underlies the proposal for community participation in health, which has been put forward recently.

II. THE PROVISION OF HEALTH CARE TO THE POOR: THE MEANING OF COMMUNITY PARTICIPATION

Justifications for the development of community health programmes are found, first of all, in the extremely uneven distribution of health resources prevailing in most capitalist countries. The utilization of auxiliary personnel and simplification in the use of technology in medical practice have accompanied the extension of health services through these programmes. To this extent, the strategy of community health deviates from the dominant concern of technological medicine.

Another reason for the development of community health programmes is the recognition that the dominant approach to health problems amongst the poor is ineffective. Many health experiments in poor areas have pointed out that, if the patient leaves the health institution (hospital, health centre, etc.) and comes back to the same unhealthy environment, he or she will probably soon need health care again. It has been widely demonstrated that the simple

provision of health care at the level of health units located outside the poor communities is not a useful way of tackling their health problems. As a result, the objective of medical practice put forward by community health programmes is not care to the individual as such, but to whole social groups, the poor communities. This kind of health programme lays stress on the participation of the whole community in the solution of its health problems. It is recognized that, unless the community involves itself in the health programme, all efforts to effect changes in the environment and in human behaviour, to produce a healthier way of life, will be lost. Community participation is seen, therefore, as an important determinant of the *effectiveness* of the health programmes.

At first glance, it appears that community health programmes question the main features of the dominant view of health care: they propose the reunification of the traditionally divided activities of public health (preventive measures) and personal medical care (curative measures); they supposedly break with the current medical approach since they bring back the lost idea that most diseases are caused by environmental factors; finally it seems that these programmes can contribute to reduce social inequalities in the health field, since they provide the extension of health care to social sectors formerly excluded from the programmes.

But, in so far as the model of community health has been designed exactly for the poor, a basic question arises: to what extent can this model be congruent with the principle of socioecological causation of diseases? The recognition of the role played by socioeconomic factors in the genesis of diseases points directly to the necessity for social reforms. The fact that the model calls for community participation at first sight, seems to be linked to such a necessity. To this extent, is the proposal of community health a modern version of the old and highly politicized concept of "social medicine"? As stated by Rosen,[3] this concept was developed in connection with the Jacobinic ideals of social equality when medicine was perceived as an instrument of social reorganization.

A brief analysis of a community health programme which has been carried out in a poor region of Brazil, can throw some light on the issue. Such an analysis will be made in the remaining sections.

III. THE NORTE DE MINAS COMMUNITY HEALTH PROGRAMME

The Health Programme Origins

In 1973, a basic agreement was signed by the Brazilian Ministry of Health and USAID to make available a loan to aid the establishment of health care delivery systems in the poorest areas of northeastern Brazil. In April 1975, a new health programme was started in Norte de Minas, utilizing the USAID loan and special donations provided by the Ministry of Health.

Strong emphasis was placed on the extension of the coverage of the health services, mainly to the rural areas. The higher authorities in the public health sector (Ministry of Health and State Secretariat of Health), increasingly saw the Norte de Minas programme as a pilot experiment for the establishment of an alternative health care delivery system in the poor areas of the country.[4] The programme was guided by the following basic principles:

First, there is the programme's *quantitative aim* to extend service coverage to at least 70% of the regional population. This is the aim that has been mainly emphasized by the international, national and state institutions that are financing the health programme.

Secondly, there is the *qualitative aim*. These services would be delivered within the scope of an integral service in which the preventive, curative and promotional activities are carried out concomitantly, as parts of one unified effort to change the population's state of health.

With the exception of the use of the experiment as a guideline for other regions in the country, the other basic principles could be seen as the *means* to achieve the model's quantitative and qualitative objectives. Among these means, one can distinguish, firstly, the basic set of politico-administrative activities which consist of the coordination of institutions, the obtaining of finance, the administrative decentralization and the establishment of a hierarchy of the health services. The centre of these activities is a set of institutions directly committed to health activities. The health system's clientele are not directly involved in these activities.

The second set of means has a sociopolitical dimension which directly involves the population who benefit from the services. These activities include the utilization of informal health manpower, the employment of auxiliary personnel and the participation of the local communities in the health system. The basic assumption here is that the region's health clientele will not only be a simple input of the system but will also become an actively integral part of it.

Now, let us briefly discuss the understanding of the programme's fundamental policy definitions among the people directly involved in the health programme implementation at the regional level.

The Regional Health Centre (RHC)* Ideology: Stress on Community Participation

At the level of the RHC, the health programme's original priorities underwent significant changes. This does not mean that a complete redefinition of principles and objectives had taken place. The RHC leadership group was conscious of the fact that the programme's continuity was dependent on the achievement of the basic goal for which the institutions providing financial support were looking. But there is strong evidence that community participation came to be regarded as a fundamental proposal which constituted an end in itself, even more important than immediate coverage extension.

But what concept of community participation did the members of the RHC technical team have in mind?

This question is very relevant because of the various views of the concept, both in the sociological literature, and in the several social contexts where there is some experience of popular involvement in concrete programmes.

In fact, the idea of community participation can, at one extreme, have a very limited scope with an emphasis on its immediate utility. For instance, it can be no more than the concern for getting the best out of human and material resources in cases where they are misued and dispersed, in order to increase the available resources for the provision of services. At the other end of the spectrum, the concept of community participation can imply a strong sense of social transformation, meaning even the redefinition of the power structure in a given social unit.[5]

The first concept of community participation can be viewed as maintaining close links with the traditional approach to community development, which lays stress on such issues as group solidarity, sharing values, consensual commitments and co-operative activities among the members of a community. The basic characteristic of this model is the weight it gives to the idea of common interests as a determinant of the social dynamics. According to this approach, the lack of mobilization of the community and of organization, supposedly found in most social units, are the main difficulties to overcome.

* In terms of the proposal of decentralization of health policy, formally stated by Minas Gerais health authorities, this state is divided into 16 Health Regions. A regional health centre constitutes the administrative body in charge of the public health activities in each region. The Norte de Minas Health Region covers around one million inhabitants.

Stressing the redefinition of the socioeconomic and political conditions inside the community, and also of the relationship between the community and the larger society, the second concept of community participation seems to be closer to the sociological approach concerned with "conflict theory". This theoretical approach emphasizes the role played by socially opposed interests in the determination of social development. This second approach questions the real possibilities of consensual commitments and cooperation. Although it does not deny the relevance of popular organization and cooperation for the solution of common problems, nevertheless it emphasizes the fact that, very often, people who are willing to engage in some kind of collective action, to realize a common goal, might be involved in a conflict situation, because people and social groups have different socioeconomic and political positions in most social units.[6] Given these differences in the social structure, too much emphasis on common interests can be unrealistic. It leads to the underestimation of actual and potential constraints which a mobilized and organized community has to face when it seeks objectives which are not so common and goals which are not so collective. This second approach would suggest that any community programme should start by identifying the main conflicts of interest inside the community.

In the Brazilian (and Latin American) context, the search for such an awareness regarding socially conflicting interests has been described by the idea of *conscientização* (consciousness raising). This concept, which owes much to Paulo Freire's approach to the educational process,[7] implies that the solution to the problems of the exploited people must ultimately come from the people themselves: those community sectors which have disadvantageous socioeconomic and political conditions must become aware of these disadvantages in order to be able to find solutions to their problems. After the people have become aware of the problems and have opted for change, they need to be mobilized to bring about changes in the socioeconomic structure and in the political structure which legitimates it.

It was verified that the RHC's top leadership group had developed a conflict view of community participation from their approach to the determinants of health problems, which underlies the model of community health.[8] Thus, the group believed that, since the main causes of ill-health in the region are related to the existing social inequalities, community participation should focus attention on the differences of interest found in the communities. The first step of this strategy should take place through *conscientização:* the programme's "clients" – the poor strata – were to become aware of the main conflicts of interest which affect their health chances within the

WHO photo by Y. Pouliquen

A health education lecture, using simple examples and advice, being given to mothers and children in Peru by a trusted member of their own community.

community structure. Thus, when the RHC started to implement the (abstract) model proposed from higher up, there was a diversion from the original proposal and all the emphasis was placed on a strategy of community participation which clearly has a political meaning. The team did not limit the proposed community action to consensual issues but devised a "maximal" strategy of community participation. Community participation in health programmes was perceived as a tool for pressing for changes in the economic and political system. Instead of th[illegible]d, the production of health services become the [illegible] of the proposed community health programmes: the highest priority was placed on using health as a way to motivate people to press for improving their overall living conditions. As a result, the model of community health which arises contains (potentially) the questioning of the social inequalities amongst classes, sectors and groups.

The following is a brief attempt to evaluate the viability of the health programme.

IV. OBSTACLES TO THE PROGRAMME

The extension of health services through community health programmes is primarily dependent on the coordination and reallocation of the available health resources, and/or the provision of additional financial and human resources in the health sector.

In terms of human resources, additional health manpower is generally provided through the wide use of auxiliary cadres. This has also been the case in the Norte de Minas Health Programme.

As for financial resources, the division of labour between the contractual health insurance sector and the public health sector, found in Brazil, is a key point. This division of labour separates those medical actions which are economically profitable (curative and mainly hospital-based medical care under the control of the health insurance sector) from those which are not profitable (curative and mainly preventive actions oriented towards large groups of people controlled by the public health sector). As such, this division can only be understood in terms of a political option towards the preservation and strengthening of private interests in the health sector.

The implication of this political option for a health programme which tries to break with the prevalent separation between preventive and curative care is that financial resources are likely to be scarce. As a

matter of fact, the overall amount of resources spent on health in the region is very low indeed. This is so because the expenditures of the social insurance sector in the region are low, particularly when they are compared to allocations in other regions. The situation could not be different since the funds of the social insurance programmes are usually spent on the more complex curative services provided by hospitals (generally under the control of the private sector), and hospital facilities are scarce in the region. The fact that 80% of the social insurance programme resources allocated to the region are spent in the main city – where hospital facilities are concentrated, and the private sector's interests are stronger – is the direct result of such a definition of priorities by those who control the health insurance sector. The result is that effective coverage achieved by the social insurance institutions in the region is very low, and the potential clients of these institutions must depend on the scarce resources of the public health sector for primary health care.

Also as a result of the dominant commitment to the private health sector interests, great difficulties have arisen in the many attempts at coordination between the RHC and the health insurance programmes operating in the region. These latter institutions continue to spend their comparatively low amount of resources on the kind of medical care which is used by a small proportion of the population.

Unless significant changes come about in the country which will redefine the priorities in health, as well as in other fields, there is little chance for the highly desirable reallocation of the resources in favour of the critical needs of the majority. The prevailing pattern of resource allocation in the health field is closely connected to wider political options which have been encouraging concentration of wealth and power in Brazilian society.

The productivity of the Norte de Minas Health Programme could be increased to some extent if the scarce resources of the public health sector in the region were spent in a more coordinated fashion. However, the very administrative structure of the Ministry of Health – organized around a number of organs which carry out their activities in a centralized and vertical way – seems to constitute the main constraint. At the same time, the poor administrative performance of the Ministry of Health seems closely linked to its growing weakness *vis-à-vis* the health insurance system.[9]

The extension of health services into the Norte de Minas is not enough to change the prevailing disease pattern, related as it is to the socioeconomic conditions existing in the region. To this extent, the concern shown by the RHC's leadership group with the transformation of the living conditions of the poorer sections of the communities surely is well-founded. As the strategy of community participation chosen by the group potentially involves questioning the basis of poverty and social inequalities, the health programme can develop into a tool for pressing for changes in the existing economic and political system. However, in view of the nature of the Brazilian State and the regional socioeconomic structure, there are very real obstacles to the RHC's attempt to achieve a greater range or depth of community participation. Some considerations of these issues are in order.

The prevailing national political strategy favouring rapid economic growth has led to a pattern of development highly dependent on the concentration of wealth and incomes. At the same time, economic efficiency has been achieved through the creation of severe constraints to political participation, mainly in relation to the popular classes. These broad trends at the national level are clearly reflected in the regional socioeconomic and political structure, where landownership remains highly concentrated, where the income levels of the majority remain extremely low, and where a new, very poor rural proletariat without rights is the result of the extension of commercial activities into the subsistence sector. The suppression of former movements towards unionization and agrarian reform, and the largely restricted political climate created after 1964, have helped to maintain the rural masses' low level of political consciousness about their situation of dependency and exploitation. Thus, on the one hand, thorough structural reforms will be needed to break the cycle of poverty-disease found in the region. On the other hand, the prevailing political climate obstructs any serious attempt to question the basis of the social disadvantages faced by the majority, as a threat to the continuity of the Health Programme. In the present context, we can hardly speak of the existence in Brazil of a national commitment to support/encourage, or even accept, active political involvement by the people. Therefore, concerning this first factor that influences the degree of community participation, the existing situation is highly unfavourable.

Concerning the institutional environment faced by the RHC, the concern with a greater range or depth of community participation separates the RHC from almost all other institutions and/or institutional levels involved in the regional health programme. Indeed, the quantitative production of health services is by far the dominant concern at the higher institutional level. This dominant over-concern with efficiency constrains the RHC team commitment to community actions, which require more time, effort and skill on the part of the health personnel. One example of conflict between the RHC and the State Secretariat of Health on the issue of the evaluation of the programme's productivity can illustrate this point.

A model for collecting information was designed by the central level to control the health units' "production". The RHC, however, expressed strong criticisms and disagreement with the great concern of the Health Secretariat for quantitative information:

"From the discussion on the Information Model, criticisms arose on its bureaucratic character. This model places emphasis on individual care in so far as it is concerned with quantitative information, such as the number of primary care contacts per person. We think that the work with collectivities needs to be emphasized. We decided, therefore, to prepare a bulletin containing general orientation on this matter, which has been delivered to the health auxiliaries."[10]

That bulletin stresses the low efficacy of individual health care to bring about changes in the population's health status and emphasizes the need for collective actions:

"We cannot limit ourselves to these actions with individuals or families. The most important task is to prevent diseases and this has to be carried out through collective actions involving many people at the same time... This is so because, for carrying out really effective action, we need to know, first of all, the real problems which influence people's health. These problems can be immediate ones as when there are cases of measles, typhus, etc., and, in this situation, quick action has to be taken in order to get people vaccinated. Or the problems may have a rather permanent character, as when they are linked to housing, nutrition, etc. In this case, there is the need for more long-term efforts."[11]

It seems that the conflict between the RHC and the central level concerning the evaluation of the health programme's performance is closely related to the frequent contradiction existing between the *effectiveness* and the *efficiency* attained by a given organization. In Norte de Minas, this contradiction between efficiency and effectiveness seems to arise because, side by side with the search for the extension of coverage – the model's *quantitative aim,* achieved through the increasing production of health services – there is the RHC's concern with the model's *qualitative aim,* i.e., the effective improvement of the population's health status. As we have seen, the RHC's leadership group stresses the social causes of health problems, as well as the need for collective actions of a political nature, which involve the complex idea of *conscientização,* for tackling the population's basic health problems. That is why, in the search for *effectiveness,* the RHC's top leadership group appears so committed to what could be called a "maximal" strategy of community participation.

At the same time, most institutions and/or institutional levels acting in the region place absolute emphasis on the vertical decision-making process, through their highly bureaucratized and centralized administrative structure. Consequently, the dominant ideas on the role of the clientele are highly inconsistent with the RHC's approach to community participation. There is far too little decentralization of government administrative decisions and procedures in the regional health sector for it to be consistent with the principle of community participation.

As for a third determinant of the degree of community participation, i.e., the degree of organization and communal solidarity at the local level, the existing constraints also cannot be underestimated. Firstly, the scattering of a great part of the regional population over a wide area leads to social isolation and acts against the development of links of horizontal solidarity among the clientele of the various auxiliary health units. Thus in some areas, even the lower degree of community involvement (for example, through self-help projects in which the whole community is supposed to contribute labour and/or material) can hardly be implemented. To this double isolation – physical and social – we must add the lack of provision of services and facilities by the state to the bulk of the regional population. Finally, there is the fact that the large landowners and traders have control over the basic means of production, namely land and the locally available credit. These factors together create a situation in which the poorer sections of the population tend to be highly dependent on the locally powerful. Such a dependency diminishes the possibilities of raising the level of collective consciousness amongst the poorer sections of the local communities. It constitutes, therefore, a limitation to the RHC's proposals in this connection.

From this summary of the main limitations to the health model, one can conclude that the proposals held by the RHC's leadership group, at the beginning of its activities, were both "idealistic" and "realistic". They seem "idealistic" in so far as they express a deep commitment to the betterment of the poor living conditions of the majority in such a discouraging social environment. But this commitment also has a strongly "realistic" sense, based as it is on the group's sensitivity to the socioenvironmental approach to health problems. It seems, therefore, that the regional health programme has faced, from its very beginning, the dilemma contained in the community health programmes which are based on the conflict model of community. Having been originally conceived as a pilot experiment for a moderate reform of the country's health system, it soon came to be viewed as a way of raising the consciousness of the poor strata about the deeply-rooted social causes of their health problems.

Thus, the dispute around the meaning of community participation, which necessarily characterizes the implementation of community health programmes in capitalist societies, emerged in Norte de Minas even before the local communities became involved in the health programme. This has been so because, first of all, the basic ambiguity posed by the fact that the call for participation in health has been directed to the poorest social strata was promptly and clearly perceived by the RHC's leadership group and secondly, because this group appears ideologically committed to serving the interests of the poorer sections of the population.

How this dilemma is going to be dealt with by the RHC's team is an open question. But there are grounds for expecting that, as the implementation of the programme proceeds, the team will conceive of concrete strategies which continue to keep the precarious balance between the many contradictions involved. This has been the case up to now. After all, when a group is really committed to the need for social transformation, its members are likely to find ways to face the contradictory features of social reality and to use them to bring about changes, even if on a small scale. There is little doubt that the RHC leadership group does indeed present such a commitment. Thus, the Norte de Minas Health Programme constitutes, without any doubt, an important experiment in the health field. It questions the basic features found in various degrees in the health sector of most capitalist societies. And, as these features – division between the activities of public health and personal medical care, prevalence of a curative approach, and wide social inequalities in the distribution of health care – are found in Brazilian society to a high level, the Norte de Minas Programme can be taken as a pilot experiment that puts into question the entire organization of the country's health sector. Given the critical problems found in this sector, that health programme will probably influence health policies, once more liberal political regimes come to be established in the country.

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CHAPTER VIII

DEVELOPMENT CAMPAIGNS IN RURAL TANZANIA

Budd L. Hall

In 1975, over three million people in rural Tanzania took part, though discussion and action groups, in a campaign on food production and nutrition called *Chakula ni Uhai,* (Food is Life). This campaign, made use of weekly radio broadcasts, printed materials and over 100,000 trained study group leaders. Early campaigns, on a small scale, were conducted on themes such as the popularization of the second five-year development plan, the 1970 presidential and parliamentary elections, and the celebration of ten years of independence.[1] The idea of development campaigns has further spread to Botswana, where a successful campaign on the first national development plan was completed in 1973.[2]

The development campaign as it exists in Tanzania and, to some extent, Botswana, is the manifestation of several different streams of activity. The illustration which follows perhaps shows this diverse parentage most clearly, regarding the most recently completed two-million-member "Man is Health" campaign.

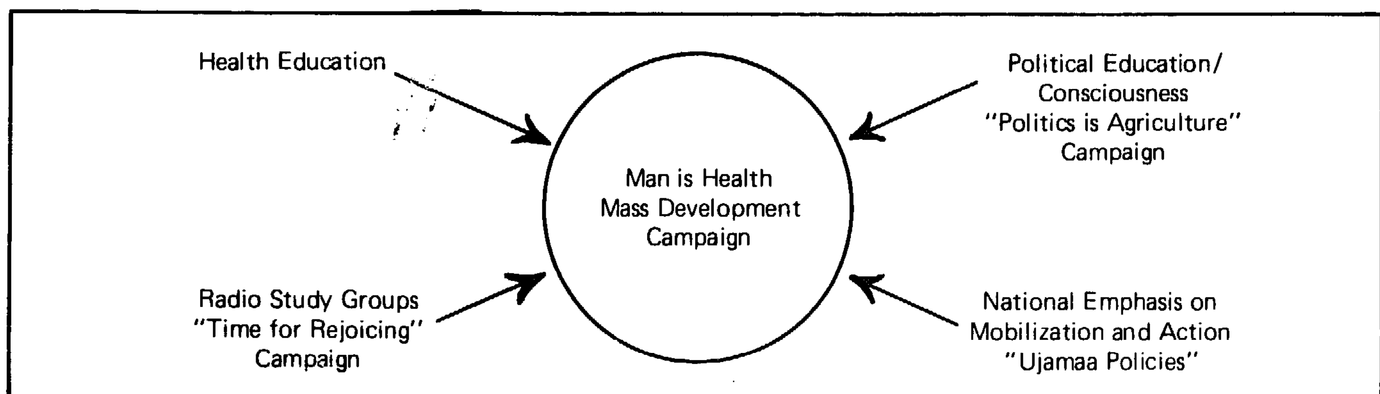
The "Man is Health" development campaign fits within the historical context of many development efforts and combined aspects of various antecedents in a national short-term (12-week) intensive campaign. It was an outgrowth of increased emphasis by the Ministry of Health on preventive or community medicine, an expansion of adult education experimentation with radio listening groups, part of the political party's (TANU) concern with increased political consciousness and awareness of the politics of health, and fell within national policies for bringing about a socialist rural transformation (Ujamaa).

The best way to illustrate how this kind of development campaign works is through a look at the results of a recently-completed campaign.

AIMS AND ORGANIZATION OF THE "MAN IS HEALTH" CAMPAIGN

The campaign had three objectives:

1. to increase participants' awareness of, and to encourage group actions on, measures which groups and individuals can take to make their lives healthier;
2. to provide information about the symptoms and prevention of specific diseases; and
3. for those who had participated in the national literacy campaign, to encourage the maintenance of newly-acquired reading skills by providing suitable follow-up materials.



Two elements were fundamental to the fulfilment of these objectives. First, there were preexisting structures available to implement the plans. Second, the planning was not rushed and it was thoroughly systematic.

Tanzania has built a widespread adult education network under the administration of the Ministry of National Education. It is composed of nearly 2,000 national, regional, district and divisional adult education coordinators and supervisors. These personnel are responsible to the thousands of adult education centres which operate using primary schools as bases. They are paralleled by a network of health education officers. Both sets of personnel were largely responsible for the day-to-day operation of the campaign, from the training of group leaders to encouragement during the broadcasting. They were supplemented by the networks of TANU and the Rural Development Division.

The planning for the campaign began 18 months before the first radio broadcast went on the air and was carried out under the guidance of a national coordinating committee which met as often as weekly during the more intense planning periods. The importance of this committee is that, from the beginning, as many agencies as were necessary to the success of the campaign were involved. A mass campaign at a rural level cannot be carried out by the activities of only one sector or one agency. It requires the coordinated efforts of all agencies working in the rural areas. At village level in this campaign, the adult education personnel worked with the rural development extension officers, the local TANU officials and the health education personnel in organizing groups before the campaign and in giving the groups support, once the radio programmes were under way.

THE STAGED TRAINING SYSTEM

Experience from the earlier radio study group campaigns indicated that a trained study group leader was essential to successful group activity. One of the most important reasons for training group leaders is to convey the message that group leaders are *not* teachers. A leader does not tell the group what to do or how to do it. The group leader is given training to guide group studies, to understand that he is only "first among equals". He must be trained in tact: to encourage the withdrawn, subdue the over-dominant and generally stimulate full participation. It is equally important to provide suggestions to leaders on how to move from discussion to action in the groups.

Logistically, the Tanzanian scheme required 75,000 study group leaders to be trained in 3 1/2 months. This was done by means of a staged training system whereby regional teams trained district teams who, in turn, trained the study group leaders at divisional level. There were 7 regional seminars for 200 participants (30 per seminar); 61 district-level seminars for 1,400 participants (25 per seminar); and 2,000 divisional seminars for roughly 75,000 study group leaders (37 per seminar). All the seminars lasted from 2 to 3 days.

An important lesson from this experience at mass training is that it is possible to ensure that the central elements of the training message survive the diffusion process from the first through the last stages. That is, no vital element need be damaged by dilution. This is one of the most crucial aspects in the development of a mass campaign. In the Tanzanian case, the key elements of the training message were maintained by several devices: centrally-prepared handouts (duplicated locally); the use of prepared flip-over charts summarizing the most important points of training; prerecorded cassettes of simulated radio programmes for role-playing experience; and copies of the actual materials to be used in the campaign.

THE GROUPS IN ACTION

The pattern which was most often followed by groups during the campaign was as follows:

1. assemble during the gathering time – the radio plays music related to the campaign, political songs, poems and short announcements;
2. the group members listen to the 20-minute radio programme;
3. the group leader or someone in the group reads aloud the appropriate section of the text;
4. discussion begins first with the question of the relevance of the material presented to the actual circumstances of the group's members;
5. discussion takes place about various persons' experience with the disease, alternative causes of the disease and possible ways of preventing it;
6. resolutions are made and agreed upon by the group for specific actions which could be implemented in the village; and
7. during the ensuing week – before the next programme – the resolutions are carried out by the group members and, most likely, others in the village.

A major difference between this campaign and previous attempts was the importance placed on action following discussions. The types of activities which individual groups undertook varied according to the reality in various areas. In a survey of 213 groups, it was found that clearing vegetation from around the homes was carried out by 28% of the

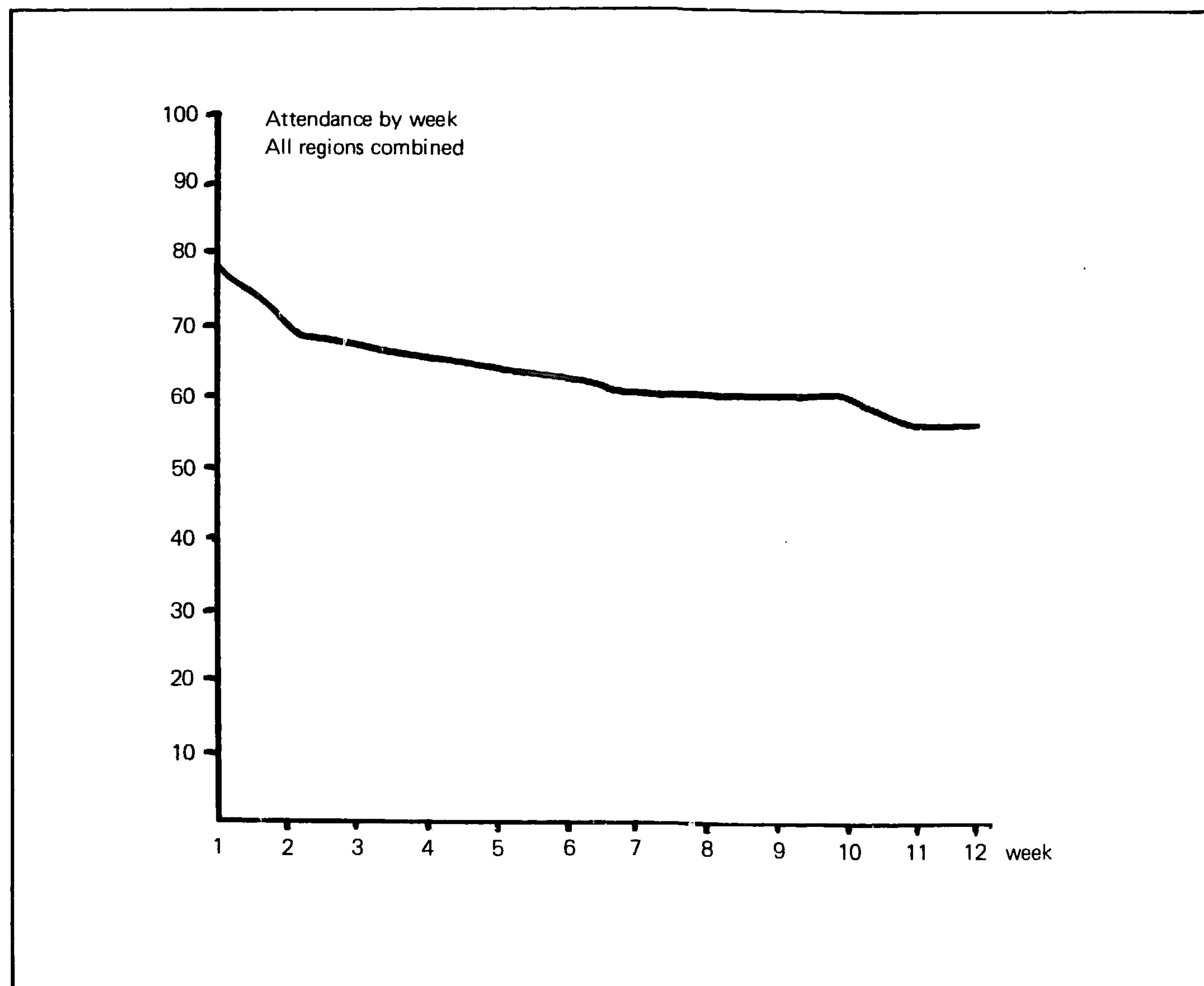
groups, digging, repairing or rebuilding latrines by 20%, destroying and cleaning the areas of stagnant water by 24%, boiling water 12% and cleaning the area around water supplies 11%. In one district, (Dodoma) about 200,000 latrines were built during the campaign period. The result at the end of the campaign was that not a single house was without a latrine. This happened in an area where colonial officers had tried to enforce latrine construction nearly 50 years previously with dismal results and much rancour. In one division in Iringa, the people decided that to have a latrine for each home was not enough. What, for example, could travellers use, while waiting on the side of the road for buses? The solution was obviously more latrines. It was agreed, accordingly, that one latrine would be built at each major bus stop in the area.

ATTENDANCE

The national average attendance figure for the campaign was 63%. That is, at any given session anywhere during the campaign, some 64% of those enrolled were probably in attendance. This figure can only be meaningful when compared with the average attendance of other forms of rural adult education such as literacy or political education classes. The Ministry of National Education estimates that actual attendance at any given session for the nearly 3 million persons enrolled in adult education classes is about 33%. The literacy project estimated between 25-40% attendances per session. This means that the attendance figures for the short-term campaign were quite satisfactory.

The following graph indicates the attendance pattern week by week. Several points are made. First it can be seen that, even for the first meeting, over 20% of those enrolled failed to show up. If the attendance figures were adjusted to exclude those who enrolled but never actually attended a session, the average attendance would rise to almost 83%. The second point that could be made (from the graph) is that attendance during the main part of the campaign was quite steady.

The change from the second through the tenth week was about 5% points.



WHO photo by Y. Pouliquen

A woman volunteers to become a health assistant. (Peru).

EVALUATION OF THE CAMPAIGN

Built into the campaign from the beginning were a series of measurements and sources of information designed to aid in an assessment of some aspects of the campaign. In addition to such routine interest as total enrolment, national distribution of groups and attendance rates, the evaluation design provided for the measurement of the amount of information gained through this method of study and a measurement of the change in observable household health practices as a result of the campaign.

As we start to examine the data from the control groups, we begin to run into some difficulties. Perhaps the foremost difficulty in selecting a control group during a campaign of this type is: how to find a group of people, in an intensive campaign designed to mobilize *everyone,* which has not taken part in the campaign in some way? In Mafia, for example, no control groups were chosen because it was said that, in a national campaign of this sort, all people had a right to participate in the health education. In Mitwara, the situation was similarly difficult as those in the control group were swept into the excitement of the campaign along with the other adult education students and began to study the material on their own. The result in this case was that the "control" group actually scored higher than the *Mtu ni Afya* groups.

Nevertheless, the *Mtu ni Afya* groups showed a relative improvement of 47% from the pretest to the posttest: an increase from 43% to 63%. The control groups taken together scored a 35% relative gain, from 43% to 58%. The *Mtu ni Afya* groups scored higher than the control groups, but this difference was not found to be statistically significant. Only when the scores from the energetic Mtwara "control" group are removed are the differences significant statistically. If the control group in Mtwara, the situation was similarly difficult as show an improvement of 21% compared with the 47% of all others. This difference is statistically significant as well.

Thus, we can say that there is a difference between the scores of all control groups and all *Mtu ni Afya* groups, but that this difference, the better scores of

the *Mtu ni Afya* groups, must be seen as a tendency only, not as a significant difference. If, however, one excludes the group in Mtwara which actually participated in the campaign, the 47% relative gain of the *Mtu ni Afya* groups is fully 26% higher than the 21% of the control groups. In this case the difference can be shown statistically *not* to be due to chance.

CHANGES IN HEALTH PRACTICES

Of particular importance to the campaign was the measurement of change in health practices. In a survey done of 8 villages before and after the campaign, a series of 11 observable health practices such as the presence of a latrine, the use of the latrine and absence of broken pots and pools of stagnant water, combined as a health practices index. Each household was surveyed and could score between 0 and 12, depending on the number of positive practices observed. Before the campaign, the mean health practices index for all houses in the 8 villages (2,084 houses) was 3.0 or 3 out of 11 observed positive health practices. After the campaign, the mean index was 4.8, a relative increase of 60%. In real terms, this means that each house in the entire sample improved their health environment by changing nearly 2 negative habits into positive ones. The largest change in these scores come from the digging and construction of pit latrines and clearing vegetation from the immediate vicinity of the house.

The final evaluation of any health education campaign must lie in the reduction of the incidence of disease. Provision of the measurement of the reduction of disease level was not provided in the evaluation of this campaign, as the isolation of the multiple factors associated with good health would have proved impossible given the nature of the campaign and the records available. There have been reports of a large increase in the number of people attending rural dispensaries in many areas. There is proof that large numbers of people participated in the campaign; that people learned from this method and that literally millions of hours were put into environmental changes as a result of the campaign.

FINANCE

The campaign was supported by a grant from the Swedish International Development Authority of 210,000 US dollars.* Of this capital, training accounted for roughly 36%, printing of study materials 50%, distribution another 6% and radio production and research the remaining 8%. The actual production of the radio programme cost less than 600 dollars additional capital. This is because production of the radio programmes made use of the already existing broadcast and radio facilities at Radio Tanzania and of the services of health education and adult education broadcasters whose work was covered in salaries already being paid by their respective institutions.** What this means is that the campaign was able to reach participants at an additional cost of roughly 0.10 US dollars per enrolee.***

SIGNIFICANT ASPECTS OF THE CAMPAIGN

It seems clear that the Tanzanian large-scale conscientization campaign in health education is one of the most interesting education projects to have taken place in Africa in recent years. Some of the most significant aspects and reasons why the campaign deserves very close study by those concerned with development, particularly rural development, are:

1. An atmosphere has been created in which people have been able to take some control of their own health. It has been all too common for people in rural areas to see illness as being related to factors outside their control, or as caused by sociological difficulties in the community with both present and past inhabitants. Where the possibility of help has been recognized, it is seen too much in terms of modern medicine – the provision of which is hopelessly inadequate in rural Tanzania. This campaign has shown that radio and other media can be used to raise people's awareness that they themselves have control over many of the common health problems and that groups of people working together can change many of the least healthy aspects of the village environment.
2. Large numbers of the rural population have been given access to specific and relevant information. The rural population makes up the bulk of all people living in Tanzania, as well as in most Third World nations. This campaign has shown itself to be very effective in reaching a very large portion of the rural population which has not, in the past, had access to more formal types of education because of high costs, shortsightedness in planning or simply different priorities.
3. The methods offer a realistic alternative to much-criticized "traditional" student-teacher relationships.

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* The Government of Tanzania annual budgets for related activities are: 1974/75 Adult Education, Ministry of National Education US$ 7,044,000.00.

** We assume, of course, that the normal work of those and other personnel continued, so that no opportunity costs were incurred.

*** This compares with about US$ 3.00 in 1972 per adult evening class student for 20 hours tuition per term.

The shortcomings of traditional student-teacher relationships have been criticized frequently by people such as Ivan Illich and Paulo Freire. It is clear that an educational setting for adults who are to direct their own development cannot rely on methods whereby one person is seen as an "expert" or teacher and possesses all knowledge and others simply recipients of knowledge. The emphasis in this approach is on complete and equal participation by the group members: they actively explore the relevance of the information to the reality of their own lives. This joint exploration creates lively understanding of a personal situation for each one involved and becomes a strong motivating element for improving community life.

4. Cost per participant is low.
   The campaign, by making use of a network of already existing extension officers and primary schools in combination with the use of radio programmes and mass-produced printed materials, was able to operate for about US$ 0.10 per group member. This is an example of the radical savings which can be obtained through a careful orchestration of mass media, mass organization and small groups. With smaller numbers of participants, the costs are higher, but still attractive. The campaign in 1971, which reached about 20,000 participants, cost US$ 0.56 per person.

5. Grassroots political structures were strengthened. The campaign was a cooperative effort by several ministries and the political party, TANU. In areas such as Dodoma or Mtwara, where the campaign was very enthusiastically received, the study group leaders were often the 10 house cell leaders of the party. The effect of this was to provide an opportunity for the house cell units to have the kind of participation in local decision making on which Tanzania is depending: people's participation in their own development, i.e., development *with* the people, not *for* the people.

6. The mobilization of large numbers of people necessitates an extensive administrative and communication network. The lesson of this campaign, however, is that it is possible to use already existing structures, such as an agriculture or community development extension system, providing these personnel are given some training in the new methods.

7. A centrally-planned campaign has some dangers. There are always dangers in a centrally-planned campaign that the educational content will be seen by both the planners and the people themselves as something which is not to be questioned but merely acted upon. There are many examples of health and family planning campaigns which merely pump the message into the heads of the people and expect results. Experience from the "Man is Health" campaign indicates that the number of campaigns which can be effectively done on a national level may be limited. The information which is presented needs to be of such universal concern to those taking part that it will stimulate their own analysis and they will thereby act in manners appropriate to specific local situations. There may not be many subjects which can by universally applicable. There is no reason why these same approaches could not be used at a regional or even smaller level.

8. An effective mass campaign in rural areas needs the coordinated efforts of all the agencies and ministries concerned.

   Without the coordinated effort of rural development officers, health education officers, adult education officers and some voluntary agencies, the results of this campaign would have been much less possible.

   Good health depends on more than the attention of the health officers. It means consciousness raising, assistance with construction skills, even increased community production in order to have the necessary cash to buy such items as window netting or malaria tablets. Effective rural development of any kind needs a frontal approach rather than a single sector approach.

   As the study of the campaign continues, it is hoped that the more detailed examination of factors contributing to the success of the campaign can be isolated. It is also hoped that some of the most important factors in planning similar campaigns can be indicated. Clearly this type of development effort has potential.

A WORD ON RECENT DEVELOPMENTS IN TANZANIA

A lot has happened in Tanzania since the 1973 health education campaign described in this study took place. In 1975, the country saw the culmination of a five-year literacy campaign that raised the literacy rate from roughly 25% in 1970 to 75-80% in 1975. This gain represents one of the most stunning educational achievements in Africa and an achievement that has taken place in a nation that is listed as one of the 25 poorest countries in the world.

1975 also saw the mounting of another mass campaign on food production and nutrition, the "Food is Life" campaign. (An excellent description of this campaign was written by the Director of the Institute of Adult Education, Fr. Daniel Mbunda, and is available in the first issue of the Tanzanian Adult Education Journal.) The "Food is Life" campaign was, in many ways, more complex than

the campaign described herein, since food habits and growing patterns vary from location to location. As with this campaign, there was a strong emphasis on practical achievement. Preschool community feeding programmes, workers' canteens, and widespread development of gardens were some of the results of the campaign.

In November 1977, the Ministry of Education announced the achievement of universal primary education ... a place for every boy and girl to attend school. The method used to accomplish this goal was to take the lessons from the mass campaigns for health, literacy, and other aspects of political education and to apply them to the task of primary education. The communities built the schools themselves with their own skills and, largely, with their own funds. The teachers have been, and are still being trained through a combination of correspondence education, face-to-face instruction, and radio lessons — methods first developed to reach the broad adult population.

What about more mass campaigns ? The situation is not completely clear. There are some in Tanzania who feel that large-scale campaigns divert resources and energies for programmes that produce short-term gains. But there are others who counter by saying that campaigns have demonstrated a capacity for doing what cannot be done in any other way and what is needed is the better linking of such large-scale efforts with ongoing programmes. Two topics for further campaigns, the role of women in development and the use of appropriate technology, are being discussed in 1978. Whatever the decision, the programmes that are adopted will be carried out with considerable boldness.

The campaigns and the successes of adult education programmes, along with other accomplishments in Tanzania, are announced with a combination of fanfare and humility. But they should not be seen as models to be picked up and used. There is much room for improvement, much need for criticism, and great cause for a continuing struggle. Nor should this paper be used as a blueprint. It should, instead, be seen as the presentation of materials for discussion and reflection.

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PART III

COMMUNITY PARTICIPATION: A PROCESS

Development planning has traditionally been focused on methods of increasing production in order to increase the GNP (gross national product) of a country. Only recently have planners begun to think that people and not products should be the focus of improvements. Because cost-benefit analysis fails to provide tools for planning for the development of people, many have taken an increasing interest in education. Rejecting the traditional teacher-student formal institutional approach, they have centred their attention on non-formal education. Essentially, non-formal education stresses the process by which adults change their attitudes and, eventually, their own behaviour. Owing much to the thinking of Ivan Illich and Paolo Freire, non-formal education denies the imposition of a Western industrial model and searches for way to bring positive change to communities within their own culture and value system. The importance of this process in supporting a community participation strategy has already been mentioned by Hall (see chapter VIII). In this section, we examine the critical dimensions of this process and their relevance for involving people in taking responsibility for their own development.

Because this process is not necessarily related to health care, although health may be a good entry point, one of the two pieces in this section analyzes some of the more general but very critical aspects of change. Both essays, however, do address questions of the necessity of changing the traditional approaches that outside planners take to a community. They deal directly with the problems and practicalities of a people-focused development strategy.

In the first article, Andreas Fuglesang explores some of the reasons new knowledge is accepted or rejected by people living in rural areas. He looks at communications in terms of an educational process and suggests ways in which it enters or remains outside people's internalized thoughts. In doing so, he analyzes the structures of a community and helps us to understand how these structures, firstly, influence community reception to change and, finally, influence change itself. It is a study of the interface between community organization and community action.

The second selection, written by David Werner, views the aspects presented by the previous authors in a health-specific context. Based on his experience of eleven years in a Mexican village and his recent travels to assess community participation in a variety of health programmes throughout Latin America, Werner illustrates the results of the Freire approach to the educational process. His matrix of "community-oppressive/community-supportive programmes" shows how and which processes help wider development in health care.

FROM EXTENSION TALK TO COMMUNITY THERAPY

Andreas Fuglesang

It may be that there is ultimately one kind of development only and that is development of consciousness. Adult-literacy programmes, agricultural extension work, health education, etc., are maybe just different angles of approach to the same basic goal. There are many paths to the centre of the village.

I have never liked the concept of the extension talk. It is a great mistake to think that something is happening just because you see somebody standing talking in front of a group of villagers. I am not sure whether I am any better off with the idea of community therapy. I may lead the reader to think that I consider the village community sick. Far from it. What I mean is that everybody, if they want to, has the right to get rid of the sickening bitterness of a low-quality life. i shall develop this idea in the following pages.

Figure A

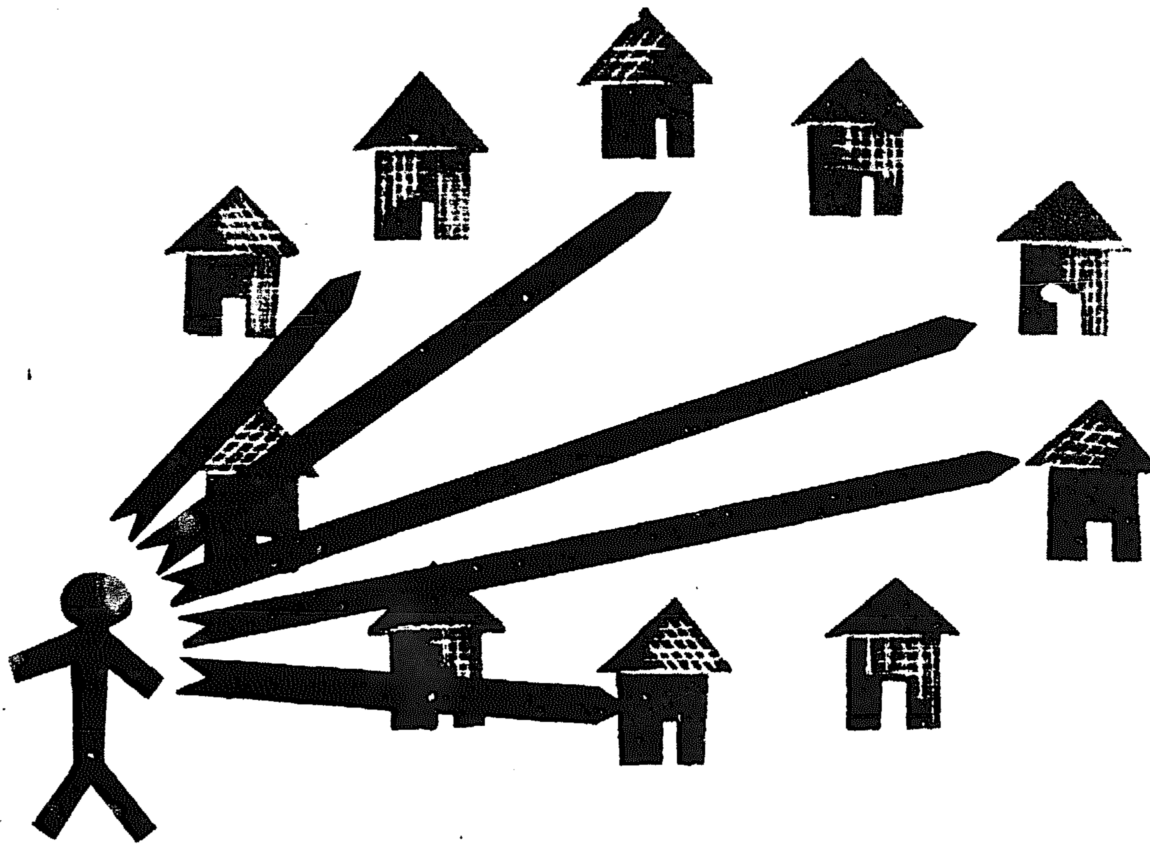


Figure B

WHAT IS A COMMUNITY?

When a stranger from the Western world or a local townsman looks at a village, he sees something like this: a number of houses, individuals or entities grouped together in space (Fig. A). It is here that the observer makes the first and fundamental mistake. He superimposes some basic experiences from his own society on his perception of the village. The modern industrialized society is characterized by increased individualization and specialization: the former in the general approach and attitude to life and the latter in the work routine. Both are definite prerequisites for development of a technological society. All development is differentiating. It moves from the general to the specific, for example, from the all-round farmer to the man who does nothing the whole day but determine the sex of chickens.

This process of individualization and specialization is also responsible for an emotional experience which seems to be unique to the citizens of the technological society and which regularly crops up in modern literature as the crisis of man: the feeling of being alone in a crowded apartment house, the fact that you don't know the chap in the flat next door; the problem that nobody visits you, because relatives and friends are all living far away or do not want to be set upon during an evening stroll; the pushing to be somebody, realizing that you are nobody; the identity problem (who am I actually?). In short, the fact that modern society is experienced just as a number of individuals.

As a logical consequence of this, the extension worker, the local professional, the "expert" or the volunteer perceives himself as somebody who is supposed to communicate with, and influence, a number of individuals living in these village houses to like a defined and desirable type of action (Fig. B). This is the extension-talk approach, the preaching approach. This is also exactly the opinion and the attitude of "the Establishment" and this is the second fundamental mistake we make in communication work. Just listen to the glossy modern terminology: TARGET POPULATION (we are going to hit them), MESSAGE DESIGN (with streamlined bullets), MULTIMEDIA (in a machine-gun), CONSENT ENGINEERING (and make them surrender). We cannot get on with the work until we realize that this approach is completely useless, linked, as it is, to the archaeology of communication: the Pavlovian stimulus/response model (call it the message model), the sender/recipient model, the action model or whatever you like.

General information, massmedia or extension field work: this model predominates in all communi-

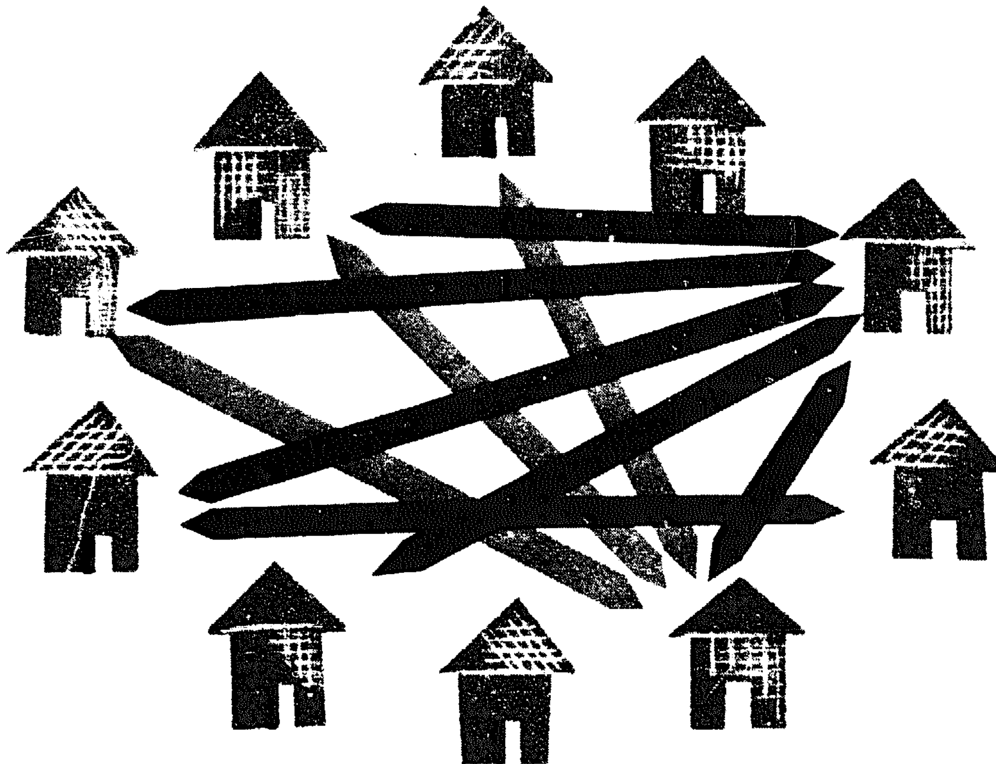


Figure C

cations thinking, so that action is based on the delusion that a defined information input automatically leads to a defined response. I have pointed to the fallacy of this model before and there is reason to expand on it here. Communication people perform a lot of verbal magic over the professional top hat and let loose dozens of rabbits in their terminology, just because they look so good on paper. The deception in these fine words is that we think we can work with a high degree of operational control and precision.

There are two other rabbits which are a bit harder to swallow: EXTENSION WORKER and CHANGE AGENT. Whose image is the extension worker extending? What social detergent is he an agent for? All this one-way thinking is simply a little embarrassing. There is no humaneness in it. Besides, it puts professionals in the villages in a very awkward position, though they are usually not aware of it. They are led to believe that they are something more than the villagers. They are educated. They are specialists. They have mastered a subject field, in contrast to the villagers who only possess knowledge of a general character.

Their experience of the modern society is that the specialists have AUTHORITY because of their professional competence. Their advice is listened to more or less automatically. Not so in the village. The "expert" is worth nothing until he can prove his worth on a purely human basis. That involves two-way communication. It involves participation. It is, therefore, more important that people in the field are good listeners than that they are good talkers.

THE INTERNAL COMMUNICATION SYSTEM

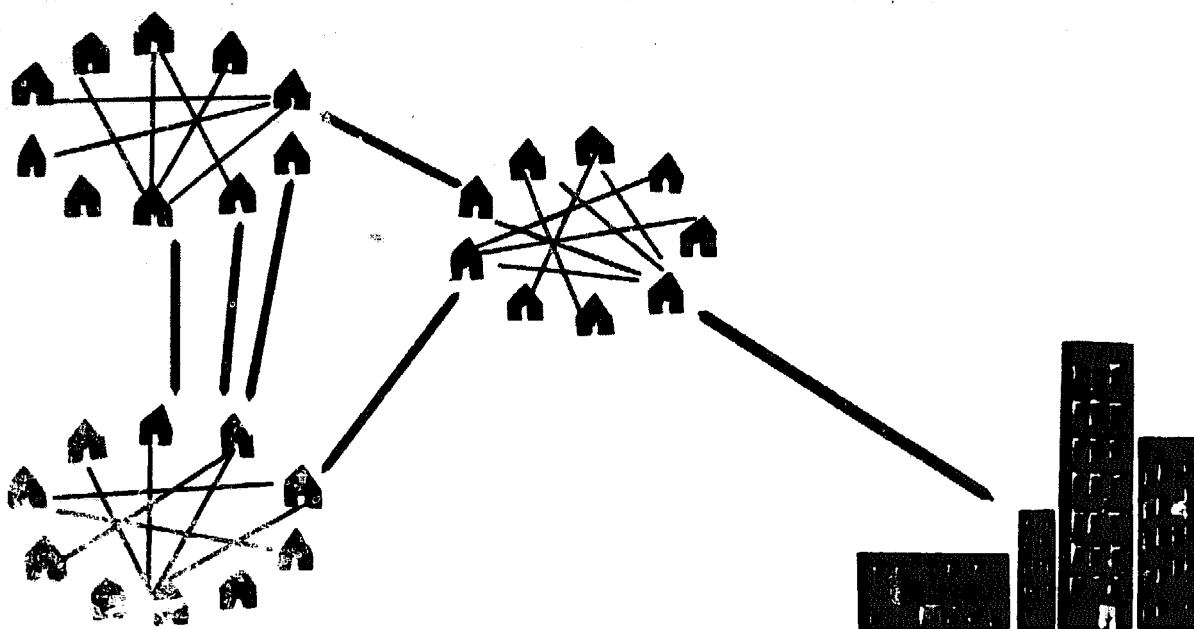
What else is a village but a number of families? It is, in a very real and true sense of the word, the fact that people live in a community with each other. They live in COMMUNION. If you stay for a while in the village and have some skill in observation, you will realize that to live in communion is very different from living in a block of flats. Life is characterized, above all, by intense internal communication and interaction. If you are a very patient observer, you will, as time passes, find that there is a set pattern in the communication activities. We can, with some justification, say that there is an INTERNAL COMMUNICATION SYSTEM in operation (Fig. C). You will observe that people are walking in and out of certain people's doors more often than they do with others. They are seeking out some people at the meeting place for a talk more often, and spending more time

with them than with others. The pattern is stable, but also somehow alters dynamically with time and circumstance, and with subject matter. To my mind, there is no doubt that this internal communication system, to a very large degree, determines the attitudes and actions of the individual in the community. The individual is, first and foremost, a group member. The internal system has a normative, steering effect on his decision making. The villager is not individualized to the same extent as his educated counterpart in town. His decisions are not to the same extent his own decisions. An illustrative example I met with was the young woman who had five children and wanted no more. The question was whether she should have a loop inserted. But the problem was that it was not her decision. Nor was it her husband's decision. It was the grandparents who had to take the decision, because they had, according to the tribal rules, the right to the children.

If we look at the community in a wider context, we shall find another very significant trait from a communication point of view. Figure D is an attempt to picture proportionately the communication contacts or exposures. There is intense internal communication in the family units and between them in the village communities; there is some communication between various village communities, and relatively little communication with the outer world. Anybody who lives in a village for a while is capable of observing this phenomenon and some of its more unpleasant consequences. The outer world is represented by the presence of mass media, often in a variant of a vernacular language which is not fully understood, the odd relative or friend who has been to the big city, but whose function as an information source is not exactly objective, and the government official, who comes and disappears in a Landrover duststorm every now and again with annoying queries, forms to be filled in, and promises. Afterwards nothing happens, and, if it happens, it is only after a very long while. When will officials and professionals realize that there are too many surveys and too little action? In my experience, the village community has every reason to be suspicious of the outer world. There is lack of communication and lack of knowledge, but there is also bad experience. These conditions impair to some extent the ability of the villager to evaluate information from outside in a reasonable way. Above all, it makes him evaluate the credibility of communication messages on a scale on which those from outside are considered less credible than those from the immediate environment.

As we shall see later, this has consequences for the communication policy in development programmes. The villager sometimes feels inferior to the stranger from outside and he fears him. The village gossip can very soon make the stranger a monster. But, as a whole, the village people's capacity, including their emotional capacity, is grossly underestimated. It hurts to be "underdeveloped".

Communication cannot succeed unless there is a sincere feeling of equality in the system. This is a premise which cannot be repeated often enough.



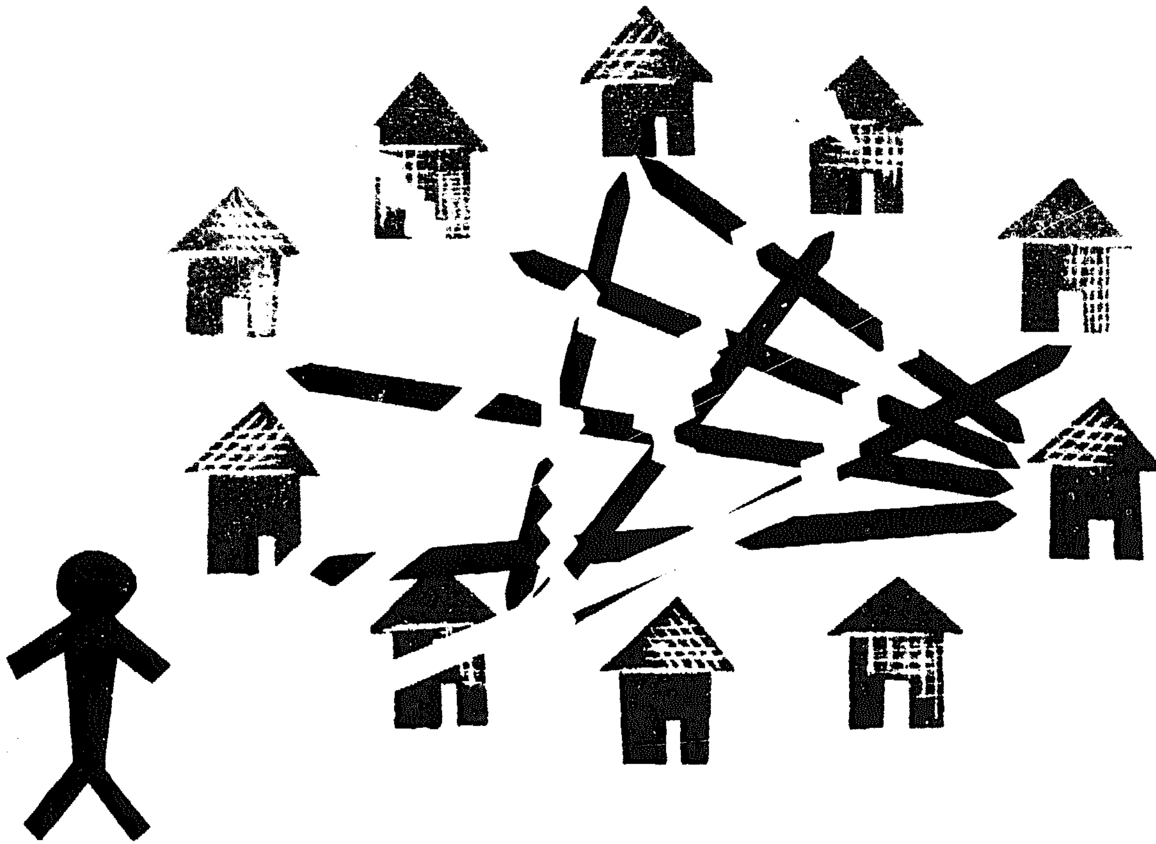


Figure E

Figure E may illustrate the mess of conflict which arises when the artificial message model communication system, the extension preaching approach, is superimposed on the natural one in the community.

The professional's messages are colliding all the time with the messages which are already floating in the internal system. The former type of message is the modern technological and scientific knowledge based on a rationale. The latter is the traditional knowledge based on authority and experience. Although I fail to see any distinct differences personally, there is undoubtedly sometimes conflict in the factual content of the messages of the two systems. When the agricultural extension worker explains to the farmer that he must lay the plough furrows in a certain profile, depending on the terrain, it may well be better applied knowledge than the traditional way of ploughing in a criss-cross fashion. But one must not always take that for granted. Traditional knowledge would not have survived through the centuries, if it did not have certain merits.

One tribe used to scrape a certain mould off rotting trees and apply this to infected wounds. The health education officer insisted that it was harmful practice, until he saw the healing effect. It was later ascertained that the mould actually contained penicillin. Nor should one underestimate the farmer's professional judgement as the agriculturist he after all is. The new plough with a steel share may be better than the traditional one in normal soil. But in certain types of hard soil it is not pointed enough and the angle of the share is too steep. The result is that the new plough bumps and the farmer can, with justification, maintain that it is more awkward to use than the old one. But the possible conflicts of the communication messages cannot be referred to the factual concept alone. They have reference also to the fundamental attitudes behind the approach to reality of the two systems.

OPINION LEADERSHIP AND AUTHORITY

There are centres of gravity in the internal communication system of the community, as I have mentioned earlier: people whose advice is sought more often than others and whose statements about matters are listened to, even if they have not been asked for, etc. A word which is often used about such people is OPINION LEADER (Fig. F). We know that they are there. The problem in practice is to identify them. The essential point is that they will, more often than not, differ with the subject concerned and their function is totally informal. It

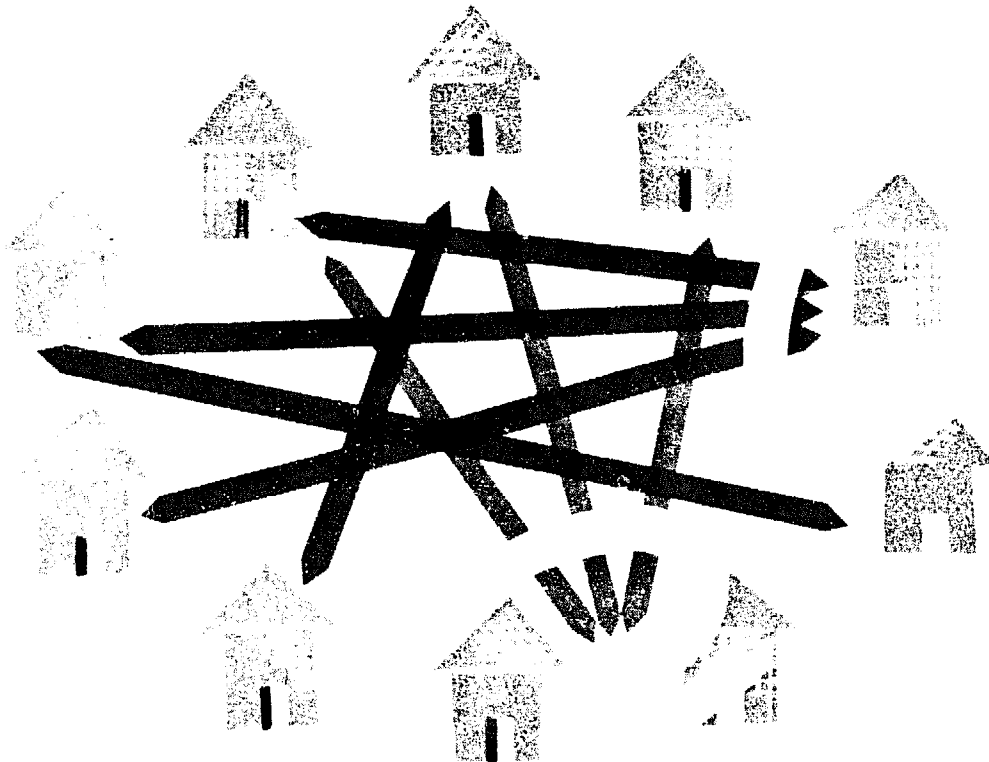


Figure F

may and it may not coincide with the formal organization of the community. The chief or the village headman may be the definite opinion leader in matters related to marriage quarrels or land disputes but in other matters he is not. The opinion leader concept may be seen also in relation to the idea of "shared interests". In a village I visited, the opinion leader in all matters related to the town and news from and about the town was an old house servant who had lived in the capital for many years. All incoming news was checked with him for credibility. In another village, the opinion leader in agriculture was a middle-aged progressive farmer. The local party branch secretary is very often the village spokesman in relation to government, at least in countries where there is political movement in the rural areas. It is necessary to realize that the importance of opinion leaders derives only partly from the fact of their specialized knowledge.

Their credibility and the authority of their personality seem to be of great significance in the eyes of the community. Although the emotional experience of exposure to authority is probably the same in modern society as in the village community, there are some differences in the premises for authority which we should have a look at.

This is an extreme simplification, but, in my experience, it carries some essential truths which it is important for the "expert" or the local professional to be aware of, if he is going to establish a working relationship with the village community. This is the difference in attitude to life. I have earlier touched on the problem of authority. I have over the years witnessed one "expert" after another falling into the same trap. The question of authority is absolutely vital in any communication context, because it stands for the credibility of the message in the eyes of the other party.

In the modern industrialized society, authority is delegated downwards in a hierarchical system. The next model (Fig. G) also illustrates the principle that development is a differentiating process, moving from the general to the particular. So the authority of the specialist or "expert" does not derive from himself but from his position in the system. It is the system which entitles him to take decisions for other people, makes them obey his orders and listen to his advice. Not so in the village. The "expert" or local professional who bases his work on that assumption is hard up, and many do that, unfortunately.

As I have tried to illustrate in Figure G, the concept of authority seems to have another dimension in the village community. Although there are, of course, hierarchical structures on the national or tribal level, a person's authority in the village does not derive from the fact that he is "high up". It is, in a way, more connected with the idea of being nearer to the

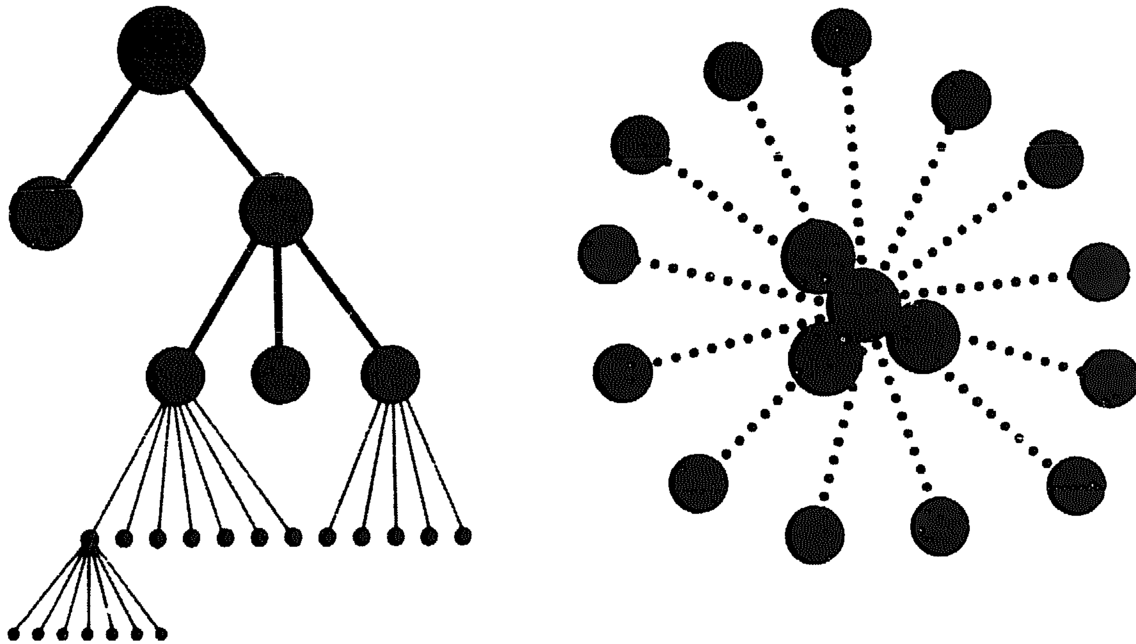
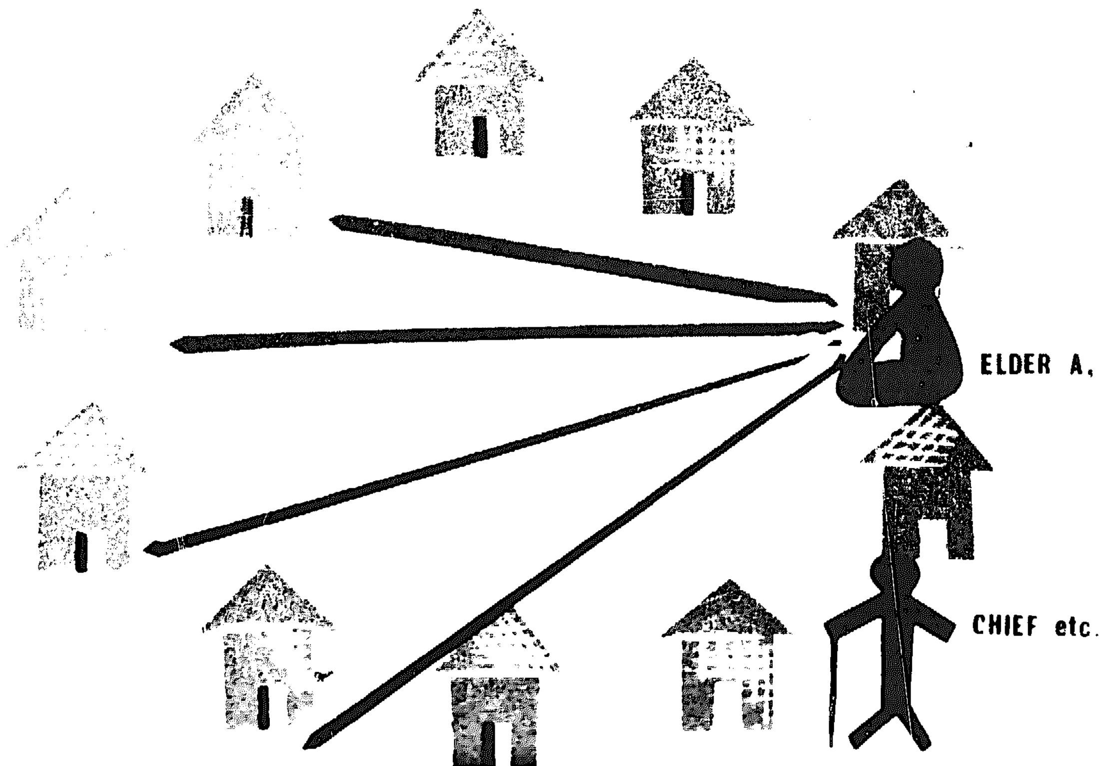


Figure G

centre of attention, both in a spiritual and physical sense. That picture is sometimes even reflected in the spatial layout of the village. Authority in the community is derived more from the person than from the system. It radiates from performance and personality. In a hostile environment, under circumstances in which the individual can survive only as a community member, the centre of the group circle has a deep significance, but so has the periphery. The centre is protected by the periphery and keeps it together at the same time. The relationship is dynamic; the centre today may be approaching to periphery tomorrow. The tale of the great hunter is still very much alive. The "expert" or professional from outside has to understand that psychology.

Figure H



INTEGRATION

Returning to our original model, we may now perhaps see that the art of applied communication in community field work is to INTEGRATE ONESELF INTO THE INTERNAL COMMUNICATION SYSTEM which is already in function. In other words, the community educates itself and the ideal "expert" or field worker eliminates his professional presence as much as possible. The village teacher, the elder A or whoever is the relevant 'opinion leader becomes instead instrumental in relation to the community (Fig. H). The approach certainly has its danger. It requires a high degree of maturity and judgement on the part of the field worker. He may very easily ally himself with the wrong people in his working context and thereby accentuate latent oppositions in the community. Therefore, initially, his problem is not a professional but a purely human one. He has to go through what can be suitably called his INITIATION period, the period of reading up and listening in. Acquiring systematic knowledge of the local customs through the available literature is essential and living in the village no less essential. If the "expert" could go to his initiation with the same humbleness and sincerity as the youngster in the Lunda tribe in the North-western Province of Zambia goes to his *WUYANG'A* ceremony, it would be very good for his future work. There are stages in the development of a good communicator. First, there is the *KUWELA* ("to wash oneself"): to be clean and ready, free from preconceived opinion and prejudice. Then there is the KU-SUKULA ("initiation to huntmanship"): the moments of sensitivity and listening, when the budding hunter is under the tutelage of experience, personified in the great hunter who teaches him the bushlore, the practical tracking of the objectives. Finally, there is the *KU-TELEKSHA* ("causing to cook"), in which the hunter kills an animal and provides a COMMUNION MEAL for an assembled company of hunters. This is the fiery ordeal, the test of his maturity, judgement and personal performance, and his acceptance as an equal in the communication system.

AWARENESS: A PRFREQUISITE

But there is a certain prerequisite which must be there. There must be AWARENESS in the community of the issues of the development programme the "expert" or field worker is working for. This is the function of the growing mass media like radio, TV, vernacular newspapers, etc., whether the issue is family planning, nutrition, health education, community development, agriculture or something else (Fig. I).

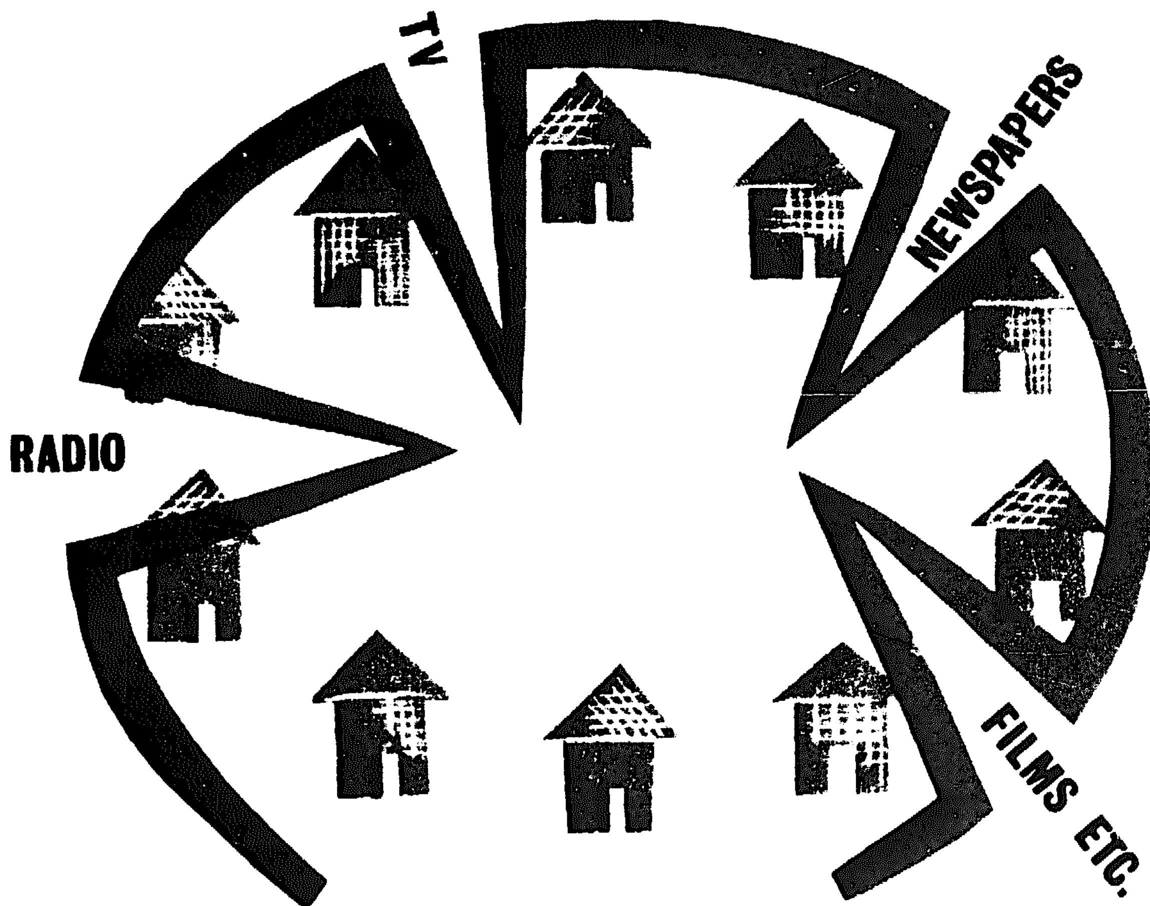


Figure I

However, it is necessary to look at the media concept in a much wider sense. It is a question of INTEGRATING THE ISSUE IN THE TOTAL INFORMATION ENVIRONMENT OF THE COMMUNITY. An information medium, therefore, is any vehicle which can carry a message. Some development issues, like nutrition and agriculture, lend themselves naturally to this total integrated approach; others are more limited in their scope. But it is, in any case, all a matter of pragmatic interaction with the reality of media opportunities. In most developing countries, the school system is a major medium. Adult literacy programmes are the same. The extension services, ranging from agriculture to public health, are also media which can carry messages related to their objective. On the other hand, there are a variety of media opportunities with origins in the traditional society which have hardly been discovered as yet. In Nigeria, touring companies of traditional actors have been used in family planning promotion and film production. In Ghana, the market women represent a social media role which should not be underestimated. Local comedians, storytellers and singers are channels open to utilization.

The creating of awareness is the standard information approach and will not be detailed here. The secret is to work on a national basis, partly FORMALLY through ministries, official committees, etc. and partly INFORMALLY through direct mail contact and other informal channels to the people in the field, ranging from primary school teachers to chiefs and district officers.

Awareness in the community of the development issue concerned is a prerequisite for any later stage of field work.

FROM AWARENESS TO CLOSENESS

What about the "expert", the volunteer, the local professional, the field worker himself: how can he integrate, rather than intrude? How can his knowledge and advice be present in the internal communication system while he is standing outside it?

The answer, communication-wise, is to advance from awareness to CLOSENESS. In my experience, closeness depends on two main factors. Firstly, it is the QUALITY OF THE FIELD WORKER as a human being, his personality, his ability to identify with the community, and above all, his SENSITIVITY in human relations. Secondly, it is a matter of a certain level of cognitive knowledge, as I have mentioned earlier, of local customs and beliefs, but also of group dynamics, perception psychology and related fields.

This viewpoint has vast implications for the selection and training of field workers. The selection must be based on personality variables like attitudes, and on performance in groups and similar criteria. The training must advance from being only the transport of cognitive knowledge from one brain storage to another to being the development of communication skills. Communication exercises and sensitivity training become keywords. The knowledge of the development issue itself is really sometimes of secondary importance.

This is not the place to go into detail regarding this issue. It shall be mentioned only that there is now available, within the field, an elaborate practical methodology. It is possible through exercises and staged learning experiences to sensitize field workers and other communicators to the feelings and needs of their recipients and to develop their consiousness and ability to analyze human interaction. This is, to a large extent, just a matter of restructuring the conventional staff training programmes and defining them in closer relation to simple performance objectives. What do we want the field staff to do with their knowledge? How do we train better communicators? An excellent introduction to the field is *"Handbook of Staff Development and Human Relations Training: Materials Developed for Use in Africa."*[1]

But the problem of better communication with the village community can ultimately be solved only by a commitment to equality on the human level.

TO BE PART OF THE CIRCLE

Some more should be said of the field worker's integration in the community.

In the development of consciousness, nobody is the teacher. The teacher is just one of the group (Fig. J). The group is teaching itself. It cannot be an objective to transfer knowledge and values from a group in society which is powerful to groups which are less powerful. It is the dialogue between groups which can bring society forward and it is the dialogue which is the tutor in the circle. Each man and woman is a creative being who has knowledge and experience of value for the development of the community and society at large. It is a complete misconception that village people are ignorant. They just have another type of knowledge.

To help people to become conscious of their potential as creative beings, to make them see that they can control their environment and themselves in a better way, is the task of the field worker, whatever his professional starting point. Regarded in this way, his work is community therapy and as such, depends entirely on his ability to BE, literally,

Figure J

IN TOUCH with the community (closeness). How do the villagers conceptualize their world? The field worker can come to understand that only by being sensitive enough to "live himself into" their thinking. But, without using as a measure stick the conceptualization he is born with himself, he must nevertheless be clearly conscious of that conceptualization all the time. We can understand other people only by understanding them in relation to ourselves. To identify the internal communication system and, above all, to identify the community as it expresses itself in its use of language becomes the field worker's immediate task.

TWO INVESTIGATIONS

I shall mention specifically and recommend for reading two recent reports which are both very illustrative of the points which I have made in the preceding pages on a communication strategy in the community.

Karl D. Jackson and Johannes Moeliono presented, in October 1972, an investigation which they undertook on communication and national integration in Sundanese villages in West Java. In their conclusion, which is based on the documentation of thoroughly quantified data, they state, amongst other things: "Rather than adopting technologically flashy, prestigeous, expensive and new communication alternatives, communication strategists should aim for maximum, short-run behaviour change in the villages. In Sundanese villages, this implies increasing the use of traditional communication networks to amplify the effectiveness of administrative and mass media communication. Policy planners must resist the all too natural tendency to adopt the newest hardware as a means of avoiding the much more difficult job of connecting existing hardware and administrative capacity with the traditional leadership structures at the local level."[2]

That the practical problem is the link-up between the mass media and the personal face-to-face communication is illustrated also in a report on a nutrition mass communication campaign undertaken in the rural areas and small towns of India by Ronald Parlato et al. (February 1973).[3] The authors realize, as in many other similar investigations, that the capacity of the mass media is limited to the creation of awareness and understanding.

Feeling the missing link between knowledge level and behavioural change, they conclude by pointing out the necessity of integration: "Without large segments of the population becoming aware of a new idea and understanding it fully, no extension agent can operate effectively. Without the credible, believable extension agent, the best information presented will never be fully used

These two practically-oriented reports are worth study by any communication practitioner.

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CHAPTER X

HEALTH CARE AND HUMAN DIGNITY – A SUBJECTIVE LOOK AT COMMUNITY-BASED RURAL HEALTH PROGRAMMES IN LATIN AMERICA

David Werner

Permit me to begin with an apology. I am not a medical professional. My experience lies in grass-roots medicine in Latin America. For the past eleven years, I have been involved in helping foster a primary health care network, run by villagers themselves, in a remote mountainous sector of western Mexico.

During the past year, a number of my coworkers and I have visited and studied nearly forty rural health projects, both government and private, throughout Central America and northern South America (Mexico, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica, Ecuador, Colombia and Venezuela). Our interest in these programmes grew out of the widespread use of *Donde No Hay Doctor* as a training and work manual for primary health workers throughout Latin America. *Donde No Hay Doctor (Where There is No Doctor)* is a villagers' medical handbook which I initially wrote for use in our programme in the mountains of Mexico. Our objective in visiting different village health programmes has been to help foster a dialogue among the various groups, as well as to try to draw together many respective experiences, insights, methods and problems into a sort of field guide for health planners, so that we can all learn from one another's experience.

I would like, on this occasion, to look at rural communities, and to explore with you the ways in which existing health programmes help either to cripple communities or to make them whole.

The idea of a health care project or programme being a crippling force may come as a surprise. Yet, as I will try to clarify, to whatever extent a village health care service creates a one-way dependency on outside resources and directives, it becomes a crippler as well as a crutch to the community.

In Latin America, as elsewhere, modern medicine has been a two-edged sword. Not long ago, there were countless remote villages that, for better or for worse, stood on their own. They had their own medicine men, midwives, bone-setters, tooth-pullers, psychic healers and priests. Life in these villages was at times hard and at times gentle, at times long, too often brief, but it was fairly much in balance. The village community was a more or less complete entity, largely self-sufficient with the pride, integration and dignity that come from self-reliance and self-direction. Then came that new magic, that new mystique – Western Medicine – with its esoteric priesthood of university-trained practitioners. Their renown and their wonder drugs, if not their physical presence, quickly spread to the most remote jungles and mountain valleys. In spite of attempts by the medical profession to legally sanctify its stronghold over prescription drugs, a clandestine market sprang up. Soon, folk healers, bone-setters, midwives and mothers had added antibiotics, oxytocics and a range of other pharmaceutics to their gamut of herbs and home remedies. A new breed of "modern" folk healer, the *medico practicante,* or empirical doctor, arose, assuming in the villages the same role of self-made diagnostician and prescriber-of-drugs that the neighbourhood pharmacist has assumed in the larger towns and cities. The magic of the injection held special power over people's imagination, and soon nearly every remote village had its *inyectadoras* or women who inject.

Needless to say, the abuse and misuse of modern medications by this army of empirical healers have been enormous (as, in fact, have been the misuse and overuse by the medical profession itself!). Yet the net impact on morbidity and mortality has been, at least from a short-sighted perspective, positive. With the introduction of antibiotics, antiparasiticals, and to a lesser extent, vaccines, fewer children have died of infectious disease. As the population has correspondingly increased, the crippling impact of malnutrition has gone forth and multiplied. Under the growing pressures of population, the [illegible]

of land tenure and distribution of wealth have become more oppressive. As a result, rural communities which once were self-sufficient and proud have come to depend more and more on outside help: for medication, for food supplements, for education, and – most demeaning of all – for values and direction. In response to the growing plight of rural populations, the political/economic powers-that-be have assumed an increasingly paternalistic stand, under which the rural poor have become the politically voiceless recipients of both aid and exploitation.

This state of concomitant *aid and exploitation* still dominates the health care picture in much of Latin America today, as it does in many parts of the world. The medical empire has geared its services, its medicines and its hardware (even its textbooks) to such tremendous profits that it has, in large part, priced itself out of reach of the majority of the people, thus making subsidized services the only obvious alternative. Compounding this dependence on charity is the fact that, in Latin America, the professionals, although rarely willing to serve communities where the needs are greatest or to work for an income that will truly serve rather than bleed such communities, have been notoriously reluctant to share their knowledge or rights-to-practice with members of these communities who are eager to learn and who would willingly serve their people's health needs, voluntarily or for modest remuneration.

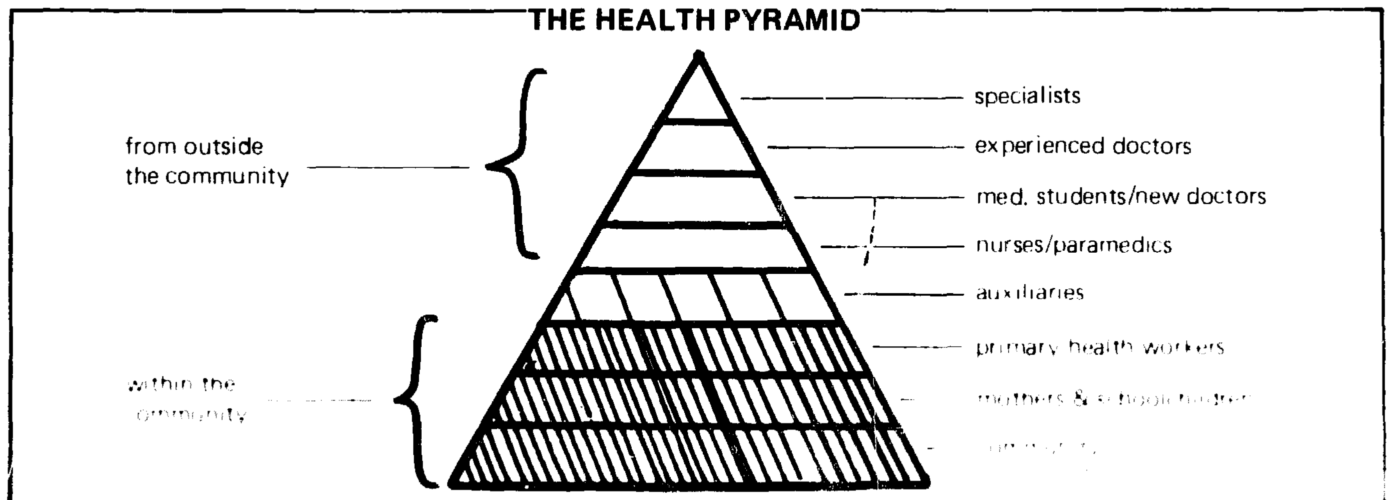
When we asked the pioneers of rural health programmes we visited in Latin America what they saw as the major obstacles to bringing effective health care to the people, the most common replies were "doctors" and "politics".

However, over the past decade, a change has been underway. There has been a general awakening, or at least the beginnings of an awakening, to the need for a more realistic, more truly equitable approach to health care. The trends which have been taking place in this recent renaissance of health care are summarized in Outline 1.

The overall trend, at least in theory, is from a fragmentary to a wholistic approach to health care. It involves a shift from providing high-cost curative services to a select few, to providing low-cost preventive and curative care to as many of the people as possible and, ideally, to all. To do this, the concept of the health "team", or skills pyramid, has been introduced, of which the basic work force is composed of local, modestly-trained village health workers, often referred to as *promotores de salud* (health promoters). In some programmes, the base level of the health team or pyramid is considered to be composed of mothers and schoolchildren – whose collaboration as health workers is fundamental – or the base line of the health team may, and I think should, be regarded as the community itself.

Perhaps one of the most important trends, but one we found actually happening in relatively few areas, is the effort to have more and more of the skills pyramid filled by local members of the rural community, and progressively less by outsiders. One programme in eastern Ecuador, working with the Shuar Indians, has set its goal to eventually replace all its field professionals – nurses, doctors, veterinarians, agronomists and even legal counselors – with persons from the Shuar villages. The programme is providing the necessary scholarships and encouragement. Whether or not the chosen few, once they get their degrees, will return to their villages and work for the modest earnings the communities can afford, is yet to be seen. Unfortunately, our formal education systems do far more to wean people away from the rural environment than to prepare them for staying there. New ways need to be explored, and new education opportunities designed, which will allow villagers to

THE HEALTH PYRAMID



substantially increase their technical knowledge and skills *without* tearing them away from their communities.

As is indicated in Outline 1 under "Focus of Action", there has, of course, been a trend in rural health care not only from curative towards preventive medicine, but, by taking into account the causes behind the causes of poor health, towards the integration of health care with other aspects of community development. Hence, the most recent trend is now to include health care as but one sector of an Integrated Development Programme which also covers education, community leadership, agricultural extension, communications and marketing improvements, intermediate technology, etc. In fact, some of the most exciting work we saw, with the greatest impact on the health and vitality of the communities involved, had its major thrust in agricultural extension rather than on health care *per se.* In one programme in Guatemala, sponsored by Oxfam and World Neighbors and focusing on agriculture, the resultant increase in food production has not only directly improved the nutrition and health of the people, but has generated an income which has permitted the community to cover costs of other improvements rather than be dependent on outside help.

If integrated development is to be taken seriously, and if a programme is really trying to confront the underlying issues which affect the health, well-being and future of a given people, it must, of course, take into consideration the sociopolitical situation, including the debilitating influence of paternalism and exploitation. Such considerations have led some rural health projects to work through group dynamics to promote *conscientization* or social awareness and to become involved with land and social reform. However, many of the groups we visited in Latin America would have nothing at all to do with such politically "hot" issues, either because they didn't dare to, or because, for obvious reasons, they didn't care to.

However, even if a programme does not touch upon issues of land reform or social justice, even if it does not hold discussion groups to encourage *conscientization,* if it is truly trying to help the community stand on its own feet, issues of social injustice and land inequity will eventually come up, if indeed they are limiting factors to people's well-being. This can be a serious consideration in nations where 10% of the populace owns 90% of the land and wealth. And it can be a serious consideration for foreign or international health and development agencies.

Perhaps the key question, then, is whether the outside agent-of-change, or sponsor – be it a private, religious or government group, be it domestic, foreign or international – really wants, or can afford, to allow rural communities to have substantial choice, or voice, in matters of their own well-being.

As is indicated at the bottom of Outline 1, another of the recent trends in rural health care has been a shift from many small pilot projects operating in circumscribed geographic areas, to large regional or even national programmes. Many of the early attempts at community-based health care, including the training of village health workers and cooperation with traditional midwives, were launched by private or religious groups, many of them "expatriate" (American, Canadian, British, German, etc.). Throughout Latin America, there has been a proliferation of these "pilot projects", some of them successful and enduring, others appearing and disappearing, here and there, like fireflies. Often there has been a lack of communication even between nearby projects, and sometimes a not-so-healthy competition. However, some of the most exciting and effective community activity we observed is being fostered by small non-government projects. One of the key questions today is *if* and *how* such activity can be replicated to reach more people. As a foreign consultant in El Salvador puts it, "We've had enough pilot projects. It's time we stopped reinventing the wheel and got busy helping it to roll! "

And so we find that on the heels of the many private and religious projects, and sometimes nipping at their heels, has come a wave of regional or national programmes administered by respective ministries of health. Today, nearly all the countries of Central and South America are engaged in launching or expanding "community-oriented" rural health programmes incorporating the use of marginally-trained health workers and the so-called "control" of traditional midwives.

Surprising similarities exist in the format and structural details of many of these different government health programmes; surprising until one realizes that nearly all of them are aided and monitored by the same small complex of foreign and international agencies: WHO/PAHO, AID, IDRC, IDB, UNICEF, FAO, Millbank Foundation, Rockefeller Foundation, Kellogg Foundation, etc. Often, a single health or integrated development programme will have financial or advisory input from as many as three or four of the above agencies or foundations.

An entire jargon has evolved for those who are "hip" on community-based rural health care. From country to country, one hears identical motifs, e.g.: "Primary decision making by the members of the community", "Response to the felt needs of the community", "The primary health worker chosen by the members of her community", "Priorities must be determined by the community itself". The ideas behind these axioms are, of course, fundamen-

tal. But, too often, they are as foreign to the communities they are aimed at as to the health ministries on which they have been superimposed. If there were a little less rhetoric behind these slogans and a little more reality, the state of rural health care in Latin America might be far better off than it is today.

In our travels through Latin America, we were struck by the fact that often the policies or activities of the many different health programmes we visited tended to fall somewhere along a continuum between two diametrically opposing poles:

1. **Community-supportive** programmes or functions are those which favourably influence the long-range welfare of the community, that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision making and self-reliance at the community level, and that build upon human dignity.

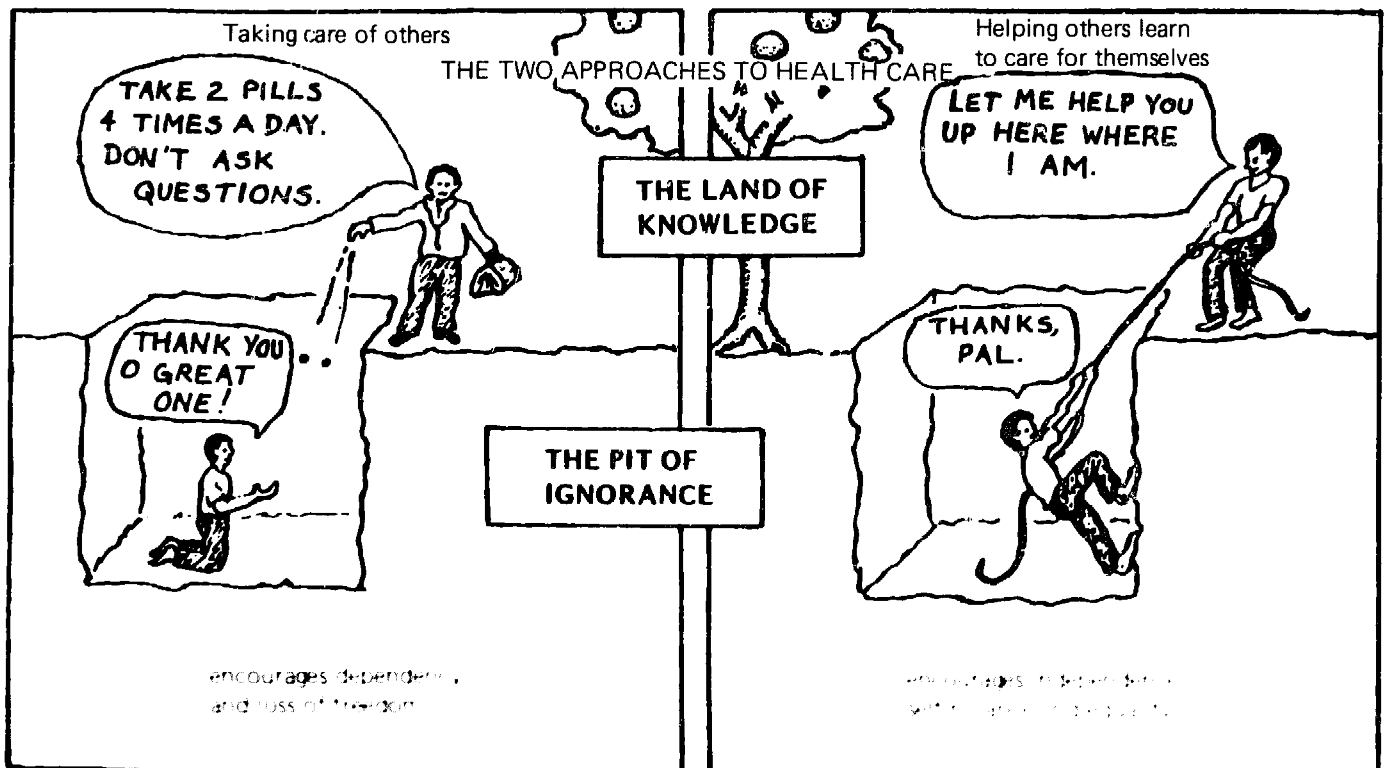
2. **Community-oppressive** programmes or functions are those which, while invariably giving lip service to the above aspects of community input, are fundamentally authoritarian, paternalistic, or are structured and carried out in such a way that they actually encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions; those which, in the long run, are crippling to the dynamics of the community.

In Outline 2, I have tried to summarize some of the various features of rural health programmes, and to point out how different approaches tend to make each feature either community-supportive or community-oppressive. I do not ask that everyone necessarily agree with me on every aspect. Often, the differences in approaches turn on "human" factors such as dignity and caring, which are hard to measure yet are, in my belief, immeasurably important. This outline, then, is intended primarily as a guide (or perhaps goad) to stimulate those involved in the planning or process of rural or periurban health care to think through each aspect of their programme and its policies in terms of what may ultimately be for the good of the community.

Needless to say, no health or development programme will explicitly profess to be community-oppressive. Nor, in any of the programmes we visited, did we encounter any in which every aspect was either oppressive or supportive. In each there was a mixture of strengths and weaknesses, as is indeed human.

However, it is interesting and, I think, somewhat disturbing, to observe that (with some notable exceptions) the programmes which, in general, we found to be more community-supportive were small, private, or at least non-government programmes, usually operating on a shoestring and with a more or less *sub rosa* status.

As for the large regional or national programmes: for all their international funding, for all their highly-trained (and highly-paid) consultants, for all their glossy bilingual brochures depicting community participation, we found that, when it came to the nitty-gritty of what was going on in the field, many of these ambitious "king-size" programmes actually had a minimum of effective community participation and a maximum of handouts, paternalism and superimposed, initiative-destroying "norms".



Perhaps the biggest challenge today concerning rural health care is: how can more people become responsibly involved in caring for their own health? Or to put it more explicitly: *How can the people-supportive features of outstanding, small, non-governmental, pilot projects be adapted for regional or country-wide outreach?*

Attempts have been made. Results have, at best, been only partially successful.

I would like to explore briefly some of the steps which are being taken, or might be taken, to implement a regional or national approach to rural health care that is genuinely community-supportive. To do this, let us focus on some of the major obstacles or limiting factors.

LIMITING FACTORS IN THE EVOLUTION OF A COMMUNITY-SUPPORTIVE HEALTH CARE SYSTEM

1. Attitudes

It has often been said, in community health work, that modifications which require changes in attitude or in the traditional way of doing things are those which are accomplished most slowly and require the most time and patience. Usually, such statements are made in reference to villagers or the marginally-educated, but, as many pioneers of health care alternatives will testify, often those whose attitudes and traditional approach are most difficult to modify are not the villagers but the professionals. Many regional or national health care programmes which "draft" young doctors or nurses find many of them unable or unwilling to adapt to working supportively with paramedics and village health workers in the rural setting. Their training not only does not prepare them for such involvement, it actively conditions them against it.

As an example, let me mention to you two classes of medical students, one first-year and one fourth-year, who were taken, on separate occasions, to visit an outstanding regional rural health programme in Costa Rica. The first-year medical students were so enthusiastic about the director's portrayal of the programme, with its "health circuses" and its community-built and -operated health posts, that they questioned him for hours and finished with a standing ovation. By contrast, the fourth-year students who visited were clearly bored, asked almost no questions, and drove back to the city as soon as they could, without even bothering to look at any of the health posts. These budding MDs seemed to feel themselves above primary care or community involvement. Their skills, and their concern, clearly related to sickness, not health!

Obviously, if doctors are to become part of a rural health team, their schooling must be radically different. It must have new content and a new set of values. Above all, it must teach the doctors-to-be that their knowledge is not sacrosanct; and that their first duty is to share it. It must help them to be humble. Some of the medical schools in Latin America are trying to work towards these changes. But many administrators and professors are still firmly set in their attitudes. It will take a long time.

2. Hazardous emphasis on safety

There seems to be a tremendous reluctance on the part of health care planners to teach or permit village health workers to do very much in the way of diagnosis and treatment of common diseases. Many programmes limit the curative role of their health workers to the symptomatic treatment of only three or four problems, such as "fever", "simple diarrhoea", "cough" and perhaps "worms". Except for aspirin and maybe piperazine, the medicines they are permitted to use have little or no clinical value. But, as is pointed out, they are "safe". Such programmes seem to ignore the fact that village stores sell to anyone over the counter a wide range of drugs – everything from chloramphenicol to vitamin B12 and pitocin – all of which are commonly used and misused by the people. Yet, because these drugs are "dangerous", the health worker is taught nothing about them: neither their uses, nor their misuses, nor their risks. Hence, the popular rampant abuse of drugs continues unabated. What is more, the village workers' trivial knowledge of medicine, in a community where many medicines are widely used, reduces the people's respect for them and makes them less effective, even in preventive measures. We found that, in villages with these insignificantly-trained health workers, far more people still used the services of *médicos practicantes* – or self-made medics – than sought assistance from the official health workers.

In Colombia, a health officer told us of a village worker, or *promotora,* who, at a time when the rivers were in flood and all transportation was cut off, was called to see a child with acute pneumonia. The health worker desperately thumbed through her official Manual of Norms. But the only instruction under "Fever with cough and difficulty breathing"* was "Refer patient to doctor". This being impossible at the time, she referred the sick child to the local shopkeeper, who at once injected the youngster with penicillin. Fortunately, the child responded.

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* The designers of the Manual of Norms had carefully avoided "difficult scientific terminology" like *pneumonia*, apparently unaware that this and many other medical names for diseases are a standard part of village vocabulary. Such inappropriate oversimplification is common to many of these official manuals.

I asked the health officer if perhaps *promotores* working in such isolated areas should not be taught something about pneumonia and the use of penicillin, or at least be given a simple reference book where they could look such things up. She replied that, officially, the health department's policy was that *promotores* administer antibiotics only with a doctor's prescription . . . and that it would "not be good for them" to have a reference book explaining things "outside their norms".

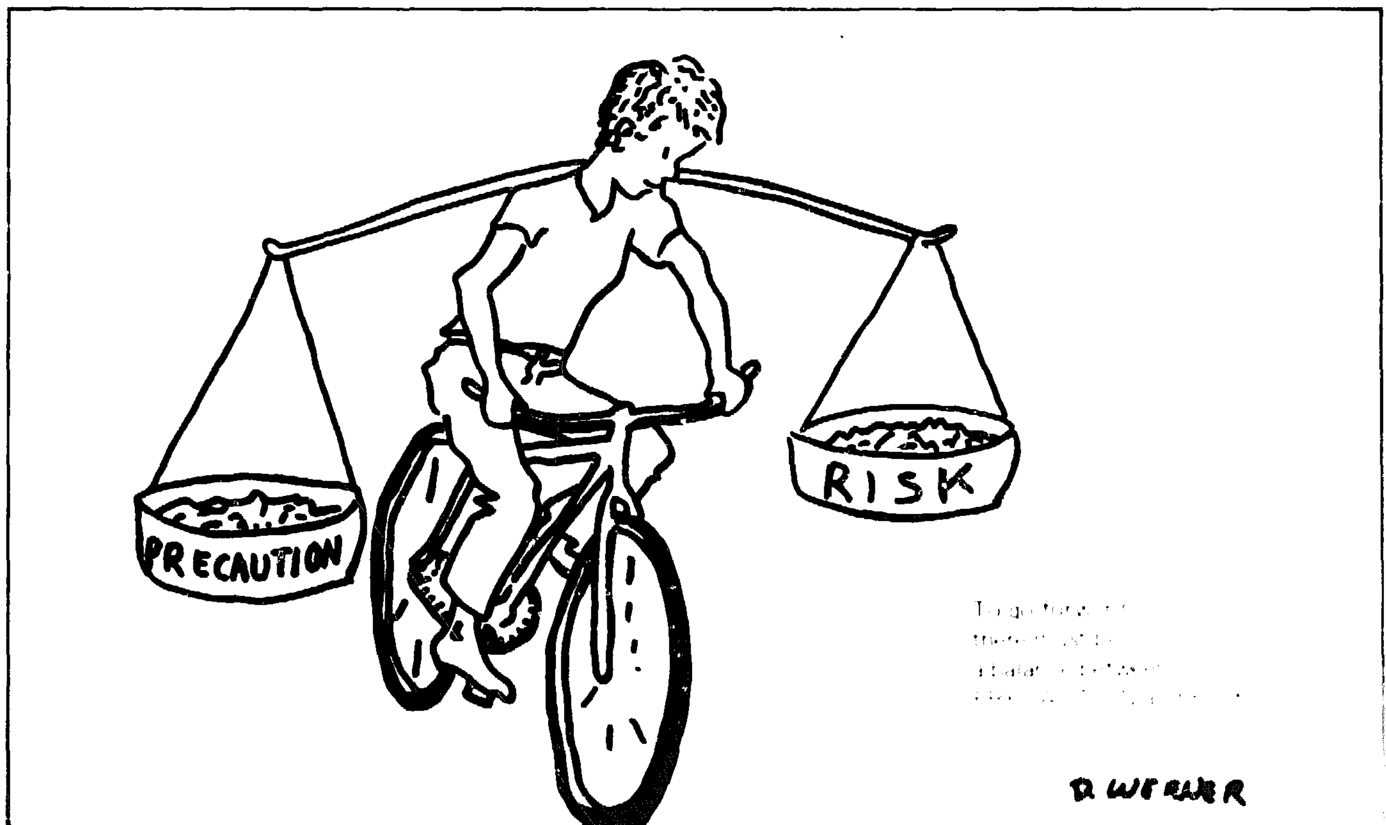
To give another example, in many programmes we found that, although village health workers were perhaps taught how to attend a normal childbirth, in the case of postpartum haemorrhage, their only instruction was, once again, to refer the patient to a doctor. Both uterine massage and use of ergotamine were considered "too risky". For health workers living hours or days away from health centres, such political over-precaution could, and surely has, cost many lives.

Basically, what we often found lacking on the part of the planners of these large health programmes was a realistic perception of what really goes on in the villages. Time and again, we found that primary health workers were taught and permitted to do far less medically than the villagers were already doing for themselves. By contrast, many of the leaders of smaller non-governmental health projects seemed to have a much better comprehension of village life, as well as greater appreciation for the ability and potential of their primary health workers. While helping their *promotores* recognize and work within their limitations, they trained them in a far wider range of skills. As a result, the health workers in these programmes were more challenged, worked with greater pride and enthusiasm, and, because of their wider knowledge and skill, had the fuller confidence of their people.

A programme which is truly community-supportive, it would seem, must help and encourage both the village health workers and their communities to learn and function to their full human potential. To do this, of course, involves certain risks. I refer to risks for programme management rather than for patients. Patient risk, in many cases, is actually reduced by giving non-professionals greater medical responsibility. But to verify this, programme planners and officials must be willing to stick their necks out, to risk the slings and arrows of an outraged medical monopoly. Risk must, of course, be balanced with precaution. Yet programmes which are top-heavy with precautions get nowhere.

3. Bureaucracy

Bureaucracy is the hobgoblin of giant programmes! Red tape, excess paperwork, waste motion, wasted money, inefficiency, poor communications and, ultimately, graft and corruption seem to inevitably enter into the picture when operations get too big (or, as one programme leader in Honduras describes it, when the superstructure overpowers the infrastructure). The very large regional or national programmes we visited characteristically suffered from breakdowns in communications, supervision and supplies, sometimes to the point where health workers became totally ineffective. One internationally-acclaimed regional programme we visited in southern Mexico was so out of touch between office and village that it was still sending paychecks to a



community worker who, six months before, had moved to another village and was collecting another salary from the Forestry Department.

The question is, how do you regionalize or nationalize an approach to rural health care without bogging it down in bureaucracy? For the answer, which is simple but not easy, I think we might look to E.F. Schumacher,[1] and consider decentralization. In a decentralized plan, the role of the ministry of health could be to coordinate and advise rather than to control and restrict. This would be true at all the intermediate levels down to the community itself. At every level, the maximum amount of self-sufficiency and self-direction would be encouraged. This would not only decrease bureaucracy, but increase personal involvement and responsibility at every level.

4. Commercialization

In Honduras, an open-minded director of one of the regional health programmes referred us to a *curandero* or native herb doctor who was acclaimed for his healing powers. His fame for curing patients not relieved by doctors had grown to the point where he was invited to Tegucigalpa by an official of the health ministry, who asked him, among other things, why it was that with his people, modern medicine was so often ineffective. The herbalist replied, *"Porque lo han comercializada!"* — because they have commercialized it!

The problem of commercialization of health care is many-sided. It has often amused me how some of the big health programme officials, many of whom receive salaries twenty to thirty times that of the average villager, can talk to a community about how important it is that the village health worker be voluntary, working for the joy of helping others and the personal satisfaction he gains from serving his community. These officials always seem so surprised and disillusioned when they discover that a health worker has been selling medicines that are supposed to be free, or is otherwise turning his "service to the community" into a lucrative business. In truth, the health worker is merely following the example of his role model.

Here again, in certain of the smaller less formal programmes, where many of the outsiders — sometimes even the doctors — are voluntary or work for minimal wages, it somehow rings truer when people speak of service for the joy of it. In general, doctors and other professionals not only *cost* too much for rural or periurban communities, they *earn* too much to serve as role models in community health programmes which would purport to be equitable. I can see no getting around this problem until we can foster a new breed of medical practitioner, who comes from the community he will serve, and who is willing to serve his community for modest earnings.

The other side of the commercialization of medicine, namely the flagrant overpricing and false promotion of pharmaceuticals, I will only touch upon. The alarming facts are painstakingly disclosed in Milton Silverman's new publication, *The Drugging of the Americas,*[2] and in other writings. Beyond doubt, the unnecessarily high cost of critical medications is one of the major obstacles to the financial self-sufficiency of community-based health activities. Honduras and Peru have begun their own production and low-cost distribution of basic medicines. Other countries would do well to follow suit. I might also dare to suggest that, if the international health agencies really want to give a boost to developing countries, rather than hand out more free medicines, they might pressure for honest promotion and fair pricing of drugs by the multinational corporations, for amendments of drug patent laws, and for other measures to bring medicines to their users, not free, but at a price nearer the cost production. (In case anyone thinks this would make a small difference, I might mention that in Colombia the hidden profits on Valium, for instance, have run as high as 6000 percent).[3]

The commercialization of medicine, and the legitimized exploitation of people by other people can perhaps be dealt with only through major social change. Yet these problems do exist and can no longer be ignored. Equitable health care at the village level will surely remain a pipe dream in countries where medicine as a whole continues to be such a flagrantly profitable institution.

5. Politics

I have already mentioned that politics are considered by many to be one of the major obstacles to a community-supportive programme. This can be as true for village politics as for national politics. However, the politico-economic structure of the country must necessarily influence the extent to which its rural health programme is community-supportive or not.

Let us consider the implications in the training and function of a primary health worker. If the village health worker is taught a respectable range of skills, if he is encouraged to think, to take initiative and to keep learning on his own, if his judgement is respected, if his limits are determined by what he knows and can do, if his supervision is supportive and educational, chances are he will work with energy and dedication, will make a major contribution to his community and will win his people's confidence and love. His example will serve as a role model to his neighbours, that they too can learn new skills and assume new responsibilities, that self-improvement is possible. Thus, the village health worker becomes an internal agent-of-change, not only for health care, but for the awakening of his people to their human potential . . . and ultimately to their human rights.

In countries where social and land reforms are sorely needed, where oppression of the poor and gross disparity of wealth is taken for granted, it is possible that the health worker I have just described knows and does and thinks too much. Such men are dangerous! They are the germ of social change.

So we find, in certain programmes, a different breed of village health worker is being moulded . . . one who is taught a pathetically limited range of skills, who is trained not to think, but to follow a list of very specific instructions or "norms", who has a neat uniform, a handsome diploma and who works in a standardized cement block health post, whose supervision is restrictive and whose limitations are rigidly predefined. Such a health worker has a limited impact on the health, and even less on the growth of his community. He spends much of his time filling out forms.

I would not like to assert that there are necessarily political motivations behind the shaping of either one or the other of these two types of health workers. Perhaps there are other reasons why national and regional programmes so often generate the second, more subservient type, hemmed in by norms and forms. Nevertheless, governments in countries with enormous inequities in land ownership, earnings and wealth must necessarily think twice before backing, or even tolerating, rural health or development projects that are community-supportive in the fullest sense.

I'm afraid I don't have any easy answers to the problems of politics. Yet political factors do influence both health and health care in ways we can ill afford to ignore. I would strongly recommend that those agencies, foundations and individuals that are truly interested in the well-being of people take a careful look at some of the recent trends in health care, and what is really going on.

Before closing, I would like to summarize a few of the steps that are now being taken, or might be taken, to implement a regional or country-wide approach to rural (or periurban) health care which is more genuinely community-supportive.

1. **Decentralization.** This means relative autonomy at every level. Advice and coordination from the top. Planning and self-direction from the bottom.

2. **Greater self-sufficiency at the community level.** This is, of course, implicit in decentralization. The more a community itself can carry the weight of its own health activities, both in cost and personnel, the less paralyzed it will be by breakdowns in supply and communications from the parent agency.

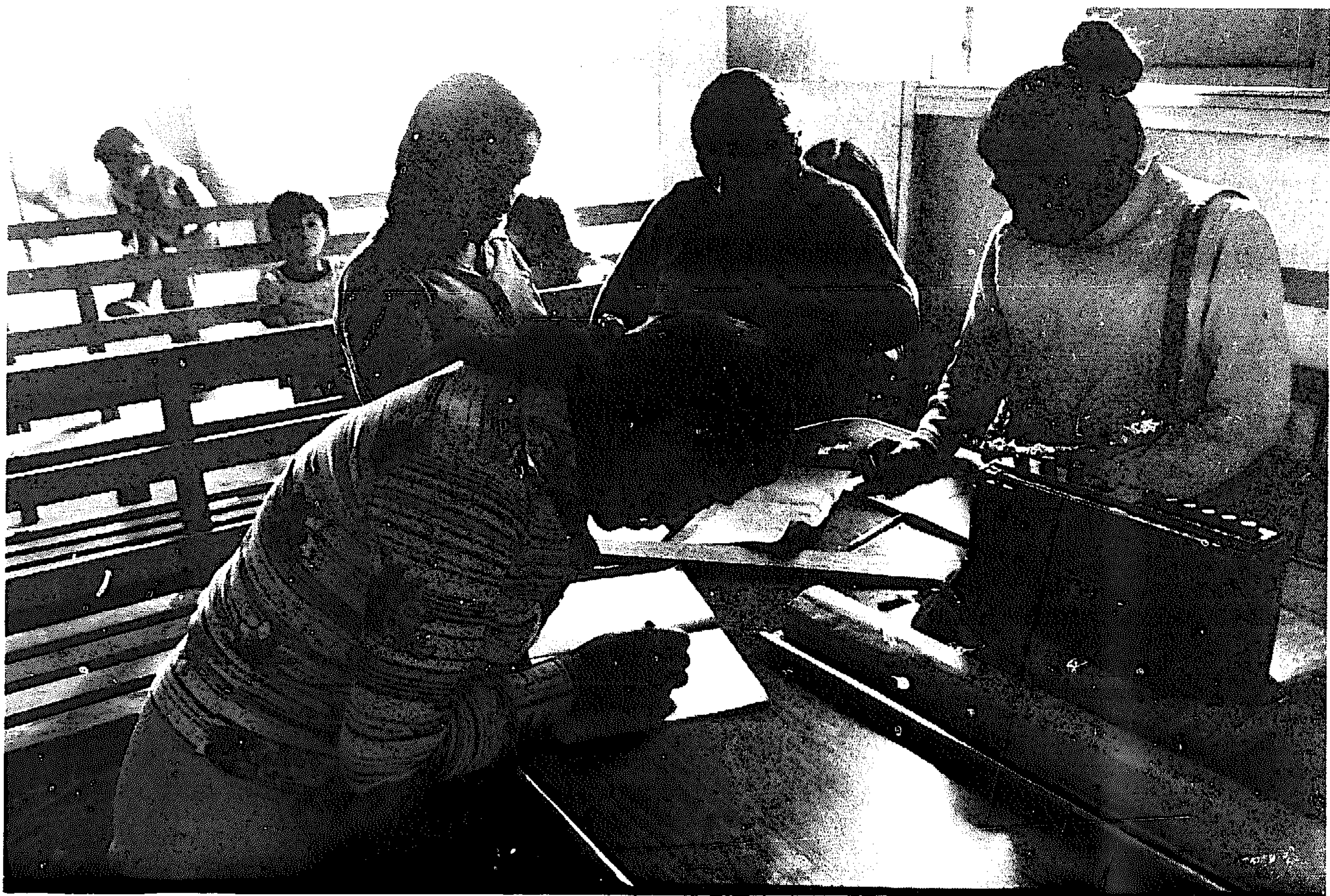
3. **Open-ended planning.** For all the talk about "primary decision making by the community", too often a programme's objectives and plans have been meticulously formulated long before the recipient communities have been consulted. If the people's felt needs are truly to be taken into account, programme plans must be open-ended and flexible. It is essential that field workers and representatives from the communities – not just top officials – attend and actively participate in policy planning and policy changing sessions.

4. **Allowance for variation and growth.** If a programme is to evolve, alternatives must be tried and compared. Substantial arrangements for conceiving and testing new approaches, methods and points of view should be built into the ongoing programme. Also, private or non-governmental projects should be observed and learned from, not forced to conform or stamped out.

5. **Planned obsolescence of outside input.** If self-sufficiency at the community level is indeed to be considered a goal, it is advisable that a cut-off date for external help be set from the first. All input of funds, materials and personnel should be conscientiously directed towards reaching the earliest possible date when such assistance is no longer needed. Thus, the outsider's or agent-of-change's first job, whether he/she be a medic or an agronomist, should be to teach local persons to take his/her place and, in so doing, make him/herself dispensible. Outside funding, likewise, should not underwrite ongoing activity, but should be in the form of "seed" money or loans to help launch undertakings which will subsequently carry their own ongoing costs.

6. **Deprofessionalization and deinstitutionalization.** We have got to get away from the idea that health care is something to be delivered. Primarily, it should not be *delivered,* but *encouraged.* Obviously, there are some aspects of medicine which will always require professional help, but these could be far fewer than is usually supposed. Most of the common health problems could be handled earlier and often better by informed people in their own homes. Health care will only become truly equitable to the extent that there is less dependency on professional or institutionalized help and more *mutual self-care.* This means more training, involvement and responsibility for and by the people themselves. It should include continuing education opportunities for villagers which reinforce their staying in, and serving, their communities.

7. **More curative medicine.** For a long time, health care experts have been pushing for more preventive medicine at the village level, and with good reason. But too often, this has been used as a convenient excuse to keep curative medicine completely – or almost completely – in professional hands. Clearly, preventive measures are basic. However, the villagers' felt needs have consistently been for curative measures (to heal the sick child, for



Salgado/Christian Aid

In the town of Chimbote, Peru, a social promotion group of women learn skill of practical everyday use and discuss how to improve their lives and environment.

instance). If primary health workers are to gain the respect and confidence of their people, they must be trained and permitted to diagnose and treat more of the common problems, especially those when referral without initial treatment increases the danger to the sick.

I should point out that when I say, "more curative medicine", I don't mean "more use of medicines". Over-medication, by both physicians and villagers, is already flagrant. I mean *more informed use,* which, in many cases, will mean far more limited use, of medications. But this will require a major grassroots demystification of Western medicine which can only happen when the people themselves learn more about how to prevent and manage their own illnesses. To promote such a change, village health workers must have a solid grasp of *sensible medicine* and, in turn, help reeducate their people. It is, of course, doubtful whether such a metamorphic awakening to sensible medicine can ever happen outside the medical institution until there has been some radical rethinking within it.

8. **More feedback between doctors and health workers.** When health workers refer patients to a doctor, the doctor should *always* provide feedback to the health worker, explaining in full, clear detail and simple language about the case. This can, and should, be an important part of the health worker's and the doctor's continuing education.

9. **Earlier orientation of medical students.** From the very beginning of their training, medical students should be involved in community health, and be encouraged to learn from experienced village health workers and paramedics.

10. **Great appreciation and respect for villagers, their traditions, their skills, their intelligence, and their potentials.** Villagers, and especially village health workers, are often treated liked children or ignoramuses by their more highly-educated trainers and supervisors. This is a great mistake. People with very little formal education often have their own special wisdom, skills and powers of observation which academicians have never acquired and therefore fail to perceive. If this native knowledge and skill is appreciated, and integrated into the health care process, this will not only make it more truly community-oriented and viable, but will help preserve the individual strengths and dignity of health workers and their people. I cannot emphasize enough how important it is that health programme planners, instructors and supervisors be "tuned in" to the capabilities and special strengths of the people they work with.

11. **That the directors and key personnel in a programme be people who are human.** This is the last, most subjective and perhaps most important point I want to make. Let me illustrate it with an example:

In Costa Rica, there is a regional programme of rural health care under the auspices of the health ministry which differs in important ways from the rural health system in the country as a whole. It has enthusiastic community participation and a remarkable impact on overall health. It may well have the lowest incidence of child and maternal mortality in rural Latin America. Its director is a paediatrician and a poet, as well as one of the warmest and hardest-working people I have met. The day I accompanied him on his trip to a half-dozen village health posts, we didn't even stop for lunch, because he was so eager to get to the last post before night fell. He assumed I was just as eager. And I was; his enthusiasm was that contagious!

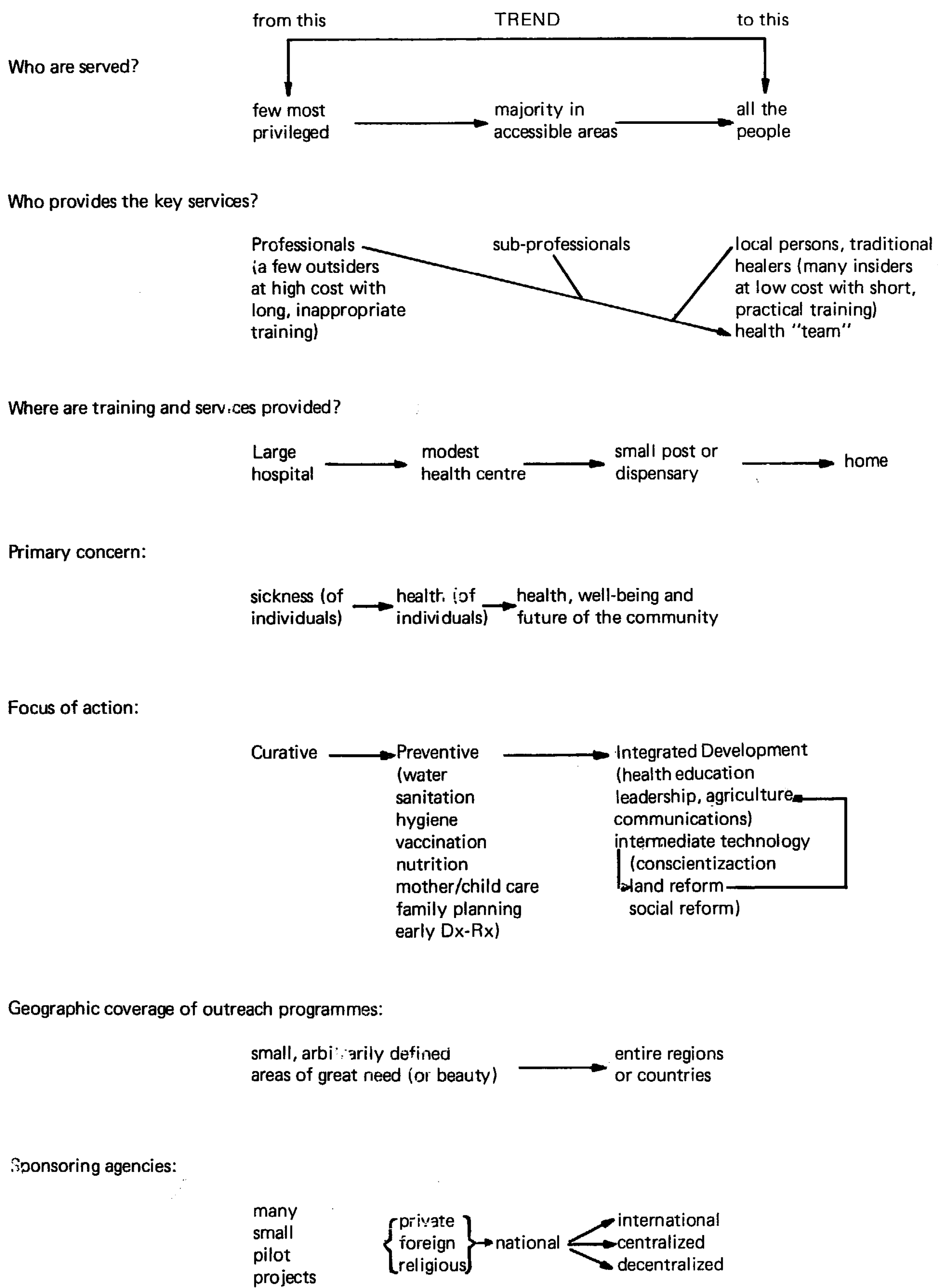
I will never forget our arrival at one of the posts. It was the day of an "under-fives" clinic. Mothers and patients were gathered on the porch of the modest building. As we approached, the doctor began to introduce me, explaining that I worked with rural health in Mexico and was the author of *Donde No Hay Doctor.* Frantically, I looked this way and that for the health worker or nurse to whom I was being introduced. As persons began to move forward to greet me, I suddenly realized he was introducing me to *all the people,* as he would to his own family. Obviously he cared for the villagers, respected them, and felt on the same level with them.

This, I must confess, was a new experience for me. I was used to being marched past the waiting lines of patients and being introduced to the health worker, who was instructed to show me around and answer my questions, while the patient, whose consultation we had interrupted, silently waited.

"This man is an exception! " I thought to myself. In our visits throughout Latin America, we found almost invariably that the truly outstanding programmes have at least one or two key people who are exceptional human beings. These people attract others like themselves. And the genuine concern of people for people, of joy in doing a job well, of a sense of service, and the sharing of knowledge permeates the entire programme clear down to the village worker and members of the community itself.

People are what make health care work.

OUTLINE 1: RECENT TRENDS OF RURAL HEALTH CARE PROGRAMMES



OUTLINE 2: RURAL HEALTH PROGRAMMES IN LATIN AMERICA

TWO APPROACHES

	COMMUNITY-SUPPORTIVE	COMMUNITY-OPPRESSIVE (CRIPPLING)
Initial objectives	Open-ended. Flexible. Consider community's felt needs. Include non-measurable (human) factors.	Closed. Pre-defined before community is consulted. Designed for hard-data evaluation only.
Size of programme	Small, or if large, effectively decentralized so that sub-programmes in each area have the authority to run their own affairs, make major decisions, and adjust to local needs.	Large. Often of state or national dimension. Top-heavy with bureaucracy, red tape, filling out forms. Superstructure overpowers infrastructure. Frequent breakdown in communication.
Planning, priorities, and decision making	Strong community participation. Outside agents-of-change inspire, advise, demonstrate, but do not make unilateral decisions.	Theoretically, community participation is great. In fact, activities and decisions are dominated or manipulated extensively by outsiders, often expatriate "consultants".
Financing and supplies	Largely from the community. Self-help is encouraged. Outside input is minimal or on the basis of "seed funds", matching funds, or loans. Agricultural extension and other activities which lead to financial self-sufficiency are promoted. Low-cost sources of medicine are arranged.	Many giveaways and handouts: free food supplements, free medicines, villagers paid for working on "community projects". Village health worker (VHW) salaried from outside. Indefinite dependency on external sources.
Way in which community participation is achieved	With time, patience, and genuine concern. Agent-of-change lives with the people at their level, gets to know them, and establishes close relationships, mutual confidence and trust. Care is taken not to start with free services or giveaways that cannot be continued.	With money and giveaways. Agents-of change visit briefly and intermittently, and later on discover that, in spite of their idealistic plans, they have to "buy" community participation. Many programmes start with free medicines and handouts to "get off to a good start", and later begin to charge. This causes great resentment on the part of the people.
Data and evaluation	Underemphasized. Data-gathering kept simple and minimal, collected by members of the community. Includes questions about the people's felt needs and concerns. Simple scheme for self-evaluation of workers and programme at all levels. Evaluation includes subjective human factors as well as "hard data".	Over-emphasized. Data gathered by outsiders. Members of the community may resent the inquisition, or feel they are guinea pigs or "statistics". Evaluation based mainly on "hard data" in reference to initial objectives.

	COMMUNITY-SUPPORTIVE	COMMUNITY-OPPRESSIVE (CRIPPLING)
Experience and background of outside agents-of-change	Much practical field experience. Often not highly "qualified" (degrees).	Much desk and conference room experience. Often highly "qualified" (degrees).
Income, standard of living, and character of outside agents-of-change. (MDs, nurses, social workers, consultants, etc.)	Modest. Often volunteers who live and dress simply, at the level of the people. Obviously they work through dedication, and inspire village workers to do likewise.	Often high, at least in comparison with the villagers and VHW (who, observing this, often finds ways to "pad" his income, and may become corrupt). The health professionals have often been drafted into "social service" and are resentful.
Sharing of knowledge and skills	At each level, from doctor to VHW to mother, a person's first responsibility is to teach: to share as much of his/her knowledge as possible with those who know less and want to learn more.	At each level of the preordained medical hierarchy (health team), a body of specific knowledge is jealously guarded and is considered dangerous for those at "lower" levels.
Regard for the people's customs and traditional folk healing, use of folk healers	Respect for local tradition. Attempt to integrate traditional and Western healing. Folk healers incorporated into the programme.	Much talk of integrating traditional and Western healing, but little attempt. Lack of respect for local tradition. Folk healers not used or respected.
Scope of clinical activities (Dx, Rx) performed by VHW	Determined realistically, in response to community needs, distance from health centre, etc.	Delimited by outsiders who reduce the curative role of the VHW to a bare minimum, and permit his/her use of only a small number of "harmless" (and often useless) medicines.
Selection of VHW and health committee	VHW is from and is chosen by community. Care is taken that the entire community is not only consulted, but is informed sufficiently so as to select wisely. Educational prerequisites are flexible.	VHW ostensibly chosen by the community. In fact, often chosen by a village power group, preacher, or outsider. Often the primary health worker is an outsider. Educational prerequisites fixed and often unrealistically high.
Training of VHW	Includes the scientific approach to problem solving. Initiative and thinking are encouraged.	VHW taught to mechanically follow inflexible, restrictive "norms" and instructions. Encouraged ***not*** to think and not to question the "system".
Does the programme include conscientization (consciousness raising) with respect to human rights, land and social reform?	Yes (if it dares).	Issues of social inequities, and especially land reform, are often avoided or glossed over.

	COMMUNITY-SUPPORTIVE	COMMUNITY-OPPRESSIVE (CRIPPLING)
Manual or guidebook for VHW	Simple and informative in language, illustrations, and content. Geared to the user's interest. Clear index and vocabulary included. All common problems covered. Folk beliefs and common use and misuse of medicines discussed. Abundant illustrations incorporated into the text. The same time and care was taken in preparing illustrations and layout as villagers take in their artwork and handicraft. Manual contains a balance of curative-preventive, and promotive information.	Cookbook-style, unattractive. Pure instruction. No index or vocabulary. Language either unnecessarily complex or childish, or both. Illustrations are few, inappropriate (cartoons), or carelessly done. Not integrated with the text. Useful information is very limited, and some of it inaccurate. Many common problems not dealt with. May use misleading and/or incomprehensive flow charts. Manual often strong on preventive and weak on curative information; overloaded with how to fill out endless forms.
Limits defining what a VHW can do	Intrinsic. Determined by the demonstrable knowledge and skills of each VHW, and modified to allow for new knowledge and skill which is continually fostered and encouraged.	Extrinsic. Rigidly and immutably delimited by outside authorities. Often these imposed limits fall far short of the VHW's interest and potential. Little opportunity for growth.
Supervision	Supportive. Dependable. Includes further training. Supervisor stays in the background and never "takes over". Reinforces community's confidence in its local workers.	Restrictive, nit-picking, authoritarian, or paternalistic. Often undependable. If supervisor is a doctor or nurse he/she often "takes over", sees patients, and lowers community's confidence in its local worker.
Encouragement of self-learning outside of norms	Yes. VHWs are provided with information and books to increase knowledge on their own.	No. VHWs are not permitted to have books providing information outside their "norms".
Feedback on referred patients (counterreference)	When patients are referred by the VHW or auxiliary, the MD or other staff at the referral centre gives ample feedback to further the health worker's training.	Doctor at the referral centre gives no feedback other than instructions for injecting a medicine he/she has prescribed.
Flow of supplies	Dependable.	Undependable.
Profit from medicines (in programmes that charge)	VHW sells medicine at cost which is posted in public. (He/she may charge a small fee for services rendered). Use of medicines is kept at a minimum.	VHW makes a modest (or not so modest) profit on sale of medicines. This may be his/her only income for services, inviting gross over-prescribing of medicines.
Evolution towards greater community involvement	As VHWs and community members gain experience and receive additional training, they move into roles initially filled by outsiders — training, supervision, management, conducting of Under-fives' clinics, etc. More and more of the skill pyramid is progressively filled by members of the community.	Little allowance is made for growth of individual members of the community to fill more and more responsible positions (unless they graduate to jobs *outside* the community). Outsiders perpetually perform activities that villagers could learn.

	COMMUNITY-SUPPORTIVE	COMMUNITY-OPPRESSIVE (CRIPPLING)
Openness to growth and change in programme structure	New approaches and possible improvements are sought and encouraged. Allowance is made for trying out alternatives in a part of the programme area, with the prospects of wider application if it works.	Entire programme is standardized with little allowance for growth or trial of ways for possible doing things better. Hence, there is no built-in way to evolve towards better meeting the community's needs. It is static.
RESULTS:	Health worker continues to learn and to grow. Takes pride in the work. Has initiative. Serves the community's felt needs. Shows villagers what one of their own can learn and do, stimulating initiative and responsibility in others. Community becomes more self-sufficient and self-confident. Human dignity and responsibility grow.	Health worker plods along obediently, or quits. He/she fulfills few of the community's felt needs. Is subservient and perhaps mercenary. Reinforces the role of dependency and unquestioning servility. Community becomes more dependent on paternalistic outside charity and control. Human dignity fades. Traditions are lost. Values and responsibility degenerate.
If outside support fails or is discontinued...	Health programme continues because it has become the community's.	Health programme flops.
TACIT OBJECTIVE	Social reform: health and equal opportunity for all.	"Don't rock the boat". Put a patch on the underlying social problems — don't resolve them!
SPONSORING AGENCIES	Often small, private, religious, or volunteer groups. Sometimes sponsored by foreign non-governmental organizations.	Often large regional or national programmes cosponsored by foreign national or multinational corporate or governmental organizations.

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PART IV

COMMUNITY PARTICIPATION: AN ILLUSTRATION

A major concern of health planners, be they government officials, medical doctors or field workers, is how to implement a community-based health programme. There are communities which, having very little health care, can, from the beginning, decide what services they need, what people can deliver them and what contributions the community will make. However, in the majority of cases, health institutions and medical professionals are already present in the community. The problem is how to restructure and reorient the existing programmes in order to realize community participation rather than simply community contributions.

The final selection in this volume is a description of how planners can develop a community-based programme, using existing health resources and medical manpower. It appeared previously in two CMC publications: CONTACT No. 43 (February 1978) and CONTACT Special Series No. 1 (April 1979). Written by Mary Johnston, who draws on her ten years' experience in developing a Dana Sehat (health insurance) programme in central Java, Indonesia, it explains in simple, concise, language the steps that can be taken. It also explicitly raises questions which are basic to any planner who must deal with the practicalities of programme planning. The programme has two features which have contributed to creating a community involvement in health care. The first is a carefully planned social preparation of the community so that both the health staff and community people can develop together the strategy and process of community participation. The second is use of a community development rather than health delivery approach which has meant the programme now includes such activities as credit unions, cooperatives and sanitary programmes.

Neither the author nor the editor claim that this is the model for developing community-based health programmes. It is the experience of one programme in a specific context. It does, however, present an approach which incorporates many of the points which have been raised by other contributors to this volume. By including it in this book, the reader is provided with one concrete example which might stimulate ideas for the creation of other programmes.

CHAPTER XI

DEVELOPMENT OF A COMMUNITY HEALTH PROGRAMME

Mary Johnston

MAJOR STEPS

A. **Promotion With the Government**

B. **Consolidation of the Health Staff**

C. **Approach to the Community**

D. **Social Preparation of the Community**

E. **Field Preparation**
  I. Selection of Initial Project Area
  II. Collection of Data about the Community
  III. Determination of Problems to be Tackled and Setting Priorities
  IV. Planning Programme Implementation

F. **Implementation of the Programme**

G. **Monitoring**

H. **Assessment**

I. **Revision**

J. **Expansion of Established Programme**

K. **Extension of Programme to other Communities**

L. **Promotion and Training in New Area and Repeat of Whole Process in New Community.**

A. PROMOTION WITH THE GOVERNMENT

- How can a doctor gain acceptance from peers and supervisors for ideas of experimentation with a community-oriented health programme?
- How can such a programme be integrated into the overall government programme?
- How can the doctor avoid friction with senior officials if the programme is eventually more successful than their programme?

→ *Government support must be gained in the initial stages of a programme.*

Purpose

1. To gain official support for the proposed programme.
2. To recruit government resources, including technical advice, facilities and funds.
3. To gain support from other disciplines at the same, or higher, levels in order to develop a comprehensive programme.
4. To integrate the programme into the government programme and prevent overlapping and competition.

Action

Discussion with senior government officials until some consensus is reached on concept of community health, and the idea to set up a community health programme in a specific locality is approved.

Information Needed for Successful Action

1. Current government health policy, including opinions and statements from senior officials and international sources, on community health.
2. Overall plan of implementation should include ideas on:
   - organization/framework within which programme will be developed,
   - financial aspects,
   - advantages over current system, eg., wider coverage, more economical use of staff, cheaper. (In discussing advantages, factors of special interest and importance to the government officials should be emphasized).

3. Criteria for the selection of locality for trial should include the following:

   – the community to be served should be manageable, viable and, preferably, an established administrative unit such as a village or kampong;
   – the unit should have economic potential;
   – it should have strong, active, honest leadership;
   – it should be strategically placed to enable expansion to other areas.

B. CONSOLIDATION OF HEALTH STAFF

- How will staff who have worked for years in a curative service accept a programme with a new orientation?
- How can a doctor secure the support of the rest of the health team for a new programme? No doctor can implement a community health programme alone.

→ *It is important to consolidate the staff of the health service.*

Purpose

1. To prepare the health staff for a programme oriented to the community.
2. To provide the staff with skills required for community work.
3. To form a cohesive team.

Action

Retraining the staff of the health service, including, if necessary, its reorganization.

Information Needed for Successful Action

1. On forming an effective team.

   A team which understands and accepts the new approach and feels confident in implementing it is needed. The team may consist of:
   – a doctor, or other team leader,
   – paramedics, and nursing staff,
   – social worker, and
   – agriculturalist (or other technical worker, depending on local community needs).

   If it is not possible to increase staff, current staff can perhaps be equipped with extra skills.

2. On training content and methods.

   i. Training should achieve changes in attitudes, through:
      – statements proving government interest in, and support of, new orientation;
      – proof of need for new orientation, eg., clinic statistics indicating limitations of existing service, reasons for non-attendance at health service, etc.;
      – contact with community health workers;
      – visits to successful community health programmes.

   ii. Training should provide skills in:
      – approaching the community,
      – communicating with the community,
      – working together with the community,
      – planning,
      – maintaining and developing a programme, and
      – simple administrative skills.

   iii. Training methods could include:
      – discussions,
      – exposure to situations followed by reflection on the situation,
      – problem solving, and
      – role playing, etc.

C. APPROACH TO COMMUNITY

- How can a health programme become a community-based programme?
- How can a doctor help the community to tackle its own health problems?

→ *It is important that the community be approached in the very early stages of development of the programme. Close cooperation between the health service and the community is essential.*

Purpose

To gain the support and the direct, active participation of the community in developing the programme.

Action

Health worker approaches the community leader

or

Health worker is approached by the community leader. (This is only likely to happen in a community where a successful programme has already been established in the vicinity.)

Information Needed for Successful Action

1. For the identification of a sympathetic community leader, criteria should include:

   – interest in health
   – active interest in community welfare,
   – innovative ideas, and
   – influence in community.

2. Method of Approach.
   Discussions should focus on:
   – particular issues, events occurring in community (death, epidemic, special day);
   – statistics from local clinic (high disease incidence, disease patterns); and
   – examples of programmes in other areas.

Important Factors

1. Official approval of local leader is prerequisite.
   If a direct approach to formal leaders is not possible, or unsuccessful, informal leaders, eg., teachers, religious leaders, may be approached. When they are convinced about the new ideas, they can be encouraged to influence the formal leadership.
   A government superior (eg., a district head) may be the needed contact person in other cases.

2. It is unusual for the initiative in setting up a health programme to be taken by the community. But where this occurs and the existing health workers are unresponsive to approaches from village leader, the help of a more senior official, eg., senior doctor, senior government official, could be requested to convince the health worker, through discussions and visits to successful programmes.

D. SOCIAL PREPARATION OF THE COMMUNITY

- How can the whole community (as opposed to leaders only) participate in programme development?
- How can a health worker make contact with members of the community? What channels can be used?
- How can the health worker avoid the danger of arousing a feeling within the community that their cooperation is desired merely to further the ambitions of the health worker?

→ *Social preparation of the community is crucial to the success of a programme.*

Purpose

1. To develop community understanding of the basic aims of the programme.
2. To encourage the community to reach a decision to implement a programme based on its particular needs.
3. To mobilize local resources.

Action

1. Informal individual and group discussions about community problems and needs and the proposed community health programme, held between health worker and leaders in the community.
2. Community leaders, assisted by the health worker, then introduce the idea of the community health programme, informally and through community groups and meetings, to community members.
3. Discussions should be held until a decision is reached by community leaders and community members (if possible) to implement the community health programme.

Information needed for successful action

1. Influential community leaders include:
   - formal leaders, eg., government, traditional, religious; and
   - informal leaders, eg., religious, educated, wealthy, political.

   The support of both formal and informal leaders is important.

2. Existing "effective" community organizations have:
   - ongoing activities,
   - membership representing the whole community,
   - sound leadership, and
   - a flexible programme.

   Approach should be made to such organizations as the community health programme could possibly be inserted as the programme of one of these organizations.

3. Research to identify community problems and needs may include investigations on:

   Health:
   - general observation, especially of deficiencies, including malnutrition, particularly in the under-fives' group;
   - noting major illnesses as recalled by members of the community (and indicative of the high incidence of certain diseases);
   - collecting data on number and causes of deaths and incidence of epidemics (or threat of);

   Education:
   - asking local teachers about their problems;
   - comparing number of school-age children with number of school attenders;
   - checking drop-out figures and reasons;

   Transport/Communication:
   - checking distance from nearest market, school and other important facilities;
   - checking means of contact with, and transport to, secondary health care facilities;

   Agriculture:
   - comparing yields with expected average yields of area;
   - asking farmers for their opinions of problems and needs;
   - observing general conditions in the field.

4. Customary ways in which the community solves problems.

   When obtaining information about major needs and concerns, also ask about ways in which the community has tried to meet these needs. Possibly the customary ways of solving

problems can be developed and incorporated into the new programme.

Eg.,: If a community collects funds to cover funeral expenses, this could be developed into a simple insurance scheme in which subscriptions are collected to provide health care for the living.

5. Methods by which the community reaches decisions.
   a. Determine which groups/group leaders are most influential in the community as they are the best channels through which to gain community support.
   b. Determine which is the officially recognized decision-making body/committee through which the final decision for acceptance of the programme should be made.
   c. Determine the type and frequency of group meetings. If the decision is reached in a formal meeting attended by a large proportion of leaders and community members, it will have stronger backing and support.
   d. Determine whether decision making is:
      - a decision by the recognized leader,
      - majority vote, or
      - discussion culminating in unanimous decision. Whichever decision-making method is used, it is important that as many community members and leaders as possible understand and agree with programme.

Important factors

1. The health worker must have an open, friendly attitude, indicating willingness to learn about the community from the people.
2. The introduction of the proposed programme should always be through discussions on major concerns of the community. Through discussions, assess what these are and start there.
   Eg., A volunter health promoter programme could be suggested as an answer to the problem of long distances from the health service.
3. In a community where health is not a major priority, eg., a poor, isolated community, implementation of a health programme may have to be postponed until other more pressing needs felt by the community are met.
   Eg., An agricultural programme which raises crop yields may provide the community with the economic means enabling them to use the proposed health service.
   Non-formal education may increase awareness and understanding of the advantages of healthier living.
4. NB: At this stage, the community health programme is accepted in principle only. Details of the programme have not yet been worked out.

E. FIELD PREPARATION

→ *Joint preparation of the field, including selection of a limited area for trial, collection of data, determination of priorities, and planning is important.*

E.I. SELECTION OF INITIAL PROJECT AREA

- How can a community be convinced that a programme is feasible and of benefit to them?
- How can ideas be tried out without their failure jeopardizing the whole programme?
- How can programme implementors gain confidence from experience?

Purpose

To select a restricted area, with high probability of success, for trial.

Action

Community leaders and health worker reach a decision on locality for trial programme.

Information needed for successful action

1. Nature of appropriate locality.

   The site most conducive to successful implementation would be:
   - an existing community, preferably a small administrative unit, eg., subhamlet or village;
   - manageable in size;
   - an economically viable community; and
   - one with good leadership.

   (In subsequent development of the programme in other areas, weaknesses can be overcome by many means, e.g., an economically weak unit could be combined with a vigorous and thriving village.)

2. Nature of local leadership.

   The leadership of the trial unit should be:
   - authoritative,
   - honest,
   - actively interested in the welfare of the community, and
   - supported by the community.

   (In subsequent development of the programme, weak leadership can be overcome by many means, eg., by working through strong informal leaders with formal leader as figurehead.)

E. II. COLLECTION OF DATA ABOUT THE COMMUNITY

- How can the community and health worker learn more about local conditions?

- How can a programme be based on real and felt needs of a community?

Purpose

1. To provide baseline data.
2. To enable local leaders to become more aware of conditions in their community.
3. To increase the awareness of the community of problems facing them.

Action

1. Prepare simple questionnaire suited to local needs and adapted to the skills of the interviewers.
2. Inform leaders of the purpose of the questionnaire and reason for collecting data.
3. Selection of interviewers, preferably from the community.
4. Training of interviewers.
5. Data collection.
6. Tabulation and analyses of data.

Information needed for successful action

1. Community to be covered.

   It is important to collect data from the whole community if conditions are favourable. However, if community to be covered is too large, sampling methods should be used. These methods can be studied in a handbook on surveys.

2. Content of survey.

   The data should cover both the community in general and individual families.
   On community, items such as number of families, average family size, public facilities and vital statistics, should be covered. On families, information on factors such as number in family, ages, education, occupations, income, health status, environment, mother and child care, agriculture and social customs should be included.

3. Method of composing questionnaire.

   - Questionnaire should be short and seek only information which can be used either directly for programme planning, or as an indicator of success for the monitoring of the programme.
   - Ensure that the questions have one meaning only and will bring the answers required.
   - Ensure that questions are not suggestive of a particular answer.
   - Ensure that answers are given in a way which is easily tabulated, eg., by using simple indicators, such as + = good; ± = fair; – = bad.

4. Selection of interviewers.

   If possible, community members should do the interviewing. Choose community members with:
   – ability to approach fellow community members,
   – ability to ask questions honestly and record answers accurately, and
   – interest in programme and time to spare.
   If volunteer health workers have been formed before collection of data, this task should be given to them to increase their awareness of community conditions, and to provide a basis for them to plan their programme.

5. Content and method of training interviewers.

   Training should include:
   – reasons for asking questions in questionnaire,
   – guidance on how to explain need for data collection to community members,
   – guidelines for interviewing techniques, including information on how to:
     - create an open, friendly atmosphere,
     - ask open and closed questions,
     - prevent bias in answers, and
     - cross-check answers, and
   – instruction on how to fill in questionnaire.

   Training methods could include: discussion, role play, trial run followed by discussion of problems.

6. Method of collecting data.

   a. Coverage: The capacity of one interviewer in a rural area where homes are widely separated is, at a rough estimate, 10 families a week;

   b. Timing: Home visits should be geared to times when community members are at home;

   c. Supervision: Supervision of interviewers is important to maintain their enthusiasm and increase validity of data. Such supervision should include spot checks of difficult questions, close recording of time taken in interview, number of interviews conducted, etc. Each interviewer should keep his/her own records. Daily discussion of results is helpful for increasing skills.

7. Method of tabulation.

   Tabulation can be done by community members with guidance from health workers.
   Response frequency for each question should be counted and tabulated.
   Respondents can be divided into groups based on employment, size of family, education of parents, or other relevant factors.

8. Method of analysis

   Each item in the tabulation can be evaluated

according to simple criteria, such as: good/bad, sufficient/insufficient, satisfactory/unsatisfactory. Those items assessed as bad, insufficient and unsatisfactory are raw material on which to base plans for programme.

Important factors

1. Data collection is important, but if problems arise (eg., suspicious community leader, suspicious community members, inappropriate timing), data can be collected in stages as the need arises for specific programmes (eg., under-fives' programme, environmental improvement programmes).

2. Data collection could also be postponed until volunteer health promoters have been trained.
   Advantages of using volunteer health promotors:
   - they are known by the community,
   - have an intimate knowledge of the community,
   - can gain increased awareness of problems, and
   - can obtain data for planning their programmes.

NB: It is especially important to safeguard bias if health promoters or other local people are used.

E. III. DETERMINATION OF PROBLEMS TO BE TACKLED AND SETTING PRIORITIES

- How can a community set priorities in the face of a large number of problems?
- How does one select the "right" initial activity?

Purpose

1. To initiate a dynamic programme.
2. To select a small-scale, low-cost activity which will produce quick results.
3. To provide stimulation for continuing development of the programme.

Action

1. Presentation of survey results to community leaders and community members (if possible).
2. Determination of priorities and of initial activity.

Information needed for successful action

1. Reporting survey results.

   Survey results should be reported back to the community in a form understandable to them. A descriptive, non-technical form highlighting problems and also potentials may be most effective. If possible, the report should be made both orally and in writing. The oral presentation to community leaders, both formal and informal, provides a good opportunity for discussion of major community problems, both those in the report and those felt by the community.

2. Criteria for determining priorities to be considered.

   Four simple criteria can be considered:
   - What is the incidence of the problem in the community?
   - How serious is it as a health problem? (Opinion of health worker)
   - What importance does the community place on the problem?
   - How difficult is it to overcome? (Management considerations).

   The health worker together with the community can make a simple analysis of results by evaluating each problem according to the above criteria using a scale of 0-3. The scores are then multiplied to gain a final score. Priorities are determined, the problem with the highest score gaining first priority.
   As far as possible, the key members of the community should be involved in determining priorities. Their involvement in all decision making will increase the validity of the decisions and increase their commitment to the programme. Both short- and long-term priorities should be determined to provide the vision of a continually developing, comprehensive programme.

3. Criteria for selecting initial activity:
   - low cost,
   - limited to small, feasible size,
   - ability to produce results within ± 6 months.

   Using these criteria, plans should be realistic and within the scope of the community. Hence success will be maximized, resulting in a relationship of trust and confidence between the community and the health worker.

   It is important also that the initial activity should stimulate further activities, leading to a more comprehensive programme, eg., that a nutrition programme might stimulate improvements in agricultural techniques, or a savings programme stimulate small productive activities.

E. IV. PLANNING PROGRAMME IMPLEMENTATION

- As experience is an invaluable teacher, how can members of the community acquire skills in planning and management though experience?

Purpose

1. To make plans acceptable to both the community and health service.
2. To involve all parties in planning and implementation.

3. To increase community skills.

Action

1. Meeting of community leaders, community members (if possible) and health worker to make plans for implementation, on invitation of community leaders.
2. Setting up committee and administration, including a division of responsibilities.

Information needed for successful action

1. Existing organizations in the community.

   If possible, the programme should be set up through existing organizations.
   If necessary, these could be reactivated, given new functions, etc.
   Only when this proves impossible should a new organization be created to carry out the programme.

2. Type of framework for programme.

   Examples of possible frameworks within which to set up a programme are as follows:

   a. A simple health insurance scheme can provide a framework for developing a comprehensive community health programme, eg., environmental improvements, credit union, volunteer health promotors, under-fives' weighing, etc., can all be built into the framework as community awareness increases and needs arise.

   b. A volunteer health promotors' programme could also provide the framework for similar activities, as well as improved use of home gardens, under-fives' nutrition programme, health posts, etc.

F. IMPLEMENTATION OF THE PROGRAMME

- How can the community best be made aware of its own strengths and resources, and encouraged to use those resources?

Purpose

1. To carry out plans efficiently with active support and participation of the community.
2. To mobilize local potential and resources.
3. To develop management and other skills in the community.

Action

Community leaders, committee and health worker meet to discuss the implementation of plans, including steps, timetable, division of tasks, manpower use, etc.
(This may take several meetings.)

Information needed for successful action

1. Simple methods of planning and management.
2. Methods of conducting a meeting so that those present contribute and plans stem from joint discussion.

   Preferably, these meetings should be called and led by the committee. If there is a division of responsibilities amongst the members, all will have a meaningful contribution to make to the meeting.

3. Resources available within the community and those from without the community (if required).

   These include: materials, equipment, funds, skills, technical knowledge and manpower.
   Data collected in initial stages should provide details on resources within the community.

Important factors

1. Plans should only be carried out *after* the community is prepared, ie., after social preparation and field preparation are completed.
2. The community leaders and members should be responsible for making the plans, not the health worker.
3. The role of the health worker is:
   - To assist the committee in considering problems which may arise during implementation,
   - to provide technical information, and
   - to "prod" the committee (if needed), eg., if committee chairman "forgets" to call a meeting.

G. MONITORING

- What should be done if action planned together is not implemented?
- How can the community closely follow the progress of a programme?

→ *Ongoing monitoring of the progress of activities is important.*

Purpose

1. To follow the progress of implementation of plans.
2. To study the relationship between input, output and impact.
3. To stimulate the community through continual feedback.
4. To revise methods, if necessary.

Action

1. During implementation of the programme, progress is monitored by trained community members.
2. The community, community leaders and health worker meet periodically to discuss the results of the monitoring.

Information needed for successful action

1. Simple methods of monitoring.

   It is essential to work out a simple recording system which is meaningful to the community, and can be kept by community members. Community members should be trained in the use of the system.

2. Effective ways to provide feedback of information.

   The opportunity must be provided for the community to receive regular reports of progress, eg., at community meetings, at regular committee meetings, through poster displays.
   Informal contacts with community leaders should also be used for feedback of information about the programme. Both formal and informal contacts provide an opportunity for the community to give feedback to the committee on reasons for success or failure to progress.

H. ASSESSMENT

- What steps should be taken if a programme becomes static because the community loses interest and no new ideas arise?
- How can the community assess the results of its programme?

→ *Assessment of end results of activities is important for programme development.*

Purpose

1. To assess whether results of activities within the programme are satisfactory and meeting the aims of the programme.
2. To stimulate the development of other activities.

Action

1. Community leaders, committee and health workers meet for discussion of results of activity. (In a long-term programme, these meetings are held periodically.)
2. Community meetings are held by community leaders where results of assessment by committee are discussed, and ideas on expansion of the programme based on results of assessment are developed.

Information Needed for Successful Action

1. Simple method of assessment.

   Criteria for measuring progress could include:
   - change of disease pattern,
   - infant mortality rate,
   - incidence of illness in community,
   - improvements in environment,
   - increased community participation in health programme,
   - community's use of service (accessibility and acceptability), and
   - effectiveness of service (cost and benefit).

   Data on results achieved through programme is compared with baseline data collected in initial stage of programme.

Important factors

The assessment must help the community to understand the results of their programme.

Therefore:

1. Community leaders (and if possible community members) should be involved in making the assessment. (Eg., the monitoring records could be used.)
2. The assessment must be prepared and presented in a form understood by the community.
3. The assessment must be reported back to the community members.

I. REVISION

NOTE: This step is only necessary if assessment reveals that an activity is not meeting programme objectives, or programme objectives are not meeting community needs.

→ *It is important to maintain a dynamic programme which meets the changing needs of the community.*

Purpose

1. To increase the effectiveness and efficiency of the programme.
2. To reorganize the programme to meet the needs of the community more closely.

Action

In a meeting of the community leaders, committee and health worker, decisions are made on the need for revision and methods of revision.

Information needed for successful action

1. Aspects needing revision.

These will be evident from the results of the monitoring and assessment.

2. Alternative activities which are more appropriate.

Important factors

A community is never static; community needs are continually changing. Therefore a flexible programme is required, and programme implementors must be openly willing to change and revise programme as needed. A programme should be dynamic, never static.

J. EXPANSION OF ESTABLISHED PROGRAMME

- How can the causes of problems be attacked? For example, the community not only collects blood samples to detect malaria infection, but also works towards the eradication of mosquitoes.
- How can the community reach the goal of healthier living?

Purpose

1. To improve the quality of the programme, through expanding the number and type of activities.
2. To meet health needs of the community more adequately through a comprehensive programme.

Action

In periodic meetings, possibly at the same time as assessment, community leaders, committee and health worker, propose, select and plan further activities.
(This meeting is preferably called by community leaders.)

Information needed for successful action

1. Methods of motivating community leaders and members to propose new activities may include:
   - visits to more advanced programmes;
   - development of a new activity in a limited locality, followed by encouragement of satisfied community members to stimulate other localities to follow their example; and
   - competitions.

2. Ways of encouraging community members to take more initiative should be based on increasing their awareness about their community and its problems.

   This can be achieved by:
   i. Training selected community members as volunteer health promotors so that they will have a deeper and more critical understanding of the causes of health problems and ways to overcome them.
   ii. Using important events to stimulate action, eg., Independence Day preparations could include work on environmental improvements.
   iii. Using dramatic events, eg., an outbreak of an epidemic or a death, to increase awareness and stimulate action to prevent a further occurrence of the same problem.

Important factors

Before implementing any new activity, it is essential to repeat the steps of social preparation and field preparation.

K. EXTENSION OF PROGRAMME TO OTHER COMMUNITIES

- How can other communities benefit from the experience gained earlier by an established community health programme?
- Who is responsible for the development of a community health programme in other communities?
- Who can find time to work with other communities, given the limited resources available?

Purpose

To motivate leaders in other communities to adopt a community health programme.

Action

Exposure of key people from other communities to the original programme.

Information needed for successful action

1. Media for promoting contact with other communities could include:
   i. Observation visits to original programme.
   ii. Contact between leaders of a community which has not yet begun a programme with experienced leaders of the community health programme.
   iii. Government channels, eg., introduction of programme at meeting of formal community.
   iv. Mass media.
   v. Audio-visual aids, eg., filmstrip describing community health programmes.
   vi. Public meetings, eg., seminars, workshops.
   vii. Printed brochures, manuals and other materials.

2. Early interest and motivation can be reinforced by the following:

   - government instruction which provides backing for the programme. To avoid negative effects of instruction from above, the community should be prepared to receive it;
   - provision of more detailed oral and written information, eg., full description of how to implement programme.

Important factors

1. This step may be carried out only when the initial programme is firmly established, i.e., when:
   - the community feels they are profiting from the programme,
   - community leaders and members are able to relate their experiences, and
   - intensive supervision is no longer required.
2. It is preferable that communities take the initiative in beginning the process of developing a programme in their area.

L. PROMOTION AND TRAINING IN NEW AREA, FOLLOWED BY REPEAT OF WHOLE PROCESS

- How can limited resources best be used to equip others to develop a satisfactory programme?
- How can the initiators of a new programme learn from the successes and failures?

→ *A newly developing programme can benefit from the experience gained through an existing programme.*

Purpose

1. To establish the programme in the new area on a firm foundation.
2. To provide a basic understanding of the philosophy and broad content of the programme.
3. To share information on setting up the programme in a new area.
4. To encourage the development of a flexible, dynamic programme related to local conditions and needs in the new area.

Action

1. Community leaders and/or health workers in new area commence promotion with the government and approaches to the community.
2. Training of key people from new area, including community leaders and health workers.

Information needed for successful action

1. On identity of key formal and informal leaders.
2. Appropriate training methods and content.

   Trainers should be people with experience in existing programme, including health workers, community leaders, volunteer health promoters. The curriculum and organization of the training should be determined by trainers and trainees together, based on needs of trainees. Training material should include basic philosophy and broad outline of programme only, as it is important that the details of the programme should be determined by the local community, according to local conditions.

Important factors

1. It is important to be aware of the disadvantages which could arise from using a programme as a training field, and attempt to forestall them. Possible disadvantages could be: oversaturation of the field; jealousy from other areas which are not used for training; or development of excessive pride and self-satisfaction resulting in an inability to receive any new ideas from outside.
2. The training is followed by social preparation, field preparation and all the subsequent steps outlined above.
3. Continuous contact between those involved in the existing programme with those developing the new programme is valuable to both parties.

COMMUNITY PARTICIPATION IN HEALTH – EIGHT PROPOSITIONS

readings in this volume review a wide range of eriences of community participation in development and health. Rather than summarize the major points, it is perhaps more useful to look at these ideas as a basis to formulate some guidelines for developing successful community-based health programmes. These guidelines can take the form of propositions in which community participation is taken to be a strategy and a process, and health is defined as a human condition rather than a delivery of a service.

PROPOSITION I:

A COMMUNITY-BASED HEALTH PROGRAMME REFLECTS AND RESPONDS TO THE POLITICAL CONTEXT IN WHICH IT DEVELOPS

A major determinant of the growth of a programme is the definition which those who have control over resources give to the programmes's objectives. The major resource holder is the national government. When, in countries like Tanzania and China, the government allocates those resources and supports community participation, programme objectives can be realized in a relatively short time. In comparison, several of the essays have shown the difficulty of developing programmes in countries where governments either show little interest or feel threatened by a community which takes too much initiative. A community-based health programme which is supported by official policy is of a very different character than one which is not.

In addition to government there are, in any community, certain groups that are in a better position than others to control resources. To develop a community health programme in which all sectors of the community can make demands and get some type of access to those resources is basically a political procedure which takes a great deal of time and effort. Much of this time and effort will be spent in ensuring that those who most need resources can have access and that the community leadership takes a responsible view of distribution. To meet this goal, those non-community residents who are working with community people to establish programmes must help the community to develop a careful understanding of vested interests and social structures in order that responsible leadership develops. A community-based health programme recognizes the political context and works with a clear understanding of that context and with the objective of evolving a structure which responds to the needs and priorities of the total community.

PROPOSITION II:

A COMMUNITY-BASED HEALTH PROGRAMME RECOGNIZES THAT CONFLICT SITUATIONS ARE INEVITABLE AND DEVELOPS A STRATEGY TO DEAL WITH THEM WHICH IS MOST ACCEPTABLE IN THE CULTURAL AND SOCIAL VALUES OF THE COMMUNITY

The very nature of community participation in the decision-making process, which has heretofore been reserved for those who are powerful and/or professional, means struggle for control will ensue. The conflicts centre around how to enpower people who, traditionally, are passive recipients of policy. This act implies that those who now control must give up resources to provide for a change. While these resources may range from information by professionals on how to treat diseases to finances for developing health services, people who now have these resources do not often give them up willingly.

There are many examples where gains have been made through direct confrontation between two opposing sides. The classical example of confrontation policy is, of course, social revolution which is

not very practical in most communities and countries at this moment in history. Each community has inherent structures and traditions that may support or deny confrontation as the best means to develop community participation. While it may be possible to define situations which, in any given community, may be responsive to confrontation, it must be remembered that different communities have different solutions to different problems at different times. A community-based health programme develops a careful analysis of problems in the context of the sociopolitical and economic structures and potentials and uses a range of methods to cope with inherent struggles for power.

PROPOSITION III:

A COMMUNITY-BASED HEALTH PROGRAMME DOES NOT DEPEND ON IDENTIFYING "FELT NEEDS" OF THE COMMUNITY BUT RATHER ON DEVELOPING A PROCESS FOR DIALOGUE BETWEEN THE PROFESSIONALS AND PEOPLE IN THE COMMUNITY

The value of the approach in which professionals go into a community and ask them what they want has been under attack by many with field experience in community work. For one reason, in a community, most people will respond to a question of "what do you want?" with an answer which either reflects their view of what you want to hear or what they think you will give them. For another reason, the question has often provoked surveys of the community upon which experts act to give the community what they think they need. The basic question in a community participation programme is how the members of a given community, with all their problems, traditions and diversities, can be motivated to act together to improve their communal environment. The answer to this question does not depend on surveys but on dialogue.

In considering the dialogue process, the most important principle is for professionals to not only involve, but also take seriously, the contribution of various community members. The often-used "community diagnosis" in which medical professionals go to the community to discover the various facets of social, economic and political life loses its meaning if the professionals, after analyzing their data, return to the community and tell the people what they, as professionals, think is good for the community. The objective of community/professional interaction, as the readings have pointed out, should be an interchange of views about how to solve a mutual, agreed-upon, problem. Failing to do this, the programme evolves in a traditional context in which the professionals give advice, give services and give everything but power of decisions and, thus, the potential of realizing human development to the community. A community-based health programme recognizes that the most important "felt need" of the community is to control the programmes that affect them.

PROPOSITION IV:

A COMMUNITY-BASED HEALTH PROGRAMME RECOGNIZES THE TENSION BETWEEN FLEXIBILITY AND REPLICABILITY AND TRIES, AS FAR AS POSSIBLE, TO KEEP A BALANCE BETWEEN THE TWO

One of the major challenges that faces community-based health programmes today is the attempt to replicate on a large scale some of the more successful small pilot programmes. The problem of replication arises, in no small part, because the pilot schemes have freedom and resources to experiment and to correct errors, but have neither the means nor machinery to implement their programme on a large scale. When programmes are implemented for large populations, either by government or a voluntary agency, they lose their flexibility and emerge from a uniform mould. Once these programmes become institutionalized, they demand a type of accountability which tends to be both hierarchical and inflexible. Recognizing this problem, one workable solution is decentralization of decision making which allows local communities to deal with local problems. However, the system of decentralization must provide channels for accountability, error correction and information sharing. A community-based health programme grows within a context of large-scale, preferably national-government support with a view towards replicability and with the authority to develop in a way which responds to its particular circumstances. This proposition is one of the most difficult to realize.

PROPOSITION V:

A COMMUNITY-BASED HEALTH PROGRAMME INCLUDES HEALTH SERVICES BUT REALIZES THAT THE PROVISION OF SERVICES MAY NOT BE THE BEST ENTRY POINT FOR DEVELOPING COMMUNITY PARTICIPATION IN DEVELOPMENT PROGRAMMES

In a community-based health programme where the goal is development of human potential, and improvement in health status is a major byproduct, there is experience to suggest that a direct attack on health problems by delivering health services does not necessarily achieve the goal. While it is true that health activities do lend themselves to involvement of ordinary people and often do produce dramatic results in a short time, it is also true that it is a field overburdened with professionalism. The efforts to overcome professional resistence in both the local and national scene may be better used directly to

attack poverty by introducing income-generating activities. Some communities have agreed to build an agriculture cooperative or find ways of implementing a cooperative credit system but have rejected a community health worker scheme. It must be recognized that improved health status is more a result of improved nutrition and better housing conditions created by increased income than it is of provision of health services. A community-based health programme considers improved health as one means of improving the community's life-style and sense of ability to control its destiny; it, therefore, sees health services as a possible, but not the only, entry point for community participation programmes.

PROPOSITION VI:

A COMMUNITY-BASED HEALTH PROGRAMME RECOGNIZES THE BASIS OF THE PROGRAMME AS AN EDUCATIONAL PROCESS, IDENTIFIES THE PROCESS AND ESTABLISHES TRAINING PROGRAMMES TO TEACH THIS PROCESS

A professor of mine in England once said that the most important task any professional can do in the developing world is to teach what he/she knows so that others can take that knowledge and spread it. In health care, this is particularly true for, as we have seen, there are only limited allocations for health services and most health improvements must come from changes in people's behaviour. Teaching, however, is not merely to pass on information but rather to help others to put that information to use. The whole study of informal education has begun to identify ways in which the vast numbers of people who still live outside the highly sophisticated world of concepts of Western science and technology can still profit from their findings. Educational techniques focus on a process of interaction between the teacher and the student in which both people are able to learn and work together to consolidate their ideas. There is a need to identify, articulate and develop this process and teach others to use it. A major component of a good community-based health programme is a teaching component where a corps of community people are trained to understand this process and to use this knowledge to effect change in the community.

PROPOSITION VII:

A COMMUNITY-BASED HEALTH PROGRAMME RECOGNIZES "SELF-RELIANCE" AS AN IMPORTANT OBJECTIVE AND, THEREFORE, CAREFULLY CONSIDERS HOW FOREIGN AID CAN BEST BE USED TO PROMOTE THIS OBJECTIVE

An important part of restoring human values and dignity is creating independence from the forces which previously have denied this realization. As has been discussed, foreign aid often has been a major contributor to preventing this growth of confidence both at a national and local level. Foreign aid all too often has meant that programmes take the shape which the donor has defined without regard to the views of those affected by the programme. It has, also, meant that foreign personnel supervise and direct the activities of the programme. This has caused much bitterness among financial recipients and has blocked the ostensible goal of the programme which is "to have the community take responsibility for its own health".

At the same time, it must be noted that nearly all the successful community participation programmes outside countries like China have had various degrees of foreign funding. Funds on a national or local level give needed impetus and resources which can allow community-based health programmes to build deep roots in a comparatively rapid time period. But they also, because of little understanding on both the part of the donor and recipient, can completely flood the programme and wash away any noticeable improvements. Foreign aid is useful and acceptable under carefully-defined and specified conditions. A community-based health programme recognizes this fact and works in tandem with the donor agency to spell out in detail how this aid can be a positive rather than a negative force.

PROPOSITION VIII:

A COMMUNITY-BASED HEALTH PROGRAMME SEEKS TO EVALUATE ITS SUCCESS BASED ON THE POSITIVE CHANGE IN ATTITUDES AND COMMITMENT OF THE COMMUNITY TO IMPROVE ITS STANDARD OF LIVING

The measurement of health status alone as an indicator for the success or failure of community-based programmes is not very useful. Not only are the statistics unreliable, but also, this criteria emphasizes the Western science and technological factor of health care rather than the development of the potential of human beings to improve their own health. We must also recognize that is very difficult to measure how much or how little a community participates. Attendance at a meeting or a vote to accept a community health worker by no means indicates a strong understanding of the goals and objectives of the programme. Success of the programmes can only be measured over a long period of time as changes in community attitudes become apparent. These changes may be evidenced in a range of activities, from demanding better and more appropriate health services from the government clinic, to the establishment of a profit-making goat cooperative. Improvement in health status will most likely be seen as the programme begins to develop.

In a community-based health programme, the objective of an evaluation is not to see how the programme compares with other similar programmes. It is to help the community to understand how it is progressing along the lines which it has laid down for its own development. Evaluation, therefore, must reflect the goals and values of the community, not of the experts. Professional opinion through dialogue can help shape an evaluation and assist in techniques to measure the suggested criteria. Evaluation, however, is part of the education and growth process of the community. A community-based health programme recognizes its success in how the people, not the professionals, judge the programme and in the evidence of responsible community leadership which reflects improvements for all groups within the community.

Does a community participation strategy represent a real alternative to the present inadequate health care system and its concommittent planning approaches? Can the human factor make a larger impact on improving health for the millions of people who now live in ill health and poverty than the provision of more and modern technology? The evidence is not yet conclusive but we do have some indication how these questions might be answered.

Another friend, Sister Mary Grenough, who has spent the past twelve years working in the rural Philippines, travelled last year to visit several community-based health programmes throughout Africa and Asia. In closing, I quote her evaluation of this experience.

"In each of the countries I visited, in each of the programmes I became acquainted with, what really makes the programmes effective and what really urged government and other groups to pay attention to what is happening is the *human* factor. Time and again, the effectiveness of programmes did not depend so much on the amount of money spent, or on the technological equipment, but on the human factors: concern, motivation, critical analysis, a steadfast commitment and focus on people's needs and people's resources".

Community participation in health care credits the value of people and their ability to improve their own lives. If it is true that development and health is about people, then we must find ways of giving people the priority.

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