UNITED NATIONS

ECONOMIC AND SOCIAL COUNCIL

Distr.
LIMITED

E/ICEF/L.1355
12 January 1977

ORIGINAL: ENGLISH

UNITED NATIONS CHILDREN'S FUND
Executive Board
1977 session

UNICEF-WHO JOINT COMMITTEE ON HEALTH POLICY

COMMUNITY INVOLVEMENT IN PRIMARY HEALTH CARE: A STUDY OF THE PROCESS OF COMMUNITY MOTIVATION AND CONTINUED PARTICIPATION

The attached study prepared by the UNICEF and WHO secretariats will be considered by the UNICEF-WHO Joint Committee on Health Policy (JCHP) at its twenty-first session to be held in Geneva, 31 January - 2 February 1977, and by the UNICEF Executive Board session to be held in Manila, Philippines, 19 May - 3 June 1977. The report of the JCHP (E/ICEF/L.1356) which will also be considered by the Executive Board will make comments and recommendations on this study.

77-01089

(57p.)

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

JC21/UNICEF-WHO/77.2

ORIGINAL: ENGLISH

UNICEF-WHO JOINT COMMITTEE ON HEALTH POLICY

Twenty-first Session

Geneva, 31 January - 2 February 1977

REPORT FOR THE 1977 UNICEF-WHO JOINT COMMITTEE ON HEALTH POLICY

COMMUNITY INVOLVEMENT IN PRIMARY HEALTH CARE: A STUDY OF THE PROCESS OF COMMUNITY MOTIVATION AND CONTINUED PARTICIPATION

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OUTLINE OF THE REPORT

Section 1: links the previous WHO-UNICEF Joint Study on Alternative Approaches to Meeting Basic Health Needs of Populations in Developing Countries, to the present study.

Section 2: describes the scope and objectives of the study and outlines the methodology used for its conduct.

Section 3: reviews the emergence of the primary health care approach, discusses the concept of community involvement in the 1950s and 1960s, as gleaned from the literature, points to the lessons to be learned from these past experiences, and provides reasons for optimism regarding contemporary community participation efforts.

Section 4: contains summaries of the nine case studies undertaken by national experts with the collaboration of staff of WHO and UNICEF.

Section 5: summarizes the findings of the case studies and draws conclusions from these findings and from other experiences, and makes recommendations for consideration by the Joint Committee on Health Policy.

Annexes I-IX: contain detailed versions of the nice case studies.

Appendix 1: contains the sets of principles basic to the primary health care approach.

Appendix 2: contains a brief note regarding current community activities in Ghana.

1. INTRODUCTION

WHO and UNICEF, fully aware that vast masses of humanity continue to live in a state of abject poverty and, as a result, carry a great burden of ill health, place a high priority on alleviating this burden. The strategy recently adopted for accomplishing this is that of providing primary health care to all underserved populations, through the integration at community level of all the resources, both human and material, needed to make an impact upon the health status of the people. The approach emphasizes the need for community involvement in the general development process - a process of which better health can and should be both an ingredient and a derivative. In communities where material resources are scarce and human resources abound, this strategy, basically one of self-reliance, is probably the only approach that a community can afford, and it could well turn out to be the most cost effective.

With respect to health care, a publication commissioned by the WHO/UNICEF Joint Committee on Health Policy[1] made references to community involvement in terms which may be summarized as follows:

(a) At the village level, preventive and curative health services that adequately cover and are sufficiently used by the population have been achieved where the population concerned has taken major responsibility for primary health care and where the government has collaborated in the effort.

(b) The notion of major responsibility implies the notion of a great deal of self-reliance not only in decision making with respect to priorities for health care but also in the provision of resources (manpower, facilities, logistic support, and probably funds) that are needed to bring health services into line with the defined priorities.

(c) The greater the participation of the community in the development of primary health care services, the greater will be their motivation to accept and use these services. The greater the acceptance and use of such services, the smaller will be the need for expensive curative care and the smaller will be the risk of unnecessary human loss.

In relation to the case studies reported on in the above publication, it was stated that:

"All the approaches employed one or more methods of gaining the understanding, cooperation and support of the population. Political methods relying on party organizations were the most common, but other techniques, for example, the use of development workers or educators, were also shown to be possible. Mass mobilization of the people has proved very effective, especially to achieve readily identifiable goals, such as the campaign against the five pests in China or the mass health education programmes in Tanzania or Ivanjica. In Cuba this method is being used to identify overall health needs and to implement community health programmes."[1]

The 20th session of the Joint Committee on Health Policy, in adopting the principles of, and approach to primary health care outlined in the report to the committee, recommended, inter alia, that:

(a) "A programme proposal such as that recommended requires a detailed awareness and understanding by all members of WHO and UNICEF staff and an organizational adaptation to respond to the new challenges. Therefore it is recommended that positive planned steps should be taken by WHO and UNICEF to inform, educate, and orientate their staffs to these policies.

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[1] UNICEF/WHO. A joint study on alternative approaches to meeting basic health needs of populations in developing countries. (Editors: V. Djukanovic and E. P. Mach) Geneva, World Health Organization, 1975.

(b) WHO and UNICEF should study in detail not only the innovations described in this study but also those that are occurring continuously in different parts of the world under different sponsorship; they should record and monitor them; learn from them; evaluate them; make their results widely available; assist them when necessary; adapt them; build upon them; and encourage similar endeavours, even though some may present some risk in the sense that their favourable outcome is not clearly predictable. Some of these risks can be minimized by adequate preparation and the building of a meaningful partnership with government.

(c) WHO and UNICEF should pursue research on the effects of rural and community development on the health of people and on the role that other sectors can play in the delivery of primary health care, develop methodology for application of the findings, and assist in its implementation.

(d) WHO and UNICEF should study promising existing or potential approaches in health education with a view to disseminating knowledge about them and sponsoring their application, so as to create health awareness in the people and encourage them to become partners in the delivery of primary health care."[1]

In response to these recommendations and in order to be able to collaborate more effectively with countries in the application of the primary health care approach, UNICEF and WHO, whilst being convinced that the participation of people in plans and programmes designed to improve their health status is a necessary condition for successful intervention, felt that more knowledge was required of those instances in which successful community-based development activities had been stimulated and maintained. It was for this reason that an agreement was reached to orient the 21st UNICEF-WHO Joint Committee on Health Policy study to review and analyse examples of community participation which were considered to have led to improved health and a rise in the general standards of living in different settings.

The findings of that study are contained in the pages of this report. It is emphasized that neither the study nor the report is intended to be all-encompassing as regards the topic of community involvement, given that community involvement is a dynamic process affected by ever-changing social, economic, and cultural conditions. This report should be viewed as an attempt to identify factors that should be taken into consideration in the design of future community-based activities.

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[1] UNICEF-WHO Joint Committee on Health Policy JC/UNICEF-WHO/75.6.

2. DEVELOPMENT OF THE STUDY

2.1 Scope and objectives

The present study evolved from the recommendations adopted by the 20th Session of the Joint Committee on Health Policy. Because of the need to fill some of the gaps in knowledge about the dynamics of the community participation process and because of renewed interest in the subject, it was decided specifically to look at the elements of community participation, including the motivational process and organization for continued action, which are necessary for the initiation and implementation of community-based primary health activities. A case-study approach was selected to examine these details. The methodology used was sufficiently flexible to allow examination of a variety of programmes in which there was local participation - the range being from total national programmes to purely local samples. The relatively unstructured research design used served the essential function of setting out the important parameters to community development as found in the situations studied.

As time did not permit an exhaustive study, it was decided to concentrate on a limited number of current developing country projects which contain a significant component of community involvement in primary health activities. Whilst focusing on the promotion of health, the process of community participation and involvement in the development of other sectors would also be examined. Although the study was not expected to supply definitive answers to the questions concerning community involvement, it was considered valuable to describe a number of cases which illustrated aspects of community involvement, and to look for underlying characteristics which might be relevant to WHO and UNICEF community development policies. The objectives of the study were defined as follows:

(a) to present examples of community involvement in primary health activities and from these and other examples:

(i) to identify elements of individual and community motivation and organization which, in the cases under study, have led to the initiation and continued implementation of community based primary health activities;

(ii) to identify and describe the characteristics of the communities themselves and the mobilization and educational processes, be they internal or external in origin to the community itself which have influenced either positively or negatively community-based primary health activities;

(b) to analyse and present this information in a format so that the socio-cultural, economic, motivational, organizational and other factors that appear to be common to the experiences described, can be taken into consideration and utilized by WHO and UNICEF in their collaborative efforts with countries in further development of community-based primary health activities.

2.2 Selection of the case studies

The following set of criteria were developed for use in the selection of relevant projects for study:

(a) A wide coverage of the community or communities should have been achieved by the programme or project.

(b) The activities should have been in existence long enough to be "self-multiplying".

(c) The activities should have continued beyond the term of a particular charismatic organizer.

(d) The potential studies should express a range of different health and other community activities, that is, be inter-sectoral rather than narrow in their content.

(e) The activities within the programme or project should have demonstrated an effectiveness in terms of reducing evident health or other problems, and of improving the quality of life of the communities.

(f) The activities should be low-cost in the sense of being within the financial and other resources available to the community.

(g) The activities should be acceptable to the population involved, as made evident by:

(i) continued use of services or facilities established through the programme or project;

(ii) local support for the activities in the form of participation through labour, and/or contribution of money or materials;

(iii) the expressed attitude towards the people and the services which form a part of the community activities.

(h) Evidence of the supportive role of the government or other agencies towards the community-based activities should be well defined and related to community needs, whether they be in health or in broader examples of rural development. This support should be in terms of training, logistics and supplies, technical supervision, referral, and administrative and political co-ordination and encouragement.

(i) There should be an overall consideration of geographical distribution.

Also taken into consideration was the necessity for a variety of studies from countries at varying levels of development, with different cultural backgrounds and political systems.

Through collaborative efforts between the headquarters, regional and field offices of WHO and UNICEF and from correspondence with numerous experts, a list of programmes and projects was prepared which were considered suitable for potential studies. The final selection of the projects for study was made by a Joint UNICEF-WHO Working Group.

There were cases which, whilst meeting some of the criteria, had been in existence too short a period of time to allow the process of development to be examined. One such project, in Ghana, has been described in a brief note in Appendix 2.

The cases finally selected for study were those which to the greatest extent fulfilled the above criteria: Botswana, and Senegal (in Africa); Costa Rica, Panama, and Mexico (in Latin America); Yugoslavia (in Europe); India, Indonesia, and Sri Lanka (in South-East Asia); and The Socialist Republic of Viet Nam, and Western Samoa (in the Western Pacific).

2.3 Collection of data

A "Data Collection Guide" was prepared while cases were being selected for study, but there was no time to field test and further refine it. The Guide provided for: a summary account of the programme or project selected; a detailed description of the community with emphasis on those features which had stimulated or limited participation; a detailed description of the infrastructure and outside support given to community based activities; and a description and analysis of the process of community involvement in the activities reviewed.

It was planned to carry out the initial data collection in two stages. The first stage of data collection was to be carried out by two nationals of the country, both familiar with the project, one being a social scientist. The second stage was to be a country visit, undertaken by a member of the Joint Committee on Health Policy Core Working Group - to ensure continuity and uniformity of approach - and a team consisting of nationals, and staff members at regional and country level of both WHO and UNICEF

For several reasons, delays occurred in the foregoing process, in obtaining government clearance for the studies to be conducted, and in identifying suitable experts to assist at the country level, hence this plan was not carried through in all cases. Because of these constraints it was only possible to report on projects in nine out of the eleven countries selected.

In some cases, national experts completed the data collection after the arrival in the country of the study group member. The method of interview and discussions used for the data collection was useful but time-consuming. Again because of the limited time available, the quantity and quality of the data was lower than anticipated and some basic data had to be added through library work.

Although an extensive literature review would have been invaluable to the study the limitation of resources restricted the activity at this time to a brief history of some of the community participation efforts over the past thirty years, especially those that contain features that best parallel the aspects enunciated in the primary health care approach now being emphasized by WHO and UNICEF, it being considered unwise to ignore the lessons learned from such experiences or to assume that this is an entirely new approach.

2.4 Preparation of the report

A framework for the organization and management of the study was set up, which included the Joint Committee on Health Policy Study Committee; the Joint Committee on Health Policy Core Working Group; and the Joint Committee on Health Policy Advisory Committee.

The function of the Study Committee was to provide general guidance for the study. The Core Working Group, together with the UNICEF focal points, were responsible for carrying out the study and preparing the report. The Advisory Committee was a multidisciplinary committee which met periodically to provide technical advice. Two consultants were recruited, one carried out the review of the literature (section 3.3), and the other assisted in the preparation and review of case study material and the preparation of the report.

Draft summaries of the case studies were discussed at a meeting of temporary advisors, consultants, and staff members of WHO and UNICEF. The final draft has been prepared incorporating many of the views, suggestions, conclusions and recommendations of this meeting, particularly as they related to fulfilling the objectives of the study.

3. BACKGROUND TO THE STUDY

3.1 Emergence of the "primary health care" approach

The fifty-first session of the Executive Board of the World Health Organization, in its "Organizational Study on Methods of Promoting the Development of Basic Health Services", drew attention to the maldistribution and lack of coverage of health services.

> "The Board is of the opinion that in many countries the health services are not keeping pace with the changing populations either in quantity or quality; and it is likely that they are getting worse. Even if this is looked at optimistically and it is said that the health services are improving, the Board considers that we are on the edge of a major crisis which we must face at once as it could result in a reaction which could be both destructive and costly. There appears to be widespread dissatisfaction of populations about their health services for varying reasons. These dissatisfactions occur in the developed as well as in the developing world. They can be summarized as a failure to meet the expectations of the populations; an inability of the health services to deliver a level of national coverage adequate to meet stated demands and the changing needs of different societies; a wide gap which is not closing in health status between countries, and between different groups within countries; rapidly rising costs without a visible and meaningful improvement in service; and a feeling of helplessness by the consumer who feels (rightly or wrongly) that the health services and the personnel within them are progressing along an uncontrollable path of their own which may be satisfying to the health professions but which is not what is wanted by the consumer."[1]

In answer to the problems identified above, some developing countries have introduced new approaches. A number of these approaches were reviewed in detail by a previously mentioned Joint Committee on Health Policy study.[2] The analysis of these alternatives revealed a set of features that appear to be central to any approach to meeting the health needs of greater numbers of the world's population. The features identified by the study were formulated into sets of principles which were included in the Joint Committee on Health Policy Study Report to the 20th UNICEF-WHO Joint Committee on Health Policy as well as in the Director-General's Report to the fifty-fifth session of the WHO Executive Board.[3] The two sets of principles became the basis for the primary health care approach, presenting a similar conceptual and operational position (Appendix 1). The following are composites of those principles, which take into account experience gained since the principles were first formulated:

(a) Health has multiple relationships with other aspects of development and, therefore, the activities of all sectors involved in development need to be fully integrated.

(b) To ensure that adequate resources are available to communities when needed, firm national will and policies in support of the primary health care approach are required along with resource allocation mechanisms that complement community efforts at the appropriate time.

(c) Communities need to be involved from the beginning in the planning and implementation of the national primary health care programme as well as of local primary health activities, so as to ensure that the programme and its activities meet the local needs and priorities, become shaped around the people's life styles and patterns, and promote community self-reliance with respect to meaningful development.

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[1] WHO Official Records, No. 206, 1973, Annex 11, pp, 103-115.

[2] UNICEF/WHO. A joint study on alternative approaches to meeting basic health needs of populations in developing countries. (Editors: V. Djukanovic and E. P. Mach) Geneva, World Health Organization, 1975.

[3] Document EB55/9.

(d) Primary health care activities require full utilization of available community resources, especially those which have hitherto remained untapped, and unrecognized.

(e) The health care component of the primary health care programme lays stress on: (i) preventive measures; (ii) health and nutrition education; (iii) meeting health care needs of high-risk groups, such as mothers and children; and (iv) utilization of allopathic and traditional medical and health technology appropriate at community level.

(f) Health interventions are undertaken at community level by appropriately trained workers who, when possible, should be selected by the community itself from amongst its own people.

(g) To ensure that the operational needs of community health care are met, other echelons of the health system are required to provide technical, logistic, supervisory and referral support.

The primary health care approach was presented to the WHO Twenty-eighth World Health Assembly[1] and to the 1975 UNICEF Executive Board.[2] Both WHO and UNICEF adopted the approach and are actively engaged, through collaboration with governments, in promoting its acceptance and implementation within national settings.

The community involvement advocated in principle (c) is amplified in the next sub-section.

3.2 Community involvement

Community participation has a wide range of application extending from consultation to a minor or major role in decision making. This involvement may be limited to the local élite or elders, or it may extend to men and women more generally and to young people interested in changes within their community. The level of decision-making with which people may be involved ranges from the community setting, through the provincial departments to the national government, as well as through the political party or parties of the country.

There are many definitions and stated positions regarding the term "community". In this study, "community" is taken to mean a group of people who can be identified as living with and having a sense of belonging to a geographic area. Depending upon the settlement pattern and population density, a community may consist of a village or town, a part of a village or town, or several non-contiguous settlements.

The group of people that make up a community have the innate collective capacity to make decisions, commit resources, and take responsibility for the conduct of activities carried out by the group. In this study, the concern is with group involvement which contributes to the implementation of community-based primary health activities. The degree to which the community exercises this innate capacity is taken as a direct measure of their involvement, which could be conceptualized in terms of a broad spectrum. Where this capacity is least exercised, the community may be "participating" in development but only in the sense of being passive recipients of benefits. At the other extreme of the involvement spectrum is the community that is actively and meaningfully involved in its own development. This situation, where purpose and content of development originate with the people and where individual voluntary contributions to programmes and projects take place, contributes to a "collective" sense of belonging and dignity. Between these two extremes of involvement is the more prevalent situation where members of communities share to a limited degree in decision-making and have marginal physical interaction with the decision-makers and where channels for communicating their opinions to the "authorities" may be reduced to the use of mass action.

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[1] Document WHA28/9.

[2] Document E/ICEF/L.1322.

Since the broad concern of the study is with community involvement for development, particularly as it relates to the primary health approach, it is also necessary to discuss the notion of development used. Development may be considered to be concerned with a general increase in production of material goods and services, a change in their distribution and consumption, and an improvement in social benefits and relationships.

Nationally, the benefits of development may be perceived in the form of quantitative measures, such as: reduction in the rate of infant mortality, increase in the number of immunizations, in the number of houses reconstructed and built, in the rate of school attendance, kilometres of roads built, numbers of communities supplied with electricity, etc. At local or community level, development can be seen in terms of improved agricultural output, improved sanitary facilities, and healthier people, whose individual and collective personality is increasingly geared to self-reliance and the attainment of their full potential for development.

Community involvement is unique to each national and local setting because it is a reflection of social dynamics which are influenced by cultural settings, economic realities, and political structure, as well as by national practices and policies. In spite of the complexity of these influencing factors, certain features can be hypothesized as dictating the location on the spectrum described above of the type(s) of community involvement obtaining. These include:

(a) a national commitment to support and accept active community involvement;

(b) the degree to which national plans reflect local aspirations and needs;

(c) the extent of decentralization of government bureaucracy;

(d) the degree of organization at community level;

(e) the degree to which a community is able to organize its own local resources;

(f) the sincerity and quality of local leadership; and

(g) the extent to which communication flows from the centre to the periphery and vice versa, and within the community itself.

Although other features could be identified as being crucial to the success of community involvement and the degree to which communities are able to exercise their inherent capacity of self-reliance for development, it is felt that the features identified above are sufficiently demanding in themselves to warrant special consideration in this study.

National commitment to community involvement could take several forms, among which the most important are: the pursuance of relevant policies, the existence of rural development bodies promoting community self-reliance, and the presence of national administrative institutions in which a strong community representation is manifested.

The extent to which local aspirations and needs are reflected in a national plan is difficult to assess precisely, because local aspirations and needs may be poorly understood or expressed. It is, however, possible to judge whether or not a plan is attempting to meet the essential needs of the majority of the population, especially the rural and urban poor.

Decentralization of government machinery may promote community involvement where it leads to government inputs being made more readily accessible at the community level, where decisions can be made as to their use. It also can enhance the degree to which the other features interact positively for community involvement, e.g. the encouragement of community organizations and proper assessment of community aspirations and needs.

Limited community organization could delay to some extent the development of the essential elements of the community involvement process. Some degree of organization is required to harness positive qualities within a community in order to channel them for development of the community. The existence of community organizational structures encourages large numbers of its people to be involved in the identification of priority concerns and of needed actions and in the marshalling of available resources for action.

In order to activate the local involvement process within an organized community, local leadership is required. This should be one which identifies with fundamental social values and local aspirations, and which complements and strengthens community development efforts.

Communication flowing to and from communities could help tie the initiatives being taken at community level with those of government, facilitating the "upward" statement of needs and the "downward" flow of resources. This could lead to the ideal situation where the "bureaucracy" is accountable to the people.[1]

3.3 History of community participation

The notion that cooperative self-help could be stimulated and promoted by outside agencies is fairly recent, though difficult to date precisely. On the other hand, the idea that members of communities can identify common problems and work towards solving them through cooperative efforts is as old as community living. Most societies have a tradition of participation at local level, through village and ethnic councils and various kinds of group meetings; and agrarian communities usually have a history of economic cooperation. Although the advance of technology and urbanization have eroded some of these conditions, in many countries new approaches to local development are being based on the traditional forms of participation inherent in the community.

It was felt that a better understanding of these adaptations of traditional structures could be gained from a brief review of development efforts over the past thirty years, which would illuminate some of the pitfalls as well as the contributions to be expected from community participation.

The following discussion is based on the national community development programmes of the 1950s and early 1960s, a period when there was much interest shown by governments and bilateral and multilateral agencies, including the United Nations, in support of local development programmes.

In 1948 the Cambridge Summer Conference on African Administration coined the definition of community development most commonly used in the immediate post-war period:

> "A movement designed to promote better living for the whole community with the active participation, and if possible on the initiative of the community, but if this initiative is not forthcoming spontaneously, by the use of techniques for arousing and stimulating it in order to secure its active and enthusiastic response to the movement."[2]

The programmes that were developed on the basis of the above definition had certain fundamental elements in common.

(a) Community development programmes had multipurpose goals and were designed to deal with across-the-board problems, especially in agriculture, health, and education. This meant that the technical specialities of a number of government ministries and departments required coordination.

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[1] Obaidullah Khan, A. Z. M. Poverty-oriented rural development and the UN system; a turning point. A working document for the ACC. New York, United Nations, 1976.

[2] Great Britain, Colonial Office, Community Development; A Handbook, Her Majesty's Stationery Office, London, 1958.

(b) Community development emphasized "cooperation" and was seen as requiring the local participation of people in the planning and execution of programmes; they and representatives of government agencies were to "cooperate" in decision making and carrying out programmes decided upon.

(c) Community development programmes, at least in theory, were to encourage local initiative rather than impose upon communities the plans of outside agencies. Local initiative was manifest through the identification of "felt needs", that is, the villagers were to determine the developmental priorities. Progress towards meeting these needs was to be achieved by the aided "self-help" process in which the community provided labour and other local resources, whilst outside agents provided technical guidance, supplies not available locally and general coordination with larger regional and national programmes.

(d) The community development method stressed the identification of local formal (elected or appointed) and informal (unofficial) community leaders to carry out the programmes. The role of these community leaders was to: encourage and arouse the enthusiasm of villagers for a variety of projects, and to be the demonstrators of new techniques and methods which would then be adopted by other villagers.

The 1956 United Nations definition of community development also embraced the above four points:

"The term community development has come into international usage to connote the processes by which the efforts of the people themselves are united with those of governmental authorities to improve the economic, social and cultural conditions of communities, to integrate these communities into the life of the nation, and to enable them to contribute fully to national programmes."[1]

This was a heady period of international concern in development. The economic model which was in vogue at the time focused on economic growth with limited benefit to the masses. Community development appeared to offer the missing ingredient in national plans for economic and social progress by solving the problems of poverty, ignorance, hunger and ill-health. The continued central position of economic growth in this model, with sporadic concern for social ills and injustices affecting the greater masses of the world's population, was perhaps the most important limiting factor to this approach; another being the over-ambitious (and unrealistic) goals set for the community development programmes of that period. Other difficulties included the appointment of paid community development workers, who had received some education and were external to the communities in which they were to work. This invariably resulted in a block in communication and lack of mutual trust and understanding which were difficult to overcome. Also, demonstration and instruction techniques were used as the means to induce change, rather than increasing the capacity of people to respond to their own problems. These difficulties hampered earlier community development efforts and disillusionment set in. Community development through community involvement, is, however, continuing today; many of the national programmes have reduced their level of operations but new programmes continue to appear and are seemingly more vigorous as they tend to spread their manpower and financial resources less widely.

3.4 Some lessons to be learned from the past

In the 1950s, those concerned with community development commonly believed that the countryside embodied the virtues of society whereas the city encouraged its vices. According to this view, the task of government was, therefore, to awaken in villagers their natural qualities for decision-making and cooperative action through the use of outside specialists. Unfortunately, in most instances, poverty - and throughout history most villages have been poor - discourages cooperation, leads to suspicion of fellow villagers, and encourages a primary commitment to family rather than community.

[1] United Nations Department of Economic and Social Affairs, Popular participation in development: emerging trends in community development, New York, 1971.

A closely-related misconception was that villagers could be taught to change their ways. A generation ago, community development workers routinely felt that all that was needed was a clear explanation of new practices that they, the technicians, perceived as being desirable for villagers. Only slowly did the specialists realize that what they felt to be desirable was not necessarily so in the local context.

Part of the frequent failure to communicate effectively with villagers stemmed from using the "demonstration field" approach in all aspects of community development work, whereas it had been developed specifically to teach new agricultural methods; when the right seeds, the right fertilizers, the right amount of water, and the appropriate cultivation techniques are combined with favourable weather, the impact is readily seen. But the demonstration technique is more difficult to apply to other kinds of developmental programmes. Although tried in health, it often does not lead to improved health practices. Villagers quickly perceive the miracles worked by antibiotics, but there is no effective way to demonstrate the benefits of immunization; statistical evidence does not convince people lacking a scientific education.

A further common misconception was that the community leaders who cooperated with the development workers were motivated only by a love of the community and that they would be willing to share new and valuable information with fellow villagers, without succumbing to any temptations of self-interest. In addition these leaders were usually identified by the community development workers, and because of the relationship with the "bureaucracy" they lost much of their indigenous leadership.

In the early years of national community development programmes, goal expectations varied greatly according to professions and/or departments. Government administrators tended to look upon community development as a device for achieving low-cost village improvements, so that more capital could be freed for infrastructure and industrial development in urban settings. Local programmes were sometimes subverted to serve the policies and politics of national leaders, and this led to disillusionment and disappointment at the outcome of community development. On the other hand, many professional community development experts felt that their primary goals were to instill in villagers a new sense of independence and self-confidence, and to help them become more self-reliant. These altruistically-motivated community developers were also guilty of ethnocentricity and often set unrealistic goals; they sometimes assumed that they knew the correct way to live and saw their task as one of converting rural people to their viewpoint, rather than of helping villagers to find their own way to better living.

As bureaucracies need to show results in order to justify their existence, there was a tendency to support material improvements, which produced visible and quantifiable results, rather than concentrate on the development of educated, self-reliant citizens able to make decisions about their future, a notion that does not easily lend itself to quantification.

An approach based entirely on the "identification of felt needs" by the community overlooked the fact that the villagers' perceptions of needs did not necessarily correspond to the steps to be taken to satisfy those needs. Healthy children are commonly a "felt need" in all communities; but sanitary latrines, fly reduction, and other environmental control steps that lead to healthy children usually are not seen as felt needs. Moreover, many national community development programmes were not organized to help meet felt needs expressed by the villagers. They were set up to offer help in agriculture, environmental sanitation, adult literacy, cottage industries etc.

In some regions most community development personnel were drawn from other government services and tended to regard their assignments as temporary. Those who entered government service via community development programmes frequently viewed it as a stepping stone to a career in one of the long-established government departments because the role of village-level worker had little prestige.

Community development, with its emphasis on agriculture, health and educational activities, has often promoted inter-ministry and department rivalries which have sometimes handicapped development programmes.

A number of the best known community development programmes have been initiated by leaders whose charismatic qualities have played a major part in the success of the programmes, both in inspiring communities to action and in attracting high financial and personnel investments. These programmes have been difficult to implement in other settings.

3.5 Prospects for the future

Community participation as a part of the community development process becomes more of a possibility as basic economic and educational levels rise. Time, and village improvements during the past generation in many countries of the world, have worked to the advantage of the community development approach. Although about half of the total population live in absolute or relative poverty, observers who have had continuing contact with the rural scene during recent decades can appreciate the changes that have taken place. In villages in 1976, education is more productive, standards of living have risen, roads have been built and the transistor radio is commonplace. The villager too is a different person, his horizons are broader, he has travelled to cities and has perhaps even worked in them, and he is less suspicious of his neighbours. It appears then that the contemporary villagers are more ready to collaborate in developmental activities, including primary health activities, than were their counterparts a few years ago.

In the 1950s, when major community development programmes were being initiated, scientific knowledge about the processes of socio-economic change began to increase. In the intervening years, more has been learned about these processes of social and cultural change. As a result of practical experience gained from developmental programmes, and from extensive behavioural science research, useful models are being developed to explain and predict the circumstances under which major change can be expected. There is more knowledge about the kinds of social, cultural, psychological and economic "barriers" that discourage the adoption of new ways, as well as the motivations that lead people to innovate. Programme planning and operations, while hardly a science, are on a much firmer footing than a generation ago, and the modes of implementation have changed.

The problem of professional prestige in community development careers continues; within health work, however, these problems are minimal. Throughout history, medicine has had a relatively high status and this extends to the health sciences in general, making participation in health programmes attractive. It seems likely that this status advantage will encourage participation in primary health activities and involvement in local affairs.

"Quality of life" factors are of far greater concern to planners and developers than they were a decade ago. Increasingly it is recognized that clean air, clean rivers, clean oceans, leisure time, and many other things that make life enjoyable are legitimate and essential goals of development. Today, many areas, such as: changes of attitudes and traditional practices, interest in the new, and the desire for an active role in determining the conditions under which life is led, are receiving sympathetic and serious attention, and the inability to quantify progress in these areas is becoming less of a handicap.

This "people-oriented" model, rather than the narrower techno-economic "growth-oriented" model, depends for its success on the degree to which the majority of the people participate in the planning and execution of development activities.[1]

The factors mentioned above, which include the changing rural scene, the increased knowledge of the dynamics of change - especially about the motivation that leads people to try new ways and become involved in carrying them out - and the new respectability of qualitative change, have increased the chances for successful implementation of the community development approach.

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[1] Haque et al., Towards a theory of rural development. United Nations Asian Development Institute, Bangkok, December 1975.

Some of the different emphases in the primary health care approach are related to the avoidance of difficulties experienced in the past. Probably the most important of these concerns the community-level health worker, whose responsibility to the community is greater than that of the earlier community development worker, whose status was that of an auxiliary government official. Secondly, a primary health care delivery system, which is ideally a component of a more comprehensive community-level services, does not expect a single multipurpose auxiliary to deal directly with services in several sectors, requiring support from several different departments or ministries. The rural extension workers are, however, expected to understand each others work and collaborate when necessary.

At international level, the attention given to the "new economic order", the commitment of international agencies to give priority to direct assistance to the developing countries, and the search for new approaches, all point to an attempt to find more effective and acceptable ways to translate technical programmes and activities into forms which have a greater chance of reaching and affecting positively the lives of those least advantaged and vulnerable groups who constitute the majority of the population in the rural areas and urban slums of the developing world. This has led to renewed interest in the community development approach, centred around community participation.

4. SUMMARIES OF CASE STUDIES

4.1 Botswana. Community organization and the building of a school at Mochudi followed by other coöperative efforts

In the early 1920s, members of the bakgatla tribe in the village of Mochudi, under the leadership of their charismatic chief, participated in the building of a primary school (the Isang school). This established a pattern of community involvement which still continues.

Background

Mochudi has a population of approximately 17 400, and is the principal village of the Kgatleng district. The population is homogeneous, the whole village being bakgatla. It is divided into five wards, each ward being divided into families. The chief is the overall guardian and each ward has a headman appointed by the chief. The families are basically patriarchal, although women are gradually playing a greater rôle in decision-making. There are no significant divisive factors in the community, no castes, and no social clan system (except for the hereditary position of the chief).

The main natural resources of Mochudi are farming and grazing land, and timber. The quality of the land is quite good and efforts are being made to prevent overgrazing; most of the water comes from boreholes and from a river. Cattle, sheep and goats are raised, and the principal crops are sorghum, maize and beans. There is a cooperative (run by the people of Mochudi), a number of shops, a bakery, a restaurant and a petrol station. Temporary wage-producing activities, such as road building, have recently developed but wage-earning possibilities are mainly found outside the village. Often, the village agricultural work-force tend cattle or raise crops in isolated "cattle posts" or "lands", spending substantial parts of the year far away from the village. Many of the young men work abroad for a major part of the year, principally in South African mines.

In Mochudi there are teachers, administrators, artisans, two physicians, a veterinarian, nurses, traditional healers and birth attendants, and shop-keepers. Both men and women participate in agricultural activities, although care of cattle and ploughing falls mainly to men. Women look after the children and the home and it is usually they who, after consultation with the men, seek medical care for the children.

There are religious gatherings on Sundays (the majority of people are Christian) where women usually predominate. But more dynamic are the political and administrative meetings in the traditional assembly, where women, encouraged by the present chief, have recently taken a more active rôle. There is a community centre where various groups meet.

Most of the homes are built of brick (not general in the villages of Botswana), with thatched roofs. Minibuses connect Mochudi with Gaborone, the capital, and Labatse. The number of privately-owned cars and lorries is increasing. The road network is largely of unengineered earth roads. Air services are available at Gaborone, and the nearest railway station to Mochudi is at Pilane.

A branch of the Information Service in Mochudi distributes the Government-owned daily paper and monthly magazine; other papers (mainly from the Republic of South Africa and Southern Rhodesia) are available in Gaborone. Nationally, some 15 to 20% of householders possess radios. Because of the close-knit nature of the community, this means that the majority of the population has access to radio. Telephone, telegraph and postal services are available in Mochudi, but there is, as yet, no television.

Health status

Although there are no specific data for Mochudi, the 1974 estimates for Botswana as a whole gave the crude birth rate as 44.5‰, the crude death rate as 14‰, and the infant mortality rates for males as 103 and for females as 91‰ live births.

Health problems in Mochudi are similar to those for the country as a whole. The most frequent cause of death for children of 0 to 4 years of age are: enteritis, measles, prematurity, pneumonia, birth injuries, nutritional deficiencies, pulmonary tuberculosis and meningitis; and for children of 5 to 14 years of age: measles, meningitis, foreign bodies, heart disease, enteritis, tuberculous meningitis, diphtheria, tetanus, acute respiratory infections, and ill-defined conditions. The main groups of diseases found in both inpatient and outpatient clinics are: acute respiratory infections, enteritis and other diarrhoeal diseases, other infectious diseases, and diseases of the eye. The incidence of tuberculosis has been reduced as a result of BCG vaccinations.

Malnutrition is a problem as the staple diet consists mainly of starchy foods: millet, sorghum and maize, together with some vegetables and, occasionally, milk. Some families, however, do eat plenty of meat. In most villages, children are breast-fed for 12 to 24 months. Solid foods (made from millet, maize, sorghum and beans) are introduced at 4 to 8 months; after weaning, children eat the same foods as the rest of the family. Cultural tradition dictates that during pregnancy and lactation, some foods (eggs, water-melon, intestines, peanuts, liver and kidney) are to be avoided; and during sickness, meat and salty foods are not eaten.

Infrastructure

In addition to the traditional assemblies, each village now has a village development council, which can propose projects to be included in the district development plan. At district level, there are district councils and district development committees.

One particular objective of the National Development Plan is to reduce the differentials between the urban and rural sectors, through rural development. In the Kgatleng district, therefore, the Government has assigned health workers, agricultural officers, veterinarians, district development officers and education officers to work in collaboration with the district council. The district itself employs school principals and teachers. The task of the district development officer is to supervise and advise the village development officer, who, after consultation with village leaders and other development workers, decides upon priorities for development in the village.

Traditionally, the local community has provided both labour and materials for the construction and maintenance of roads, drainage, simple bridges, schools, clinics and other communal buildings; however, these tasks are increasingly seen as government functions and the government has, in fact, taken over many projects initiated by local groups. Several international and bilateral agencies and religious missions have also contributed materially and financially.

Education is a government priority. Schools are financed by the district councils and by the missions. Mochudi, with its six primary and two secondary schools, compares favourably with the capital city. This emphasizes the interest of the bakgatla in education.

The present National Development Plan stresses the importance of extending rural health services. This follows a decade of concentrating on hospital development which has resulted in the impressive bed to population ratio of 1:390.

Mochudi has a 146-bed mission hospital, and there is a district outpatient clinic (financed by the Ministry of Health) specializing in maternal and child health and family planning. The hospital and clinic have: 2 full-time physicians, 14 nurses, 8 nurse-midwives, 4 nurse-aides, 1 X-ray technician, and 7 family welfare educators. The nursing school, attached to the hospital, has 52 student nurses enrolled in a two-year course.

The Ministry of Health gives priority to programmes for disease prevention; these include: immunization programmes, malaria control, maternal and child health programmes, dental health programmes, nutrition, trypanosomiasis and plague surveillance, and the national tuberculosis programme. The country has been divided into 8 regional health areas, each with a team composed of: medical officer, health inspector(s), public health nurse(s), field officer(s), health assistants and family welfare educators. The team is responsible for all health activities in their region.

Immunizations are carried out regularly. At mid-1976, approximately 96% of the entire population had been immunized against smallpox and 90% of all children between 0 and 14 years of age against tuberculosis.

The Water Affairs Department has a programme to provide treated water supplies to villages, but the smaller villages and rural areas (including Mochudi) generally have rather poor sanitation.

In 1975, 58% of the estimated total births in the country took place in health units; in Mochudi hospital there were 611 births. Ante-natal and family planning services are available in hospitals and clinics and are used extensively.

The family welfare educators are literate women, selected by the villagers, who receive 11 months of training in Gaborone. Their tasks include: nutrition education (especially on breast-feeding, weaning, and advice to pregnant mothers), family planning, personal hygiene and immunization.

Distance sometimes becomes an obstacle to the utilization of health services. In Mochudi, however, 77% of the patients travel less than 5 km to reach the hospital, thus it is well utilized. People still resort to witch-doctors for diseases thought to be caused by "evil-doers"; and traditional healers also still practice. Modern medicine is hindered by the tendency to cease taking medication once symptoms have disappeared.

Anopheles mosquito control is carried out in the endemic malaria regions of north Botswana; tsetse control also in Ngamiland; and rat flea surveillance teams are on guard against the vectors of plague.

Analysis of community participation

In 1920, the mission school in Mochudi refused to accept the chief-designate and one of his relatives on the grounds that they were too young to understand the word of God. The regent, Isang Pilane, appealed against the decision, but in vain. At the same time, the bakgatla felt the need for a school teaching basic educational knowledge and skills, the curriculum of the mission school being solely religious instruction.

The regent convened a meeting at which it was decided to build a school. Each adult male, whatever his economic status, was to contribute the same amount of money, to be obtained through wage-labour and not through selling cattle or property. The villagers, both men and women, worked together to construct the school which opened in 1923. The community employed a headmaster and built a house for him. It was decided that each family should send at least one son to the school and another to the "cattle post" (because cattle were the main source of income for the people of Mochudi).

Another community effort resulted from the drought of 1921. The Government refused assistance in drilling boreholes, so the regent levied a tax on each man and went to South Africa to purchase the necessary drilling equipment.

Having witnessed the extent of community participation in building the Isang school, the mission extended its activities to include a homecraft school and a day-care service.

In 1963, it was decided at the assembly that the Isang school should continue solely as a primary school and that secondary courses should be provided at the Molefi school. A year later, the Government tried to close the Molefi school in an attempt to cut education costs but the community resisted and the Government finally gave way and provided funds to keep the school open.

Recently, a group of mothers, with the help of the Young Women's Christian Association, raised 40 US dollars to start a day-care centre. The wife of the chief managed to raise the rest of the money that was needed. Other projects include a resource centre for the blind and a homecraft centre where domestic science is taught.

The Isang school project also sparked off activities in other parts of the country; for example, the baMangwato built the first secondary school of Botswana at Moeng in the central district, and this in turn led to the Botswana University Campus appeal.

Conclusions

The Isang school project was a success for several reasons: the original idea came from the community itself; the whole project was led by a progressive and dynamic chief; and the community was highly motivated and ready to contribute land, labour, materials and finance. Decisions were taken at traditional meetings; the people were ethnically, religiously and politically homogeneous; and thus already had a strong tradition of communal agricultural labour.

The success of the Isang school project led to other community activities, to which the Government policy of encouraging local initiative provided support. Community participation has improved education, communication, agriculture and other services; and it would seem, from the diminished incidence of malnutrition and the lower mortality and morbidity levels, that these projects have indirectly improved the health of the people.

4.2 Costa Rica. Community participation in development projects in the Canton of San Carlos

Community participation in primary health care activities have improved the health status of the people of the Canton of San Carlos. These activities were promoted by community workers, through the rural health programme and the National Office for Community Development (DINADECO).

Background

The Canton of San Carlos covers 3435 km^2 and, in 1975, had a population of some 58 400. It is essentially a rural area made up of small dispersed communities (only two have more than 1000 inhabitants). The population is relatively homogeneous, being mainly Ladino.

Households are not usually shared with relatives, although larger family networks exist in the most rural areas. There is little stratification between socio-economic groups. Status is based on the values of being "proper and hard working" and on humility in social relations. Although Protestant missionary groups have recently become active, 80% of the population are Catholic.

All municipal posts are filled by public elections that are held every four years and, within the four-year period, the posts of municipal president and other high-level local government officers are rotated yearly, to ensure that officials become familiar with a wide range of cantonal issues.

At local level, each community elects a leader who organizes public meetings at which new projects, ideas or problems can be discussed. There are also political meetings. At present, few women participate actively in local politics and community affairs.

The Canton of San Carlos has extremely fertile lands: cattle rearing and dairy production are important; principal crops are coffee, cocoa and sugar; and there are forests producing high-quality timber. Rivers and streams are abundant, the water table is sufficiently high to make drilling wells relatively easy, but potable water is scarce. Some reservoirs and water tanks have been constructed and, where funds are insufficient, domestic wells have been cemented to reduce the risk of contamination.

The level of employment is high and the region has in recent years enjoyed a significant economic growth. The majority of the population is employed in agriculture; incomes are also earned from the dairy and timber industries, from transport, machine maintenance businesses, catering and small commercial concerns. New industries are emerging in Ciudad Quezada, the urban centre for the Canton; and most communities have carpenters, builders, etc. Salaries, however, are slightly below the average for Costa Rica as a whole. In general, the men are responsible for agricultural activities, the women for the home and children.

In the last six years, 366 km of new roads have been constructed and for the first time there is transport between the various municipalities of San Carlos all the year round.

National newspapers are readily available, and there is a local newspaper with a circulation of around 2500. Some 90% of the population have radios, there are some televisions, a good public telephone system and an increasing number of private telephones.

Health status

Attendance at health centres and hospitals is mainly due to: infections, parasitic, respiratory, skin and urinary tract diseases; accidents; and problems of nutrition and the nervous system. The main causes of death in children from 0 to 5 years of age are: tetanus; diarrhoeal diseases, pneumonia, and bronchitis.

Cultural beliefs still dictate that some illnesses (such as fevers and digestive problems) are treated by traditional healers. Other hinderances to modern health care are the beliefs that immunization may lead to male sterility and that vaccination of a healthy person causes sickness.

Infrastructure

The National Office for Community Development (DINADECO) was formed in 1967 to promote, direct, coordinate and evaluate community development activities. Its principal function has been to promote the idea of community development, to assist in the identification of needs and to provide technical expertise. In the Canton of San Carlos, DINADECO has a permanent staff of a regional chief, a general supervisor, an administrative supervisor, a field-work supervisor, nine field-level promoters, and two promoters based in Ciudad Quezada.

At the local level, autonomous community development associations have been formed (25 in San Carlos), through which DINADECO has been able to support many of the community projects currently under way. Each DINADECO promoter is responsible for 6000 inhabitants and most have previously worked as school-teachers in small villages.

The government supports both DINADECO and the community development associations as part of its rural development programme.

There is a 175-bed hospital at Ciudad Quezada, and in the Canton of San Carlos there are a further 13 health posts, a health centre, a mobile clinic specializing in dental problems, and five dispensaries. Efforts have been made to integrate national health staff with traditional practitioners; for example, 60 traditional midwives have followed a training course.

Each health post is manned by one rural health worker and one nursing auxiliary, who undertake the epidemiological surveillance for their area. They are trained in early diagnosis, provision of basic health care, and immunization activities. Through them, an intensive immunization programme was undertaken which has immunized 85% of children under six years of age against whooping cough, measles, diphtheria, poliomyelitis and tuberculosis. This programme was modelled on the successful antimalaria programme, where each health worker was responsible for a given number of households.

There has been an intensive campaign to encourage communities to build their own pumps and wells; and a latrine programme.

UNICEF has furnished rural health personnel with kits, equipment and vehicles (usually motor cycles), and given fellowships for the nursing auxiliaries training programme. CARE (Cooperative for American Relief Everywhere) has provided money. WHO has sent epidemiologists and rural health specialists to work in the field and has contributed extensively to the training of local personnel through fellowships. UNDP has supplied funds, in conjunction with WHO activities, to improve health posts, for nutrition education, and for water supply programmes. USAID (United States Agency for International Development) has financed the training of health personnel.

The Ministry of Health has contributed financial aid and medicaments. A credit banking system has provided funds for agricultural development and the government has made available some 19 million US dollars (for the country as a whole) to promote educational, nutritional, health and housing development schemes. The cooperatives of San Carlos also direct some of their working capital towards agricultural and economic development.

In 1975, some 15% of the population over 10 years of age were illiterate; however, San Carlos now has a school programme of primary, secondary, and technical education. The government provides free transport for students who have to travel outside their own communities to secondary school.

Analysis of community participation

The initial experience of community endeavour occurred in the late 1960s when the feeling arose among coffee farmers that they were being exploited by large international coffee corporations. They amalgamated their resources, unified their sales policies and formed a cooperative, which was successful in dealing with the problem. The idea of cooperatives has now been extended to farming, marketing, dairy production, stock raising and retailing.

Community participation in development activities has been increasingly encouraged by the promoters, who themselves come from the communities. They have helped community development associations define appropriate plans of action to meet priority needs. In particular, the DINADECO promoters have been responsible for coordination and for obtaining the necessary material resources and technical expertise. In the early stages, some community projects suffered set-backs because promised materials did not arrive.

Rural health personnel and DINADECO staff have been sensitive to community structures and culture, and have understood that only projects related to needs felt by the communities themselves would be successful. The communities have thus been responsible for identifying needs, defining plans of action and delegating responsibilities.

Conclusions

Many factors have contributed to the success of community development activities in San Carlos. The cooperative movement started in response to a particular problem and was successful. The population is relatively homogeneous, with no rigid social stratification, so intergroup conflicts are negligible. The underlying values of hard work and humility and the possibility of free exchange of ideas between individuals are a fundamental strength. The improved road network, especially the link between Ciudad Quezada and San José, inspired the communities to a new way of life, new values and new horizons. The economic expansion in San Carlos was also significant. Both national and international agencies compensated for the lack of local financial and technical resources.

The government introduced a wide range of development activities through its rural health programme. Both health personnel and DINADECO promoters were sensitive to local customs and needs, and worked through community groups. Finally, many international agencies provided financial, technical, practical and material aid.

4.3 Indonesia. Community participation in developmental activities in two villages

The villages of Balongmasin in East Java, and Nglebak, in Central Java, have an impressive record of community development projects, accomplished through gotong royong (mutual self-help practice) complemented by Government subsidy.

Background

Balongmasin is situated in a low-lying valley; it has an annual rainfall of 1535 mm and temperature range of between 25°C and 32°C. Nglebak lies on a mountainside, 900 m above sea level; the annual rainfall is 3180 mm and the average temperature is 23°C.

In 1975 the population of Balongmasin was 2461; the crude birth rate was 15.4‰, the crude death rate 5.2‰, and the infant mortality rate 52.6‰ live births; and 42.7% of the population was under 15 years of age. In Nglebak, at mid-1976, the population was 3531; the crude birth rate was 19‰, the crude death rate 8‰, and the infant mortality rate was 15‰ live births; and 38.1% of the population was under 15 years of age. These figures are markedly better than the national statistics. It has been suggested that this may be due to under-reporting, but the higher than average living conditions in the two villages could have lead to this improvement. Officials in the two villages are convinced that there has been a considerable advance in their standard of living.

The population of the villages remains stable, with no seasonal migration; the people are of Malay stock and almost all are Muslim. There is, however, some idological religious division among the communities.

In 1974, the Government decentralized a large part of its powers and this gave impetus to village development projects.

The village administration, which was based on a traditional structure, consists broadly of: the village headman, the village secretary, and the village "messenger" in East Java or the hamlet head in Central Java. The headman administers the village, collects land tax, and represents both the people and the Government at village level. The secretary assists the headman in the performance of his duties, and keeps records of vital events. The hamlet head or "messenger" forms the link between the village administration and the community. The Islamic leader is responsible for the religious life of the community, and has great influence. Other important posts are those of the person responsible for distribution of water for irrigation, the person responsible for agriculture, and the person responsible for security. All posts must be approved by the district and regency levels of authority.

The hamlets are divided into neighbourhood groups, consisting of 20 to 25 families, each with a chairman. Volunteer facilitators have recently been selected in Balongmasin and trained in promoting health, agriculture and other areas of development.

The family is a compact unit of parents and children living in their own home; but grown-up children are responsible for caring for parents and dependent relatives. The male is usually head of the family and dominant in decision-making, although older family members may have some influence. The women care for the home and children.

Neither village has a caste or social class system, although a new social class is emerging as a result of material wealth and education.

Anyone can suggest a community improvement scheme, but the idea must be accepted by the headman to stand any chance of success. The idea is then discussed in the neighbourhood groups until a consensus is reached. An annual village meeting, attended by village officials and family heads, legitimizes decisions that have been taken in consultation with, and with the consensus of, various groups.

Decisions are usually implemented through the village social institute, formed in response to the Government's desire to strengthen village administration in 1952, which is concerned with social welfare and economic development through its different branches. Its members serve on a voluntary basis. The family welfare association is a unit of the village social institute, run by women, which is concerned with improving the status of women and children in the villages, and the family as a whole.

Agriculture is the basic occupation in the two villages. Balongmasin occupies an area of 208.9 hectares, of which 55% is irrigated rice fields. Income is thus mainly derived from rice, but other sources are: sugar-cane, eggs, coconuts, chilli, peanuts, soya beans and maize. There are two rivers which, with a system of dams and channels, provide irrigation. A veriety of occupations exist in the village which could enhance further development, these include: schoolteachers, health centre staff (an assistant field worker for family planning, a malaria worker, and a vaccinator), carpenters, retired policemen, farmers, farm labourers and merchants.

The land area of Nglebak is 227.7 hectares, of which 70.7% is irrigated. Again, rice is the chief crop, supplemented by cassava, sweet potatoes, peanuts, soya beans and a large variety of fruit and vegetables. Water is obtained from natural springs, and there are wells with cement run-off bases. There are village officials, farmers, farm labourers, merchants, and herbalists.

As a part of the improved nutrition programme, fishponds have been introduced in both villages; and the main livestock are: buffaloes, cows, goats and poultry.

Women may help with light agricultural tasks, and some are engaged in home industries, such as batik-making and weaving.

Ideas are exchanged at the annual village meeting, at emergency meetings and at meetings of the village social institute, the family welfare association, and meetings held for communal capital accumulation (a club where participants each regularly contribute a sum of money, or some product such as rice, and take it in turns to receive the accumulated "capital").

There is no direct public transport to Balongmasin: villagers have to walk 1.5 km to the highway to get a bus or taxi. Some people in the village, however, have bicycles, motorcycles, or wagons. A regular bus service connects Nglebak with Tawang Mangu and Solo.

Neither village has a post office, telephone or telgraphic service; mail is delivered to the village headman's office. Radios are quite common and Nglebak possesses two televisions. The village headmen receive a Government daily newspaper and newsletter; and some local newspapers and magazines are available in the villages.

The houses in Balongmasin are constructed of brick, bamboo, or a combination of the two; all have tiled roofs and more than half have concrete floors and windows. In Nglebak, the houses are of stone, with tiled roofs and the village streets are paved with rocks. There is no electricity in either village.

Health status

In both villages, the leading causes of morbidity were: respiratory, gastro-intestinal, and skin diseases; malaria is also a problem. Probably the main causes of death among children from 5 to 15 years of age are pneumonia and influenza; and among infants, respiratory infections and gastro-intestinal diseases. Malnutrition does not appear to be a problem.

Infrastructure

Government policy is to promote village development, and funds are available to complement village initiatives, though villagers themselves finance most of the local development projects. The district administration provides technicians to help with specific projects: social workers from the Ministry of Social Affairs; irrigation advisers, agricultural extension workers, animal husbandry and fishery advisers from the Ministry of Agriculture; and community development workers from the Ministry of the Interior.

The agricultural credit scheme makes available seeds, equipment, fertilizers, pesticides and implements. The district and regency administrations monitor all development activities in the villages.

Education is subsidized by the Government. There is one primary school in Balongmasin and there are two in Nglebak. Secondary education is available at nearby towns. Both villages have high literacy rates.

The second socio-economic plan (1974-1979) emphasizes the provision of health services to rural communities. The only health services in Balongmasin and Nglebak are provided by the Government, although doctors and midwives may take on additional private practice. The health services are financed by the Government, by local communities, and by payments from patients. Government assistance is provided in three ways: the regular budget is used for operational expenses; the development budget is used for housing of the health staff; and there is a special fund for building health training centres and for the construction of rural water supplies. Health posts in the villages are entirely supported by the local communities.

There is a health post in Balongmasin, where a weekly clinic is held by a nurse or midwife from the health centre (about 1.5 km away). Maternal care is provided by two traditional midwives, who have been given some training at the health centre, and by the visiting midwife. The nearest hospital is 7 km away.

There is no health post in Nglebak; the nearest health centre is 1.5 km away, up the mountain, with a staff of: a nurse, a midwife, an auxiliary nurse, an auxiliary midwife, two immunization staff, a health educator, and three malaria workers. In Nglebak there are three traditional midwives, who have had training at the health centre, and eight traditional practitioners. The nearest hospital is 23 km away.

Villagers are discouraged from using the health centres by distance, cost, the propensity of health centre staff to favour private practice, shortage of equipment and drugs, and the preference for using traditional healers for some diseases.

Analysis of community participation

Both villages have a long tradition of community participation, which forms a basis for the events described. In 1952, the headman of Balongmasin returned from a leadership improvement course (organized by the regent), anxious to implement some of the new ideas he had acquired; however, it took six years to achieve the initial organizational structure for effective community participation within the village. The building of a four-room school was the first of a series of village improvements.

It seems that community participation in Nglebak is closely linked with the diminishing availability of agricultural land, resulting from population increase. In order to bring all available land under cultivation, a great deal of manpower was needed for terracing, dyke and canal building, ploughing, planting, weeding, and harvesting. These tasks, necessary to maximize the productivity of land, could only be carried out through mutual assistance.

Although projects can originate anywhere within the community, the villagers usually look to the headman for ideas. The regular meetings of the headman with the district authority mean that there is a regular flow of communication from outside the community.

Facilitators, initially trained as village health workers for Balongmasin, later extended their activities to other areas of development. In both villages it has been noted that development workers who do not integrate with socio-cultural community patterns, or who inspect, rather than take part in, community activities, are not generally accepted by the villagers.

The discussion and dissemination of ideas has become easier with the introduction of village social institutes and volunteer facilitators. Funds for the projects are raised through the proceeds from village lands, communal capital accumulation, and personal levies. For large projects, requests are made for Government funds. The village meeting organizes the labour force to carry out projects. The village social institute has volunteers who are responsible for such activities as: rice storage, irrigation, fishery, home industry, nutrition demonstrations, general education, and sport. These volunteers, who may not have the necessary qualifications for their particular duty, are assisted by outside agents.

Successful projects in Balongmasin include the building of corrals for cattle away from the dwellings and, in conjunction with other villages, the building of a dam for irrigation purposes and to minimize the effects of the annual floods. In Nglebak, fish-breeding activities have been introduced, and more people are now engaged in traditional home industries (such as, batik-making, hand-loom and basket weaving).

In 1958 there was a project in Balongmasin to build public latrines; however, when the project was completed, interest waned and the latrines were not maintained. Since the introduction of facilitators, the villagers show continued interest in completed projects.

That headman and officials can have a negative effect on projects is shown by the following two examples. In one instance community activities came to a halt when the headman was discredited. When this headman was replaced the projects were revived. A further case occurred when officials recommended that apple trees should be planted to replace diseased citrus trees. As no financial incentives were offered, only the wealthier villagers could implement the suggestion, and this led to a general discrediting of all advice offered.

Conclusions

The tradition of mutual self-help and the Government policy of rural development are basic to the success of community activities in Balongmasin and Nglebak. But the two villages have achieved a higher than average level of development, thus other factors must have also been important. These include: the leadership provided by the village headmen, strengthened by the training courses for the headmen organized by the district authority and the regular meetings with the district authority; the decision-making process that permits issues to be discussed at all levels until a consensus emerges; the village social institutes, which implement the social welfare and economic development activities; the possibilities of raising funds at local level; the willingness of the community to provide labour to carry out projects; and the complementary technical advice and financial help provided by Governmental agencies.

4.4 Mexico. The stimulation and coordination activities of PRODESCH (Programe de Desarrollo Socio-Economico de "Los Altos de Chiapas")

Since 1972, PRODESCH (Programe de Desarrollo Socio-Economico de "Los Altos de Chiapas") has worked in the Chiapas highlands to stimulate and coordinate socio-economic and health development. Between 1500 and 2000 km of new roads have been built, electrification and piped water have been brought to most of the communities of the area, and primary health care is being promoted at the community level through the use of local volunteers.

Background

The population of the Chiapas highlands is approximately 335 000, dispersed in relatively isolated, small communities. In 1970 there were 1584 such communities; only one, San Cristobal de las Casas, with a population of 25 700, could be said to constitute an urban centre; and over 1000 communities were of less than 100 inhabitants. In 1973, the birth rate was 31.4‰, infant mortality was 40.6‰, and the crude death rate was 7.0‰. There is extensive seasonal migration.

The population is predominantly Indian (indigenous) and of Catholic religion. Recently, religious groups belonging to the Church of the Latter Day Saints, the Seventh Day Adventists, and Methodists have come into the region and are providing health and educational services to a number of communities.

The main administrative unit in Chiapas is the municipality and the most important political administrative institution within the community is the municipal government. There is also a traditional politico-religious hierarchy in which all adult men are expected, at some time, to hold a post for a period of one year. In some communities there are, in addition, tribal councils (made up of elders) whose responsibility it is to deal with local social welfare.

PRODESCH activities have led to the formation of "responsible groups" designed to deal with such matters as road construction and maintenance, health, electrification, and youth affairs. These responsible groups generally merge with the traditional groups but some new leadership is being identified, for example, through youth groups.

Although 82% of the population is engaged in agriculture, agricultural productivity is low and does not meet the normal needs of the people. According to the 1960 Agricultural Census, only 12.5% of the land was workable. The main crops are corn and beans, and these, together with chilli, form the staple food of the indigenous population. One effect of the generally poor agricultural productivity is the migration, two or three times a year, of some 20 000 men, who go to work in the coffee-growing region of Soconuso.

As far as other occupations are concerned, carpenters, builders, etc. exist, but PRODESCH has felt it necessary to instigate the teaching of technical skills on a broader scale. To men fall agricultural duties and politico-religious responsibilities. The women care for the home and the children, collect wood, etc.

Timber and timber-related industries represent the most potentially productive natural resource, and PRODESCH is promoting the development of a furniture industry. Tourism is limited to San Cristobal de las Casas. There are oil and coal deposits but these have not yet been extensively exploited. Hydro-electric power schemes are being developed.

Rainfall is sufficient and new agricultural lands have been created through terracing designed to maximize land use and water catchment. Village hand-pumps, village taps, the piping of water to individual homes, and improved community water catchment facilities have been introduced as a result of PRODESCH-motivated activities.

The recent road-building programme has connected all the main municipalities and linked them with the national road network. There are about 1000 landing strips throughout the state, and small planes regularly service the area. Buses, trucks, horse or foot are the alternative means of transport.

Several newspapers exist, dealing with local matters. There are two local radio stations in San Cristobal. One was established by the state for PRODESCH and its daily transmission in four local Indian languages of health, education, agriculture and social affairs programmes has been one of the main forces in opening up the indigenous communities. The other transmits mainly pre-recorded music and commercial advertising. There are some 15 000 radios and 4000 televisions in the area, together with 16 post offices and 40 telegraph offices.

The markets, held weekly in the municipalities, provide a setting for the exchange of news and ideas.

Health status

The health situation of the area reflects the general level of poverty, exacerbated by the harsh terrain and inclement climate. The main illnesses are: gastroenteritis, amoebic dysentery, bronchitis, pneumonia, and intestinal parasites. In children from 0 to 5 years of age, the main causes of death are: diarrhoeal diseases, influenza and pneumonia, whooping cough, heart diseases, measles, tetanus, accidents, typhoid and bronchitis. Poor housing is a health hazard: few homes have windows or chimneys and the central ground-level fire fills the home with smoke, contributing to the high incidence of respiratory diseases. Nutrition is generally poor, and malnutrition is common among children.

Among the indigenous population, some diseases are seen as having a supernatural origin. Traditional medicine continues to be practised; and the traditional birth attendants and shamen are being successfully integrated with modern health services.

Infrastructure

There has been a long history of socio-economic development in the area, particularly with reference to the Indian population. For example, the Instituto Nacional Indigenista was founded in 1948 to assist the integration of the Indian population into the mainstream of Mexican society and it continues to provide education and basic health services in some communities.

The rôle of PRODESCH has mainly been concerned with the coordination of the manpower and technological resources necessary to accelerate community-based development. There is a network of cultural development workers, which functions around the 130 schools of the area. There are 187 bilingual (in Spanish and one of the Indian languages of the area) teachers, complemented by 80 agricultural development workers, 9 agricultural engineers, 7 agronomists, and 20 home economists. The main task of the agricultural development workers is to increase production and improve nutrition and the economic livelihood of the people. They are also expected to motivate the communities in other activities, such as the formation of youth clubs and agricultural committees.

Supporting the educational programme, there is a network of technical teachers, physical education teachers, administrators and cooks who visit the schools to advise on programme development and general administration.

In 1975, there were 540 schools in the area. The communities recognize the importance of education and help to support the teachers assigned to their communities through food donations. In order to optimize the use of the school as a focus for community action, teachers are taught the local Indian languages of the area and are trained to give instruction in first-aid, hygiene and physical education.

Students are encouraged to form alumni associations and these, together with the youth clubs, constitute two of the principal motivating forces in the agricultural and social development of the area, as well as being settings for fostering natural leadership qualities.

PRODESCH has encouraged the use of audiovisual aids to emphasize and preserve traditional Indian culture: an aim which has predisposed the communities of the region to accept other PRODESCH activities.

The youth clubs are becoming increasingly important in the field-work undertaken by PRODESCH. There are 288 such clubs in 19 municipal areas, with approximately 6300 (male and female) members.

In 1976, the communities covered by PRODESCH had at their disposal a health team composed of: 18 general practitioners, 3 residents, 5 specialists, 30 first-year graduate physicians, 3 dentists, 34 pharmacists, 4 trained nurses, 96 nursing auxiliaries, 10 medical auxiliaries, 8 medical students, 33 administrators, and 188 other health workers.

Health workers, after a four-month training period, are given the responsibility for providing diagnostic and primary therapeutic care to their communities, and for introducing health education.

One relatively innovative arrangement has been the sharing, between PRODESCH - with the assistance of the WHO adviser - and the State Health Department, of the supervision and training of first-year medical graduates assigned to the area. The graduates thus have the backing of PRODESCH and can, in turn, support the health workers.

Serious cases can be referred first to one of the two hospitals in San Cristobal de las Casas, or if necessary to the state capital hospital system.

With respect to external resources, the Federal and State Governments provide technicians, equipment and educational materials, as well as credit and loan facilities for the purchase of seed, fertilizer and agricultural equipment. International support comes from FAO, PAHO/WHO, and UNICEF in the form of technical staff, advisers, scholarships and materials. UNDESA and UNESCO have also provided help.

Analysis of community participation

In 1970, the Governor of Chiapas, a native of San Cristobal, knowing the problems of the area well, envisaged a project to promote and assist in the socio-economic development of the Indian populations: this was the origin of PRODESCH. The Governor enjoyed the support of the President, and this facilitated both national and international cooperation.

In the early stages of the project, community leaders and technical personnel suggested that education should be the first priority, but further discussion resulted in the identification of nutrition as the principal need, followed by the need for roads.

Within the communities, the rôle of PRODESCH staff is to assist community leaders in defining needs and methods of implementing appropriate projects. The community selects for training, as promoters in agriculture, health and education, individuals who are already well-known, having been active in youth clubs or agricultural associations. Traditional healers traditional midwives, and others who have previously been engaged in providing specific services have also been successfully integrated into new types of activity.

The organization of labour for projects has been left entirely to local leaders and has thus remained within the traditional work pattern of the community.

On occasions when large numbers of men have been required to work for extended periods of time on the road construction programmes, food-for-work projects have been initiated to recompense their labour with food.

On smaller-scale projects, the practice has been for a given number of days' work to be donated by each male. Terracing; the improvement of community buildings, schools, churches and meeting halls; fitting of water pipes; and the construction of reservoirs or tanks have all been undertaken in this way.

In the initial phases, materials were provided by PRODESCH, but as communities have become more involved, they have gradually assumed responsibility for collecting funds and purchasing as much of the required material as possible. Transport cooperatives have emerged, and the need for UNICEF vehicles has diminished.

Communities are now becoming much more prepared to present their ideas and requests and take the initiative in seeking innovative ways of meeting their needs. The overall success of this scheme can be judged by the fact that two neighbouring states are now attempting to replicate the work that was initiated and organized by PRODESCH.

Conclusions

The work of the Instituto Nacional Indigenista had gone some way to prepare the community for further developmental activities. Traditions of community participation existed and all adult males were involved in some type of community service through the politico-religious hierarchy. There was a lack of factionalism within the Indian communities and equality was traditionally seen as a virtue. The communities had a strong sense of identity, which facilitated collaboration in projects, administration and organization. All these factors meant that the community was ready to accept the activities proposed by PRODESCH.

It proved important that promoters were able to initiate projects other than those which were their particular responsibility. The improvement of the road system was a major step towards further development. The indigenous radio system, developed by PRODESCH, was a source of information and generated community involvement. The original community decision-making processes were respected and the community was involved, from the beginning, in defining needs and priorities.

International support was available, through WHO and FAO, at field level. At national level, PRODESCH provided leadership and administrative resources without which the community development would have been impossible; and supported activities that gave rapid results, to encourage the continued involvement of the communities.

4.5 Senegal. Self-help activities in the Sahelian area

The people of the region of Thies have constructed and are operating on a self-help basis: rural maternity centres, village dispensaries, and nutrition rehabilitation centres. The communities of Casamance run children's day-care centres. The Rural Promotion Movement, Animation Rurale (later, the Human Advancement Movement, Promotion Humaine), has been instrumental in instigating many of the projects.

Background

The region of Thies had, in 1974, a population of 547 477 and a population density of 83.7 persons/km^2, who lived in some 2000 villages; 57% of the land is cultivated for agricultural purposes by 74% of the population. For the country as a whole, the crude birth rate is 46.3‰, the crude death rate 22.9‰, and the infant mortality rate 92.9‰ live births. The country is predominantly Muslim and the population is ethnically homogenous with two basic groups predominating: the Sereres (45%) grouped into large towns in the southern Diobasse area, and the Wolofs (42%) dispersed in the northern Cayor area. All the ethnic groups have different languages; there is no doubt that they have a common heritage.

With the government reform in 1972, decentralization conferred to the regions many of the responsibilities previously resting at national level. This administrative reform was introduced as a result of a political decision taken by the President and the Parliament on the basis of a large-scale study. The region of Thies is administered by a governor and a regional advisory council; it is divided into several departments, each with a prefect and departmental council. The departments are further subdivided into districts, headed by sub-prefects, who are in close contact with the population. The sub-prefects have the responsibility for the economic and social development of the district and they are in charge of the district rural extension centres. The most peripheral entity with financial and legal status is the rural community. There are 31 rural communities in the Thies region, each comprised of between 15 and 100 villages usually not more than 10 km apart, and with a population of 10 000 at most. The managing rural council is made up each five years; two-thirds of the members are elected and one-third is nominated by the assemblies of the agricultural cooperatives. The rural council is headed by an executive chairman and has its own financial resources derived from a rural tax and a tax levied on animals within its territory. These taxes are spent entirely on local projects. The rural council is also responsible for running the affairs of the community, including decisions with regard to community projects. In this way the citizens become aware of the direct connexion between the payment of taxes and their use for projects of direct benefit to the community. The council is also responsible for the use of state land. The smallest unit is the village, made up of several extended families.

All adult males of the village are allowed to vote and express their opinions on the decisions to be made. Women are allowed to attend the meetings but do not vote. Village meetings are called whenever a community decision is needed and, after discussion of the topic, the majority opinion dictates the course of action.

The extended patriarchal family is headed by the oldest man (who makes all family decisions) and usually includes several generations, from aunts and uncles to sons with their wives, or divorced daughters with their children. Polygamy is widespread among Muslim families. The head of the family provides food for all its members from the crop of the communal field where all the family work in the morning. The men farm the communal field, or their own land, or work in agricultural cooperatives. The women care for the home, tend the family vegetable plot, take part in agricultural labour and sometimes make small domestic articles for sale.

Transport between villages is by animal-drawn cart or walking.

Health status

Among the cases most often treated at local clinics are: parasitic diseases, such as schistosomiasis and trypanosomiasis; bacterial infections; and malaria. In Thies, the main causes of death among children from 0 to 5 years of age were: measles, diarrhoea, broncho-pneumonia, malnutrition, accidents, tonsilitis, jaundice, and "other neonatal infections". The main causes of death among the 5 to 15 year olds were: broncho-pneumonia, measles, diarrhoea, accidents, and "unknown causes".

The people are aware of the importance to health of proper nutrition. Breast-feeding continues for prolonged periods, but at the time of weaning protein deficiencies occur causing malnutrition, which remains a major problem.

In Thies, both modern and traditional medicine exist. The people widely believe in non-scientific explanations of health problems and often turn to modern medicine only because of the severity of an illness.

The region has a regional hospital, 6 health centres, and 37 primary care dispensaries usually staffed by one or two nurses, providing limited services.

Infrastructure

The Rural Promotion Movement, instituted in 1959, trained voluntary promoters (animateurs) from each village, who then organized the village to undertake community projects. This Movement declined around 1970 because of the unfavourable economic climate caused, among other things, by the long period of drought. The Human Advancement Movement then replaced the Rural Promotion Movement. Although it does not recruit promoters, it maintains close ties with those trained earlier. Rather, it trains and pays extension workers (moniteurs) to promote rural development. It creates social awareness and provides vocational education through 26 community houses, 22 training centres in Senegal, and through the enseignement moyen pratique programme. Three or four of its rural extension workers are attached to the rural extension centres in each district, and they advise the village communities on home economics, health, hygiene, the rôle of women in society, and on any topics which make the community more receptive to the services offered by Government technical agencies.

The rural extension centres are under the administrative supervision of the Ministry of Rural Development and have a National Coordinating Committee, of which representatives of the Prime Minister, and of the Ministries of Internal Affairs, Finance, Education, Planning and Governors of the Region, are members. The rural extension centres were established in 1954 to bring technological advances to the rural areas. Each district-level rural extension centre is staffed by a chief, three or four teachers, together with specialists in agriculture, building, construction, forests and water, fishing, land management, youth and sports, and nursing.

The National Bureau for Cooperation and Development Assistance (ONCAD), in cooperation with the Banque Nationale de Développement de Sénégal, serves as wholesaler, purchasing agent, and financier to the farmers; it sets up guidelines for the running of agricultural cooperatives; and it gives advice on crops and rural planning.

In 1974, the Societé du Développement et de Vulgarisation Agricole (SODEVA) was created to provide agricultural technical assistance and to introduce modern farming techniques, which it does through a network of technical assistants based throughout the country. SODEVA has also trained young farmers to be community representatives and it has set up a model farm.

The Government health services provide training for local birth attendants and village dispensers.

Analysis of community participation

The distance of the health centres from the rural communities and the high neonatal mortality rate caused enough concern among the people to spur them to act on their own (though with outside advice) to build maternity units. This community spirit also manifested itself in other health projects including village pharmacies, nutrition centres, and day-care centres.

In 1957 a pilot project was instituted in Khombole, a town in the region of Thies, to study methods of protecting mothers and children. Two years later, the Government established a school for sanitarians nearby. Prompted by staff of the Rural Promotion Movement, neighbouring villages sent more than 200 traditional birth attendants to the district health centre to learn about safe midwifery techniques. A Khombole-based team then visited the birth attendants periodically to check procedures and collect birth statistics. As it was difficult for the small staff of supervisors to visit the widely scattered birth attendants, it seemed wiser to group them at fixed points. This led to the idea of "confinement huts" which, together with another group of huts, were to constitute a maternity centre.

The villagers, prompted by promoters and the Dakar Institute of Social Paediatrics, took up collections to buy furniture and materials for the construction of the centres. The Government provided lamps and blankets. The huts are built of local materials provided by the villagers: the walls of plaited millet stalks; the conical roof thatched; the supporting timbers of sections of palmyia trunk or the leaf stalks; and the floor of mud or of concrete. There are latrines, built by the villagers; and a development worker (a former animateur) is responsible for the cleanliness of the compound. The Institute of Social Paediatrics provides a table for the delivery hut, and UNICEF provides a kit of the necessary instruments. The delivery huts are also used for pre-natal clinics; and the centres are used for maternal and child health clinics. This was not possible when the traditional birth attendants practised in the villages. The centres are staffed by traditional birth attendants who work for periods of 48 hours. Two to four birth attendants are always available.

The midwife of the Khombole Centre visits each rural maternity centre on a pre-arranged day to carry out pre-natal examinations; 561 women have been examined regularly since March 1971. Women with high-risk pregnancies are sent to specialist centres for delivery.

In the early 1960s, on the advice of the promoters trained through the Rural Promotion Movement, the villagers decided to collect money and materials and to provide labour to establish village dispensaries. In general, these dispensaries are situated in the most underprivileged areas, far from health posts, and where transport is difficult. The dispenser undergoes a one-month training provided by the rural extension centre at the chief town of the department (during which the trainee is fed but not paid). The training enables the dispenser to diagnose and treat local health problems, dress wounds and undertake simple stitching. Each patient pays a fee. The village dispenser is not paid, and continues to carry on his own activity (usually farming).

In the village of Gott, the dispensary has been in existence since 1962, and is linked with a pre-paid system. At the beginning of the year, following the sale of groundnuts (their only cash product), the villagers pay a fixed sum which entitles them to simple treatment and medicines throughout the year. The dispensary is controlled by the villagers and they are responsible for stocking it (although this is not a problem, as UNICEF generously supplements dispensary stocks).

At Notto, where from June 1975 to June 1976 the dispensary dealt with 275 patients from a dozen villages, the dispensers are two young boys, one aged 17 with a school-leaving certificate, the other holding an intermediate certificate. Each patient attending pays 10 CFA francs as a fee. For this he is examined and diagnosed and receives sufficient medicine for 2 to 3 days of treatment. The village dispenser looks after the drugs and keeps simple accounts in a copybook in which he records the patient's name and village of origin, the diagnosis, the name and quantity of the drug administered and the amount of money charged.

Although originally built by foreign religious groups, the nutritional centres involve a large amount of community participation. In some cases, villagers have contributed labour to improve buildings and to carry out maintenance. The mothers look after the children, prepare meals, keep the huts and courtyards clean and help with other small household tasks. In the village of Babak there is a nutrition rehabilitation service attached to the health centre which has been functioning since 1968. The villagers donated the land, collected money to build a hut for the midwives, and pay a fee for each birth.

The day-care centre programme was initiated by the Rural Promotion Movement in the region of Casamance in the early 1960s to provide care for the children while the mothers helped with the harvest.

The first children's day-care centre was set up at Tandième in the 1962 rainy season for the two months in which the women had to work intensively in the rice-fields. Part of the cost was covered by the produce of a collective field, which the villagers had cultivated in advance. Contributions of rice and other foods ensured the successful operation of the centre, and provided a mid-day meal for the children. The director and deputy of the rural extension centre, where the day-care centre was located, gave their assistance, but the village women were actually responsible for organizing the day-care centre. They collected money to buy meat, fish and vegetables, and they took turns in looking after the children and attending to the various maintenance tasks, such as cleaning the premises, carrying water, preparing and serving meals. The day-care centre operated smoothly and the villagers decided to repeat the activity the following year.

The idea of day-care centres spread rapidly. The communities were able to take joint decisions, assemble material resources, list and register the children, organize sessions for preventive vaccinations, and delegate people to take training courses in the management of child-care centres. It proved essential for one or two women to have the responsibility for supervising the day-care centre as a whole, thus natural leaders emerged. The only obstacle to running the day-care centre has been the difficulty of fulfilling immunization requirements.

Conclusions

Probably the greatest factor in the success of these programmes is the solidarity of the village communities.

Although popular participation did not emerge spontaneously, after initial mobilization the villagers took an active part in projects. A tradition of working together was inherent in the extended family; and communities recognized the need for maternity services, nutritional advice, and the day-care centres.

Projects were usually initiated by the various Governmental agencies concerned with rural development. External assistance came from international agencies and foreign religious groups. While this study cannot assess the totality of these actions, it supports the view that the overall developmental effort and the administrative arrangements were favourable to the activities of rural communities in attempting to cope on a self-help basis with their worst health problems.

In the maternity centres constructed and run by the villagers in the area described, the death rate caused by tetanus neonatorum was reduced to 3 per 2335 deliveries within five years. Other achievements are less visible and more difficult to attribute to one single action, but there are certain positive indications: women go to the maternity centres for delivery; a considerable number of people purchase medicaments from the village pharmacies for modest sums or are prepared to participate in a pre-paid system; mothers use the nutritional rehabilitation centres; and the villagers obviously consider the day-nurseries useful otherwise the women would not organize themselves to run them. In all cases there is a willingness to contribute in cash and in kind. It is unlikely that people would provide support on a continuous basis if they did not consider it worthwhile.

However, success is not yet complete: out of the 31 maternity centres planned in Thies region, 13 are functioning; out of 40 day nurseries in Casamance, many did not operate in 1975 because they could not comply with the vaccination requirements of the health authorities. The region of Sine Saloum, with a population of 850 000, is, however, following the example of Thies: groups of confinement huts are under construction, traditional birth attendants and village pharmacists are being trained, councils of rural communities have made provisions in their local budgets for these simple maternity centres and even pledged to work collectively three days per year on the fields of birth attendants and pharmacists in return for their voluntary services. The system can by no means be considered as final, but appears to be the best solution in the present situation and obviously has to be further improved in accordance with the progress of the economy and general development.

In analysing development activities with the involvement of rural communities in Senegal, the sincere commitment by national leaders to promote community participation is most noteworthy. There was, and is, a willingness to create the necessary institutional structure and other political conditions that make the people's participation possible. The administrative reform initiated by the President in consultation with a great number of people and approved by Parliament has decentralized power to the regions and created a local government structure including a system of rural councils for groups of villages

4.6 The Socialist Republic of Viet Nam. The health service development experience of the Democratic Republic of Viet Nam before the creation of the Socialist Republic of Viet Nam on 2 July 1976

Community participation in solving health problems throughout the country is illustrated by descriptions of three villages: Quang An, Dong Tien, and Tan Ly.

Background

The village of Quang An is in the suburbs of Hanoi and is 3 km in length and 1.5 km in width. Of a population of 3331, 45% are male, and 40% are under 15 years of age (1975 statistics).

Dong Tien and Tan Ly are both in rural areas. Dong Tien is 4.5 km in length and 3.5 km in width, and is composed of five separate hamlets. The population is 5238, of which 45% are male and 50% are under 15 years of age. Tan Ly is 4.5 km long and 3 km wide and includes four hamlets. It has a population of 2717, of which 43% are male, and 47% under 15 years of age.

For the country as a whole, in 1975, the mortality rate was 7.2‰, the infant mortality rate was 32.6‰, and the birth rate was 30.1‰. The establishment of an efficient health care system has brought about significant progress, as is evident when the figures for 1975 are compared with earlier statistics. For example, in 1938, the mortality rate was 26‰, the infant mortality rate was 300-400‰, and the birth rate was 48‰.

The highest authority in all villages is the people's council, which is elected by universal, direct and secret ballot. There is a people's committee, elected by the people's council, which administers all village activities (finance, transport, communications, agriculture, education, culture, information, public health, maternal and child health services, security, the militia, etc.). Specialized services, such as health services, although administered by the people's committee, are under the technical supervision of the service at district, provincial and national levels. There is also a village court. All administrative staff are trained, encouraged, and directed by the higher authorities.

The administrative staff of cooperatives and popular organizations are elected by their members.

People have the right to participate in the discussion of general affairs at village and cooperative meetings; in general, members of youth and other popular organizations are very active. In some cases, the people elect delegates (who are informed of the electors' views) for consultative and decision-making meetings.

The villages have a production cooperative system, whose managing committee is elected by a general assembly of members. The committee is responsible for organizing production and for the standard of living of all members. The members of the cooperatives are divided into production brigades on the basis of their skills and occupations.

The economy of Dong Tien is based on rice and silkworms; that of Quang An on the sale of flowers, ornamental plants, vegetables, figs, poultry, fish, and fruit; and that of Tan Ly on rice, fish, lotus, longans and other fruit. The organization of collective farming and the introduction of agricultural improvements have raised yields considerably.

In all three villages, the main occupation is agriculture and a high proportion of women work.

Bicycles are used extensively as a means of transport: there are 400 in Dong Tien, 700 in Quang An, and 300 in Tan Ly. Dong Tien and Quang An are close to public transport; Tan Ly is about 7 km from the nearest bus terminal. Public transport is, however, inadequate to meet the needs of the villages.

Most of the villagers have access to radios, and the rural post office distributes newspapers issued by central and provincial bodies.

People still assemble to discuss public affairs in the traditional communal house, and contacts also occur at local or neighbouring markets.

Health status

In the country as a whole, malaria has almost been eradicated, and the incidence of infectious diseases (such as poliomyelitis, typhoid fever, diphtheria, and whooping cough) has also drastically declined.

Following the introduction of family planning in 1970, the birth rate in Dong Tien, Quang An and Tan Ly has decreased to below 2%. Infant mortality is also very low.

In Dong Tien, from 1970 to 1975, only one child under one year of age died (the cause being severe diarrhoea); and 13 children between one and 15 years of age died (the causes being pneumonia, acute bronchial asthma, toxic diarrhoea, meningitis, bacillary dysentery, and leukaemia).

Families take advantage of the health services and they are aware of the importance of proper nutrition to health. Villagers reserve rations of eggs, shrimps, meat, and fruit for their children.

Medical examinations carried out in the three villages showed that a high proportion of the people examined were in excellent or good health.

Infrastructure

Illiteracy has virtually been eradicated, and there has been extensive school enrolment. The education system is used to the maximum extent to support the action of the health services.

The Party formulates directives aimed at building up health services, safeguarding health, and ensuring wellbeing; it then ensures that the general population, as well as Party members, understand the directives; and it promotes, supervises and controls the implementation of the directives.

The Government administers the health plan as an integrated and important part of the total national plan; it organizes the health network to cover the whole country, including remote areas; it mobilizes community participation and gives assistance to poor areas; and it monitors the efficiency of health work.

The health care system is composed of two closely interrelated parts: the state-organized central, provincial, and district health care facilities; and the communal health services. All health care institutions are functionally and administratively integrated. The central health service is the highest level of the nationwide referral system and provides the tools for technical evaluation, planning, programming and supervision of all the health services in the country. It is responsible for the technical and administrative guidance and supervision of the provincial level health services, which in turn are responsible for the district level services. The district-level health services assist and supervise the work of the communal health centres.

The central level, under the direct responsibility of the Ministry of Health, is composed of research institutes, central general hospitals and specialized clinics, medical schools, a postgraduate training school, drug factories and pharmaceutical corporations, a central institute of hygiene and epidemiology, and five schools for the training of assistant physicians, X-ray and laboratory technicians.

The provincial health care centre consists of general and specialized activities, including a hospital practising traditional medicine, an outpatient department, specialized clinics, a hygiene and epidemiological centre, maternal and child health/family planning centres, drug control services, drug distribution and production services, and schools for the training of health personnel.

The district health centre is composed of dispensaries, a polyclinic, a public health laboratory, and a hospital. In addition to providing a comprehensive range of communal health services, the district health centre assists in setting up the basic health system, and gives advice to the staff of the communal health centre. The district pharmacy sells the necessary drugs to the communal centre. The district physician reports on local health work and plans the further training of rural health workers.

Analysis of community participation

Within the mass organizations and the people's councils, each citizen studies and discusses the directives of the Party and Government, takes decisions, and implements these decisions with the encouragement of the various health services. The people participate actively according to their capacity, in carrying out the various health projects. An important rôle is played by animators, who serve as a liaison between the family, the community and the health services.

In each commune, there is a communal health centre, which is built and managed by the commune itself. The activities of the communal health centre are to provide health education, to construct sanitary facilities, to carry out immunological and epidemiological services, to provide curative and emergency care, and to ensure maternal and child welfare. They also keep family health records and distribute drugs.

In each of the three villages, the communal people's committees, with community participation, have established health centres. In Dong Tien, the health centre staff consists of: an assistant physician, two nurses, a midwife, and an assistant pharmacist. In Quang An, the staff is composed of: an assistant physician, a male nurse, a midwife, an assistant pharmacist, and four traditional medicine practitioners. In Tan Ly, the present health staff consists of: a chief assistant physician, an assistant physician in maternal and child health, an assistant physician in clinical medicine, a midwife, an assistant pharmacist, two persons for growing medicinal herbs and preparing traditional drugs, and three maternal and child health home visitors.

The health workers live in the villages and they know and are known by the village people. The village or cooperative meets the cost of the health workers' board, travel and studies, for the entire period of study.

All three villages are organized into cooperatives, which participate in village health care. For example, a percentage of their budgets go towards health care. Each cooperative has members who are trained and work part-time in health and part-time in normal cooperative work. Their activities are closely related to the work of the communal health centre and family health workers.

The cooperatives also participate in the creation of kindergartens; the agricultural cooperative reserves part of its production of foods of high nutritive value for delivery to the day-nurseries, either free of charge or at reduced prices. Each nursery has an orchard to supply fruit, and poultry for eggs. Part of the profits of the cooperatives are used to build day-nurseries of the number and quality required, to train nurses, to furnish, and to equip the nurseries.

Each cooperative has an antituberculosis group which counsels patients on personal hygiene, reminds them of control visits, organizes drug distribution, assists the families of patients, provides transport to hospital in emergencies, and detects new cases.

Each family has a designated member in the Red Cross society, who works voluntarily as the "family health worker". His or her duties include: the building and proper maintenance of the septic tank, the bathroom and well; ensuring that family members are vaccinated; and first aid. In case of serious illness, the family health workers inform a more qualified person. Under the supervision of the assistant medical officer and cooperative nurse, they act as the family nurse. They are responsible for the family medicine box, and they provide family planning instruction.

Women's organizations exist in each village and they participate actively in health work as do youth organizations and schools.

The villages construct health premises (including supplying the materials needed), provide equipment and salaries for health personnel, and cultivate medicinal plants. In Tan Ly, for example, the village population provided 16 300 days of work and paid for the building of the health centre.

All three villages have gardens for growing medicinal plants, which are also grown along paths and in hedges. School children are encouraged to grow medicinal plants to add to the village supply. Tan Ly has managed to grow 80% of its requirements.

Conclusions

The health services form an integral part of national policy, and primary care has been provided to meet the needs of the entire population.

Dong Tien, Quang An and Tan Ly provide typical examples of the integration of the various levels of health care.

The political belief in the possibility and necessity for community participation in health activities led to an organizational structure which supported and emphasized the rôle of the communities themselves.

4.7 Sri Lanka. The Sarvodaya Shramadana Movement

Initiated during the 1950s, the Sarvodaya Shramadana Movement has promoted development activities at village level throughout the country. The term Sarvodaya means universal awakening or welfare of all and Shramadana means the sharing of one's time, thought and energy for the benefit of all. Projects include: pre-school and community kitchens, children's libraries, crèches, cottage and small industries, agriculture and irrigation, skill-training courses for youth, preventive health work, emergency curative work, cooperative farms and youth settlement schemes, and marketing.

Background

In 1972, the population of Sri Lanka was estimated at 13 022 000, of which 52% were male and 42% under 15 years of age. Statistics for 1973 give the crude birth rate as 27.8‰, the crude death rate as 7.7‰, the natural increase as 2.01%, and the infant mortality rate as 46.2‰ live births.

The 1971 census reported that 77.6% of the population lived in rural areas, where there are appoximately 23 000 villages, and that ethnic groups were: 71.9% Sinhalese, 20.5% Tamils, and the rest Sri Lanka Moors and others. Buddhism is the religion of most of the Sinhalese, Hinduism that of the Tamils.

Caste is a dominant factor in the social organization of the Sinhalese and Tamils, although it is less strict among the Sinhalese. Village leaders are usually priests, school-teachers, educated men, or men of high caste (especially when they are economically powerful); and the family is patriarchal.

There are several government-appointed local officials who are closely involved with village life and development: the village worker, who administers the village, conveys government messages and keeps the peace; the revenue officer, who is responsible at the divisional level for the administration of several village areas; the agricultural officer, who promotes agricultural development; the land settlement officer; and the public health inspector.

There are three levels of local government: the village council; the town or urban council; and the municipal council. Members of these councils re elected by secret ballot, the elections being contested on political party lines. The coun ils are responsible to the Ministry of Local Government. In the village councils, the members elect a chairman and all decisions are made on the basis of a majority vote.

Tea, rubber and coconuts are Sri Lanka's most important agricultural products, providing employment for about 20% of the work force. On the coast, income is mainly derived from fishing. There is some light industry, tourism has developed, and some villages produce handicrafts, such as ceramic ware, baskets, and mats. The distribution of income in the villages is however uneven.

Teak, ebony and mahogany grow in the forests; gem mining has recently been developed; cattle are raised, mainly for milk products; buffalo are used for work in the rice paddies; and poultry, pigs, goats, and sheep are also raised by the non-Buddhist population.

Land is owned by the state, the temple, and the villagers. The recent land act limited the amount of land permitted to each individual to 50 acres. Land over this amount was turned into cooperative farms or given to landless peasants, but there are still many families in the villages who have no land.

Sources of water are: rivers, streams, lakes, ponds, springs, wells, and tanks. Relatively few villages have safe potable water supplies. Irrigation systems are needed for agriculture in the dry and intermediate zones of the country.

In the Sinhalese villages, religious meetings take place at least once a month. Every family sends at least one representative to these meetings, but usually all the adults of the village attend. Formal political gatherings take place at the time of local or national elections.

Health status

The crude birth and death rates have declined gradually over the past 10 years. The leading causes of death for all ages were: diseases of infancy and immaturity, heart diseases, gastrointestinal diseases, respiratory diseases, accidents, suicides, anaemia, and malnutrition. Malaria remains a problem in the dry zone, and filariasis along the coast.

The main causes of death in hospitals for children between 0 and 15 years of age were listed as: upper respiratory tract infection, anaemia, malnutrition, diarrhoeal disease, neonatal tetanus and cerebral malaria.

The staple diet consists of rice and curry; it includes maize, kwakkan, yams, tapioca, coconuts, and vegetables, but fish, meat, and other animal proteins are eaten only occasionally.

Breast-feeding lasts from 10 months to one year, and the first additional foods given are citrus juices, bananas, and vegetable broth. Solid foods are introduced in the form of rice cooked with milk, bread, and rusks. Certain foods are avoided during pregnancy, lactation and illness.

Malnutrition is not considered to be a major problem in the country, although up to 50% suffer from deficiency of one or more of the following: iron, calcium, vitamins A and B, and protein.

Infrastructure

The government plan, introduced in 1972, noted among other things the need to improve living standards, particularly those of the low income groups who live mainly in rural areas. The system of divisional development councils was established, under the Regional Development Division of the Ministry of Planning and Employment, to decentralize decision-making and involve people in development. The chairmen of these councils are usually elected members of the National State Assembly, the members of the councils being government administrative and technical officers and representatives of village councils.

Rural people's banks have recently been introduced to bring credit facilities to people in the lowest income brackets. Projects supported by the divisional development councils may be backed by government grants or through loans from the rural people's banks. Projects are run on cooperative lines and are mainly directed to the training and employment of youth.

Government officers (agricultural extension officers, veterinary surgeons, development officers, rural development officers, medical officers, and other health personnel) work within the administrative system of the country, and their services are coordinated by government agents. The Sarvodaya Movement works with these officials, often providing a link between their services and the community.

Attempts are being made to help the villages become self-sufficient in terms of food production. Government officers advise and supervise the villagers; and materials such as improved seeds, fertilizers, and equipment are provided by both governmental and nongovernmental organizations.

A government agent helped the Sarvodaya Movement to obtain 500 acres of uncleared land on which to establish a model farm; an agricultural training programme; a dairy farm, which already exists and has led neighbouring villagers to improve the quality of their cattle; and model settlements for trainees.

Although literacy is high, the education system has produced many unemployable graduates. The programmes of the divisional development councils and the Sarvodaya Movement are aimed at reducing this effect.

Health care is provided by the government allopathic and ayurvedic sectors, the private allopathic and ayurvedic sectors, and the "other" private sector.

The function of the medical care services (part of the government allopathic sector) is to promote health and prevent disease. There are 98 health units, divided into 700 ranges for public health inspectors and 2277 ranges for public health midwives. In addition, there are specialized campaigns for malaria, filariasis, tuberculosis, leprosy, and venereal disease. The only organized health scheme under the private allopathic sector is the Planters' Association Estates Health Scheme.

The ayurvedic services play an important rôle in providing health services; and there are many "other" health care providers. Thus the people have a choice between allopathic and traditional modes of care near their homes.

A network of railways connects the major cities and towns, and all-weather roads connect most cities, towns and villages. Bus services are available to most villages, and short journeys are made by bullock cart or bicycle.

There are radio broadcasts in Sinhalese, Tamil, and English and although many rural families do not possess radios, most have access to one. There are a number of national newspapers and periodicals, and the Sarvodaya Movement also publishes newspapers and periodicals. There are cinemas in urban areas.

The main cities and towns, as well as some villages, are linked by post, telegraph and telephone services. The regular markets in the villages provide a further channel of communication.

Analysis of community participation

The tradition of community participation goes far back in the history of Sri Lanka. With the introduction of new technology, the centre of power shifted from the village communities to the urban élite, and the act of sharing labour declined. Thus, in the early 1950s, the government launched a rural development programme aimed at mobilizing people for self-help at village level. Although some projects were carried out (e.g. construction of access roads, school buildings and community halls) the programme soon lost its dynamism. Many other governmental and nongovernmental programmes have been initiated, with varying degrees of success.

The Sarvodaya Shramadana Movement started when the staff and students of a Colombo College became involved with neighbouring communities in social development projects.

In 1958, the idea was expanded to the educational extension and community service camps, which took place in remote, socially and economically depressed villages. The Movement grew rapidly out of its college environment into a national movement with its own offices and in 1972 was eventually recognized by the government as a charitable institution. This made it easier for the Movement to attract and use external resources.

The Movement aims, through the Shramadana camps, to bring together and integrate ideas, resources, manpower, know-how, and organizational structures from the village community level up to the international level: from village re-awakening, through national re-awakening to world re-awakening.

The Shramadana camps provide psychological and physical infrastructures which are indispensable for further economic development. The villagers, together with the trained leaders of the Movement, identify the most urgent need of the village which could be met with village labour and resources (e.g. the building of an access road, the repairing of a village tank, or an irrigation scheme). The Movement then helps the villagers to organize a work camp to carry out the project. The labour for the work camps comes from the village, from neighbouring villages, from Sarvodaya workers, and (recently) from foreign volunteers. The programme lasts from three days to three weeks; activities take place from 5 a.m. to 10 p.m., with eight hours for physical work and three to four hours for general meetings, which are known as family gatherings. All members of the community come to the meetings and join in discussion, meditation, singing, and folk dances. Barriers of caste, creed, race, colour, and nationality are thus broken down.

Village re-awakening depends on leadership training, socio-economic fact-finding and social reorganization. Trained personnel return to the villages and, with the help of senior leaders within the Movement and the cooperation of the villagers, conduct a simple socio-economic survey. On the basis of this survey, the village community draws up short- and long-term development plans. The newly-trained leaders also build up a framework of social organization so that every villager belongs to a functional group. These groups are: the three children's groups, the youth group, the mothers' group, the farmers' group, and the elders' group. The village re-awakening council has representation from all groups, and coordinates activities.

The steps towards economic development to be taken next are: to free the village of debt, to plan for production based on the resources of the village or its vicinity, to organize the necessary management skills, to obtain finance, and to develop technological and marketing techniques. The Gramodaya Revolving Fund has been established to assist villages.

One priority of the development programme is the promotion of employment for the village youth. The Sarvodaya Movement headquarters provides training for villagers in: agriculture, carpentry, metalwork, bamboo and rattan work, batik-making, photography, printing, community leadership, and running pre-school care centres, village kitchens and crèches. A special development educational institute trains Buddhist monks for community leadership.

Apart from the 500 acre farm, the Movement has 30 smaller farms which are used for training purposes.

The crèche project was launched in 1975. The crèches are managed by volunteer community workers and are registered with the Department of Social Services, which provides some financial support.

Pre-school projects have grown in importance since 1972, when the school entry age was raised from 5 to 7 years of age. Village mothers', youth and elders' groups and religious leaders select pre-school teachers to be trained at the Movement's headquarters. The trained pre-school worker, together with the mothers' and elders' groups, arranges for a suitable building (either an existing building or a new one built through community effort).

The community kitchen project is designed, not only to supply a basic ration of food in the form of biscuits and milk powder received from abroad, but also to unite the village in sharing whatever food is available, especially with children, pregnant and lactating mothers, the sick and infirm, to develop food products and to organize food storage, preservation and handling. Trained youth in the villages, under the guidance of the elders, locate a suitable centre for the kitchen. Each family is encouraged to contribute either food, firewood or money. Helpers, usually village mothers, take turns to assist in preparing the food and the volunteer in charge keeps careful accounts.

Health work forms part of the crèches, pre-school and community kitchen projects.

The Sarvodaya Movement has set up 46 extension centres throughout the country to assist villagers in their development activities and to coordinate the village re-awakening councils.

Conclusions

The socio-cultural framework and philosophy adopted by the Sarvodaya Shramadana Movement was already present in Buddhism and in the rural life of the Sinhalese. The philosophy was, however, flexible enough to be adopted by other ethnic and religious groups.

The smallness of the village communities enabled them to work together as a single unit. The educated urban élite, who maintained strong contacts with their villages of origin, were the motivating force in improving the quality of village life.

The charismatic and dynamic leadership of the Movement's President helped to surmount inevitable difficulties, and the recognition by the government facilitated the Movement's activities.

4.8 Western Samoa. The women's committees

Throughout the country, and for more than 50 years, the village women's committees have played an active rôle in providing health care.

Background

The population of Western Samoa was estimated, in 1973, to be 151 100, of which 21% lived in Apia, and the remainder in 357 villages mostly situated along the shores of the two main islands. The usual range of village populations is from 250 to 750 people. Half of the population is under 15 years of age.

The population is ethnically homogeneous, the few with other ethnic backgrounds being well assimilated. The majority of the people are Christians.

Social organization is based on the chieftain system, and there is a hierarchy of chiefs both within the villages and throughout the country. The chiefs do not talk in the weekly meetings of the village councils but have orators who speak for them, using a stylized "chiefly language".

The chiefs (usually, but not always, male) are selected through discussion amongst the adult members of the extended families. The chiefs are the decision-makers at family and village levels. A chief who does not perform his duties satisfactorily may have his title removed, but this is not common. Within the family, the women usually make decisions concerning the children.

The extended family is a clan-like unit in which all persons claiming relationship through blood or marriage may participate. An individual may belong to a number of extended families.

The untitled men implement the decisions taken by the chiefs and decide how certain activities are to be carried out.

Traditionally, the wives of the chiefs formed a separate social category, as did the daughters of chiefs, and the wives and daughters of untitled men. These groups had traditional functions of providing food and ceremonial hospitality for visitors, making mats, helping in the construction of village meeting places and churches, and providing food to the local pastor's family. The various groupings and ranks among the village women continue to have significance, but women's activities are now carried out within the overall framework of the women's committees. The women's committees were originally concerned with health promotion, but their activities have expanded to include such interests as schools and farming. Almost every village has at least one such committee, to which the majority of women belong.

Health status

Life expectancy is about 60 for males and 65 for females. Infant mortality is approximately 40‰ live births (whereas in the 1920s it was around 200‰ live births). In 1975, the leading causes of morbidity in hospitals were gastrointestinal, respiratory and parasitic diseases. A similar morbidity pattern was found throughout the country, related in part to the unhygienic environment. Malnutrition and sub-optimal health among pre-school children is a problem, although there are generally no food shortages. Obesity is a nutritional problem affecting the adolescent and adult population; it has a cultural basis in that being thin is equated with being unhealthy.

Infrastructure

The third national five-year plan encourages village development using the traditional village chieftain system. A village development fund has been created, with a coordinating committee consisting of all deputy directors of government departments concerned with village development. The plan aims to encourage villagers to decide which development projects they wish to undertake so that the Government may respond with suitable forms of assistance. The community provides free labour, donates land, contributes money to repay loans, and provides accommodation and other necessities to the government technical personnel. Projects so far include: a lighting plant, church construction, water supply schemes, agricultural projects, building of access roads, development of tourist facilities, medical facility construction, and equipping a brass band.

The Agricultural Department has a staff of some 35 extension agents who work at village level in various agricultural activities, providing teaching, technical advice, seed and fertilizers.

The Health Department has six divisions: public health, the Apia General Hospital, nursing, dental health, laboratory services, and administration. The Chief of the Division of Public Health is in charge of all health services in the 14 health districts, including the 14 hospitals and health centres and the 11 sub-centres. Each district is served by either a hospital or a health centre. There are also specialized campaigns, such as those against tuberculosis, leprosy, and filariasis.

The district medical officer is responsible for the curative and preventive services in his or her district, and is assisted by a team of nurses and other health workers. Most of the health services are free of charge and drugs are sold at a minimum price.

The district nurses provide health services to the villagers through monthly visits. They hold maternal and child health clinics, make home visits, supervise school health activities, and give technical support and guidance to the women's committees. Assistant health inspectors also visit the villages, for environmental sanitation activities.

Traditional birth attendants are responsible for the majority of deliveries, especially in the rural areas. They generally have a high status and are members of the women's committees. In 1975, a training programme for traditional birth attendants was started in one district; so far 30 have been trained and issued with UNICEF kits.

Traditional health practitioners are widespread but are not recognized by the national health authorities.

Analysis of community participation

The women's committees grew out of the traditional village women's groups. In the 1920s, these women's groups were encouraged by health personnel to tackle tasks related to the primary health problems of the time (such as yaws, hookworm, infantile diarrhoea and lack of health care facilities). At about that time the women's groups took on their present structure and became known as village women's committees.

The early women's committees were stimulated by the rôles taken and the knowledge provided by the wives of the local pastors and local government officials; but it was the wives of the chiefs who had the positions of leadership on the committees.

The advantages of the activities undertaken in one village were readily recognized by neighbouring villagers, and a natural competitiveness may have prompted their spread.

The support and approval of the chief is necessary for any effective community activity, and, because of their leadership, the women's committees can usually count on this support. The chieftain system and the extended families provide support to the women's committees in their efforts to marshal resources (money, materials, and labour).

The village women's committees play an important rôle in the monthly visits of the district nurses. The meeting hall where the clinics are held is often constructed by the women's committee. They decorate the hall with flowers and welcome the nurse with traditional ceremony. The women's committee is responsible for organizing the clinic, seeing that people are notified and present, accounting for those absent, providing food and other necessities for the nurse, and participating in such activities as weighing babies and recording information.

There are also women's district health committees, composed of representatives of the village women's committees in the district, which organize the maintenance and cleanliness of the grounds of the district hospitals and health centres, provide food for the staff, and assist families who require help in caring for patients. Women's committees have also raised funds and contributed labour for the construction of hospitals and health centres within their districts.

Women's committees are active in environmental sanitation and household hygiene. They supervise the general cleanliness of the areas around houses, refuse collection, and latrines and they inspect household bedding and mosquito netting.

The activities of these committees have expanded to include the raising of dairy cattle and vegetable gardening. New organizations have resulted from the success of the village women's committees, and the women's committees form the base of the National Council of Women, which promotes women's work.

Conclusions

The most important characteristic favouring the growth of the women's committees has been the chieftain system which gives support to, and is reflected in, their structure.

Present government policy encourages development efforts at village level and bases its own development programme on the village chieftain system. The Government, in its training programme for health workers, emphasizes the importance of understanding the culture and traditions of the society and, in particular, the use of the stylized phrases of the chiefly language for communication with village leaders. There is a government scheme for supplying drugs to the women's committees. Other factors favouring community involvement are the presence of traditional cooperative practices within the community, the absence of major factions, the relatively even distribution of wealth, good communications, and the availability of local leadership.

4.9 Yugoslavia. Local participation in community development at Ivanjica

Although the political system of Yugoslavia encourages community participation, and there has been general development throughout the country, only a few districts have achieved the remarkable progress of Ivanjica. Here, the initial improvement of health services led to other developmental activities.

Background

The district of Ivanjica lies in a mountain region and covers 109 000 hectares, of which 59 000 hectares are forest, 36 000 hectares are arable land, and the rest pasture. It has a population of 39 250. The town of Ivanjica is situated at the centre of the district and has a population of 5505. There are 48 villages in the district, with populations varying between 140 and 1784.

In 1974 in the district of Ivanjica, the crude birth rate was 15.3‰ the mortality rate 6.6‰ and the infant mortality rate 13‰. These rates are dramatically lower than the rates for 1964. The population of Ivanjica is homogeneous: all are Serbs and speak Serbo-Croation.

The extended-family structure has generally given way to the nuclear family; and although traditionally a patriarchal society, women have influence within the family, many decisions are made mutually, and in some projects women have played a dominant role in decision-making.

Each commune in Yugoslavia has a high degree of autonomy. The system is based on experiments begun in the 1950s with workers' self-management, decentralization of investment decisions and freer markets; and the trend has now encompassed social insurance, health insurance, and cultural and educational institutions.

The local community leaders are elected every four years to form the Commune Assembly, which then appoints leaders for specific tasks. All important local problems are solved at the Commune Assembly and all citizens over 18 years of age may attend.

The basic sources of income in Ivanjica are from agriculture, trades, industry, health, education, and administration, as well as from tourism.

The soil is of relatively low productivity but rye, barley, wheat, corn, potatoes, apples, plums and cherries are grown. Conifers are grown in certain forest areas and this has led to the development of a forestry industry. Water is abundant.

Most men work in farming and livestock raising; women do housework, look after the children and livestock, prepare meals and milk products and assist the men in agricultural work, particularly at harvest time. Men and women are almost equally employed in the few industries.

Both men and women take part in traditional gatherings (e.g. markets and marriages), but usually only men attend formal meetings (which are held to solve community problems and to review and implement official state and party policies).

Bus, lorry and cart are the usual means of transport, though the number of cars is increasing. There are now 282 km of paved roads. Almost every household has a radio and there is a growing number of televisions. Cinema is popular, regional and national newpapers are available daily, the furniture factory produces its own monthly magazine, and three schools produce periodicals.

Ivanjica has post-office, telephone and telegraph services and postal services reach all the villages. Some villages do not yet have telephone connexions, but services are available within a distance of 5 km.

Modern houses with windows, plumbing and electricity are now commonplace, although some 30 years ago houses were built of logs with an open hearth in the middle of the only room, lavatories were rare and water might be several hundred metres away.

Health status

In 1975 the leading causes of death at the Ivanjica Clinic were: respiratory conditions, cardiovascular conditions, injuries and poisoning, muscle and bone conditions, skin and subcutaneous diseases, and diseases of the digestive system. The most frequent causes of infant and childhood mortality were: respiratory infections, gastroenteritis, and other infectious diseases.

The staple diet has improved but in winter months in the villages the diet is vitamin-deficient and this occasionally leads to malnutrition among pre-school children. School cafeterias have improved the nutritional status of schoolchildren.

Infants are usually breast-fed for 12 and sometimes 15 months. Maternal and child health clinics advise mothers to give fruit juice at 15 days; egg yolk and fruit are gradually introduced later; and liver is added at six months of age.

Infrastructure

Efforts to offset natural disasters (such as drought) have included increasing the availability of fertilizer, introducing more productive and drought-resistant grain varieties, and improving livestock bloodlines and agricultural land.

Elementary school is of eight years' duration and is compulsory; secondary school lasts four years; and industrial school, two years. Education is free but students have to purchase their books. Further education is obtainable outside Ivanjica.

Health services in Ivanjica have developed tremendously since 1929. The House of Health and the hospital now employ: 16 physicians, 5 stomatologists, 35 nurses, 4 midwives, 4 pharmaceutical technicians, 5 laboratory technicians, 1 dentist, 4 dental technicians, 4 dental and pharmaceutical assistants, and 40 other personnel, including administrative workers, drivers, cooks and storekeepers. The health staff are located either at the public health centre in Ivanjica or at the health stations in the villages. Financial sources for the development of health care are: local budgets, worker organizations, and the provincial- and federal-level budgets.

Immunization programmes (particularly BCG) are an important component of health care. Safe water is monitored by the public health centre staff.

Assistance is given to mothers during pregnancy, delivery and in the post-natal period: 80% of mothers are delivered in the hospital.

Health education is provided by health workers. There are mobile well-baby care and nutrition demonstrations, and the school cafeterias also provide nutritional information, as mothers help in preparing food.

Simple medical care is available through the health centre and health stations. Patients with serious conditions are transferred to the provincial hospital at Titovo Uzice or to Belgrade. Mobile counselling services reach the remote villages, and the telephone plays an important rôle in health services during the winter when roads are impassable.

Analysis of community participation

In 1929 two physicians, a husband and wife, established a practice in Ivanjica. They travelled miles on horseback to bring health care to the villages, and gained the confidence of the people. During the Second World War, three medical students came to assist them, and one of the students returned to the area after qualifying and married their daughter. He also was sensitive to community needs and eventually became as popular as his parents-in-law.

In 1954, a health centre, the House of Health, was established in Ivanjica. Following the tradition established by the physician couple, the staff took a broader view of development than one limited strictly to health activities. They gradually became involved in the construction of health stations in the villages, in the construction and maintenance of water supplies, in the construction of school canteens, toilets, bathrooms and roads, as well as in encouraging horticulture and poultry raising.

Ivanjica has a long tradition of collective work. Farmers have always worked together at harvest time and, in 1927, a water-mill, and later a school, were built in one village through collective effort.

In the 1930s a plan to bring safe water to the villages was rejected by the people, but by 1958 the situation had changed. Staff from the House of Health and the engineer who had proposed the original plan assisted the people in drawing up a safe-water scheme. The people contributed both money and labour and, by 1959, every house had safe running water.

The House of Health staff constructed a small hydro-electric plant to serve the local health station in the village of Kovilje. Its main purpose, however, was to demonstrate the advantages of electricity. Subsequently, a larger plant was constructed with the cooperation of the people.

The Ivanjica Assembly provides assistance for projects, though the major part is paid by the village. UNICEF has also provided assistance (for example, for water supplies and school kitchens).

Since the Second World War, a 2.5% tax has been levied on the net income of all employed persons and a 10% tax on the income of farmers to be used for local development activities. Interest-free loans, "seed" money and equipment have come from the Government and such agencies as the Red Cross and UNICEF.

A committee is formed to organize each new project, and after completion, the committee is entrusted with its maintenance. Each project is part of the overall community development plan and projects are tackled one at a time, in order of priority.

Individuals are engaged in the project according to their ability and without consideration of their official positions.

Conclusions

A number of factors seem to have contributed to the successful community development projects in Ivanjica: the arrival of the two physicians, the unchannelled but felt needs of the people for a better life, the hardship conditions of a mountainous area with poor roads, the establishment by the Government of a system of self-management committees, the availability of loans and credit for developmental activities, from the Government and some interested agencies, the establishment of the House of Health with its interested staff who devoted themselves to the community, the long tradition of collective work in the community, the continued interest in completed projects by their managing committees, and the success of initial projects which created a sense of social responsibility within the community.

5. STUDY FINDINGS, CONCLUSIONS AND DRAFT RECOMMENDATIONS

The nine case studies presented describe activities of different peoples engaged in the development of their community through community participation. The cases reflect a broad spectrum of social, cultural, economic and political backgrounds and conditions and have been drawn from a variety of geographical settings. In all cases there are viable, community-based projects which were found to be effective examples of primary health activities and which led to improvements in the health status of people.

From one setting to another the methods that were used and the manner in which the communities' participation was organized varied according to the projects, the structure and culture of the communities and the resources available. Despite these variations, however, certain common observations can be made which are prevalent throughout the processes that have been documented. These observations, together with the experience and knowledge of people contacted throughout the world, as well as those of the Joint Review Committee and experience of the WHO and UNICEF Secretariats are outlined below as conclusions. The findings and conclusions are not meant as an exhaustive summary of the numerous characteristics of community involvement per se. Rather, they represent features which suggest how community participation may be encouraged in the pursuance of the primary health care approach.

5.1 Findings

The factors favourable to community participation, as found from the case studies, are listed below. The external conditions and those within the communities themselves are mutually reinforcing and any attempt to separate these "external" and "internal" factors would have led to unnecessary repetition. It is hoped that the straightforward presentation chosen will be useful to those people who are involved in initiating or strengthening community-based primary health activities.

(a) Specific government policies to encourage community participation were found to enhance the extent and depth of participation.

Strong government commitment to both national and local community participation programmes was found throughout the case studies. This was expressed in terms of specific national policies supporting community participation in a variety of sectoral and multi-sectoral programmes at national or local level. National development plans and, in some instances, governmental reforms reflecting government policies were found to revitalize or strengthen traditional decision-making structures. In other instances, new decision-making structures which fostered community participation were created. Political parties and their ideologies have also played a role in the evolution of new decision-making structures, such as were observed in The Socialist Republic of Viet Nam, Yugoslavia and, to a lesser degree, in Indonesia. The formulation of favourable national policies together with the strengthening or creation of appropriate structures which allow active community involvement were found to increase the community's capacity to identify their own needs, establish their own priorities for action, and to propose ways in which these needs might be met.

(b) Maximal community participation was achieved when limited local resources were complemented by external resources, especially those provided by the government.

Where there was adequate government financial commitment, it was found that goals and priorities set out in national and local developmental plans were achieved to a greater degree. Resources were made available at national, regional or local levels. Assistance provided by governments through subsidies to local authorities stimulated community participation by increasing local initiatives in planning and implementation of local programmes.

In some of the nine cases, the establishment of credit facilities at the local level for use by small land-owners, businessmen, or cooperative groups, who would otherwise have been unable to find the necessary credit, contributed significantly to the success of local programmes. Credit systems, that were supervised by the people and designed to meet their specific needs, clearly facilitated local development. An example of this was the control exercised by the village social institutes in Indonesia over credit funds supplied by government.

Technical advice and knowledge have also been provided by governments. In all cases, government provision of technical personnel played a significant role in the development of local activities. They were seen to have worked hand in hand with the community, wherever necessary offering guidance and advice, and assisting communities to obtain materials and funds likely to be required at critical times. Thus, agricultural workers, teachers, various technical experts, physicians and other health staff were highly visible throughout the nine cases, and in one way or another participated with the community from the inception of the programmes. Such external inputs of personnel were seen to be vital to the success of the programmes in Mexico, Senegal, Yugoslavia and Indonesia, and were most effective when these personnel were sensitive to local concerns, traditions and values.

The provision by various governmental agencies of material not found locally or beyond the financial means of the community, enabled the completion of projects, thereby promoting the people's confidence to undertake further activities. The provision of these funds, technical expertise, and materials was important in that it demonstrated that external support was available, and could be drawn upon. These external resources were valuable not only because of their immediate practical convenience but also for the psychological reinforcement that they represented in demonstrating continued government commitment.

(c) <u>Government administrative decentralization and regional planning appears to have given an impetus to community participation</u>.

Introduction of the idea of self-management in Yugoslavia, administrative decentralization in Senegal, regional planning in Indonesia, the development of People's Committees in The Socialist Republic of Viet Nam, and efforts of the Western Samoa Government to encourage village development based on the chieftain system, stimulated local discussion and action on development matters, of which health is a major part. Decentralization differs considerably in extent in the case studies; it was most often linked to specific areas of development, but was sometimes applied nationally.

The centrifugal dispersion of legal and financial status resulting from decentralization brought the administrative machinery closer to the people. In some cases this process gave the peripheral communities the power to raise financial resources through local taxation. In Senegal, funds were raised in this way and were spent entirely on local projects. The degree of decentralization appears to have a direct relationship to the way in which external resources may be marshalled to complement local resources and thus facilitate development.

(d) <u>Specific government programmes for rural and urban development were found to favour community involvement in primary health activities</u>.

These case studies illustrate how local involvement was aroused through rural development programmes which aimed at encouraging people to participate in self-help projects at the local level. Rural development programmes sponsored by the National Office for Community Development in Costa Rica, PRODESCH in Mexico, and the <u>Promotion Humaine</u> in Senegal all attached high priority to community participation and specified ways in which it could be stimulated. The Youth Settlement Programme, the Land Army, and the JANAVASAS People's Settlement Programme in Sri Lanka also represent governmental programmes aimed at mobilizing people, as did the emphasis on rural development in Indonesia's Second Five Year Development Plan which revitalized people's interest in community participation.

Where governments have created a department concerned with development, coordination of the activities of the various sectors has become easier, and this allows for a comprehensive approach.

(e) Development programmes in specific sectors have served as an entry point for the introduction of comprehensive programmes, which have encouraged community participation in wider developmental activities.

In many countries, efforts to arouse community participation were often launched in one sector, such as health, education, or agriculture. Participation brought about a spread of activities into other sectors in which communities wanted services, which in turn increased the amount of local involvement, as for example in The Socialist Republic of Viet Nam, where cooperatives provided the part-time services of a hygienist, and carried out anti-tuberculosis activities; in Costa Rica, community development promoters were intimately involved with health work, particularly in the fight against alcoholism and malnutrition; in Senegal, Maisons Familiales Rurales (Community Houses), which are a part of the Ministry of Education's Promotion Humaine, have stimulated interest and action by communities in improved sanitation and hygiene; in other countries, projects by the Health Ministry have created a demand for other services; in Indonesia facilitators, originally trained to promote health, are now stimulating the communities to participate in other sectors' programmes, linking one sectoral concern with another, such as malnutrition and food production.

(f) Non-governmental organizations provided channels for community participation.

While most of the examples of technical and logistical backing to communities mentioned above were provided by government, the study also showed that non-governmental organizations, such as the Sarvodaya Shramadana Movement in Sri Lanka, can play an important role in providing the support required at the community level to encourage participation. The Sri Lanka case, in particular, illustrates how a non-governmental organization encouraged the rational use of available government infrastructures, making them more responsive to communities' needs and aspirations. The Sarvodaya Movement also provided, where necessary, organizational skills, finance, and material resources to initiate and maintain village self-help projects. Community participation was also carried out under the auspices of organizations such as church, schools, women's committee, YMCA, etc. These community-based groups were sometimes part of an overall national and, at times, international organization, and were therefore able to attract external resources for use by the communities in carrying out their local programmes.

(g) The capacity of communities to undertake projects was seen to be enhanced by the presence and ready accessibility of regional and national communications and other infrastructures.

The communities presented in this report all had reasonably good extra-community infrastructures, such as roads, telephones, telegraph, radio, television, newsprint, postal services, and electricity. The combination of a reasonably good external infrastructure and a developing local infrastructure helped to produce a living standard that encouraged participation. The importance of a communication network of all-weather roads and transport facilities, was cited frequently. This provided the means for travellers, migrants, or workers commuting from urban to rural settings to bring with them the type of information that stimulated the desire for change. In all cases, the mass media of one type or another played a significant role in the education of the community. Radio and television broadcasts, posters, booklets, comic strips and other forms of communication contributed to the spread of information and ideas, thus creating an awareness of the need for change within the community. In many cases schools provided not only a medium for formal instruction but also a forum for the dissemination of ideas concerning the needs of the community. Such essential infrastructures were generally provided by the different echelons of government services.

(h) The ability of the community to generate activities and participate in them was dependent upon the availability of and the extent to which local resources could be mobilized.

The availability of local resources and the extent to which they were marshalled for development varied from one case study to another. However, in most communities, the success of community participation in projects appeared to be dependent on the fact that whenever possible, local resources were used.

The cases showed that communities were able to finance a wide range of activities from funds collected locally. The extent to which these funds were generated and used locally seemed to be dependent upon the degree of organization for decision-making within the community, fund-raising being a function of the involvement of the community. In most cases funds were raised through direct and indirect taxation, personal levies, the sale of produce from land set aside for development, and the use of traditional capital accumulation practices (as in Indonesia). The success of projects funded through the use of these traditional approaches encouraged further contribution and participation.

In most of the communities studied, the success of community participation projects appeared to have been enhanced through the utilization of respected local personnel who became a part of integrated development activities. Traditional birth attendants and healers, for example, were provided with additional skills and became identified with new health delivery systems. The training supervision and use of primary-level workers whose orientation was not entirely restricted to health, is a constant feature in all the cases presented. These primary-level workers were selected for training by the communities from amongst their own people. Individuals and groups within communities, who have wider visions and perspectives and who are motivated to do things for others, were found to be valuable resources. Local leaders were often the specific dynamic force through which community-based activities were initiated and sustained. The characteristics of such leaders were difficult to describe, but most of the programmes were dependent, at least initially, on their organizational and motivational skills. This leadership included the ability to tap available community resources and to express community needs in a manner which attracted external resources.

In one of the cases, participation was seen to have waned when the local leader was discredited but regained its importance when he was replaced. As local projects grew into national programmes, their initially local leadership assumed national prominence.

In the Sarvodaya case study, deliberate attempts were made to identify and train potential leaders. In other instances, leaders were offered what might be considered as continuing education programmes; such as those attended by the village headmen in Indonesia and the promoters in Mexico. It is significant to note that in a number of case studies some resource personnel, external to the community, worked closely with local leaders in developing the process of community participation.

In most cases, local materials were used whenever they were readily available, thereby minimizing the cost to the community of projects undertaken. Similarly, the cultivation and processing of medicinal herbs was promoted in a number of settings. This not only saved foreign exchange but also legitimized the traditional system of medicine.

(i) Traditional structures formed the basis for expanded community participation efforts.

In the nine cases studied, there existed traditional structures such as local government, cooperative work endeavours, ancient philosophies and other mobilization processes, which were found to have significance for the individual and the community. These structures lent themselves to the evaluation of needs and the setting of priorities as well as to the tapping of required resources.

Traditions were used as a foundation for further community participation. The mobilization processes were often observed to revolve around traditional ceremonies, religious philosophies or practices and sports activities. The use of well-accepted and established beliefs and practices was significant in promoting a sense of continuity between the old and what could be interpreted as the new. Examples of these are the emphasis on ancient virtues and family gatherings of the Sarvodaya Movement in Sri Lanka, and the recent administrative structures being built upon the Matai system of Western Samoa. A number of the communities studied used songs with mobilization themes. It was, however, observed that some traditions may perpetrate inequalities, in that they protect the interests of special groups and thereby prejudice the effective involvement of all members of the community as well as the equitable sharing of developmental benefits.

(j) The community participation process was accelerated when there was readiness for change.

In most of the cases studied, the initiators of programmes, together with community members, had attempted to evaluate the existing state of readiness of the communities. Where communities were too depressed and disorganized, steps were taken, through a significant infusion of outside support, to bring about a state of readiness. This process took a considerable length of time. Old and new mobilization and motivating techniques were used to bring about or reinforce the understanding of the community with regard to their situation and to create or strengthen homogeneity of purpose. Community members, who had migrated to towns and cities but who had maintained contact with their rural backgrounds, were found to contribute to the mobilizing and modernizing experiences of community members. This was illustrated in the Botswana, Mexico, and Sri Lanka case studies.

(k) Awareness of the benefits of community participation stimulated further participation.

The case studies demonstrated that participation was further encouraged when projects with attainable objectives and with obvious benefits to individuals and groups within communities were undertaken. In some instances, communities initially saw the necessity for cooperative action to meet immediate and easily recognizable needs, and this gave impetus to further community activities. For example in an Indonesian village the building of a dam increased the productivity of the land, and encouraged further community participation, and in Ivanjica the community recognized the benefits of initial curative health care provided by the physicians and then participated enthusiastically in activities that improved their health status.

(l) Projects and activities where children were the immediate beneficiaries were used as a starting point for further community efforts.

In Senegal and Costa Rica, the communities recognized the need to improve the nutritional status of their children and actively participated in the nutrition-related activities. Mothers recognized that through cooperative efforts they could more efficiently and effectively provide care for their children and participate in harvesting activities.

In Sri Lanka, the Sarvodaya community kitchen and pre-school schemes provided the means for instruction in simple hygiene and good nutrition and gave the children experience in cooperative enterprises at an early age.

(m) Ethnic and cultural homogeneity of the population and the absence of extreme factionalism or inter-group friction was observed in most of the communities studied.

The absence of conflict permitted the development of the community participation processes. In some cases, specific mechanisms were used to avoid open conflict, in the Indonesian villages, for instance, issues were discussed in small groups and consensus obtained prior to ratification at larger gatherings and a similar process was used in Chiapas. The absence of conflict channelled energies into useful cooperative enterprises.

(n) The community participation activities observed covered a varied developmental range.

Members of communities participated by providing money, labour and materials required for the building and improvement of their local physical infrastructure. Examples drawn from the study include the building and improvement of houses, schools, health units, dams and irrigation systems, environmental sanitation facilities, roads, and recreational facilities. Communities supported the programmes of government departments by collaborating with government and other resource personnel external to the communities. These personnel introduced new methods and techniques in agriculture, home economics, and general and health education. Many of the activities were supported through funds raised in a variety of ways.

Specifically in the health field, communities were seen to participate actively in immunization and vaccination campaigns. In some instances, local organizations, such as the women's committees, prepared the population of their villages for the visits of health staff, ensuring that vulnerable groups were given appropriate care; for example, that pregnant women received ante- and post-natal examinations, and that immunization programmes for children were completed. Community members sometimes helped with detection and reporting of notifiable diseases. Villagers selected people for training as health workers, who then carried out simple health activities within the communities.

The activities described above took place through various local structures, which were either traditional, a combination of traditional and modern, or entirely new. These structures included village meetings, commune assemblies, village councils, family gatherings and various types of village committees. Non-governmental organizations such as churches, schools, political groups and voluntary organizations, also provided a framework for participation.

5.2 Conclusions

The concern of WHO and UNICEF regarding the burden of ill health of so much of the world's population, and the message of hope for its alleviation sounded through the adoption of the primary health care approach, are especially relevant at a time when similar concerns are being articulated throughout the world.

The alternative approaches to meeting the basic health needs in developing countries presented in the previous Joint Committee on Health Policy study helped to place health within the totality of development, in accordance with the statement on health enunciated in the preamble to the WHO Constitution.[1]

[1] WHO Official Records, 1948, No. 2, p. 100.

Meeting community needs is the basis for the design and implementation of any primary health activity. It calls for the involvement of community members in all stages of planning and implementation of such activities and, in satisfying those needs, promotes the confidence of the community for further involvement in developmental activities. The concern of WHO and UNICEF for further knowledge of the processes of community participation resulted in the 21st Joint Committee on Health Policy study being undertaken. In retrospect, it seems that in spite of the constraints encountered in conducting the study, the issues that were raised, as reflected in the objectives outlined, were highly appropriate ones for investigation.

The optimism and renewed interest in the community development approach centred around community participation, as expressed in section 3.5 of the report, is justified by the analyses of the case studies. Access to education, both formal and informal, has increased and has led to a greater involvement of people in community activities. The readiness of communities to want and accept change has also increased under the influence of such factors as communication in its broadest sense (roads, radio, television, newsprint, etc.). The approach taken by personnel external to the communities has changed since the earlier community development programmes of the 1960s. The importance of involving people in national, regional, and local planning is better understood and some methods for achieving this involvement have been evolved. The recent concern for "people" rather than "economic growth", has shifted the emphasis from quantitative measures of progress to a qualitative approach, where factors that improve the quality of life are beginning to play a major role in the planning process.

The concept of community involvement developed in an early section of this report hypothesized certain factors that could determine the degree of involvement of a particular community.

These hypotheses were consistent with the findings of the case studies, where participation in development ranged from merely token participation to situations where communities were seen to be actively involved in the total development process. In spite of the support for these hypotheses, certain key factors are still not sufficiently understood and exploited, for example: community involvement in the totality of the planning process, the importance of traditional decision-making structures, and the nature and extent of both national and international external support. These factors are important in terms of replication of development experiences and would therefore seem to merit further attention, including an extensive and analytical review of the literature.

The findings of the study as a whole, together with the experiences of the past and from on-going community participation experiences, provide guidance for action to be taken by national and international bodies in the promotion of community participation as a vital component of the primary health care approach.

5.3 Draft recommendations

The examples of community participation presented as case studies in this report, the findings derived from an analysis of these studies, the conclusions arrived at from these examples and findings and from additional observations gathered during the development of the study and from the experience of WHO and UNICEF, confirm the importance of community participation as a vital component of the primary health care approach.

Taking all these factors into consideration, the following recommendations are therefore made.

(a) WHO and UNICEF, having accepted the principles of and approach to primary health care as one way of achieving social and economic development, should now intensify their efforts and concentrate on the promotion and implementation of specific programmes that will assist countries in further development of their national primary health care programmes with special emphasis being placed on community participation.

(b) WHO and UNICEF, having recognized that community participation is best promoted when all levels of the community are involved and in order to ensure complementarity of national and local plans, should actively encourage governments to involve all relevant parts of their populations in the planning and implementation of their primary health care programmes.

(c) WHO and UNICEF should disseminate the information gathered through this study to:

(i) government officials, and specifically to policy-makers, social and economic planners, and those departments which are responsible for rural and urban development programmes;

(ii) international and bilateral assistance agencies;

(iii) non-governmental organizations supporting health and general development programmes.

(d) WHO and UNICEF, in sharing their experience with relevant United Nations agencies, should encourage and promote a common approach to community participation for development.

(e) WHO and UNICEF, in their collaboration with countries, should provide technical material and financial support for national primary health care programmes. Recognizing that some of the areas in which support is required may fall outside the usual forms of their assistance, WHO and UNICEF should therefore adjust the form and substance of their inputs accordingly, so as to reach communities effectively.

(f) WHO and UNICEF, in their collaboration with countries, should assist in the identification of traditional decision-making structures which have the potential for further adaptation and utilization in the development of community participation in primary health care programmes.

(g) WHO and UNICEF, in collaboration with countries, should undertake action-oriented studies of other aspects of community participation at national, regional, and local levels in order to shed further light on the changing structure and processes of community participation for practical application in the implementation of their primary health care programmes.

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(17*) ENGLISH | CORR.1 (B-4); CORR.2 (C-4) | UNICEF

(6)(7)(8) "NR" | 12 Jan 1977 | 2/2 = L. 1355/Cor[redacted]k.1 + Corr.2 | 14p + 2b (9)

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Date 2003-Oct-31
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CF/RAD/USAA/DB01/2003-01577

Document Register Number [auto] **CF/RAD/USAA/DB01/2003-01577**

ExRef: Document Series / Year / Number **E/ICEF/1977/L.1355 (PDF-Eng)**

Doc Item Record Title

Community Involvement in Primary Health Care - Report by the UNICEF-WHO Joint Committee on Health Policy (JCHP). 56 pp

Date Created / On Doc	Date Registered	Date Closed / Superseeded
1977-Jan-12	2003-Oct-30	

Primary Contact
Owner Location **Office of the Secretary, Executive Bo = 3024**
Home Location **Office of the Secretary, Executive Bo = 3024**
Current Location **Office of the Secretary, Executive Bo = 3024**

1: In Out Internal, Rec or Conv Copy?
Fd2: Language, Orig Pub Dist **English , L.Avail: E,F,S,R.. ; L.Orig: E-?**
Fd3: Doc Type or Format **pp = 56 p + ? b**

Container File Folder Record
Container Record (Title)

Nu1: Number of pages	Nu2: Doc Year	Nu3: Doc Number
56	1977	1355

Full GCG File Plan Code

Da1: Date Published	Da2: Date Received	Da3: Date Distributed	Priority

If Doc Series?: **CF/RA/DS/USAA/DB01/2001-0008**

Record Type **A04 Doc Item: E/ICEF 1946 to 1997 Ex Bd**

DOS File Name

Electronic Details **No Document**

Alt Bar code = RAMP-TRIM Record Numb : **CF/RAD/USAA/DB01/2003-01577**

Notes
CF/RAD/USAA/DB01/1997-01531
= related original Doc RAMP-TRIM ref #

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