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

Corrigendum

Replace pages 49-56 of document E/ICEF/L.1355 by the attached text.

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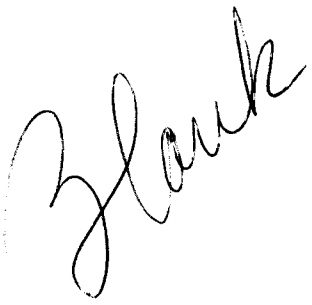

5. STUDY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

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 were prevalent throughout the processes that have been documented. The findings and conclusions presented below outline some of these observations and suggest how community participation may be encouraged in the pursuance of the primary health care approach.

5.1 Findings

Community participation observed covered a varied developmental range. Members of communities participated by providing money, labour, materials required for buildings and the improvement of their local physical infrastructure, such as the building and improvement of houses, schools, health units, dams, 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 methods and techniques in agriculture, home economics, and general and health education. The way in which the activities were funded also varied considerably from one setting to another.

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. Villages 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.

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The factors that appear to have been favourable to community participation, as observed in 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 repitition. 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. They include issues related to national policy, national structure, national participation and are linked to other factors more specific to the community, such as local resources, traditions, readiness for change and awareness of benefits. Entry points for initiating and encouraging community participation are also identified and discussed.

(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 nine 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 government 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 community and designed to meet their specific needs, clearly facilitated local development. An example of this

was Indonesia where the village social institute exercised control over credit funds supplied by government.

Technical advice and knowledge were also provided by governments. In all cases, government provision of technical personnel played a significant role in the development of local activities. They worked hand in hand with the communities, wherever necessary, offering guidance and advice, and assisting communities in obtaining materials and funds likely to be required at critical times. 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. External inputs of personnel such as these were 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 of 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, a fact that was important not only because of the immediate practical convenience this constituted but also for the psychological reinforcement it represented in demonstrating continued government commitment to the projects.

(c) Specific government programmes for rural and urban development were found to favour community involvement in primary health activities.

The case studies illustrate how local involvement was aroused through rural development programmes 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 Promotion Humaine 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 does the emphasis on rural development in Indonesia's Second Five Year Development Plan which revitalized people's interest in community participation.

(d) Government administrative decentralization and regional planning appears to have given an impetus to community participation.

Introduction of the idea of self-management in Yugoslavia, administrative decentralization in Senegal, and Mexico, 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 devolution of legal and financial responsibilities 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.

(e) 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, human, financial and material, were utilized.

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 PRODESCH programme and the Sarvodaya case study in Indonesia, deliberate attempts were made to identify and train potential leaders. 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.

Local personnel: 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 financing: 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. The success of projects funded through the use of these traditional approaches encouraged further contribution and participation.

Local materials: 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.

(f) Traditions sometimes formed the basis for expanded community participation efforts.

In the nine cases studied, there existed long-standing traditions of local government, cooperative work endeavours, ancient philosophies and other mobilization processes, which were found to have significance for the individual and the community. These, though at times requiring adaptation, 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 or the politico-religious jerarquia of Mexico. 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.

(g) 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, Costa Rica, Mexico, and Sri Lanka case studies.

(h) Awareness of the benefits of community participation, including the satisfaction of felt needs, stimulated further participation.

The case studies demonstrated that participation was further encouraged when projects with attainable objectives meeting the community's felt needs and with obvious benefits to individuals and groups 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. In Mexico, terracing similarly increased productivity and enhanced community involvement in subsequent projects.

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

In Senegal, Costa Rica, and Mexico, 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 co-operative 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.

(j) 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 Mexico community development promoters, teachers and agricultural extension workers were intimately involved with health work, and in Costa Rica were instrumental 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.

(k) 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 the 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.

(l) 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.

(m) Positive factors in some communities could be negative in other instances.

The findings listed above are positive and promotive of community participation and involvement. They are not, however, intended to present an entirely positive picture, and as can readily be seen from the case studies, some negative features were observed. These include such issues as: changes of Government policy; dwindling government support; failure of logistics;

unrealistic targets which in turn made for a seemingly lengthy process of development; centrally developed programmes sometimes proved too inflexible to adequately respond to the variety of community needs; the role of charismatic leaders can also be ambiguous in the sense that although they may be essential to the initiation of the process of community participation, they can be a deterrent to the spread of development because motivation becomes centralized in one person and may not be readily shared with other potential leaders. These negative factors, whilst not operative in all communities, should not be neglected in considering community participation in the primary health care approach.

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/

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.

1/ WHO Official Records, 1948, No. 2, p. 100.

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 nnd 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 Recommendations

(a) UNICEF and WHO having accepted the principles of primary health care as essential to achieving economic and social development should now intensify their collaboration with countries in further developing their national primary health care programmes, with special emphasis being placed on community participation.

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

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

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

(ii) international and bilateral assistance agencies; and

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

(d) UNICEF and WHO, recognizing that the formulation and implementation of primary health care programmes, of which community involvement is an integral part, are a national responsibility, reaffirm that it is incumbent on the two organizations to promote such community involvement processes by disseminating the type of information that will enhance the understanding of these principles through the provision of guidelines for the planning and programming of such activities.

(e) UNICEF and WHO should collaborate with countries, on request, in the development of methods for identifying community resources - human, economic and material - that can contribute to the development of local primary health care activities.

(f) UNICEF and WHO should assist in appropriate training programmes to develop local leadership for primary health care activities. This training should build upon the already existing skills of such local personnel as administrators, school teachers, extension agents, health and voluntary agency staff, in such a way as to further develop their capacity as facilitators of development. To support these activities, appropriate attention should also be paid to the development of managerial and administrative capacities at every level.

(g) UNICEF and WHO should encourage and assist governments to develop appropriate support to communities that are engaged in their primary health care and development projects. Such support should include health and development technologies, credit and loan arrangements, communication approaches and material, and other supplies as required.

(h) UNICEF and WHO should encourage and assist governments to further study and evaluate community involvement in primary health care as an integral part of general development.

(i) UNICEF and WHO should intensify the orientation of their personnel in the promotion of primary health care approaches, including the methodologies of community participation.

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