CMC (77) II

COMMUNITY PARTICIPATION

Paper prepared by the Commonwealth Secretariat

The involvement of individual members of the community and of its special social and service groups is essential for the success of all national health programmes. Developed or developing, there is hardly a country in the world today where this is not now a major health goal. The level of attainment, however, has been variable and much remains to be done in most countries. Approaches differ both within and between countries and it is essential for each to seek its own solutions. In all of them many private and public services and functions need to be co-ordinated and new approaches to community education and motivation need to be worked out. A wide range of fresh problems have to be dealt with, requiring untraditional concepts and techniques.

2. It is against this background that member countries will need to take up the challenge; and it is here that self-reliance and self-help become of special significance. Health is a total community problem and coming to grips with it means taking a completely new look at the whole of the community. Individual members of the community need not only to participate in identifying their community's problems, but to play a role in reaching solutions. What is relevant in Tanzania may be irrelevant in Trinidad, and what holds in Fiji may not apply to Canada. There is little difference between countries, however, in the problems to be overcome. These will almost certainly include community education and motivation, the roles of special groups, national health policies and the level of popular and political support that can be mobilised in support of them.

3. Commonwealth member countries have already begun to grapple with the task of actively involving the community in the solution of local health problems. A few examples will suffice. In *Ghana* there is currently a joint Ghana/WHO project on research in community involvement in local health programmes. There are town or village development committees throughout the country actively promoting community health education and participation, and efforts are also being made to train and integrate special groups such as traditional birth attendants in the general public health service.

4. In *Botswana* district development committees have been formed with representatives from the Health Department, the local council, the Agriculture and Education Departments and related groups. Decisions have been taken or are being worked out on new health plans, the selection of village health workers, the site of new health facilities, the selection and roles of village health committees, health seminars, community education, village motivation projects and the development of family welfare educators. Similar community-based activities are also under way in *Malawi.*

5. In *New Zealand* a special Advisory Committee on Health Services Organisation is actively examining the complex system of communication that effective community participation in health requires. New Zealand also recognises the importance of up-to-date policies for health education in schools. A similar emphasis on education and motivation at an early age has been placed in *Cyprus,* where there is also active participation in community health programmes or special groups, including the St. John's Ambulance, the Family Planning Association, the Mental Health Association and local teacher's associations.

6. In *Swaziland* the curricular emphasis for the community health worker is appropriately on the preventive aspects of common diseases. The role to be played at the village level by health workers, school teachers and other local groups is also recognised. The village health committee which contributes so much to community participation in Swaziland is an example of a local organisation whose goal is to apply local resources to achieve locally defined and locally understood objectives.

7. Comparable approaches have been adopted in many other countries. However, in spite of the enthusiasm that has characterised these new initiatives, a real breakthrough has yet to be achieved. In most member countries there is still an uneven distribution and a lack of access to adequate health facilities and inadequate community participation in them. The future, however, is not entirely gloomy. What has been particularly encouraging is the catalytic effect on national health development that has been achieved in a number of countries by village committees, community health workers, teacher's associations and other special groups planning and working entirely at the local level. In *Tanzania,* for instance, national campaigns for the involvement of community members, youth, women and other special groups gave achieved much, not only in health but in overall national development.

8. The basic principle, therefore, of involving health workers from the community itself in community health plans remains valid. The health plans, however, need to be both within the community's planning and executive capacities and also within its economic and personnel resources. All this has to be achieved in the context of societies many of which are geared towards consumerism, personal rather than group aspirations, escape from rural areas to the city, the career objectives of richer communities. The question of creating alternative goals and motivations and appropriate roles for individuals and community groups is probably one of the most important problems to be tackled by member governments in the general field of social and economic development and particularly in the health sector.

9. The particular questions which the Conference may wish to consider have already been set out in the annotation of this agenda item. It is suggested that they might be discussed under the following heads:

(a) techniques for community health education and motivation;

(b) the roles and potential contributions of special groups;

(c) national policies and programmes for community participation in health planning and health care delivery.

14 October 1977

CMC (77) II/B1

COMMUNITY HEALTH AND COMMUNITY PARTICIPATION

Background paper prepared by the Government of Australia

Australia is a federation of six States with power shared between the Australian Government and the six State governments. The country is large and sparsely populated. Eighty-five per cent of the population live in urban areas, sixty-eight per cent in the ten largest cities.

2. Health services are provided in a variable mix by private practitioners and organisations, by the six State governments and by the Australian Government. The usual primary source of health care is the local private general medical practitioner. The State governments are the main providers of governmental services.

3. In Australia it is becoming recognised that the improvement of community health is not a matter of providing more and bigger hospitals where high-cost sophisticated technology is used on on a small number of people, but a matter of modifying the social environment and personal attitudes so that patterns of living assist in the preservation of health, and a matter of modifying the physical environment to reduce the risks of injury and disease. This cannot be accomplished by one type of worker alone. It requires group efforts, teams of workers with different specialities and common goals, and it requires the co-operation of the community.

4. The basic requirements for involving local people in improving community health are an acknowledgement that local communities are capable of assessing some of the problmes confronting them, a willingness of health planners, administrators and providers to listen and to respond to requests from the community, and a willingness to allow local communities to be involved in the planning and management of services provided for them.

5. Since 1973, the Community Health Programme has been operating in Australia as an initiative by the Australian Government in co-operation with the State governments. This Programme has as its objective the provision of comprehensive, accessible services where they are needed. Key components of the Programme are primary care which stresses prevention and health education, early detection programmes, rehabilitation and assistance for the chronically disabled, as well as appropriate community-based diagnostic and therapeutic services.

6. From its inception, community participation was highlighted as an integral part of the Programme. Initial publicity was wide and involved the Federal Government in an advertising campaign, and involved State government officials in direct contacts with local community groups and non-governmental health services. Many projects were established after this as a direct result of community group action, while others were established in response to requests from health and hospital authorities, private medical practitioners or national charitable organisations.

7. Where local community groups have some measure of executive power over the planning and administration of the service in their area sustained participation by the community group has been seen. Groups which are advisory in function also have exhibited sustained activity where feedback of information to them is good, especially important in cases where advice has had to be disregarded. In one State, South Australia, legislation to establish a network of community consultative councils has been enacted, while in Victoria, community groups were involved in the planning of community health centres and now are involved in the management of the centres with the ability to hire and dismiss staff.

8. The largest single category of health facilities provided under the scheme are community health centres. These vary from comprehensive primary care centres to health support centres (without primary medical care) to small bases for community nurses.

9. Staffing of these services emphasises the team approach to the provision of care. Patients are viewed not just as individuals but as people who have come from a particular social, family and physical environment and whose disability has to be dealt with in those terms. Social workers, psychologists, community health nurses, doctors and other personnel combine in an approach to the patient as a social being.

10. Two new types of health workers have developed to work specifically within the community: the para-medical aide and the comprehensive community nurse. Both are trained under the programme and work within the community as part of a health care team. Community nurses particularly provide preliminary screening, health counselling and preventive health education.

11. Preventive medicine and health education are stressed with the team approach and health education officers work directly from many centres. Specific health education programmes and training schemes have been funded under the Programme. Of particular interest is the Social Biology Resources Centre in Victoria which provides a consultant service in health education and team communication skills for community health workers.

12. A feature of the Programme has been its emphasis upon community mental health services as an integral part of community health. Some centres which started as mental health centres have widened their focus and changed their image. Nevertheless, many services for the retarded, for the mentally ill and for those suffering from alcoholism and drug dependence, have continued to develop, particularly on the basis of regional resource centres.

13. One problem confronting the Community Health Programme has been the need to change the attitudes of those concerned with health care delivery (doctors, nurses and health administrators) away from an unrealistic reliance on technology and reparative techniques and towards prevention and rehabilitation as an essential ingredient for the improvement of the quality of life. Departments for the teaching of community health have been established at the medical schools to promote the concept of the delivery of health care outside the hospital environment, to stimulate a multi-disciplinary approach by doctors to problems and to stress the role of social factors in disease. Projects inspired and sometimes organised by the Australian Medical Students' Association which have similar aims have also been funded under the Programme. The Family Medicine Programme conducted by the Royal Australian College of General Practitioners provides vocational training in family medical practice for recently graduated doctors, and re-orientation courses for mature medical graduates (particularly women) who wish to enter family medical practice after an absence of some years.

14. So far over 700 projects of a wide ranging nature have been funded under the Community Health Programme. The list includes comprehensive health services, mental health services, women's health services and refuges, family planning, health education and occupational health services. While by no means all of the community health services in Australia are funded under this one Programme, it is one of the most important initiatives in Australian health in the last decade and it is the first major health programme to recognise the necessity of community involvement in the improvement of health.

15. From the beginning it was recognised that an agency directly engaged in the provision of health care should accept responsibility for the quality of that care. Evaluation is therefore an integral part of the operation of the Programme. Both process and outcome evaluations have been developed, and some 30 major evaluation programmes are under way, supported by funds from the Community Health Programme and by Health Services Research and Planning Grants.

16. Improved comprehensive primary health services are now accepted as both necessary and a right in Australia. The real challenge now to be faced is to build from the few projects adequately emphasising environmental and attitude change, prevention, self-help, and the use of health aides drawn from the local community, to a position of much greater concern for these matters. Australia hopes to learn from the greater experience of some of the developing nations with a view to modifying and improving its own Community Health Programme in the near future.

25 August 1977

CMC (77) II/B2

COMMUNITY PARTICIPATION IN HEALTH EDUCATION WITH RESPECT TO DRUGS

Background paper prepared by the Government of Australia

As part of a total drug abuse prevention programme, the National Drug Education Programme, funded by the Australian Federal Government, was established in Australia in 1970/71. The aim of the Programme is to integrate and co-ordinate educational activities in the areas of drug abuse prevention.

Community motivation and health education programmes

2. Before the National Programme commenced, health (drug) education programmes in Australia were mainly conducted in the form of single lectures. While it is recognised that this approach still has a role, more comprehensive programmes involving discussion groups, seminars, workshops, etc., have been found to be more effective in eliciting greater community and individual involvement.

3. With regard to "producing the right motivation", the following has been the experience of the National Programme.

4. With health (drug) education conferences of professional people, successful initiation and participation have been established through an authoritative professional organisation assuming the responsibility for the conduct of such a conference.

5. A further way of successfully involving the community has been through the use of key personnel, for example, hospital, community and school nurses; teachers; law enforcement agents; and staff of social welfare institutions. Prominent "lay" people in the community are also involved through their membership of such active organisations as Rotary International or certain women's groups, etc. Training courses are made available to these key personnel.

6. In country areas, several of the Australian States have experienced considerable success with programmes which seek to involve key people in the community and which are conducted over several weeks. These multi-sessional programmes have been requested by community organisations operating in the country areas and, under their sponsorship and active enlistment of community interest and participation, have achieved a greater degree of interaction than has been experienced with programmes in city areas. This is attributed to the compact nature of small towns.

Community involvement in health education delivery

7. Health authorities in the various States and Territories of Australia are responsible for the conduct of health education programmes with respect to drugs at the local level. In order to make maximum use of resources in achieving an effective approach in health education, in this field Health Authorities are seeking to meet the growing demands of the community in this area by involving and training groups such as teachers, medical/para-medical professions, and police. In addition, in all Australian States, social welfare bodies and other areas of local government, such as those involved in industry, are being encouraged to take part in health education with respect to drugs and to offer related programmes.

8. In order to more adequately service communities, a "decentralisation" scheme of regionalisation has been and is being developed in some States. Where it is in operation, the scheme has enabled more immediate, widespread and effective contact with local communities.

Regionalisation involves the establishment of several health education centres within the State with the intention that they should tailor their services to the local needs.

9. Of particular interest in the fostering of successful community participation in health education is the establishment in a small town in the State of Victoria in 1974 of an association for alcohol and drug dependence. The association was formed by a group of townspeople who were concerned that local needs should be met by the community. With funds provided by both Federal and State Governments, a Centre set up by the association provides counselling, referral and advice for drug dependents and conducts an active drug abuse prevention campaign in the community. This is carried out with support from the Victorian Health Education Centre.

10. Although a National Drug Education Programme has been operating on a fully co-operative basis between the Federal and State authorities concerned since 1970/71, the escalation of the drug problem in Australia calls urgently for a reassessment of the value of the Programme in relation to current needs and as to the scale and scope of future activities to deal with the growing problems. The economic situation makes it difficult to achieve expansion of the Programme at the present time.

25 August 1977

CMC (77) II/B3

COMMUNITY PARTICIPATION IN DELIVERY OF HEALTH CARE

Background paper prepared by the Government of Swaziland

The present distribution of health services has favoured concentration in the urban areas. Seventy-five per cent of Swaziland's population live in rural areas and are engaged in subsistence farming. It is clear, therefore, that to reach the majority of the people, the Ministry of Health must direct its future efforts to this target group.

2. In 1974 the recurrent preventive service in the rural areas accounted for 19 per cent of the total health recurrent budget, but their share is projected to increase to 27 per cent by 1979 and 33 per cent by 1984. The policy of the Ministry has therefore as its goal the improvement of the health status of the Swaziland population through the strategies that are directed at increasing the emphasis on rural preventive health services, and by the turn of the century every household should have access to health services.

3. Although the qualified nurse will remain the most important figure in the expanded health service, supplemented by the auxiliary, in order to obtain the widest possible coverage of the population with the given budget an increased use will be made of the community health worker (rural health visitor).

COMMUNITY HEALTH WORKERS

4. These are rural health visitors whose function is to educate the community on matters affecting health, to motivate the community to be responsible for disease surveillance, to give first-aid care, to collect information on births and deaths within the community, and to promote health generally.

5. Each community health worker is responsible for 40–50 homesteads (the rural population is scattered). To date 80 of these workers have been trained. The third group of 40 will qualify in December. Training output is to be 100 per year, with a final total of 800 workers to serve the whole country by 1985. Their training is for two months and the full curriculum is contained in the Annex to this paper.

6. These health workers are directly responsible to the area clinic, which serves as their referral point. The clinic is staffed by a doubly qualified state registered staff nurse. Supervision in the field is by the public health personnel, who deal mainly with preventive health and MCH family planning services.

Community involvement and the involvement of leaders

7. Although the Ministry of Health is greatly involved in the training of this cadre of health workers, the cadre is regarded as a community responsibility. As a behavioural change is implied in the programme, in order to establish its acceptability and to ensure its non-conflict with traditional and cultural values the area chief is involved from the outset of the programme.

Selection of candidates

8. The process of selecting trainees is one of community participation. The chief and his community select suitable candidates for training in his area. Using as a criterion one worker for

40–50 households, the total number is arrived at. It is usually between 40 and 50 candidates. The only prerequisite of the Ministry of Health is that the candidates be able to read and write Siswati (the local language) and have a strong sense of responsibility.

9. The rationale behind this involvement is to select someone who understands the community, its problems, needs, level of development and its socio-political organisation. Selection of candidates is therefore from *within* the country *by* the community.

Education methods and implementation

10. The Annex to this paper shows the curriculum of the community health worker. The group are taught within their own environment by senior personnel of the Public Health Unit and invited lecturers from other Ministries on relevant subjects; for example, "the home garden" in the nutrition section would involve the agricultural extension officer. Demonstration of such tasks as the erection of toilets is done by making a permanent structure at one of the houses. In the curriculum the emphasis is on the preventive aspects of the common diseases, bearing in mind that most of the diseases occurring in Swaziland are in fact preventable. All instruction is in Siswati.

STRATEGIES TO MOTIVATE COMMUNITIES

11. Strategies to motivate communities towards participation in health improvement involve health education through group talks and demonstrations and home visits as well as the formal training already referred to.

Health education: group talks and demonstrations

12. Health education is aimed at making the individual aware of his "at risk" role and his obligations to himself, his family and to society. It involves giving the individual or community the necessary information and knowledge to motivate him into arriving at a decision to take action.

13. Health education is one of the media through which the problem (from the community) and the health service are brought together into a system where communication, interchange of ideas and confidence can be established.

14. Interest is aroused when there is actual involvement of the community in demonstrations and seeing the benefits occurring – for example, the use of a garbage pit, eliminating the fly nuisance.

Home visits

15. Home visits are made to advise on problems encountered in the daily household routine which have a positive health impact. Preparation of food using actual existing facilities within the home and advice on ventilation and cleanliness and on personel hygienic habits are some of the matters dealt with. Illness detection and treatment, or referral to the nearest clinic, are some of the responsibilities of the rural health visitor. By these visits the community begins to feel that there is interest in their welfare – someone cares – and they begin to understand and co-operate and indeed to see the advantages. This maintains and sustains their participation. They begin to see the reasons for the programme and request certain services to meet their own needs and demands – as they see them.

Communicable diseases

16. The stress placed on communicable diseases and the knowledge imparted on their mode of transmission makes the community appreciate *why* they are requested to build pit latrines, dig garbage pits, immunise their children and protect water supplies.

The leaders

17. Motivation of the leaders in the community, discussions with them and their involvement in all community activities act as a stimulus to the members of the community. Failure to involve the chiefs and leaders can jeopardise any community programme.

School health

18. The school is an important vehicle for inculcating good hygienic habits and imparting education on health. With the realisation that the school-going child can bring a change of ideas and habits into the home, the school health programme has been scrutinised more critically with this and other factors in mind. There is need for greater co-operation between the health and education authorities and community leaders.

Evaluation of health education programmes

19. There has been enthusiastic response in the community. Indicators used to evaluate the health education programme are established in the light of what has been brought to the awareness of the community. These indicators can be divided into short and long term:

Short term: (a) Use of health facilities
(b) Response to immunisation
(c) Number of toilets built and used
(d) Water protection

Long term: Improvement in the health of the community as reflected by improvement in the state of nutrition, reduction in water-borne diseases, and reduction in infant mortality.

20. An evaluation exercise has been undertaken in the Ntfonjeni community, where the first community health workers were introduced in late 1976. A brief comparison is given below of the first six months of 1976 and 1977, before and after their introduction into the community.

	Ante-natal care	*Child welfare*	*Pre-school*	*Immunisation*
January–June 1976	321	1135	446	878
January–June 1977	561	1545	639	1048

The actual total attendances at the rural clinic in the area were 8,985 for January–June 1976 and 11,273 for January–June 1977. Pit latrine construction increased from almost zero to 160 within six months. Garbage pits have been dug and springs protected.

COMMUNITY INTERESTS AND CONTRIBUTIONS

21. In the majority of cases, the most frequent request of communities is for a rural clinic to be built in their area. If the Ministry feels there is a need, taking into account the population density and the distance from the nearest health facility, then the communities are requested to contribute towards some aspect of construction. This may involve labour in making bricks – for the construction of a causeway over a stream, for example – or a contribution towards the cost of a water supply for the clinic and community. This latter is seldom successful, however, and the Ministry has to pay the capital as well as recurrent costs. The major aspects of health development readily contributed to, perhaps because of less financial involvement, are the construction of pit latrines, protection of water and digging of garbage pits.

22. For any health programme or activity to be successful within a community, the local chief must be involved from the start. The contribution of the community here is participation in response to health education. This involvement of the chief stresses the relationship with tradition, the chief being the custodian of the people.

Training programmes

23. The health educators in the broadest sense are the community health workers (rural health visitors), who are formally taught as outlined above. However, as health education is not regarded as the prerogative of the Ministry of Health only, many other persons are involved, such as women's organisations, community development workers, agricultural extension officers, teachers and domestic science demonstrators – personnel who are available within the community. The health education personnel of the Ministry are frequently invited to participate in regional or national seminars organised by various Ministries, and it is here that the participants are exposed to health education.

Health education specialists

24. Health education is defined as being the application of behavioural science in the health field. It is intended to motivate the patient into making decisions, if ill, to seek early treatment, to return to a healthy state and, by virtue of his newly acquired knowledge, to take the necessary precautions to remain there. It is geared to prevent persons from becoming ill, and to encourage them to better life.

25. The art of delivering health education so as to have the effect that is intended is not an easy one. Success is not gauged by the size of the audience but by the positive *action* the individual takes as a result of health talks. It is quite clear, therefore, that the major role of specialists should be to train others in the skills of delivering the message, taking into account visual aids and demonstrations that may be necessary.

26. The health education specialist should be able to organise programmes to strengthen the education unit, to synchronise health education with the health programmes implemented, so that there is a clear understanding of the aims and objectives of the programmes. Most medical personnel are not trained in this discipline, and it is the duty of the health education specialist to increase their awareness of health education as a tool to supplement their professional competence.

27. The specialist therefore must be the identifier and co-ordinator of community resources which have potential to participate in health education activities. He must be responsible for the introduction of new accepted and proven techniques and procedures of health education as they apply to the situation within a given community. He is responsible for the development of information and education material and teaching for various target groups, and for the distribution of such material as part of the strategy to make proper use of health services. He must evaluate the programmes for feed-back and subsequent planning.

Special groups

28. While the health worker plays the major role in the community from the health point of view, other special groups are encouraged to contribute towards social and cultural well-being through an educational process which will improve the health of the individual and thus contribute to the development of the country.

29. Thus the group known as "Women in Development" has a role to play in the economic aspect of the community and family life. The "Programme for Better Living" is generally involved at family level and emphasises the spacing of families and nutrition of the family. This is an education and communications project, designed to focus attention on the needs of rural families. There is emphasis on strengthening and servicing existing programmes. These two groups are naturally encouraged to co-ordinate and supplement each other.

30. A national women's group called "Zenzele" (do it yourself) has launched a fight against malnutrition and towards environmental sanitation and health. Amongst its membership it has nutritionists and home economics personnel. Demonstrations and competitions (e.g. the house with the cleanest surroundings, the healthiest baby, etc.) are encouraged to sustain interest and participation.

31. The Red Cross is concerned as part of its activities with nutrition, particularly of the under fives, and with health education.

32. All these groups liaise with the personnel of the Ministry of Health in activities and programmes which have a health implication. It is these groups which the health education specialist should explore and exploit as health educators, especially as membership is drawn from within communities. Special community groups should amalgamate their efforts so that duplication is avoided, or should co-ordinate in such a way that each group is given a specific task. With such an approach, progress can be enhanced to stimulate the community to becoming better organised towards the goal of self-sufficiency.

33. The first step should be to identify the needs of the community. If it is known that there is a high incidence of bilharzia within a community, for example, efforts can be made with proper leadership, to erect ablution and laundry blocks. Because the winter months are the lean periods, in order to avoid malnourishment and hunger proper grain storage could be encouraged.

34. Sports facilities for the community during periods when people are not employed, or are on recreation (e.g. weekends), can go a long way to reduce the crime rate, mischievous loitering, excessive drinking and so forth. This is an area in which most local private concerns are interested. The usual contribution is a trophy for the best soccer team of the year.

35. The role of some private international organisations in community health has not been clearly identified. UNICEF contributes financial assistance to the training programme of community workers. A workshop on "Community Health Workers" was held in 1976, sponsored by WHO.

School health education policy

36. There is as yet no firm policy on health education in schools. However, a National School Health Committee is to be formed, and amongst its functions will be to make recommendations to the Education Authorities, which hopefully will lead to a health education policy. There is a need to review the present status of health education activities at primary and secondary schools and to determine the health education needs of school children.

Traditional medical workers

37. As yet no steps have been taken to incorporate traditional medicine into Western medicine.

National health programmes

38. As stated in a previous section, community participation in national programmes embraces the role of the health worker identified by the community for training. She is the first line of contact in the echelons of the health service.

39. The training is organised by the Ministry of Health with lectureres drawn from other Ministries such as Agriculture, Local Administration, etc. and their field staff within communities are called upon periodically, for talks and demonstrations. In each district several structures have been built by the Government for use by communities to hold meetings, demonstrations, etc.; but in addition, buildings belonging to other Ministries such as Farmer Training Centres (Ministry of Agriculture) and Rural Curriculum Centres (Ministry of Education) are made available on request for training or lectures.

Family planning

40. Swaziland has a family planning policy which states that growth rate is to be reduced from approximately 2.8 per cent to 2.3 per cent during the plan period 1973–1977. However, the policy of the Ministry of Health is directed towards family spacing in the interest of better family health and the reduction of infant mortality and wastage of life. Thus the approach is not primarily demographic but rather one of promoting the health of the population. The service is entirely the responsibility of the Ministry of Health, and the issue of family spacing devices and pills is conducted by health personnel in government and private practice.

25 August 1977

Annex to
CMC (77) II/B3

SWAZILAND GOVERNMENT

Ministry of Health: Division of Public Health

CURRICULUM FOR RURAL HEALTH VISITORS' COURSE

Preface

The health and happiness of families living in rural areas depends greatly on the availability of health units within reasonable walking distances (5—10km) and their knowledge and practice of how to live a healthy life. The outlined syllabus is intended to train a cadre of workers to deliver these services to every homestead in the rural areas. The process of selecting trainess is one of community participation where the communities choose the people to be trained and assist when possible in their training.

To live a healthy life requires the knowledge of sectors other than health. As is stated in a report on an FAO/WHO workshop: "Integrated rural development is seen as a process of balanced social and economic development in a given community. Its components may include, among others, development of family health, education, agriculture, industry and co-operative enterprises, social welfare, socio-cultural and other aspects of community life. It represents a concerted effort by organisations serving them to solve their inter-related problems within the framework of the national development plan, making the best use of resources and personnel so that a better quality of life may be achieved". Hence training is inter-disciplinary and the trained product (rural health visitor) is a co-ordinator at grass-roots level.

"Because of the interdependence of the causes and consequences of development problems and issues, there is a need to focus on rural development through an integrated approach. In the past many development programmes failed because they focused primarily on social aspects without considering the economic aspect necessary to carry out social development programmes effectively". The syllabus will aid the worker in teaching the most effective methods of raising the standard of living of the rural people.

In the FAO/WHO workshop report, "an important principle of integrated rural development is that action must be generated among the population which is benefiting and not imposed from outside". The syllabus will therefore aid the worker in teaching the most effective methods of raising the standard of living of the rural people. It will aid the worker with knowledge to involve the people in discussions and decision-making situations on the subject of improving health by practising good hygienic methods, better nutrition, environment and adequate housing.

The rural health visitor requires support from higher officials of Ministries to effect and make meaningful her educational programme.

It is the Ministry of Health's belief that the syllabus and the cadre of workers it aims to create will enable the people to understand health in its entirety rather than the narrow meaning of alleviation of pain.

Objectives of the course

1. To produce rural health visitors who will educate the community on the importance of latrines and a protected water supply in the prevention of communicable diseases.

2. To produce rural health visitors who will educate the community on attending the ante-natal clinic.

3. To educate families on the importance of child welfare services.

4. To educate families on the importance of family planning services as a means for the maintenance of good health of both the mother and the baby.

5. To educate the community on good nutrition for prevention of nutritional diseases by having backyard gardens and fish ponds.

6. To educate families on improving their homes for the prevention of communicable infection by having dust pits and by the control of house pests.

7. To educate the community on the importance of participation in community activities for the improvement of health and the economic structure of the community.

8. To give immediate care (first aid) to families in cases of emergencies.

9. To create a cadre of personnel from amongst members of the community that will be responsible for disease surveillance and will refer to the nearest clinic any serious illness.

10. To provide rural communities with personnel that will supervise home treatment or chronic illness where applicable.

11. To provide rural communities with a co-ordinator (rural health visitor) between Ministries involved in rural development.

Philosophy of the rural health visitors course

We believe that effective teaching is achieved by communicating with the learner in a language that he understands. "Public health represents nothing other than the exploitation of all economic, educational, social, cultural and religious resources in order that each individual can find the possibility to lead his life to the full in relation to his aptitude and aspiration, in order that the whole social group may make progress."* Therefore, producing rural health visitors who understand the total community, its problems, needs, level of development and its socio-political organisation would be an answer in meeting the health needs of this country.

We believe that improvement of the economic, educational, social and cultural background of the community through an educational process would improve the health of individuals and thus aid in the development of this country. Rural health visitors are an answer.

UNIT I: COMMUNICABLE DISEASES *hrs. 25*

To identify communicable diseases.

To identify principles of control of communicable infection.

To apply principles of control of communicable infection.

1. Diptheria, whooping cough, tetanus, polio, smallpox, measles, tuberculosis, typhoid, bilharzia, worms, gastro-enteritis, syphilis, gonorrhoea, malaria.
2. Immunisation.
3. Personal hygiene.
4. Environmental sanitation.
   (a) water supply – rural
   (b) latrines – rural
   protection of food from contamination
   (c) dust pits
   (d) housing – control of house pests.

*Collier, Marie F., "The Functions of the Public Health Nurse", International Nursing Review Vol. 18, 1971 p. 8.

UNIT II: NUTRITION *hrs. 20*

To identify food groups.

To plan nutritious meals for the families.

To identify nutritional diseases.

1. The three food groups.
2. Diet during pregnancy. Food habits (e.g. pregnant mothers, infants). Food values, especially of locally available foods.
3. Diet during lactation.
4. Breast feeding.
5. Bottle feeding.
6. Weaning – weaning foods.
7. Nutritional diseases
   (a) marasmus
   (b) kwashiokor
   (c) pellagra.

Demonstration practicals

Weaning foods

Bottles and bottle feeding

Milk formulas

UNIT III: MATERNAL CARE *hrs. 12*

To identify importance of ante-natal care.

To identify importance of hospital delivery.

To identify diseases of pregnancy including those that may be transmitted to the foetus.

1. Anatomy of female reproductive system.
2. Conception.
3. Signs and symptoms of pregnancy – pregnancy.
4. Ante-natal care – its importance.
5. Preparation of the home for delivery.
6. Labour and delivery.
7. Post-partum care (immediate).
8. Post-natal care.
9. Family planning – family size norms, problems of abortion, age at first marriage, status of woman.

UNIT IV: CHILD CARE *hrs. 12*

To identify the importance of child welfare services.

1. Care of the new-born.
2. Baby bath – layette.
3. Child welfare – its importance.
4. Pre-school child.

UNIT V: ELEMENTARY SOCIOLOGY *hrs. 5*

To identify social structure of a Swazi rural community.

1. Rural social organisation –
   (a) roles of a chief, induna and umgijimi
   (b) roles of community members.

2. The family – members, their roles and expectations.
3. Illness in a Swazi community.
4. Traditional medicine – Western medicine.

UNIT VI: COMMUNITY HEALTH *hrs. 18*

To identify activities of public health centres.

To apply principles of community health in state principles.

1. Activities of public health centres
   (a) treatments available
   (b) importance of early treatment
   (c) dangers of lack of early treatment.
2. Community health work.
3. The health team and other community workers.
4. The big five –
   (a) water
   (b) housing
   (c) nutrition
   (d) refuse disposal and latrines.
5. Prevention is better than cure.
6. Home accidents.
7. The home visit.
8. Care of the aged in the home.
9. Health education.
10. Mental health – mental diseases.

UNIT VII: COMMUNITY DEVELOPMENT *hrs. 10*

To identify principles of community development.

To apply principles of community development.

1. Introduction –
   (a) the functions of the department of community development in Swaziland
   (b) what is community development?
2. Some principles of community development.
3. Methods of community development.
4. Working with formal groups.
5. The use of group discussions as a training method.
6. Developing leadership – the different kinds of leaders.
7. The community development worker's role in the community.
8. Communication and social change.
9. Human relations.

UNIT VIII: FIRST AID *hrs. 15*

To identify principles of first aid.

To apply principles of first aid.

1. Scope of first aid
   (a) what is first aid
   (b) the objectives of first aid
   (c) the good first aider's task
   (d) the equipment needed for first aid.

2. Asphyxia and resuscitation
   (a) smothering
   (b) choking
   (c) drowning
   (d) strangulation
   Artificial respiration – mouth to mouth method.
3. Bleeding
   (a) from cuts
   (b) from inside the ear
   (c) from a tooth socket
   (d) from a wound
   (e) from the nose.
4. Bruising.
5. Shock.
   (a) signs and symptoms
   (b) treatment
   (c) prevention.
6. Fractures
   (a) of the leg
   (b) jaw
   (c) arm
   (d) pelvis
   (e) foot.
   Signs and symptoms.
   Rules of treatment.
   Transportation to hospital.
7. Unconsciousness
   (a) fainting
   (b) fractured skull compression
   (c) convulsion in young children
   (d) epilepsy
   (e) hysteria.
8. Burns and scalds
   (a) treatment – burns or scalds
   (b) poisoning – corrosive plants and medicines.
9. Foreign bodies
   (a) eye
   (b) ear
   (c) nose.
10. Snake bite treatment.
11. Action in an emergency.
12. Sending messages (if medical help is needed the message must be clear and accurate).
13. The use of a triangular bandage and improvised slings.

UNIT IX: HOME ECONOMICS

To identify principles of home economics.

To apply principles of home economics in the community.

1. Food and nutrition
   (a) growing of fruit trees
   (b) home gardens for trees
   (c) production of legumes
   (d) fisheries and poultry keeping.

2. Good food preparation – methods, especially for children.
3. Home improvement
   (a) environmental sanitation (latrines, garbage disposal)
   (b) home cleaning (pests prevention).
4. Consumers education and budgeting.
5. Child care.

UNIT X: WOMEN'S ROLE IN DEVELOPMENT

To identify women's role in development.

1. Role of women in development
   (structured in way of questions thus stimulating active participation in learners).
2. Home improvement or an ideal home
   (a) traditional and modern homestead
   (b) simple village technology – theory and demonstration.
3. Organisation of women's groups.

UNIT XI: AGRICULTURE

To identify activities of agriculture in the community.

To relate these activities in to the health of individuals.

1. Agricultural activities in the rural areas
   (a) production of vegetables
   (b) production of fruit trees
   (c) poultry production.

UNIT XII: ADULT LITERACY

To identify activities of adult literacy in the rural areas.

To co-ordinate health activities.

1. Activities of Sebenta (adult literacy) programmes in the rural areas.
2. Integration of health in the Sebenta programme.
3. Distribution of Sebenta programme in Lubombo District.

EVALUATION

Evaluation is the process of determining what these changes are and of appraising them against the value represented in objectives to find out how far the objectives of education are being achieved.

Considering the educational level of the rural health visitors, the following methods of evaluation are considered ideal.

1. Questions and discussion on subjects covered.
2. Group presentation on covered materials.
3. Individual presentation on covered materials, followed by self evaluation and then group evaluation.
4. Mock teaching in the classroom on materials that have been covered.
5. Evaluation of actual home visit and health teaching in the home.

25 August 1977

CMC (77) II/B4

COMMUNITY PARTICIPATION

Background paper prepared by the Government of Cyprus

It is generally recognised that community participation is essential for the effective delivery of health care. Participation by the community may take the form of collaboration with the local or national authorities in the planning and/or operation of health programmes or it may involve the actual delivery of health care by organised groups of the community. Participation may also be indirect, as in the case where clubs or organisations undertake the promotion of health education.

EDUCATION AND MOTIVATION

2. Education and motivation constitute the most effective means by which the community at large can be made conscious of the significance of health in the achievement of progress, well-being and happiness. Such an awareness will stimulate interest in health, will foster organised activity in health matters and will encourage the individual to take self-help measures in the home or in his work environment to protect his own health and the health of his co-workers as well as that of his family. Acquiring good healthy habits in such matters as nutrition and hygiene, and sufficient knowledge about disease and protective measures against the causes of disease, is very important and education in these matters should start at a very early age. This can be done through the introduction of appropriate teaching material in the upper classes of primary schools and in the curriculum of secondary schools.

3. In Cyprus, health education is included in the curriculum of primary and secondary schools and the experience acquired has shown that this policy has paid good dividends. The success of health education in schools depends mainly on the knowledge about health matters imparted to teachers in the course of their training or thereafter. It also depends to some extent on close and sustained contacts between the school and the parents. On the one hand this will provide the necessary feed-back to the teachers, and on the other hand it will afford ample opportunity to the teachers to impart to parents knowledge about health matters. In Cyprus, teachers come into contact with parents through the parents' associations; they also establish direct contacts with individual parents and this helps in promoting health education.

4. Health education in general is undertaken by the government health services (doctors, dentists, health visitors and health inspectors, as part of their other work). The school health services, which operate as an integral part of the public health services, are also engaged in health education activities at school and family level. A secondary objective of the health education activities of the government health services is to encourage community participation in health programmes, including the stimulation of activities in the field of health education on the part of local clubs and other associations, so that the mass of the local people can acquire such knowledge about health as will create motivation to participate in health promotion activities.

SPECIAL GROUPS

5. In Cyprus health care services are provided mainly by the public health services; the private sector provides almost exclusively curative services to those patients who can afford to pay the full cost. Local authorities have responsibilities for general sanitation in their localities and also for some other matters such as the control of slaughterhouses, meat markets and refuse disposal. There are, however, a number of special groups which participate in one way or another in the delivery of health care services. Some of the more significant of these groups are mentioned hereafter.

Cyprus Red Cross

6. The Cyprus Red Cross has established and has been operating a convalescent home for sick children. It also provides financial support for health programmes and contributes towards the cost of the treatment of needy persons.

Anti-Cancer Society

7. The Anti-Cancer Society has established and is operating a special institution for the accommodation and nursing of cancer patients who cannot be looked after adequately at home. This institution collaborates closely with the radiotherapy department of the Nicosia General Hospital.

Anti-Tuberculosis League

8. The Anti-Tuberculosis League's functions are mainly to provide financial assistance to needy tuberculosis patients and patients with chest diseases (silicosis, etc.) and their families.

Anti-Anaemia Association

9. The Anti-Anaemia Association has been formed in order to help the government health services in their plans to combat thalassaemia (Cooley's anaemia) which is a major medical and social problem in Cyprus. The activities of the Association include health education with regard to this disease, close collaboration with the health authorities in such matters as the practical implementation of the anti-anaemia programme and the procurement of the blood needed for transfusion to patients suffering from the disease. The Association also raises funds for the support of the programme.

St. John's Ambulance Association

10. The main activity of the St. John's Ambulance Association is to foster training in first aid. Many groups of first aiders are trained every year. The Association co-operates closely with government hospitals, the civil defence service, schools and associations which undertake the running of first aid courses.

Trade unions and employers

11. Trade unions and individual employers participate significantly in the delivery of health care to workers by establishing medical care schemes.

School for Parents and the Family Planning Association

12. The School for Parents provides health education on health matters which are of special interest to parents. The Family Planning Association offers advice and guidance in matters of family planning including sex education.

Mental Health Association

13. The Mental Health Association is interested in scientific matters relating to mental health and it offers advice to the government health services in the field of metal health. It is actively involved in health education activities and participates in the health activities of other associations such as the School for Parents, the Retarded Children Association, the Prison Board and the Family Planning Association.

Hospital welfare boards

14. For each government hospital there is a welfare board composed mainly of private persons. The function of the boards is to promote the welfare of patients by providing the means for recreation and by supporting the families of patients who face financial difficulties.

Blood donation movement

15. In view of the large number of persons suffering from thalassaemia (Cooley's anaemia), considerable quantities of blood are needed on a continuous basis for regular transfusion to these patients. In order to secure sufficient quantities of blood, a campaign has been undertaken on an island-wide basis. Many associations have joined the campaign and it is hoped that they will put into operation programmes for blood collection from among their members. The public at large will thus have the opportunity to participate in a direct and practical way in the delivery of health services to those in need of blood transfusion in general and particularly those who suffer from thalassaemia and need regular blood transfusion on a long-term basis.

Community participation in cleanliness campaigns

16. Every year cleanliness campaigns lasting for a week are organised throughout the island with special emphasis on the rural areas. There is mass participation of the communities in the campaigns. These campaigns have been very successful both from the point of view of practical results achieved and from the point of view of health education.

Miscellaneous groups

17. There are various small groups participating in health promotion activities. We can mention Rotary, the Lions Clubs, the Scouts movement, the associations which organise health-promotion excursions and campaigns for children, the Association for Disabled Persons, philanthropic societies, and parents' associations which, among other activities, participate in the running of the school feeding programmes.

Traditional health workers

18. The community practical nurse and midwife, the only traditional health workers that existed in Cyprus in the past, have disappeared and we now have properly trained nurses and midwives offering services in the communities as members of the local health team.

NATIONAL HEALTH PROGRAMMES

19. Health development in Cyprus is an integral part of the Government's general plans for economic and social development. Health care services are provided by and large by the government health services. In view of the fact that Cyprus is a small country with a population of about 650,000, planning for development is not a very difficult task. The problems which have to be faced and solved are well-known and the strategies to be followed in attaining objectives are not generally in controversy. The main question which has to be decided in the planning stage is that of the relative priority to be accorded to the various projects or schemes, having regard to the resources available within a particular period of time.

20. Views and suggestions about health development reach the Ministry of Health from various quarters, not necessarily at the time of the planning exercise, and these are taken into consideration. Various interested associations, and especially the Medical, Dental, Pharmacists' and Nurses' Associations, participate in one way or another in planning by making suggestions or by expressing views on particular areas of health. Very often the Ministry of Health solicits such views. It is intended to set up in the future an advisory body composed of officials and of representatives of

private associations the main function of which will be to advise the Ministry of Health on health matters including the planning for development. When this body has come into being, it will put the participation of the public in the planning process, and in the implementation of health programmes, on a more systematic, institutionalised basis.

5 September 1977

CMC (77) II/B5

COMMUNITY PARTICIPATION

Background paper prepared by the Government of New Zealand

Until recently the planning and structure of New Zealand's health services was almost completely dominated by the professional groups delivering health care and by political expediency. However, there is growing emphasis on the need for community participation in the promotion of health and in the structure and delivery of health care, as well as increasing recognition of the relationship between health, education, welfare, housing and attendant social reactions. Change in one of these areas must reflect in changes in the others.

Education and motivation

2. It is recognised that education and motivation are necessary on two levels: (a) that of the individual and his personal health, and (b) that of the community and its needs. It is accepted that new approaches must be developed to cope with modern health problems of lifestyle and degenerative diseases. To a large extent, prevention must depend upon the individual's recognition of his responsibility and motivation to accept and fulfil that responsibility. Any blanket intervention from authority may be regarded as an infringement of personal liberty.

3. A basic requirement for involving local people in the improvement of community health is to obtain a consensus on the community needs. This can best be reached by the people constituting the community meeting to discuss and identify their needs and suggesting solutions for dealing with them, and by ensuring that the health system is so organised that it can and does take account of the people's assessments. In other words, there must be a sharing of power with the community.

4. Such a change cannot be achieved or implemented overnight and effective means of communication must be established or allowed to develop. A complex system of communication becomes suspect and, although spontaneity is desired, it requires a catalyst. These are among the problems being faced by the Special Advisory Committee on Health Services Organisation which is setting up a pilot scheme for a reorganised health service in New Zealand. This scheme proposes that the majority of the members of the proposed health board will be elected locally and machinery introduced whereby complaints and suggestions are given full consideration. This in itself does not give the community full access to and voice in the promotion and planning of its health service, but as the pilot scheme develops and is supplemented further community participation will be encouraged.

5. Other areas where this problem is being tackled include the Porirua Community Health Project, where the Department of Health, the Porirua City Council, the epidemiological unit of the Wellington Hospital and the people of Porirua have combined in a most successful effort to define the health needs of that community and the means of dealing with those needs.

6. Education must be more than a mere imparting of knowledge: it should include motivation for individuals and communities to work on their own behalf. It should show methods and means of accomplishment. It must be a continuing process with a wide range of direct and indirect approaches through television, radio, the press, discussion groups, meetings, schools and community leaders and community groups. Its aim must be not only to inform but to engender an involvement leading to changes in attitudes, behaviour and ultimately health status.

7. Efforts along these lines are already under way in New Zealand. Several involvement projects have been held and others are proposed, on national and local bases. A Special Committee on Health and Social Education reported to the Ministers of Education and Health in August this year on policy and programmes for health education in schools. Its terms of reference were to

identify the conditions under which healthy growth and development may be fostered in schools and to make recommendations on the studies and activities that should constitute school programmes, organisation and relationships.

Special groups

8. Attempts by local and volunteer organisations to foster education and motivation in health are encouraged but to date reaction has been rather spasmodic and success limited. Perhaps the most interest and action have been evinced by women's groups but here, too, participants have tended to concentrate more on sectional interests than on the total community needs. The transfer of public interest from established systems of health care to wider involvement is receiving help and encouragement.

National health programmes

9. At this stage no specific role has been planned for community participation in national health programmes. Efforts are being made to ensure this through representation on hospital boards and encouraging these boards to extend their interest and activities out into the community. It is recognised that involvement in preventive health and care outside the hospitals is necessary and desirable. Many voluntary organisations working in this field are subsidised by Government, most rely heavily on these subsidies, and this help will continue.

10. New Zealand does not have a population policy, although the Planning Council is working towards this. Family planning is accepted as a basic human right, as a public health measure and as an integral part of a modern health service. Community involvement in this is strong, in that the greater part of the service is provided by the New Zealand Family Planning Association (Inc.), a voluntary organisation which is subsidised by the Government. Further, fertility control is an important topic for women's organisations, and was a major theme in the recent Conference on Women and Health (March 1977).

28 September 1977

CMC (77) II/B6

COMMUNITY PARTICIPATION

Background paper prepared by the Government of Ghana

The role of community participation in the solution of local health problems is fully recognised in Ghana and efforts are made to secure community involvement in all health programmes.

2. There is also currently a joint Ghana/WHO Project on research in community involvement in the solution of local health programmes. This Project is based in two districts (Wenchi and Nkoranza/Techiman) in the Brong-Ahafo Region. The project was implemented in 1974 and is expected to be completed in 1979.

Education and Motivation

3. The basic principles and techniques of community information and health education, as well as community organisation, are used to motivate and secure community participation in health programmes. Virtually every community in the country has a town or village development committee. A number of communities also have town or village health education committees. These and also other influential groups, such as religious groups, youth associations and other voluntary organisations, as well as individuals, are used.

4. The level of enthusiasm and degree of participation in health projects and programmes varies considerably from area to area as well as from project to project. In some areas communities undertake projects such as the construction of clinics, latrines, schools, feeder roads, etc., without any external influence. In some other areas, on the other hand, it is extremely difficult or virtually impossible to get communities organised to provide labour and services for the construction of health facilities even where there is a heavy demand for health services.

5. One may argue that community participation is easily secured where a project or activity is a felt need of the community. This may be true to some extent but it is certainly not the whole answer. Perhaps the truth is that we have not really recognised those factors that influence attitudes, behaviour and practices and also the acceptance, demand and utilisation of health services. This indeed will explain why health education has as yet to make a significant impact on certain unhealthy attitudes, practices and behaviour. For example, in an area where anthrax is a problem, the population appear to be receptive when there is an outbreak of the disease but surprisingly enough further outbreaks occur year after year. Similarly, when there is an outbreak of cholera, people are expected to be receptive to health education on the prevention of diarrhoeal and faesco-oral diseases. However, outbreaks reoccur in the same communities again and again. This is certainly where the medical sociologist and the health educator can and should play a significant role.

6. There are no training programmes for health education specialists in Ghana. Until recently the Ministry's health education specialists were trained in the USA, but with the establishment of a regional training centre at the University of Ibadan, candidates are now being sponsored for training in Nigeria.

7. Not only the health education specialist but also the medical sociologist has an important role to play in community motivation. The roles of these specialists are seen as follows:

(a) basic and applied research – into factors influencing specific attitudes, behaviour patterns and practices as well as the acceptance, demand and utilisation of health services;

(b) planning, organisation and evaluation of the health education components of health programmes and activities;

(c) training of health workers to provide each category and grade of worker with the appropriate knowledge and skills for the incorporation of health education into their day-to-day activities.

8. The actual health education and motivation should be done by the health worker who is in contact with the patient or the community.

Special groups

9. In those areas where the health education committees or the development committees are active, considerable motivation is undertaken at the local level. Where a health worker or an individual or group of persons with influence has interest in health and socio-economic development, there also tends to be considerable motivation at the local level. In this respect, special community groups like women's groups, youth associations and religious organisations tend to make a useful contribution with or without external influence and support. People generally tend to be more interested in clinics and curative services than projects aimed at health promotion and protection.

10. Health science is taught as a matter of policy in all schools. The subject is however currently under review by the Ministry of Health to see how best the Ministry of Health and the Education Service can collaborate more effectively in the field of health.

11. It is fully recognised that in spite of the harm that is caused by some procedures of traditional medicine, this system of medicine is the only form of medical care that is readily accessible to large segments of the population. In this connection, although it is not intended to integrate the traditional system of medicine into the Western system of medicine, steps have been initiated to introduce legislation and appropriate mechanisms for the regulation and control of traditional medicine. Research activities into traditional medicine are being actively promoted. The aim is, firstly, to identify useful, safe and effective medicaments that can be promoted and further developed; secondly, to identify and abolish dangerous and harmful practices and procedures; and thirdly, to develop, improve and retain traditional medicine as a national heritage.

12. Although it is not yet a policy to integrate traditional systems of medical care into the Western-style system of health care, it has been official policy for some time now to utilise the services of traditional birth attendants (TBAs) for the strengthening of maternal health services. This came about for a number of reasons. Firstly, at best only 25 per cent of pregnancies are attended by a trained health worker during pregnancy. Secondly, of the pregnancies seen at ante-natal clinics, at best only 25 per cent are attended to by at least a trained midwife during delivery. An analysis of the situation and the factors influencing it, reveals that, except for the major urban centres, it will take a very long time indeed to attain a satisfactory degree of coverage as far as maternal health services are concerned.

13. It was therefore concluded that if the TBAs are going to play a significant role in maternal health care for several years to come then the rational thing to do is to recognise them and improve their knowledge and skills. Steps have therefore been taken to improve the skills of TBAs and integrate them into the general public health service. The primary objectives are that on the completion of training the TBA should be able to:

(a) recognise his/her limits of competence;

(b) recognise danger signs which demand that a case should be referred to a higher level for management;

(c) manage a pregnancy properly;

(d) manage labour hygienically and safely;

(e) accept further training as and when necessary;

(f) accept supervision from trained health workers.

National health programmes

14. In Ghana, broad policies and guidelines for health services development are formulated at the central level. Planning of health programmes and projects within the broad policies and guidelines, taking special local problems into account, is done from the periphery. At the district level, for example, the local plans are co-ordinated to form an integrated component of a district socio-economic development plan. The district plans are co-ordinated at the regional level and subsequently the regional plans are co-ordinated at the central or national level. This system of planning from the periphery to the centre promotes the appropriate involvement of communities in national health planning, thus allowing community needs to be considered and satisfied as far as practicable within available resources and taking national as well as local priorities into consideration.

15. In the past, the tendency was for each Ministry or sector of the economy to formulate and implement plans and programmes without steps to promote or ensure collaboration and integration of programmes and projects. For some time now the integrated approach has been adopted for reasons that are obvious and therefore need not be dwelt on here. Thus in each district there is a district planning committee and in each region a planning committee. These committees are multidisciplinary and multi-sectoral. The roles of different sectors of the economy in the formulation and implementation of socio-economic development programmes are identified at meetings of the committees. It is then left up to each sector to formulate its own detailed strategies and approaches.

16. In the Ghana/WHO research project on community involvement in the solution of local health problems mentioned earlier, special attention is focused on the role and responsibilities of the different participating agencies (health, agriculture, education, social welfare and community development) in the promotion of community involvement in local socio-economic development. The project is now in its second operational year and the models and systems developed will be replicated in other parts of the country with or without modification to suit each local situation.

17. In Ghana the population has been observed to be growing at a rate which is higher than the economic growth rate. High infant mortality rates ranging from about 60 to 200 per 1,000 live births, with an average of about 133, have been observed. The maternal mortality rate is also high and ranges from about 4 to 6 or more per 1,000. Demographic data obtained from the 1960 and 1970 censuses, as well as data from special studies, reveal that the fertility rate is rather high. Family size also tends to be rather large. All these are recognised as serious health and social problems requiring priority attention. In particular, the high infant and maternal mortality from largely preventable causes is a matter of great concern.

18. High priority has therefore been given to the organisation of health services for women and children (MCH services). The main objectives are:

(a) to strengthen maternal and child health services including family planning within the general health services;

(b) to reduce maternal and infant mortality, especially from preventable causes, to as low a level as possible;

(c) to promote the proper growth and development of infants and children.

19. Because of the health, social and economic implications of identified demographic factors, and more particularly because of the health implications of high fertility rates, large family size and short spacing of pregnancies, family planning is seen as a necessary and integral component of maternal and child health services. The policy now, therefore, is to provide family planning services at all levels of health care as part of the health services in general and MCH services in particular.

20. In Ghana, an inter-sectoral approach is used in the delivery of family planning services. Family planning services are delivered by the Ministry of Health and voluntary agencies, the principal ones of which are the Planned Parenthood Federation of Ghana (PPAG) and the

Christian Council of Ghana. The Ministry of Information has responsibility for the organisation of community education and information programmes while the Department of Social Welfare and Community Development has responsibility for motivation activities at the community level. All these activities are co-ordinated by a National Family Planning Secretariat which is under the Ministry of Economic Planning. This Ministry has primary responsibility for the co-ordination of technical co-operation and the planning and implementation of development programmes in the country. Family planning services being a multi-sectoral activity and part of population activities, it was considered rational to place the secretariat under the Ministry of Economic Planning.

21. Currently, communities have not been actually involved in the organisation and provision of services. It has however been suggested that communities can play a significant and useful role in matters relating to family planning. A proposal for a special study in collaboration with the PPAG and IPPF is, therefore, currently under consideration.

28 September 1977

CMC (77) II/B7

COMMUNITY PARTICIPATION

Background paper prepared by the Government of Botswana

Community participation in Botswana is a traditional type of activity. Projects belonging to a particular community were done through community effort, either by men or women depending on the type of work involved.

2. Community participation in this paper will be dealt with under the following headings:

Health care
Education
Village nutrition projects
Family welfare educators

HEALTH CARE

3. The participation of the community in its health care is encouraged.

Decision-making

4. Decisions at community level are made about plans for the development of the district, including health care. Districts have development committees (DDCs) which meet periodically and make plans with representatives from the local council, health, agriculture, community development and education. At present the Government is encouraging DDCs to formulate plans in detail and to ensure that they are in line with the national development plans.

5. The siting of new health facilities is decided after consultation with the community which will be using the facility. Selection of a village health worker called the family welfare educator, about whom more will be written later, is made by the community.

6. The regional health team, consisting of a medical officer, a public health nurse and a health inspector, are the health staff who act as catalysts in formulating decisions about health care in the districts.

Buildings

7. Whenever the need to house a health activity has been recognised, the community have organised themselves to construct, either wholly or with support from Government, such a structure. As a result a number of health clinics, maternity wards and health posts have been either initiated or constructed completely through the collective effort of the community.

8. With the accelerated rural development construction of health facilities all projects have had a built-in component of community participation to the extent of 25 per cent. This has been in the form of making bricks, bringing stones to the construction site, providing grass for thatching, and fetching water where there has been no water laid on. When the construction was completed, in the case of mobile health stops village women in rotation cleaned the premises and fetched water for use by the health teams. This practice still holds in areas where a health post has no general duty assistant and no running water.

Health supporting activities

9. Villagers, usually women, give the following participation in health supporting activities:

(a) *Assisting in the weighing of babies* in a small percentage of clinics. This was the rule especially before maternal and child health clinics were government-staffed and organisations like the Red Cross and voluntary women's organisations were running these centres. There is still some of this type of activity, especially where the clinic is very rural and the staff (usually one staff member) is overworked.

(b) *Feeding of under-fives groups.* This is either at day care centres run by women's groups or at voluntary feeding centres where children below the age of five are given rations of World Food Programme supplies.

(c) *Village health committees.* In the Kgatleng area the idea of a village health committee is being introduced. This is like a sub-committee of the district committee. Village members, in co-operation with the staff nurse of a clinic or family welfare educator, each have responsibility for one field of health care -- e.g. immunisation, TB defaulters, toilets, births registration, etc. The village members are elected at a "Kgotla" meeting and work closely with the staff of the clinic. If the clinic staff feel that all is not going well in a particular field they seek the help of the responsible village health committee member. Together they can organise a village meeting to sort out the matter or visit the particular families to encourage them to attend the clinic.

Community leaders' health seminars

10. Over the last one and a half years seminars for community leaders have been organised in all the health regions. The objectives of the seminars are:

(a) to inform community leaders about the country's health programmes – what they are, what they aim to achieve and how they aim to achieve it;

(b) to discuss problems of implementation of health programmes with the leaders and to suggest ways of overcoming these problems.

So far each region has had one seminar and the seminars have been organised around the above objectives. Subjects that have been discussed are subjects of high priority in our health plans, i.e. our health care delivery system, tuberculosis, immunisation of children, maternal health and family planning, nutrition, environmental sanitation.

11. Participating community leaders (usually between 20 and 30 at each seminar) have been local administrators, headmen, teachers, women's group leaders, religious leaders, local traditional healers and youth group leaders. The seminars have resulted in better understanding of local beliefs and barriers to participation in health programmes. Suggestions made for improvement in organisation of health care delivery have included:

(a) formation of village committees to help health staff;

(b) encouragement of villagers to attend meetings arranged to discuss health programmes;

(c) suggestions as to how the young health workers should discuss matters like family planning and sexually transmitted diseases without embarassing elders of the community.

EDUCATION

12. The building of two of the country's oldest schools was entirely a community effort organised by the chiefs. These are a primary school (Isang School) in Mochudi and Moeng College in the Central District. At present for all primary schools the communities participate in the construction of the schools by way of providing bricks for building and helping so that labour costs are cut down. Parent-teacher associations have a major contribution in the management of the schools, especially in the organisation of fund-raising events.

13. All primary school children are given a midday meal. The staff preparing this meal are employed and paid by parents through the collection of contributions to cover their salaries. The pots, wood and water are provided by the village and the school provides only the food.

VILLAGE NUTRITION PROJECTS

14. Several villages are starting nutrition rehabilitation projects attached to the local clinics. Following on the pattern of one "Nutrition Village" which was constructed in Serowe in 1972, villagers in two villages (Tlokweng and Gabane) have made a start towards the establishment of their own nutrition projects. This will involve raising funds for:

(a) fencing of a piece of ground;

(b) construction of a simple building for cooking; demonstration and storage of food.

(c) employment of a gardener;

(d) establishment of a garden, partly to supply vegetables for the children and partly for horticultural education of mothers.

The projects will be controlled by the villagers themselves with the help of the clinic health workers. Several villages are planning to have such projects besides the two which have made a start.

FAMILY WELFARE EDUCATORS

15. For the last seven years a cadre of health worker called the family welfare educator has been trained in Botswana. These are young people (minimum age 20 years) with at least seven years education. They are selected by the village through the village development committee, trained for 11 weeks at a Rural Training Centre, and return to their own village to work as health motivators. Family welfare educators are given short training in the basics of nutrition, child care, maternal care, tuberculosis, prevention of communicable diseases and family planning.

16. Back in their own village they work under the supervision of trained nurses who also give them constant in-service training. They spend at least half of their working time visiting homes, identifying health problems and encouraging families to utilise health facilities. Home visits are also to make contact with defaulters of continuous care, e.g. tuberculosis, immunisation etc. The family welfare educator (of whom there are just over 300 to date) is the first point of contact for most of the people in remote or small villages. Because they are members of the community they are well accepted and have proved invaluable in disseminating health education to families on a one-to-one basis and to groups of patients attending clinics.

28 September 1977

CMC (77) II/B8

COMMUNITY PARTICPATION IN DELIVERY OF HEALTH CARE

Background paper prepared by the Government of Tanzania

The Party and the Government in Tanzania put great emphasis on community participation in health and other programmes. The participation is not only at the implementation stage but also at the planning stage.

2. Thus, TANU guidelines of 1971 state: "The duty of our party is not to urge the people to implement plans which have been decided upon by a few experts and leaders. The duty of our party is to ensure that the leaders and experts implement the plans that have been agreed upon by the people themselves". A big advantage of community involvement at the planning stage is that community participate in projects and programmes that they have helped to plan.

3. One of the aims of the 1972 decentralisation of government was to allow for more community participation. At each administrative level – village, district, region and national headquarters – there are planning committees consisting of technocrats and elected representatives of the people. Most development projects in Tanzania include an element of participation in their implementation. Thus in the construction of a health centre, certain buildings such as kitchens and mortuaries are not usually provided for in the financial estimates: it is expected that they will be built through community effort. In this way the urge to help in nation-building is directed to the right areas.

4. As regards education and motivation in community participation, a campaign popularly known as "Mtu ni Afya" or "Man is Health", which was launched in 1973, was a great success. A total population of two million people took part, with some 75,000 study groups. Radio broadcasts, including two speeches by the Prime Minister, and the wide distribution of magazines, newspapers, booklets and posters were used to disseminate health information. This group approach of the campaign increased the participants' awareness and encouraged group action to bring about better health for the group. Discussions were held after the groups listened to a radio programme or read a relevant section in a magazine. The campaign was followed by another known as "Chakula ni Uhai" or "Food is Life", which was conducted on similar lines. The next one, on environmental sanitation, is in the planning stage.

Maternal and child health

5. "What is the national policy on family planning and related matters and what steps are taken to involve the community?" In Tanzania family planning is part and parcel of the MCH programme, which is a priority area. The MCH services themselves are integrated with the general health services. At the central level there is an MCH unit with the following responsibilities:

(a) defining MCH policies;

(b) conducting or participating in MCH training programmes;

(c) conducting operational problem-solving research to develop and test methods of delivering services that are both effective and feasible.

6. At the primary level, the basic unit of MCH services is the MCH clinic. These clinics combine as far as possible on one day all the various services for mothers and children, including nutritional evaluation, immunisation, ante-natal care, family planning, malaria chemo-suppression, and treatment of minor diseases. This combination of services has several advantages:

(a) It allows mothers who are currently coming to several different services to be taken care of on one day. This will save their time and also decrease the total clinic load.

(b) Mothers who are coming only for the more popular, familiar services like curative treatment and ante-natal care will now also be exposed to newer programmes like family planning.

7. An important component of family planning and all the other health services is health education and general community involvement. Despite our effort in this direction, it must be admitted that a lot remains to be done. If one looks at health as an inalienable right it is obvious that it is the people and only the people themselves who can bring about good health for themselves. All that ministries of health and others can do is to help the people in carrying out this enormous task. We therefore must continue with our effort of finding better ways of making the community feel really responsible for their health.

7 October 1977

CMC (77) II/B9

COMMUNITY PARTICIPATION

Background paper prepared by the Government of Sri Lanka

The need for community participation in health care becomes obvious when the pattern of utilisation of health services is observed. The over-use of existing facilities at some points, symptomatised by overcrowding of out-patient departments of general hospitals, congestion of wards for simple preventable conditions like diarrhoea and dehydration and long waiting lists for simple operations like hernias at sophisticated centres, expresses one end of the spectrum. On the other hand the under-use and by-pass of rural health institutions continues to be a phenomenon in health care utilisation. The entry into, and seeking of, health care is again characterised by inordinate delay. These features in the pattern of utilisation which is characteristic of developing and even developed countries is also true of Sri Lanka.

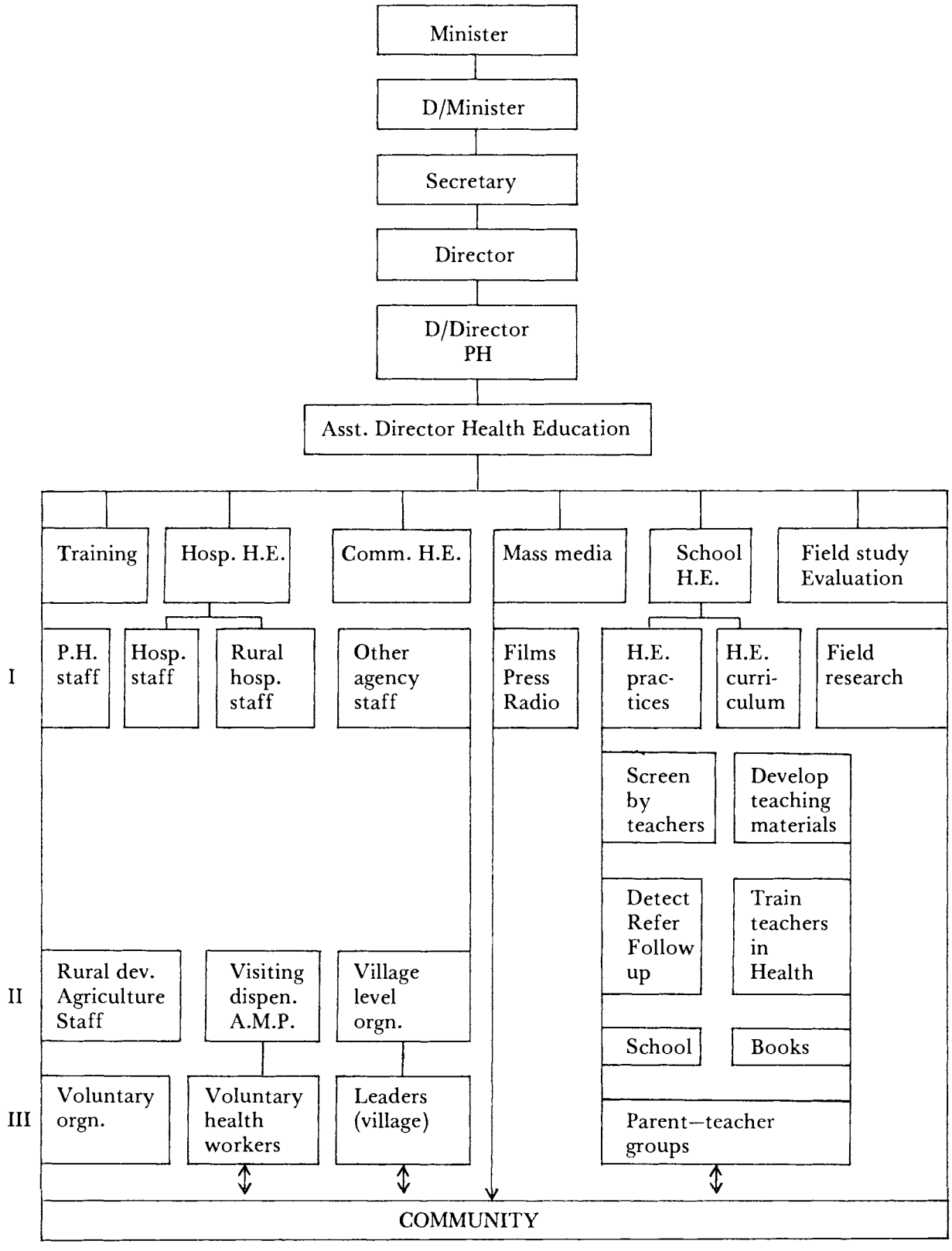
2. The demand for medical care is quite high in Sri Lanka. An average of 5.7 out-patient visits are made by a person annually. The in-patient admissions are 16 per 100 persons.

3. About 40 to 45 per cent of persons seeking such care in Sri Lanka suffer from some easily preventable condition. The consequent loss in national work output, as well as the cost of care of this sector of the population, is enormous. The health budget forms 7 per cent of the national budget, of which about 70 per cent is devoted to maintaining hospitals and similar curative institutions and about 21 per cent for the public health services. The financial commitment to established service institutions and the recurring expenditure of such institutions make it difficult to deploy resources to public health. However, the expenditures on public health have been increased in the last few years. Along with this growth has been the development of health education. The national agency, the Health Education Bureau, is primarily responsible for community-centred health programmes in Sri Lanka. The rapid development of the Health Education Bureau at the national and regional levels reflects the policy of the Government to stimulate people's participation in health. Postgraduate training in the behavioural sciences has been provided to doctors and other para-medical staff like public health inspectors and nurses to enable them to design and direct educational programmes in the community.

5. Community participation as a national goal and asset is being given greater emphasis in government policy, particularly in rural development, agriculture and health. At least two discrete models for community development are seen in Sri Lanka. One aspect of this is observed in the older established villages where specific health problems like malaria, filaria, epidemics of diarrhoea, etc., crystallise issues for action. The other pattern is noticed in the newer developmental regions where resettlement and colonisation of new lands have occurred where a more holistic and generalised approach seems to be occurring in which community organisation for health is part of a total package of development, particularly education, agriculture, small or cottage industries and transport. Between these two polarisations intermediate and mixed types exist, depending mainly on the style of the change agent and the roles and functions of the agencies operating in these areas. The need for a national health agency to promote such policies to improve and increase community participation is met to a great extent by the Health Education Bureau of the Ministry of Health.

6. The educational system in Sri Lanka reaches every village and hamlet. There are 3.1 million school children. The content and process of education to this group of children in Sri Lanka has been changing along with the dramatic social changes in the last decade. The emphasis in relating educational experiences to the environment and life styles of people, their needs and aspirations, has provided greater opportunities in bringing together the student body, the teachers and the parents to view health as an early, if not immediate, asset to be gained by modifying one's behaviour. Students working on health projects in the higher classes (Grade IX and X) attempt along with teachers and parents to solve some pertinent health problems of a selected area. The Health Education Bureau provides the expertise in training the health staff, Medical Officers of Health and School Medical Officers, as well as project teachers to conduct such projects.

MODEL FOR THE COMMUNITY EDUCATION PROGRAMME



Levels: I – Staff II – Village level orgn. III – Village level change agents, leaders & volunteers

7. The developmental areas, consequent to the opening up of new areas for irrigation and agriculture, have created new and highly productive communities. In this new environment people brought to colonise these areas have rapidly to adapt to their new environment and evolving social units. Therefore, community participation becomes an integral need for their development.

Education and motivation

8. To involve local people in the improvement of their health some of the pre-requisites are:

(a) The recognition of the right of the individual/community to know his/their own or family status – "The right to know".

(b) The transference of a significant component of the responsibility for health care to individuals/communities – "Responsibility for self-care".

(c) To stimulate alternative patterns of local leadership for health instead of only reinforcing existing formal "networks" for health.

9. To achieve these to any significant and meaningful extent, the health professional needs to deliberately underplay his role and alter the dogmatic authoritarian model breeding dependence, to one stimulating greater participation by the client, so as to develop individual and group initiative towards preserving health. This new educational role and non-traditional outlook for health professionals is often disquieting. It requires early exposure of the trainee in basic training to field-oriented, community-based health education training programmes. This is being attempted in the health education training programmes for the basic health workers, the public health mid-wife, the public health inspector (sanitarian) and the nurse and to a lesser extent in the assistant medical practitioners' training. The physicians are provided with health education courses in basic training, but more so during their post-graduate period in public health training as Medical Officer of Health. Not only does the content of training need to emphasise community participation, but more so the process of achieving community collaboration in village health projects. This would provide enduring practical experiences to the student, likely to change his feelings and attitudes.

10. The educational strategy is woven into the sociological fabric of leadership and the network of kinship, cultural ways and the underlying beliefs that give it meaning. The need for change and urgency with which this need is felt and translated into action is the basis of the Community Health Education Programme in Sri Lanka.

Family health education action programme

11. The ideological thrust for self-help is promoted through activating volunteers in villages. One volunteer serves as a point of stimulus of health care for a family cluster of about 10–15 families, so that a village of 100–200 families would have 10–15 "health volunteers". These volunteers are linked to the public health staff, the midwife and public health inspector, who supervise and advise them in the solution of simple health problems, and the clients are referred for early care. The volunteers are also linked on the other hand to the formal and informal leadership of the village who provide them with the status and backing for their health role activities, so that the volunteers form a real bridge with the people themselves, in channelling health care services as well as developing the responsibility of the community for its own health needs.

12. About 5 per cent of the villages (500 hamlets) have such programmes, and the achievements in improved immunisation, environmental sanitation, control of communicable diseases (especially diarrhoeal diseases) have been remarkable. Besides these parameters of success, a core of change agents is being continuously generated at the grass-root level, educating and committing the larger community to a positive role towards health.

13. The manpower needs to initiate and sustain this programme are met by short-term training programmes for health educators, and in-service training programmes for public health inspectors, midwives and nurses, and medical officers in hospitals and health units. About 70 per cent of the Medical Officers of Health and 55 per cent of the medical officers in charge of institutions have

been provided with orientation courses to gain their support for this programme. School teachers who are teaching health have also been exposed to such village-level programmes.

14. The training and consultancy load for maintaining the initiative for such a national programme essentially falls on the Health Education Bureau of the Ministry of Health. These specialists provide the technical expertise in conducting model or demonstration projects and through the regional health educators sustain the activities initiated. The health education specialists have had extensive training in behavioural sciences and educational methodology and some of them have medical backgrounds, which is undoubtedly a great asset in gaining acceptance for the health education discipline into professional enclaves. This has enriched the particular discipline and brought in aspects of field-oriented practice in the teaching of community health.

Special groups

15. The voluntary organisations play a vital role in providing some of the volunteers for the Family Help programmes. In fact, volunteers with previous experience in voluntary organisations are given preference during the screening and selection process. Some of the more important organisations that are closely linked with the Ministry's volunteer health worker (VHW) programme are: the Sarvodaya (self-help movement), the YMCA Mahila and Kantha Samithies (Women's organisations), the Saukyadana (student medical corps), the Red Cross and the St. John's Ambulance Brigade. The Lions, Rotarians and Jaycees have indicated their support and are beginning to back these activities.

16. Some of these organisations, like the YMCA and Sarvodaya, assist in the training programmes. Organisations like the Saukyadana, St. John's Ambulance Brigade, the Sri Lanka Cancer Society and the Society for the Prevention of Tuberculosis are broadening their fields of activity to provide a more comprehensive family self-help service, which is the primary role of the Health Ministry's programme. The service and funding groups like the Lions and Jaycees are providing only the initial resources needed for take-off of the programmes in selected areas.

School health education

17. School health is the joint responsibility of the Ministry of Education and the Ministry of Health, and the health education policy for schools relates to:

(a) the development of the health curriculum;

(b) the training of teachers;

(c) the use of teachers in medical screening, referral for care, and follow-up;

(d) health education project activities undertaken by students.

Traditional medical practitioners

18. The Ayurvedic physicians form the major group of traditional practitioners, and training institutes provide such groups with current concepts in medicine. The Ayurvedic physicians play a significant role in the delivery of health care and more service points for Ayurvedic patient care are being opened up at government institutions.

National health programmes

19. Local health councils and committees determine the needs and priorities and assist health officials in hospitals and community settings. Through the political and administrative framework, needs are expressed and services and institutions are created to meet such needs.

20. At the national level advisory councils assist in policy formulation. National level voluntary organisations like the Cancer Society, the Family Planning Association, etc., also serve in this advisory as well as advocacy role. Governmental subsidies and grants are provided to such bodies.

4 November 1977

CMC (77) II/B10

COMMUNITY PARTICIPATION

Background paper prepared by the Government of Canada

An introduction to background papers prepared by the Government of Canada is contained in document CMC (77) Gen/1.

EDUCATION AND MOTIVATION

2. The most important requirement for involving local people in the improvement of community health is the recognition by officials and professionals that the community's participation is essential to effective health care. In order to involve people appropriately, it is essential that sincere attention be paid to the opinions of the elected and natural leaders within a community. These individuals usually reflect the interests, concerns and priorities of the community at any given time, and it is they who will formulate the community's response to a particular problem. Theoretically, the individual participates in the decision-making process. In practice, he generally follows the advice provided by his leaders. On local issues, such leaders are capable of mobilising community opinion and directing priority attention to a planned course of action. It is therefore important that community leaders be well-informed and aware of options so that they can promote permanent changes through the dynamics of education and persuasion.

Methods and strategies

3. There is no single educational method or strategy which is appropriate to every community or for every purpose. Educational efforts in a community will be affected by numerous variables such as the cultural environment, the school system, the availability and nature of the mass media, activities of special interest groups, etc. The approach to be taken will also depend upon the type of problem to be resolved. For example, there is a considerable difference between a programme to educate people to accept and/or to seek immunisation and a programme to educate community members in the planning of complex health service systems.

4. Methodologies and strategies are only limited by the levels of comprehension of the target population and the creative genius of community leaders. But caution is necessary to ensure that communication occurs, that misinformation is avoided and that integrity is maintained. Deceptive tactics or poor communication skills have often left well-intentioned and well-motivated individuals labelled as intruders by a suspicious and resentful community. The community must have all of the facts of an issue without pressure; it must be given time to debate and to comprehend. If it balks at a prescribed course of action, out of ignorance or fear, then the educative processes might be accelerated. However, once the level of awareness has been raised within a community so that the problem is understood from various perspectives, and so that the adversary attitudes have been dissipated, then those delivering the service must be willing to debate optional solutions, to accept compromises imposed by the community, and to commit themselves to a partnership role with community leaders. Consensus is followed by commitment and results, and it should reflect the views of the health professionals or special interest groups, or such vested institutions as local volunteer groups, the church or the school. This is a basic principle of community participation, and where health programmes have involved the community from the planning stages to the implementation stages, the Canadian experience has been positive and encouraging.

Participation in health education programmes

5. There are innumerable examples of community participation in programmes designed to improve community health in Canada. They tend to be piecemeal, or fragmented, by virtue of

our geographic mass, isolated population and constitutional division of powers. They are, nonetheless, significant indicators of a trend toward more community involvement in the health delivery system. Frequently, they are the results of initiatives developed spontaneously at the grass-roots level. In fact, government educational programmes which have met with relative success have often been spawned by requests from community leaders for guidance and assistance. The community's role then is critical in identifying the problem as well as in proposing or assisting to implement its resolution. For example, the lay dispenser and the community health representative programmes administered by the Federal Government for Indians and Inuit both resulted from community requests for assistance, followed by joint planning with health professionals. In numerous communities physical fitness programmes, health fairs, etc., have been initiated and largely carried out by members of the community, with apparent success in increasing community knowledge and interest in health matters.

The special contribution of local people

6. People are concerned about the real issues of unemployment, housing, inflation, recreation, family life, nutrition, education, and health. These issues are inter-related and have a direct bearing on the health of the individual. Consequently, a community is likely to be interested in any health programme so long as it has a direct relationship with the individuals' needs, as they perceive them.

7. The sanitation needs of Canadians are usually well met; communicable diseases are controlled; basic health services are generally available and accessible; Canadians are fairly knowledgeable about health care. Consequently, local interest and involvement in recent years has most frequently been related to the resolution of a specific local "problem" or situation – such as the desire of a community for a new hospital, opposition to proposed reductions in services, or a specific environmental hazard such as mercury pollution. Usually there is also particular interest in services which are often not provided by governments, such as transportation or recreation programmes for the handicapped.

8. There are a number of factors which complement or enhance the process of community participation. Political support at every level of government and the inter-sectoral coordination of various institutions and agencies focusing on the community are two such variables. Similarly, the powers controlling material and human resources, the relevant legislation or information exchange systems all can play a positive role in strengthening some manifestation of community participation.

9. The community may provide information or feedback on health-related issues, and although the information may be fragmented, it nonetheless will be factual and indicate conditions which might otherwise have been overlooked from the professional's perspective. In recent years, there has been notable improvement in the area of information and feedback reflected in the new emphasis on funding research activities. There is a concern amongst governments to involve the people at community levels and in defining problems and discussing the feasibility of different solutions, or options. Advanced technology in various media has enhanced the governments' ability to exchange information and to establish a dialogue within the parameters of a community. Witness the accelerated use of information centres, libraries, community cable television, local newsletters, radio talk shows and educational television.

10. Communities also contribute to a dialogue when they play the role of consultants to the experts. In this sense, the community participates in a planning activity in a structured way, so that the scope of popular participation and decision-making might be broadened. Mechanics for such procedures of consultation vary according to the problem and its magnitude, but they include such traditional processes as royal commissions and public hearings as well as specific task forces and white papers. All of these depend on community input for reliability and validity.

Training for health educators

11. In Canada, there are many institutions which offer a variety of training programmes for health educators. The health educator is basically a community developer, not unlike a school teacher or a leader of a co-op. There are some programmes designed specifically to produce a health educator professional. However, the health educator is a facilitator, skilled in communication techniques, and he does not have to be an expert in any specific aspect of health. He should be capable of promoting, on a developmental continuum, an active dialogue between the population in a community and those who speak for the various professions delivering services to the community. There are special training programmes in Canada developed with such purposes in mind.

12. Training programmes for school teachers include health education in their curricula, but several provincial reports have suggested that school teachers are inadequately prepared in this area.

13. The Department of National Health and Welfare teaches the principles of community participation in their ad hoc training programmes for community health representatives. Designed at the regional level, and tailored to meet the expressed needs of the people on Indian reserves, these programmes develop indigenous health educators to cooperate on a health team, including public health nurses and environmental health officers. The community health representative has a unique cultural qualification and consequently is capable of crossing the cultural barrier between the Indian and white, from professional to non-professional, from government to community dweller.

14. In addition, there are many commendable programmes which are not necessarily initiated by government, but which complement governmental activities. OUTREACH programmes, and university extension activities, as well as the community leadership programmes run by various unions and community associations, are just some of the health-related enterprises designed specifically to respond to community needs. A myriad of resources can be brought to bear on community problem-solving, but regardless of the input in manpower or finance, regardless of how imaginative a programme may be, in the final analysis success will depend directly on the extent to which community participation is enlisted.

The role of the health educator

15. The role of the professional health educator has not always been well-defined. Many of the papers presented at a recent International Congress on Health Education held in Canada reflected this dilemma. This is perhaps understandable when one considers the various points of entry into the health system (family doctor, public health nurse, hospital emergency department, health inspector, etc.) and the wide variety of subject areas (nutrition, lifestyles, dental hygiene, child care, etc.). Part of the confusion arises from the lack of clarity as to the roles played by other health professionals in health education and the support of community participation, and lack of agreement over the relative importance of individual education and mass education or participation.

16. Those who emphasize the importance of the health education specialist argue that the health educator not only knows various strategies and techniques for mobilizing community participation, but is charged with the responsibility of honestly reflecting the priorities and concerns of that community to other health professionals. In this way, he is a liaison between community interests and the various resources outside of the community. He should facilitate effective communication and establish and maintain credibility between the people served and those delivering the service. This is a catalytic role simplified only by the community's willingness to participate in a particular course of action.

SPECIAL GROUPS

17. It is difficult to determine to what extent education and motivation is undertaken by local organizations at the community level. This is primarily because the most effective use of human resources at the community level is directly related to initiatives emanating from individuals within the community. There are easily identified examples of initiatives encouraged through incentives proffered through government agencies. However, it is far more difficult to identify and evaluate those initiatives which develop spontaneously and raise a community's level of awareness or challenge it to mobilize its resources.

18. However, there is no question that there are numerous such groups undertaking some type of health education. Examples include: the Canadian Mothercraft Society (pre-natal and child care); Women's Institutes (nutrition); Red Cross and St. John Ambulance (first aid); Boy Scouts and Girl Guides (many aspects of health education); La Lêche League (breast feeding); YM-YWCA (drug education, physical fitness, nutrition). In addition, there are other large national organizations concerned with particular diseases (e.g. Heart Foundation, Cancer Society, Canadian Association for Mentally Retarded), as well as the many local groups mentioned previously who are involved in educating the public, promoting research and providing care.

Private organisations and voluntary agencies

19. Many "service clubs" in Canada are involved in community health activities. Optimist Clubs, Lions Clubs, Kiwanis Clubs, and the like, have been active in raising funds for hospitals, clinics, transportation services for the handicapped and numerous other health-related activities. At all levels of government in Canada, private organisations such as service clubs and voluntary health agencies are encouraged to participate in health efforts. The voluntary health agencies, in particular, receive "sustaining grants" from federal and provincial governments in order to assist them with their overhead costs. In addition, governments frequently contract with such organisations to provide services (including public education programmes).

20. Experience in Canada suggests that voluntary groups can and will become involved in almost any aspect of health development. Traditionally, groups such as service clubs have been most interested in "bricks and mortar" and in services for children. The specific disease-oriented agencies have, naturally, been primarily self-help groups for those afflicted by the disease or their relatives. Increasingly, however, we have seen shifts in emphasis to more involvement in health promotion ("lifestyle campaigns", etc.), to services for the elderly and to concerns about environmental hazards. Increasingly, too, these special groups have become somewhat less involved in direct services (as these have become more often provided by government) and more involved in "advocacy" in its various forms.

Schools

21. On the surface, the issue of health education in schools appears to be fairly critical. No one would question that it is an essential subject which affects a child's lifestyle and his contribution to and participation within the community. It is, however, difficult to agree on the prescribed policy for health education in schools, especially because of the constitutional issue over federal-provincial authority. All levels of government agree that health education is necessary; they do not agree on what methods or institutions should be utilized in delivering that education. Significantly, school boards which are closely related to the community welcome consultation with community leaders and attempt to adapt a curriculum which reflects regional characteristics and issues. Perhaps health education, *per se*, receives low priority within the elementary and secondary curriculum because its content is often inter-related with courses in family life education, religious training and a myriad of social psychology courses? Many citizens will claim that there are innumerable sources of health education besides those offered through the school system. Until the community expresses a need to change the school curriculum so that it incorporates health education more fully, it is doubtful that any permanent change will occur.

Traditional medical workers

22. It is generally argued that there are no "traditional medical workers" in Canada. Even among the Indians and Inuit (who constitute less than one per cent of the total population) only a very few have been identified. Nevertheless, it is recognized that there are people filling this function, particularly in our most remote areas. Furthermore, if one considers the "traditional community health system" to include the means by which the community has traditionally maintained its health or treated its minor illnesses, the question still has some relevance to Canada. Recently in this country there has been considerable discussion of the need to promote "personal responsibility for health". This term embraces not only the concept of reducing personal risk of disease by improving one's lifestyle, but also the concept of avoiding unnecessary use of health care services for minor ailments which the individual or his family should be capable of managing without professional assistance.

NATIONAL HEALTH PROGRAMMES

23. There have been few official Federal or Provincial Government statements in Canada on the conceptual basis for citizen participation in the health field. However, in recent years, virtually every major report at both levels of government has indirectly supported the concept by recommending the establishment of various kinds of consumer boards or councils for the planning and/or administration of health services. Furthermore, the Federal Government and Provincial Governments have published general policy statements advocating greater involvement of the public in a whole range of "government" programmes and activities.

24. One of the few specific statements on the role of the consumer in health care is found in *Health Security for British Columbians* (Foulkes Report) which noted that "to achieve the standard of health care required, the needs of the consumer must be pre-eminent in the planning and operation of the total system. In our view, the proposed system must place emphasis on defining and understanding the consumer's needs, now and as they change in the future, so that the services provided are in accordance with these needs . . . We also recognise the role that public participation can play in achieving total objectives:

- the individual must become active in his own health, especially in the preventive field;
- new policies mean change and this requires that those most directly involved be consulted;
- national planning requires first-hand information of community needs;
- complaints must be heard and properly considered, thereby diminishing alienation;
- the public must realize that perfect health cannot be provided on a silver platter either by physicians or governments.

Consumers are now much more sophisticated and better informed than in any other era. Experience, involvement and educational programmes will make them even more so. This is an inter-active process."

25. *A New Perspective on the Health of Canadians,* an important Federal Government document of 1973, while it did not refer specifically to "community participation", contained a number of recommendations urging the involvement of community groups such as women's organisations, sports clubs, and labour unions in the development of fitness and other health promotion programmes.

Promotion of community involvement

26. It may be said that the conceptual basis for community participation in the health field has rarely, if ever, been well articulated in official or semi-official government policy statements in Canada. Nevertheless, Canada does have a long history of such community participation in the health field, and its importance is being increasingly recognized. Traditionally this involvement of the community has been not only through its elected representatives, at all levels of govern-

ment, but particularly at the local level, but also through the myriad of voluntary health agencies and voluntary boards which have operated at the local, provincial and federal levels.

27. At the community level, hospitals in Canada have been mainly operated by voluntary, lay boards of directors. Despite the fact that the hospitals now receive virtually all their financial support from Provincial Governments (who in turn receive assistance from the Federal Government), hospitals continue to be operated by these community representatives. In most parts of Canada, public health services are also administered by voluntary, local boards. The voluntary health agencies, which operate at all levels, tend to represent the interests of people with particular health problems (e.g. diabetes, heart disease, mental illness, etc.). Increasingly, community groups are becoming involved in the administration of primary health care services and in health promotion programmes. Finally, there have been opportunities for community participation in numerous task force reports, royal commissions and public hearings on various aspects of health services in Canada.

28. In summary, community participation in Canada is tied to its commitment to the democratic form of government at all levels and the traditional beliefs and practices of Canadians which are reflected in their extensive voluntary involvement in the health sector.

29. As indicated, there is extensive community participation in the health sector in Canada, and the extent and range of means of participation are growing steadily. Nevertheless, while there is a serious commitment to this concept on the part of both governments and the public, there have been difficulties in its implementation and/or maintenance in some situations, particularly in the newly developing community planning bodies and in the administration of community health centres. There has sometimes been confusion and even debate and confrontation over both the purposes and methods of involving citizens in health care.

30. Some argue that involving citizens in these activities is simply an extension of the time-honoured tradition of hospital boards and boards of public health. The citizen's role is seen as one of bringing forth information about the needs of the community. Others see community involvement in planning bodies as an important mechanism for community change and reform. Finally, there are a few (mainly health professionals) who view the purpose of citizen boards as primarily one of community health education in its broadest sense.

31. When proponents of two or three of these different ideologies end up on the same planning body, confusion and controversy are inevitable. This is a common problem at present with social planning councils, health planning councils and voluntary agencies.

32. Those who view citizen participation as an extension of the hospital board concept now face the same dilemma as members of those hospital boards. Since government funding has removed the need for fund-raising activities and there is a profusion of government guidelines for the operation of services, what meaningful role remains for the community board? If it is reduced to a community liaison role, could that function be performed as well by an advisory committee or even by a patient/client ombudsman? Some argue that the consumer is only concerned with the responsiveness of the programme to his needs, not with the amount of authority he has.

33. Those who advocate citizen participation for community change and reform stress the need for board or council members to be truly representative of the community. But how is representation to be achieved? The traditional method is by election. Who should be allowed to vote – those who use services or those who live in a defined area? If only a small number cast votes, is the chosen board truly representative? Should providers be allowed to vote? Should they be allowed to stand for election? If the board of council is appointed, which interest groups must be represented, and will the final "mix" be an effective one?

34. Those who view a community board or council as primarily a tool for community health education do not face the identity crisis of the first group or the conflict situations of the second, but they may have to cope with a great deal of community apathy. If they succeed in mobilising community interest and avoiding domination of the board-staff relationship by health professionals, they may fill an extremely useful role.

35. Some of the suggestions which have been made for improving the effectiveness of community participation include:

(a) continuation of the process of establishing community/regional health planning bodies;

(b) clarification of expectations of citizen boards/councils (role definition, limits of authority, etc.);

(c) improved training programmes for volunteers (including board and council members) so that they will have an adequate knowledge base from which to operate;

(d) education (and re-education) of health professionals to understand and accept the consumer as a member of the health care team;

(e) acceleration of the trend to appoint community representatives on accreditation and professional review bodies;

(f) greater involvement of voluntary health agencies in health policy and programme development at all levels of government;

(g) exploration of new approaches to community participation (e.g. patient ombudsman).

Annex to CMC(77)II/B10

THE LAKESHORE AREA MULTI-SERVICES PROJECT (LAMP): AN EXAMPLE OF COMMUNITY RESPONSE TO COMMUNITY NEEDS

The LAMP story is a story of successful community "self-help"

What is LAMP?

2. LAMP means many things to many people in the community it serves. This project provides a wide spectrum of services, ranging from day care to foot care, health services and dental services, to name but a few. The ideas for this multi-service unit were developed by the residents of the community. Furthermore the translation of the ideas into a fully operational centre was the result of the determination and hard work of these residents.

Why was LAMP founded?

3. A sense of isolation felt by four small but established communities, with a combined population of 54,000 residents, provided the initial impetus for the development of this programme. When these communities became part of a larger borough with a population of 300,000, they replaced previous rivalries with a spirit of co-operation. They found that they possessed a common viewpoint, a wealth of talent and similar experiences. They were not surprised that their answers to the problems of delivering health and social services for their community were not the same as those more appropriate to the newer, wealthier communities in the same borough.

How was LAMP started?

4. The residents of these communities began by asking themselves some questions. Through discussion the community came to the realisation that what they wanted and what would serve them best would be a community programme. In this light the concept of LAMP was forged. The concept was formally proposed at a public meeting in 1971 and approval in principle was received. A committee was then established to explore more fully the possible goals and methods that would be undertaken.

5. The community underwent the agonising process of discussing the alternatives and hammering out specific objectives. Citizens and professionals from local agencies were brought together in these discussions. It was not until 1973 that the original concept became a concrete shape and the first LAMP Association was established.

The survey

6. A survey of residents and doctors was then conducted to determine the needs and potential target groups. It was discovered that senior citizens comprising close to 11 per cent of the population were represented at a higher level than the national average. The community also discovered that there was a large number of transients. A significant number of people in the area did not have family doctors. Improved delivery of medical services was clearly indicated as a major need. Once the target groups had been defined and the survey had discovered the needs, the community were ready to begin their response.

The first project

7. The first project was a monthly footcare service for the senior citizens. A hundred dollars for the purchase of supplies including an old barber's chair, the donation of time by volunteers to handle the administration, and to act as chauffeurs, plus the goodwill of a local podiatrist enabled the programme to begin. It is interesting to note that this "no charge" service now runs five days a month and is still staffed by volunteers and funded by local donations.

The next steps

8. The next tasks to be faced were the major problems of locating a permanent service building and funding for the project. By a fortunate coincidence, a former Town Hall, strategically located in the centre of the area became available. The citizen board won the confidence of the borough council which agreed to renovate the building and rent it to LAMP. At the same time, a group of directors arranged a contract with the municipality that would provide funding from the province to operate an innovative project in the delivery of social services.

Re-organization

9. A re-organization of directors led to the establishment of a management board, and a health services committee. Both of these are composed of unpaid citizen representatives elected at an annual general meeting. The LAMP Management Board ties the project together by planning and evaluating the participation of member agencies, and operating the committee structure. It is responsible for regularly reporting and listening to all members. It is also responsible for management of the finances. The LAMP Health Services Committee is charged with the task of providing quality health care.

Funding

10. The LAMP building is rented from the borough on a break-even basis, making the municipality an important partner in the enterprise. LAMP in turn rents space to participating agencies. Any profits made on these rentals are turned over to the municipality. The province funds the basic social service operation – i.e. salaries for the core staff, telephone costs and other expenses. The shortfall of this funding is made up by a small grant from the city and local donors.

11. The LAMP Health Services Committee is funded by the provincial Ministry of Health with a negotiated annual budget. The health programme funding is dependent on the provision of services to 1800 people by March 1978. Currently the programme is providing services to 1750 people and the numbers are climbing. The provincial Ministry will save financially through this response since there will be no increase in funding even if the target is exceeded.

The goals

12. The goals of LAMP include the coordinated delivery of services, elimination where possible of duplication of services and the provision of a wide range of services to the individual client. Target groups for special attention are identified but the goal serves the entire community.

Operations

13. In order to provide a wide range of coordinated service, the LAMP Management Board negotiates a contract with each participating agency not merely regarding rent for space occupied but also on the contribution which that particular agency will make within the community. A central intake system is maintained as well as an ongoing evaluation of the services. This is critical since there are twelve agencies involved.

14. There are two health agencies: LAMP Health Services and the municipal Public Health Department. The health service staff consists of two doctors (both family practitioners), one nurse and a receptionist-bookkeeper. There is a twenty-four hour phone service and the doctor will make house calls as needed.

15. The focus of the Health Service Committee is on health rather than sickness. The emphasis is on prevention. An example of this is the routine checking of all patients for hypertension. Education programmes are central to the concept of prevention. Education programmes offered so far include "Fitness" and "Stop Smoking" clinics. Stress and mental problems are dealt with

through psychiatric and counselling services as opposed to relying on drugs. LAMP's structure means that skilled professionals from the psychiatric hospital and the Addiction Research Foundation can be called upon when needed.

16. The municipal Public Health Department participation in the project also stresses education and prevention. Programmes offered include hearing tests, immunisation, family planning and pre-natal classes. The municipality also operates a dental programme that is part of LAMP. This consists of free flouride treatment for all children one day per week, as well as free dental care for all qualifying residents one and a half days per month.

17. Other agencies often make referrals to these health services. Thus, some medical problems are now treated in the early stages. For example, the day care supervisor has detected children with health difficulties and after reporting the matter to their parents and obtaining the necessary permission has had the children treated by the doctors. Similarly some older citizens visiting the "seniors' foot care clinic" will have serious foot problems detected by the podiatrist. Appointments for necessary treatment and referrals to specialists can be made while the patent is still at the centre.

Conclusion

18. The strong community involvement in LAMP is adequately demonstrated by the contributions made by the volunteers. It must be recognized that without the volunteers, over a hundred of whom work on the project, this project would not have been successful. People visiting LAMP find a warm welcome extended to them by both the volunteers and staff. Involvement of the community in this program is an ongoing and two-way affair. Many will benefit from the services and programs provided. Many will also take some of their own time to contribute to the programme by volunteering to serve their neighbours.

19. The LAMP concept, it should be emphasised, treats the whole person and promotes the philosophy of prevention. The LAMP concept depends on community support for although funding comes from all levels of government the inspiration, the motivation and the sweat that make it all possible come from the local people. LAMP is building a stronger and healthier community in every sense of the word, and is looking forward to the future with confidence.

Current LAMP services

Day care: A new day care centre is here for children from 2 to 5 years. Operated by the YMCA, it is open to anyone in the community. Fee assistance is available for families that qualify. Well equipped indoor and outdoor facilities offer a healthy, stimulating setting for the pre-schooler.

Community health: Promoting better health for all citizens. Borough health staff offer clinics in family planning, immunization, hearing testing, counselling, pre-natal classes.

Alcohol and drug problems: Experienced staff of the Addiction Research Foundation are on hand to provide counselling, information, and self-help programs.

Seniors recreation: A friendly drop-in lounge for senior citizens, open seven days a week for coffee, tea, conversation, fellowship and recreational activities. Operated by Etobicoke's Parks and Recreation department.

Family counselling: Professional counselling for families and single parents, family life education, child management programs, help for families under stress, offered through the Family Service Association.

Volunteer services: "Care-Ring" provides volunteers to help with driving, home care, friendly visiting for shut-ins. Or it can help you be a volunteer yourself.

Seniors' foot care: Podiatrists and volunteers are available without charge several days a month to help older people with foot problems. Call for an appointment.

Help with problems: Legal Aid on Monday afternoons and evenings, credit counselling, youth programs, information and referral services, provided by Action Service Contact Centre.

Community room: LAMP has a large, newly-decorated meeting/event room which it can make available to public service groups looking for a place to hold a meeting or put on a program. Many community organizations would be eligible to use this facility free of charge.

Dental services: There is a fluoride treatment clinic for children, and a dentist is available to provide full dental services (excluding dentures) for qualifying residents of any age. Operated by the Borough of Etobicoke.

Mental health: Lakeshore Psychiatric Hospital provides individual counselling and group programs. Hospital staff are available to advise and assist clients and staff of LAMP when needed.

Children's aid: Services and programs to strengthen family life for single and two-parent families are offered by the Children's Aid Society and the Catholic Children's Aid Society. Help is provided for children under 16 to protect their physical, emotional and social well-being.

Health Services: Two full-time family doctors are available to serve anyone in the community. Preventive care is stressed. House calls and 24-hour coverage.

Social assistance: Metro Social Services adminsters financial assistance and related programmes, including wage supplementation to low income families. Referrals for hostel accommodation, applications for assisted day care, senior citizens apartments, homes for the aged, nursing homes.

CMC (77) II/B11

COMMUNITY PARTICIPATION

Background paper prepared by the British Government

THE UNITED KINGDOM SITUATION

The National Health Service took over in 1948 all the hospitals previously administered by the elected local authorities and similarly, with minor exceptions, those administered by voluntary bodies. The new hospital authorities had no elected members but the lay members appointed by the Minister or the higher hospital authority included well-known people prominent in local affairs. All members were on these bodies as individuals, not delegates. The bodies set up in 1948, Executive Councils, to administer the contracts with the general practitioners (doctors, dentists, pharmacists and opticians) also had a lay membership partly composed of people appointed by the local authorities and partly people appointed by the Minister. The local authorities continued to be responsible for domiciliary health services such as midwifery and health visiting. These arrangements applied to England and there have been differences in administration in other parts of the United Kingdom.

2. Thus from 1948 in the management of health services there was a varying degree of community involvement through either elected representatives or other local lay people. Although the National Health Service was comprehensive, voluntary movements were not deprived of a place in the service. For example in hospitals there were Leagues of Friends who could look to amenities. A number of activities were still carried on by voluntary organisations. By the Health Services and Public Health Act 1968, both the Minister and the hospital authorities were empowered to make grants to voluntary organisations and the sums so made have been mounting steadily since until now some £5m per annum is devoted to voluntary organisations covering health and personal social services. Most goes on the latter but the provision of such services is very helpful in complementing health services and reducing the call that would be made upon them if the vulnerable groups like the elderly were not enabled to live in the community.

3. When the National Health Service was reorganised in 1974, the three separately administered parts of the service (by hospital authorities, executive councils and local authorities) were all brought together under the new Health Authorities. These match local authorities in area but are in no respect elected bodies. The lay members still represent a cross-section of well-known and prominent local people. However the need was seen to include a strong element of community participation and Community Health Councils were introduced. The nature of these is explained in paragraph 17 below. At the same time a Health Service Commissioner (popularly called the Ombudsman) was appointed to investigate complaints about the administration of health services.

4. The notes below are related to the three headings in the outline questions posed for this subject on the agenda. This is a wide subject on which only a sketch is therefore given.

Education and motivation

5. Community participation in health care can best be brought about by developing better public awareness of the nature of the health services available and the importance of self-care in health. In 1976 the United Kingdom Government launched a new initiative on preventive medicine with the publication of the consultative document (to stimulate comments and expression of views) 'Prevention and Health: Everybody's Business'. A major theme in the new emphasis on prevention is the contribution which the individual can make to his own and his family's health. Health education is a vital element in the preventive initiative – giving information and advice on how to minimise risks of illness and handicap, and emphasising the positive benefits of a healthy life-style.

The public debate is being continued by the issue of detailed follow-up papers on particular topics – the first, 'Reducing the Risk', is concerned with the health of mother and child in pregnancy and reducing the risk of handicap.

6. The Health Education Council was established in 1968 with responsibilities for the promotion of health education at national level in England, Wales and Northern Ireland. In Scotland the equivalent body is the Scottish Health Education Unit. The Council is financed by central government, with a budget for 1977–78 of £2.6m, but is not a government department. Its members are appointed by the Secretary of State for Social Services after wide consultations. The present chairman is Sir George Godber, former Chief Medical Officer of the Department of Health and Social Security (DHSS). The Council is concerned with producing health education materials (pamphlets, posters etc.), with the development of research and training in health education, and runs national campaigns on topics of wide interest, e.g. family planning, and the dangers of smoking and of alcohol abuse.

7. The main operational responsibility for health education within the National Health Service at local level rests with the Area Health Authorities. Health education officers have an important role in encouraging interest and involvement in health education – they have relatively little direct contact with the public themselves but are supportive and encouraging to those who do. They are responsible for organising local campaigns and for co-ordinating the activities of health professionals who have good opportunities in their day-to-day and face-to-face work with individual patients to communicate with those at greatest risk and influence their habits and life-styles. Health education officers also co-ordinate and encourage widespread involvement in health education through liaison with community health councils, local authorities, voluntary organisations, schools and self-help groups (for dieting or controlling smoking and alcohol abuse, for example).

8. Schools can influence the attitudes of children to the health services, and on such matters as nutrition, exercise, smoking, drugs and alcohol, the general approach to behaviour and more specifically by introducing elements in lessons on physical education, biology, religion, home economics etc. Schools are also increasingly providing specific courses on health education and social education. While responsibility for school curricula lies with the Local Education Authorities, and individual head teachers, Her Majesty's Inspectorate gives active encouragement to schools and teacher trainers to consider the adequacy of provision on health education. This is done, for example, through the provision of courses and the handbook for Her Majesty's Inspectors 'Health Education in Schools'.

9. Local health education services are geared towards increasing the effectiveness of health and other professionals in their health education activities with the public. It is felt that the one-to-one situation with the general practitioner, health visitor, dentist, etc., is particularly useful for health education. The Health Education Council and local health education units also run campaigns with posters, leaflets, and use of the media (paid or unpaid). The effectiveness of different methods is still a matter for debate – for example, it is difficult to compare the one-to-one situation described above with advertising on TV or radio, which is relatively expensive but reaches a wide audience. There is little doubt that in health education there is room for a wide variety of approaches. The Council sponsors and promotes research into the effectiveness of health education but there is still insufficient knowledge and expertise about methodologies in health education both in relation to mass audiences, particular target groups, and individuals, and evaluation techniques and activities are still in their infancy. More research is needed into both methodology and evaluation.

10. There are a variety of training schemes in health education. Many health education officers are not specifically trained in health education – they are trained teachers or health visitors, for example, who switch to a health education career with little or no additional training. However, the Health Departments and the Health Education Council encourage the specific training of health education officers and two diploma courses (1 year's full-time study) have been established to which serving officers can be seconded. The syllabus of the diploma courses covers a study of historical background and development of health education, the growth and development of individuals within society, the causes and prevention of disease and the principles and methods in

the practice of education. For those health education officers with appropriate qualifications a small number of full time postgraduate (MSc) degree courses are available at Liverpool, Manchester, Nottingham and Chelsea College, London. For the non-specialist, there are a number of part-time certificate courses for in-service training. These are available for teachers, health visitors, nurses, etc. and other professional groups who have opportunities to act as health educators in their day-to-day work.

Special groups

11. For many years the Department has recognised that a general purpose worker can make a valuable contribution in maternity and child health centres by freeing professional staff for duties requiring their skills and this has been mentioned in guidance to health authorities. Voluntary workers play an important role in this respect. Examples of ways in which volunteers assist in the running of maternity and child health centres are:

(a) reception and record keeping duties;

(b) sale and distribution of welfare foods;

(c) interpreting – to assist immigrant families;

(d) providing refreshments;

(e) weighing babies;

(f) generally assisting clinic nursing staff;

(g) individual volunteers and members of voluntary organisations concerned with the young child in co-operation with the health visitor can be of great assistance in running small play-groups during clinic sessions and during health education sessions, and in conjunction with mother and toddler clubs.

Voluntary groups may also be able to advise health authorities on ways of ensuring that preventive health services reach vulnerable families who may not otherwise attend clinics, and ethnic leaders in the community can help by explaining the purpose of child health services to their people to encourage immigrant families to use them.

12. In general, the volunteers' contribution to health services is complementary to that of paid staff: for example, in hospitals they provide the additional comforts, amenities, companionship and contact with the 'outside world' which paid staff do not have time to provide. Some of the services provided by voluntary organisations could never be provided by health authorities whatever the financial situation. In some cases it is possible for volunteers to relieve skilled staff of routine, unskilled tasks, so leaving them more time to exercise the particular skills for which they have been trained, and organisations such as the British Red Cross Society and the St. John's Ambulance Association provide emergency and first aid services on a large scale. Local branches of voluntary organisations also arrange fund-raising activities, the proceeds of which are mainly used to provide extra comforts, amenities and facilities for both patients and staff. Leagues of Hospital Friends raise about £3m. each year to make gifts to their hospitals. They also help on a personal level to maintain contacts between long-stay hospital patients and their families, and help to provide companionship for the bereaved.

13. The following list illustrates some of the services given to health authorities by voluntary bodies both in the community and in hospitals.

Personal care of the patient: auxiliary nursing; escort duties outside hospital; reception and escorting of in-patients inside hospital; feeding individual patients.

Personal needs of the patient: shops, trolley shops and shopping errands; canteens (out-patients and visitors); telephone trolleys; care of relatives visiting dangerously ill patients, hospitality and general help including visiting relatives at home; care of children whose mothers are attending hospital for treatment or whose parents are visiting patients; visiting and befriending lonely patients; reading (especially arranging short-term attachment of regular readers to patients undergoing eye operation); writing letters; interpreter services for foreign patients; outings and holidays away from hospitals for the elderly; escorting children

to and from hospitals and out-patient clinics when it is impossible for mothers to do so; taking convalescent children for walks; visiting child long-term patients in hospitals some distance from their homes; collecting mother's milk for premature babies.

Recreation and occupations: libraries, including film and picture libraries; handicrafts of all kinds; appropriate hobbies; entertainments such as music, dramatics and youth organisation groups in long-term hospitals.

14. The national umbrella organisations (e.g. the British Red Cross Society) provide co-ordination in their particular fields. The Department has encouraged the appointment of voluntary help organisers whose main functions are to recruit, prepare and place volunteers; to establish good relationships between voluntary and paid workers; to develop contact with local authorities, local voluntary and other organisations and the public in general, and to look for ways of expanding the scope for voluntary effort. About 300 voluntary help organisers are now estimated to be employed in the health service and experience has shown their effectiveness in developing and co-ordinating voluntary work in hospitals, particularly long-stay hospitals where the needs are especially great and where about half of them are employed.

15. The Department's consultative document "Priorities in the Health and Personal Social Services in England", published in 1976, said (paragraph 1.23):

> "In the coming years, the contributions – of time, ideas and money – that people in the community voluntarily make to the running of the services will be more than ever important. Health and local authorities should give every support to voluntary bodies in their work of harnessing community effort."

Guidance for health authorities has pointed to the opportunities created by National Health Service reorganisation for the more effective use of volunteers, for example in co-ordinating operations in the hospital and community fields.

16. Financial help is given to various voluntary organisations. Generally this is limited to funds for a limited period of years to start up and develop an activity which the organisation could not entirely finance itself through other grants, fund-raising and, where appropriate, charging for services. There is emphasis on partnerships to initiate innovating projects.

National health programmes

17. The reorganised National Health Service of 1974 required the introduction of new health authorities covering the whole range of services over a wide area. In addition Community Health Councils were set up to represent the public interest. Their role is advisory; they have no management responsibility. There is one for each health district so that in England there are some 200 councils each covering an area of about a quarter of a million people. The number of members varies between 18 and 36, according to the size of the district, and they are appointed one-half by the local authority, one-third by voluntary organisations and one-sixth by the regional health authority. None of the members is elected and they are not intended to act as delegates of the appointing bodies. The expenses of the Councils are met from public funds. They have paid staff employed by regional health authorities but chosen by and accountable to the Councils.

18. In the early days of the reorganised service, the new bodies had to establish their roles both in informing themselves about the services in their districts so that they could comment usefully upon them and also about planning for the future. Relationships between Community Health Councils and local health management are generally well-developed but links between the Councils and the general public are still being forged. Public meetings of Councils are very thinly attended and the public are generally not very well aware even of their existence. This is not greatly different from the public awareness of the consumer bodies set up for various nationalised industries such as electricity, gas, railways and the Post Office. If there is some burning local issue, such as the proposed closure of a hospital, this helps to make the local Council better known.

19. A second new feature of the service since the 1974 reorganisation is the appointment of a Health Service Commissioner (an 'ombudsman') who investigates complaints made to him, after the complaint has been made to the health authority without satisfaction. He can investigate

where a person claims to have suffered hardship or injustice through a failure in service, or failure to provide a service or maladministration. Some matters are outside his jurisdiction, the main ones being actions involving clinical judgment, where a person has legal redress and complains about the family practitioner services.

20. There has always been a procedure for investigation of complaints that a family practitioner has failed to comply with his terms of service – e.g. has failed to visit when he should have done. Trivial or frivolous complaints are cleared without a hearing and the remainder are given an informal private hearing. The purpose of the complaint is to determine whether the practitioner has complied with the terms under which he agreed to provide National Health services and the complainant is not able to benefit personally from the hearing other than knowing as a conscientious citizen that he is helping to maintain the standard of the service. Redress of grievancies about the health service is an important factor in maintaining the public confidence in its standard.

21. Under this heading a question was raised about family planning. Since 1974 a free family planning service has been available from family planning clinics, domiciliary services and most general practitioners, and from hospitals since July 1975. The previous position was that the provision of a family planning service for other than medical reasons was at the discretion of local health authorities, leaving a considerable scope for voluntary bodies like the Family Planning Association and others to provide advice and help and private treatment from general practitioners. The Family Planning Association and other voluntary bodies combine to play a role in this field, in particular through a Family Planning Information Service provided jointly by the HEC and FPA and funded by the Government.

BRITISH AID POLICY AND THE DEVELOPING WORLD

22. In recent years there has been an increasing recognition of the fact that most of the disease in the developing world is due to poverty and ignorance and that prevention, based on public health measures, is more effective and less costly than curative medication, desirable though this always is.

23. This relatively new 'community health approach', directed chiefly at the poorest people, was officially introduced for the first time into British aid policy in late 1975 with the publication of the White Paper "More Help for the Poorest". The fundamental message behind this new policy document was that British aid should be concentrated increasingly on the poorest countries and on the poorest people within those countries.

24. One of the activities required to meet the demands of the new policy is an improvement in health facilities in the rural areas, where most of the poorest live. This entails a change in British health aid policy, which in the past was largely based on exporting the concept of a network of hospitals and doctors on the developed country model, to one which seeks to encourage community health and preventive measures. This community health approach means a concentration on the socio-economic and environmental elements of health care: improvement of nutrition and child health, provision of safe water and sanitation, control of communicable diseases, and encouragement of population programmes. All these elements, which feature in British health aid policy, are susceptible to improvement with the help of community participation programmes.

25. Experiences with community participation in health services around the world are few in comparison with the amount of interest which is now being shown in its possibilities, as a result of the growing realisation that conventional health systems often fail to bring adequate primary care to all the people. Because the experiences about which much is known are few, and because research into the features contributing to the success or failure of these experiences has barely begun, much of what can be said about the question must be a matter of surmise.

Why community participation?

26. The favour with which community participation is at present being viewed appears to be based on growing evidence that:

(a) There is little or no loss in quality in the performance of simple health tasks when performed by persons with little formal education and only a short, task-oriented health training.

(b) Often professional and semi-professional health workers have little motivation for serving the majority whose health needs are mainly conditioned by their general poverty and poor living standards. This is particularly so in relation to the people living in rural communities, because the health workers' educational and training have prepared them for urban life and for a higher level of health care: the training is inappropriate for rural work, and would be difficult to change because of expectations held. Therefore, the only group of persons with positive motivation for health work in rural communities are those within these communities and who expect to remain there.

(c) There is often a wide social gulf between even the lower semi-professional health personnel and the majority of the population, which hinders communication and detracts from the value of preventive and promotional health work. The people living in urban slums and shanties, and the villagers, are the only people who know their problems in intimate detail, but such knowledge can be utilised properly only in the context of their active participation in the work.

(d) There are, in most poor urban communities and villages, potential resources which can be tapped, as usually the people are willing to contribute in various ways to health measures which they see will be to their benefit.

(e) One model of community participation, that of China, has achieved considerable success. The Chinese model of health organisation has to be seen in its wider social context, and is clearly not directly replicable in very different societies. But one element of the background is common to many countries, namely the aspiration for self-reliance together with the reaffirmation of the indigenous national culture including its medical tradition. There is interest in the Chinese policy of 'walking on two legs' or developing modern technology while also encouraging local self-reliant processes incorporating relevant traditional skills.

27. The significant diseases of the Third World are diseases of poverty more than they are diseases of tropical climate. Or, like malaria, they are diseases of the tropics whose ravages would be minimised with increased wealth and the necessary resources. Many of them (tuberculosis, malnutrition) tend to disappear with the changes in pattern of living which occur with increased income: changes in diet, housing, etc. Others can only be attacked when community or national resources grow large enough. With modern drugs, especially antibiotics, many of these diseases of poverty, or their complications, can be easily treated. But their recurrence is certain unless preventive measures are taken. In this sense promoting better living conditions through rising incomes is the best preventive health care, but specific 'public health' measures can, if pursued vigorously, have a considerable impact. Both should be sought together. Such preventive measures often involve interventions which are simple and low-cost in themselves but which require large-scale application of knowledge and organisation. *It is in these areas of prevention that community participation in health has the potential for making the greatest contribution.* It can achieve reductions in the diseases of poverty in advance of the pace of reduction in poverty itself, by mobilising preventive activities and fostering specific changes in patterns of living.

Which forms of community participation?

28. Community participation has many forms and is not always concerned with prevention. No realistic assessment of the place of community participation can treat it as if it were a single type of activity, like immunisation or family planning. It could be taken to exist in a minimal form even when no more is involved than the consultation of community authorities before health measures are taken; or local health advisory committees may be formed to provide a more permanent link between community and health service.

29. If a more active participation is under discussion here, the forms may still vary considerably within the currently argued 'package approach' to health problems. Such an approach, applied to community participation, would require the provision to be undertaken of information and education with respect to hygiene and nutrition, vaccination, mother and child care, as well as serving for the base point for the referral of cases from village clinic levels to higher links in the chain of the health services system.

30. Other forms of active participation may still vary considerably. There are those which involve little more than a material contribution from the community or its members; this may be for capital items required by the health service, such as a building and furniture, or it may be a form of financing the current expenditures themselves – the drugs and dressings, the remuneration of the health worker. This may be through fees for services administered and controlled by community authorities, through a local levy or tax, or through a health insurance scheme. But that means that a service which in most countries has been at least formally regarded as the responsibility of the state, and has normally been provided at its expense (at least to some part of the population), is to be paid for by recipients who are among the poorer inhabitants. If it does not imply an actual shift in burden from rich to poor, since it is a question of new services, it implies a shift in where the burden is to be expected to fall in the future. The conclusion to be drawn here is that *the tapping of community resources must not come to be regarded as replacing national budgetary commitments* and as an easy way out of the need to commit such national resources to the poorest population groups, *but as a means of complementing such national efforts.*

31. Community participation may also take forms which engage villagers directly in the health activities: from the use of voluntary assistants as health aides, to the training and employment of fully-fledged village health workers and from the use of communal labour in action to improve the healthiness of the environment, to efforts by the organised community to change the health-related behaviour of people in their homes.

32. A growing number of Ministries of Health in the Third World are taking an interest in community participation as a means to extend their coverage and effectiveness. Often they start programmes on an experimental or initial basis in one region. Interest has so far usually centred on the training of villagers in various aspects of health work: as village health workers, or in more narrowly delimited roles. Communities are often called upon to make a material contribution or even to pay entirely for this extension of health services. Here in particular the earlier mentioned possibility arises that community participation implies shifting on to the rural community a financial burden which would otherwise have fallen upon the state.

33. In the absence, or with poor coverage, of national health services especially in rural areas, agencies or groups which are not part of the national health service have mounted programmes or projects involving community participation. The agency is often a voluntary, non-governmental organisation, though in some countries (such as Iran) a separate official or semi-official institution has initiated such projects. Other bodies which do so include medical schools, and particularly their community health departments, whose aims combine training with experimentation. In some countries, where the production of doctors already exceeds the effective demand for their services, given established levels and modes of remuneration (e.g. parts of South India), there is an interest among doctors in starting projects of the community health insurance type, to generate additional demand for their own services.

34. Where conventional health services are lacking, there is a *prima facie* case that the interest of the poor community will be served by any type of effective community health scheme which can be established. However, *the benefits of schemes which involve little more than payments by villagers to outsiders for curative services are clearly minimal.* In contrast, community participation in local health activities guided by expert advice, but primarily relying on the work and other contributions (in kind) of local persons, and mainly directed to preventive measures, is likely to be of real benefit. Thus *the real potential of community participation lies in form of direct community involvement.* These are the ones which use the resources which are abundant in most poor and particularly rural environments: labour power, and in villages especially people's

willingness to use for community activities spare time, not needed for agricultural work. More important, perhaps, *these are the forms which make use of the direct knowledge that people have of their own life situation.* Before preventive work can be well directed, this local knowledge – e.g. of existing health-related practices and the reasons for them – needs to be brought together with the technical knowledge of health personnel concerning the causes of disease. If that can be done, then there is a prospect of overcoming the social gap between health personnel and villager, making health education much more effective.

35. As suggested above, the development of community health systems depends in large measure on what governments and local institutions decide, and are able to provide the resources to do. The discussions at this conference will be of considerable value to Britain (and perhaps to other developed countries of the Commonwealth) in indicating what the UK might be able to offer to facilitate such development. For example, clear indications are already appearing of implications for the type of training which should be provided – and indeed should not be provided.

Some factors which influence the chances of success

36. It is impossible to generalise about the type of person most likely to take on a village health role successfully. In some cases traditional healers (or birth attendants) have been incorporated with good results, but this has not been universally so. Also, age, sex and educational qualifications of those who, once chosen, do a particularly good job are by no means uniform. Sometimes young and relatively educated people – women or sometimes men – are recommended; elsewhere mature, respected persons have been preferred. Socio-cultural factors appear to be mainly responsible for the differences, which need to be investigated and taken into account.

37. As for the difficulty of bridging the social and educational gap between poor people and health workers, a problem lies in the existence among the former of patterns of thought and behaviour relating to health, many of which have developed through the generations. These may be difficult to change by conventional methods of health education which rely essentially on verbal exposition of modern views. It is important to attack the incorrect or harmful beliefs, or insist on new practices which are found essential, at the household or neighbourhood level, in a face-to-face manner. The implication is that *community participation involves neither just one or two 'village health workers', nor merely 'the community at large'.* It *needs community members who become intermediaries between the health system and the people,* who help their kinsmen or neighbours to learn (and to unlearn) health related behaviour and can 'monitor' health problems and report them (or act upon them).

38. But also among health service personnel there are likely to be established views on health and health care which can be impediments to achieving community participation. Such views often reflect vested interests in their own roles and functions (not least their positions of authority) which may make it difficult to go far in training and sharing responsibilities with village health workers. Even so, this may still be easier to achieve than re-organising the training – and functions – of the health professionals themselves, in the face of opposition from professional bodies.

39. A different set of reasons why community participation may have disappointing results lies in the social environment in which it is promoted. Two of the factors involved here are the extent to which there are inequalities within the community itself, and the extent to which national policies favour the rich and powerful or are genuinely committed to promote the well-being of the poor and perhaps oppressed.

40. *Where great inequalities in status, power and wealth exist within communities,* where for example land is monopolised by a few large landlords, *the socio-economic reasons for bad health among the poor majority may be so overwhelming that little can be achieved by focusing on a 'health project'.* If children starve because parents have no land to grow food or do not earn enough to buy it, community enthusiasm for health care is likely to be short-lived. This will be especially so if, in terms of the second factor mentioned, the state effectively underwrites these inequalities, allowing income distribution to worsen and the locally powerful to exercise their

domination unchecked. In those circumstances it is *only when government shows determination to tackle the deeper causes of poverty that schemes of community participation* – also beyond the narrow confines of health care – *make sense.*

41. In this context it may be noted that in countries where forms of collective or co-operative organisation characterise the economy and social system as a whole, health services may make use of the organisations which mobilise collective effort (as in Cuba) or may at the village level operate entirely through them (as in China and Vietnam)' Health campaigns have been a feature of the mobilisation process itself, in many cases. Interesting (and successful) was the 'Man is Health' campaign in Tanzania, in which village groups were organised nation-wide to listen to and discuss a series of radio broadcasts on specific health problems.

42. One of the greatest difficulties, however, stems from the *maladaptation of administrative organisations for the kinds of co-ordination required.* In a service which has been largely urban-oriented in the past there are likely to be shortages of transport or of supervisory personnel in rural areas, which can constitute bottlenecks in any rapid expansion of community participation. But this maladaptation more centrally concerns established categories of staff and their role and remuneration. Paradoxically, it may happen that although one of the advantages of using village labour power is that it is cheap, a Ministry is unable to pay even low rates, for instance for part-time work. It may be a reasonable fear that those taken on in any capacity will in future clamour successfully for regular employment at established rates. Other problems may lie in the attitudes of established staff toward minimally-trained people taking over what they may see as aspects of their job. Unless such staff are given a clearly defined role, for instance as supervisors and appropriate retraining for this role, they may legitimately fear that their status is threatened. The use of existing staff as supervisors or as promoters of community participation can bring its own problems because of their long-standing familiarity with a dogmatic and prescriptive approach to rural communities, an approach not helpful to the promotion of dialogue on health problems which incorporates both local and expert knowledge.

43. *The difficulties in restructuring health administration for community participation* as a means of extending services, and of finding the necessary additional budgetary allocations for the recurrent expenditure required, *may well be generally greater than the difficulties in assuring the co-operation of village communities* for at least some forms of participation in health work. Where villages have representative bodies or authorities in effective control of village affairs, it is likely that an initiative presented by a health administration would meet a positive response and that this would be sustained as long as the regular contact of interested health personnel as promoters and supervisors is sustained. But the initiative likely to be exercised by the average village community is limited, to some extent because of lack of knowledge of what needs to be done, and to some extent because village authorities may need to preserve the goodwill of the population, and cannot make demands which go beyond what is thought necessary.

44. It will be *easier to sustain forms of participation which do not make heavy demands* or make them only in one-off campaigns; it will be *easier if there is reinforcement of the message concerning the need,* for instance through the mass media; it will be *easier to sustain forms of participation which are,* to the villager, *more obviously needed.*

45. But, more generally, the earlier mentioned *link between health and wider socio-economic issues must not be forgotten here.* At the very least health must be explicitly related to socio-economic development, and to such changes as are needed to bring the benefits of that development to the mass of the population. This may be much facilitated if the national authorities conceive of development itself in terms of the generation by collective effort of improved living conditions, particularly in villages, and concentrate on the changes in (rural) social structure needed to give such an effort a chance of success.

CMC (77) 11/B12

COMMUNITY PARTICIPATION IN HEALTH CARE

Background paper prepared by the Government of Trinidad and Tobago

The emphasis in health care has shifted from curative to preventive. Community participation is absolutely essential for the success of any such programme, which relies on personal responsibility for its success, and therefore methods designed to encourage participation by the public should be an integral part in any national planning policy.

2. For the implementation of a health care programme the following basic requirements should be determined:

(a) level of education of the community;

(b) socio-economic status;

(c) types of interest groups or organisations through which efforts can be channelled;

(d) customs and religious reliefs;

(e) level of health

HEALTH EDUCATION

3. Education is a crucial factor in stimulating and motivating the community to act, and the methods would vary according to the level of education of the target population. Teaching methods can be classified into three groups:

Mass methods

4. These are usually designed to create a general awareness and interest in new ideas among the people. They include such things as radio, TV, newspapers, circulars, posters, cartoons and cinema. These methods have been very successfully applied for promoting the immunization programme and the family planning programme. The public has responded by discussing the benefits of the programme in group meetings and in letters to the newspapers and even those not in favour of the programme have created a public awareness by their opposition.

Group methods

5. These are used to advance people from awareness and interest to the desire and trial stages of accepting a new practice. They include general meetings, group discussions and short courses of instruction. These can be held at schools, health centres, hospitals, and community centres. Members of the group would then have opportunity to ask questions, exchange ideas and stimulate each other to action.

6. Alcoholic Anonymous, with branches all over the world, is a very vibrant group in Trinidad and Tobago. Participation occurs in all strata of the society and the general support given to persons suffering from alcholism by the group participation is well known.

Individual methods

7. Since learning is always an individual process, sometimes it may be necessary for the health educator to meet personally with the individual and obtain his confidence before he can convince him of the need to adopt certain health practices.

8. Sustained participation in the community in the health field is very difficult to obtain and one of the means used to encourage this is the requirement by law for all children of school entry age to be immunized against DPT, polio and smallpox.

Public involvement

9. Community participation in health care must be based on the development of incentives and rewards which would stimulate the people to involve themselves in the programmes as well as to maintain their interest. Because this is so, the population would most likely be interested in those aspects of health from which they may derive immediate personal benefits. These areas include:

(a) environmental sanitation;

(b) industrial pollution;

(c) sexually transmitted diseases;

(d) child health;

(e) family planning;

(f) nutrition.

Once members of the public become intimately involved in these problems as a group, they are quickly motivated to act as individuals for their own good and can therefore be utilised in the preventive health aspects of these special areas.

10. National health programmes should take this into consideration. A suggestion here would be to organize a national competition both at the school and community level in the areas of environmental sanitation and preventive health practices.

Department of Health Education

11. There is a Department of Health Education in the Health Ministry which undertakes the responsibility of educating the public in the basics of preventive health care. Education programmes in the following fields have started:

(a) infectious diseases;

(b) immunization;

(c) sexually transmitted diseases;

(d) environmental sanitation;

(e) family planning.

Centres for these programmes have been schools, health centres, hospitals and factories.

12. There have also been in-service training courses for public health inspectors, district nurses and health visitors, emphasising the fact that every member of the health team is an educator.

13. The Health Education Department has a major role to play in community participation as it is its job to instill into the public a total awareness and interest in preventive health practices. It is from this awareness that the public is then stimulated to act.

SPECIAL GROUPS

14. Special groups also have a very important part to play in community participation. Voluntary organisations of international origin – e.g. Lions, Rotary, Red Cross, St. John's Ambulance Brigade and religious bodies – have already made significant contributions to health care and their continued contribution is essential. Groups of local origin can also be found at all socio-economic levels of society, from chambers of commerce to village councils and youth clubs. These organisations are capable of making a tremendous impact on the health scene and their true potential in the area has not yet been maximised.

15. The above groups are supplemental to the special groups at the political level. There is considerable participation in health programmes by local government councillors who are particularly interested in all aspects of environmental sanitation and represent the views of the community who have elected them to office. These same councillors also have an excellent role to play as community leaders in motivating general community interest in the programme.

16. Hospital and visiting committees are functioning in the district hospitals, and in addition to receiving complaints and making suggestions for the welfare of patients to hospital and administration they also liaise with government representatives in office, such as county councillors and parliamentarians.

17. In addition there are voluntary bodies comprising persons from all walks of life, who have formed an association because of a common interest in a particular sphere of health care delivery. Thus there are our Associations for Mental Health, a Diabetic Association, a Chest and Heart Association, a Cancer Society, etc. These societies help to educate the public about their specific area of interest, conducting active health education campaigns, assisting patients, and generally collaborating with Government in its efforts to deliver health care to particular sections of the community. Government, in turn, co-operates readily with these organizations and in many cases gives financial assistance by direct grants and/or remission of taxes on equipment and vehicles. Experience shows that this type of organisation is playing an increasingly important role in developing community participation in health programmes.

SELF-RELIANCE

18. People who develop themselves out of their own determination and with their own effort tend to build a spirit of self-reliance and self respect. "Hand-out" programmes will lead to dependency which stifles initiative. This should be borne in mind when national health programmes are being planned. Sustained community participation is therefore an absolute must for an effective health programme.

November, 1977

CMC (77) 11/B13

COMMUNITY PARTICIPATION IN HEALTH SERVICES

Background paper prepared by the Government of Malawi

This paper gives a brief outline of the ways in which the general public in Malawi are encouraged to take an active interest in developing health services in the area in which they live.

2. Malawi is a land-locked country in East Central Africa, which became an independent state on 6 July 1964. With a total area of 45,746 square miles (of which 9,432 square miles is the water of Lake Malawi) and an average population density of 138 persons per square mile of land area, Malawi is one of the smaller countries within the Commonwealth with a medium density of population. The country is long and narrow, being 530 miles in length, but never more than 100 miles in breadth. The present population is estimated to be about five and a half million, and 98 per cent of the people live in the rural areas, depending mainly on agriculture for their livelihood.

DISTRICT DEVELOPMENT

3. In November 1967 His Excellency the Life President of the Republic of Malawi, Ngwazi Dr. H. Kamuzu Banda set up a National Development Council under his personal chairmanship. This Council is the main planning and co-ordinating body of the Government in the development of the country. Under it, in each District there is a District Development Committee, the membership of which is comprised of the following:

District Commissioner (Chairman)
Local Members of Parliament
District Chairman of the Malawi Congress Party
Chairman of the District Council
Chairman of the League of Malawi Youth
Chairman of the League of Malawi Women
Clerk to the District Council
Agricultural Development Marketing Corporation Supervisor
District Agricultural Officer
Community Development Worker

In addition, the Chairman has power to co-opt the senior district representative of other Ministries or Departments, Chiefs, and other influential people in the community, and is directed to co-opt the District Medical Officer whenever health matters are discussed.

4. The terms of reference of these committees are:

(a) to make the farmer aware of the possibility of improving the standard of living and assisting the national economy by the introduction of modern methods of farming;

(b) to assist Government in achieving the goals established in the National Development Programme;

(c) to advise Government on local needs;

(d) to co-ordinate the activities of the Malawi Congress Party with those of government departments to ensure the rapid development of the economy throughout the country;

(e) to co-ordinate major self-helf projects which involve the collection of funds or require outside assistance.

5. In order to implement its work, each Committee sets up action groups at area and village levels. Each member of the Committee represents an organisation or constituency through which decisions can be implemented. For example, the District Chairman of the Malawi Congress Party can see to

it that information is disseminated down to village level through the Party machinery, and the District Commissioner effects decisions through the Chiefs and Headmen. The women and the young people in the community are also separately represented. Action groups are formed at village levels by local leaders and are used to enlist the latent enthusiasm of the villagers into productive work in support of the National Development Plan. These action groups can also bring to the attention of the District Development Committee, through the member representing them, the locally felt needs of the people.

6. A major function of the District Development Committee is to be responsible for the co-ordination at District level of self-help schemes and to approve all local development projects. Although the major work of these Committees is concerned with agriculture and education, they are also involved in all health proposals for the district, particularly as there is a continuing demand from the people for more health facilities.

MINISTRY OF HEALTH GUIDELINES FOR SELF-HELP

7. In February 1969 the Government issued a guide for District Development Committees which laid down the requirements for each Ministry.

8. The Ministry of Health, which provides free medical attention for all at its units, starts off its advice as follows:

> "The most important point to be considered by the District Development Committee is that this Ministry is unable to assume additional financial responsibility on its present recurrent expenditure".

It then goes on to detail the cost of running a rural hospital and a dispensary, and advises that the best return on money spent can be obtained from preventive medicine and health education. Detailed advice is given on practical ways the Committees can help, such as supporting the work of health assistants, persuading patients to continue taking their treatment for as long as necessary (particularly important for tuberculosis and leprosy), educating people that they must not expect an injection as well as tablets when they go for treatment, and building guardians' shelters where relatives who take the patients to hospital can stay the night. The ways in which these guidelines have been implemented are discussed in more detail below.

Village health committees

9. Village health committees arose as a logical extension of the action groups mentioned above. They are usually convened by the health assistant or the cholera assistant, and in some places by the medical assistant in charge of the local health sub-centre. They are more active in some areas than others, and this has arisen as a result of the cholera epidemic of 1973–75 which only affected certain districts. As a result of the advent of cholera, local villagers with very basic education were employed by the Ministry to teach people how to combat cholera by digging latrines and protecting water supplies, and going promptly for re-hydration treatment. They were taught "on-the-job" by the health staff in the field. They have proved so useful in improving rural sanitation and teaching hygiene that, although the cholera has subsided, they are still being employed. The village health committees are mainly involved in dissemination of health education, controlling leprosy and tuberculosis patients defaulting in treatment, and generally helping at the local clinics.

Guardians' shelters

10. It is traditional in Malawi that at least one relative should accompany the patient to hospital and, if he is admitted, to stay there until he is fit to go home, so that he can be visited and comforted, and perhaps brought some special food he fancies. As some people live far from the hospital, the relatives have to sleep nearby, and this is where the District Development Committee can help, by getting the local people to build and maintain a guardians' shelter near the hospital. All hospitals in Malawi are provided with guardians' shelters.

District council dispensaries and maternity units

11. All District Council dispensaries and maternity units have been built on a self-help basis by the local people, through the District Development Committee. There are at present 18 dispensaries, 65 maternity units and 4 health sub-centres (dispensary and maternity), run by District Councils in Malawi. Before they can be built, the Committee must obtain the agreement of the Ministry of Health, which must be satisfied that the health facility to be provided is in accordance with the National Health Plan of Malawi, which was adopted as a 15-year plan in 1973, having been drawn up by a team of experts from the World Health Organisation who visited Malawi in 1971. Briefly, it is stipulated in the National Health Plan that health sub-centres (maternity and dispensary) must be at least ten miles apart, and able to serve a population of 10,000 people. If these conditions are satisfied, the Ministry of Health will agree to the building of a new health sub-centre or maternity unit, but usually only on condition that the District Council guarantees to staff, run, and maintain it. In a few instances the Ministry have agreed to take over responsibility for staffing and running a unit, but only if the Ministry of Works and Supplies has inspected the building and agreed to maintain the structure thereafter.

A new district nospital: Ntcheu

12. The most ambitious self-help project to date has not yet come to fruition, but it is considered worth recording how the project was initiated, the problems that arose, and the solutions proposed, as these details may be of help and interest to other developing countries who wish to involve the community in taking an active part in their health services.

13. Ntcheu District is in a semi-mountainous region of Central Malawi bordering Mozambique to the West, and is one of the more populous areas with an estimated population of 217,700 in 1977. On 21 December 1976 there was a special District Development Committee meeting at Ntcheu Township. As well as being attended by all Committee members, the meeting was attended by all heads of government departments working in the District and all Chiefs and Headmen.

14. The meeting was asked what it regarded as a priority project for the District, and there was unanimous agreement that what all the people wanted was a replacement hospital on a new site. The old hospital, which was built in 1933, had had various additions over the years but was on a hilly site which impeded proper development, and the Ministry of Health had already decided that it needed complete replacement as many of the buildings had become delapidated.

15. The District Development Committee meeting therefore decided that it would mobilise the people to build a new hospital of 120 beds, subject to Government approval, using their own money and labour. A follow-up meeting on 31 December 1976 decided on a site for the new hospital, and planning really began in earnest on 8 February 1977, when those concerned were informed that Government had approved in principle their plan to build a hospital on self-help basis.

16. The first step was the establishment of a Ntcheu District Hospital Construction Sub-committee, a Supervisory Buildings Sub-committee, and a Materials Sub-committee. All these got to work immediately, and extensive minutes from many meetings were produced. Among the decisions made were that the hospital would be built to modern standards, using the standard plan of the Ministry of Health for a District Hospital; that all people in the District should be asked to contribute cash; and that each Group Village Headman should arrange for his people to mould and bake not less than 80,000 bricks to the standard Ministry of Works design.

17. The method of assessing how much everybody should be asked to donate was most democratically arrived at. The main Committee called meetings with groups of people according to their occupation. First government employees, then the African Businessmen Association, the Asian Businessmen, the Teachers' Union, master farmers, corporations, church elders, and last but not least, Chiefs, Headmen and villagers. In each case a scale of contribution depending on their salaries or occupations was agreed for all. Meanwhile, both the Ministry of Health and the Ministry of Works and Supplies had been informed of the plans of the people of Ntcheu District, and it is

a fact that should be recorded, because this is a world-wide problem when employing experts, that the news was first received with a certain amount of scepticism by some officials. A recently-built replacement district hospital had cost K1 million ($1,000,000), the Ministry of Health had no development funds of this order available to help the project, and previous experience of self-help projects had led them to believe that high standards could not be achieved. However, the enthusiasm of the people could not be ignored, and ways and means of helping to make the project a success were worked out.

18. At a meeting in July attended by senior officers of the Office of the President and Cabinet, the Ministry of Health, the Ministry of Works and Supplies, and the Ministry of Community Development and Social Welfare, it was proposed that:

(a) the self-help participation from the people should be limited to the moulding of bricks, their financial contribution, and labour for bringing sand and stone;

(b) the Ministry of Works would carry out the actual construction, using their own skilled labour and all material available locally;

(c) the hospital should be built in phases, starting with the administration and out-patient block – the Ministry of Health would use development money that was available for this;

(d) the Treasury should be asked to find funds for completing the hospital in 1980/81;

(e) the Ministry of Community Development and Social Welfare would co-ordinate the self-help work of the local people.

These proposals were approved by Government in August and a suitable site was chosen, and site plans and building plans drawn up by the Ministry of Works were approved by the Ministry of Health. By early September, the District Development Committee reported that nearly K10,000 ($11,000) had been collected and 44 brick kilns were in operation. On 10 September 1977 construction work on the new hospital started.

OTHER AREAS OF COMMUNITY PARTICIPATION IN HEALTH SERVICES

District councils, town and city councils

19. All local government bodies have Health Committees which have responsibility for environmental sanitation, and for a certain amount of preventive medicine.

Hospital Advisory Committees

20. Each hospital has a Hospital Advisory Committee which has on it members representing the District Council, and prominent local citizens nominated by the Minister of Health.

Ministry of Community Development and Social Welfare

21. The Ministry of Community Development and Social Welfare is the key Ministry where public participation in development is concerned. It always has a representative member on the District Development Committee, and its field workers have long experience in the customs and psychology of the people, so that they can arouse public enthusiasm for a project sufficiently to persuade people to give their time and effort to help, without any reward apart from the satisfaction of seeing a job well done. In the health field, the Ministry of Community Development and Social Welfare is responsible for many small piped water schemes for villages in addition to their involvement in self-help health projects.

Private Hospital Association of Malawi

22. Another area in which there is considerable public participation in health services concerns the many mission hospitals in Malawi which are organised under a certain administration known as the private Hospital Association of Malawi. The Association has an executive council which

co-ordinates the work of all mission hospitals with the Ministry of Health. Mission hospitals provide nearly 40 per cent of hospital beds available in the country, but unlike government hospitals, they charge patients for their services, and rely to a large extent for their upkeep on donations from the public at home as well as overseas. They also receive considerable assistance from voluntary workers and from workers who are willing to receive very small emoluments for serving their particular mission.

November 1977

CMC (77) 11/B14

COMMUNITY PARTICIPATION IN THE PROVISION OF HEALTH CARE IN WESTERN SAMOA

Background paper prepared by the Government of Western Samoa

The traditional pattern of life of Samoan communities depends to a large extent upon communal participation in activities and the provision of health services in Western Samoa proves no exception. In particular, the women's committee's in Western Samoa are extensively involved in promoting and providing health care at the village level. Women's committees have evolved to the point where they are now major forces in the construction and maintenance of district hospital, health centre and health sub-centre facilities, in the support of health personnel in the form of provision of food and housing, and in the organisation and facilitation of regular visits to the villages by nurses who hold ante-natal and child care clinics. Simple medical care is provided through trained primary health care workers and intra-natal care through trained traditional birth attendants, who receive remuneration in a traditional manner. The latter two categories of health workers have been trained only in recent years in an on-going programme, but there is no doubt that their contribution in the provision of health care is significant.

2. Women's committees, therefore, are involved with the areas of maternal and child health, including family planning, communicable disease control, health education, environmental sanitation, intra-natal care and simple medical care.

3. The development of specific health-related activities of the women's committees can be traced back to the 1920s. At that time, health authorities were worried about the prevalence of yaws (among many other conditions) affecting Samoans, as well as about the lack of facilities at the periphery. Women's committees were encouraged by health personnel to get involved in the provision of health care, a challenge which was taken up and developed into the complex of activities of today.

Social organisation

4. Western Samoan society is based on a chieftain system. Chiefs are selected by extended families to represent the family in the village council and to be responsible for the affairs of the family in general. The responsibility for the family is a great one, as the *matai* (chief) is considered totally responsible. Being a chief, however, confers upon him also the right to request contributions from better endowed members of the *aiga* (extended family), whose contribution will serve the greater good of the *aiga*. Obedience to the word of the *matai* is also implicit in the system, although irresponsibility in the execution of his task may cost the *matai* his title. The latter, however, occurs but rarely once a *matai* title is confirmed. *Matai* can be *ali'i* (chiefs) or *failauga* (orators). The orator represents his chief in the village council.

5. *Matai* of the extended families organise the work to be carried out for the good of the family, and communality of spirit in carrying out appointed tasks is a characteristic of village groups.

6. In the light of this historic attitude, the request of the health officials in the 1920s did not fall on deaf ears. Given a purpose, the women's committees acquitted themselves admirably in their tasks. Hierarchical form is adhered to and, although women are not usually title holders, the wives of the chiefs usually hold positions of rank in the women's committees. Traditionally the wives of chiefs formed a separate social category, as did the daughters of chiefs and the wives and daughters of untitled men. The usual functions of providing food and drink for visitors, the display of ceremonial hospitality and a multitude of other home-making tasks, such as the provision of foods for the local pastor and his family, were the tasks of the women's groups. The request for extension of these tasks into the realm of provision of health care was almost a natural one and therefore proved very successful.

7. The early women's health committees served as a mechanism for the identification of health problems and for mobilising group efforts towards solving these problems. The committees are active throughout Western Samoa and, with few exceptions, all families belong to them. Not being a member of a women's committee is tantamount to being a-social and incurs a certain disdain for the person concerned. Activities of the women's committees have extended to other areas of interest such as schools and farming; funds are raised for the building or extending of schools and several women's committees have milking cows, the dairy produce of which is sold, the latter serving the dual purpose of providing extra protein as well as money for the women's committees' other programmes.

Health care and the women's committees

8. Health care is provided under the auspices of the Department of Health, whose director is responsible to the Minister of Health. Health services are carried out under the direction of the chief of public health, assisted by district medical officers, district nurses, staff nurses and health inspectors. Dental officers carry out dental care, preventive as well as curative, under the supervision of a chief dental officer. Nursing services are supported by the Apia School of Nursing and supervised by the superintendent of nursing. The Apia-based National Hospital is headed by a medical superintendent.

9. District health and medical care are the responsibility of district medical officers, assisted by district nurses. The district medical officer's task is made easier by co-operation with the women's committees, with whom he maintains regular contact. It is necessary for the district medical officer to have knowledge of traditional custom in addressing chiefs and orators, as he needs to contact the village council not infrequently. As these customs may differ from district to district, the medical officer needs to learn these customs to be effective.

10. District nurses are the points of contact with women's committees. The co-operation of the women's committees makes their task infinitely lighter than in many other countries, as women's committees see to it that all members of their committees needing health care come to see the district nurse on her visit to the village. To facilitate the visit, a women's committee builds a women's committee *fale*, which is a meeting house clinic during the district nurse's visit. Traditional exchange of greetings, acknowledgment and gratitude for the visit and the partaking in the dinner provided for the district nurse all take a considerable period of time and here, once more, skill in the upholding of the traditions is an absolute *sine qua non*. In fact, it is widely acknowledged that much time must be set aside for the upholding of traditions *(faa Samoa)*, which necessitates the recognition that attempting to keep to a time schedule is sometimes impossible.

11. Women's committees are organised on a district scale with representation to a district committee, which, among other things, decides on the division of work relating to maintenance of district hospital buildings (or health centres or sub-centres, as the case may be), the cleanliness of the grounds, and the provision of food to the health staff and to patients. As well as maintenance activities, women's committees have raised funds and directly contributed labour for the construction of hospitals and or other health facilities in their districts. This, in effect, means a significant monetary saving to the Government of Western Samoa, as a significant proportion of health costs are directly met by the community.

12. A significant development of the last few years has been the training of *faatoaaga* (traditional birth attendants). Slightly more than 50 per cent of all births in Western Samoa are attended by *faatosaga* and have been for many years. These traditional birth attendants (TBAs) are members of women's committees and, depending on its size, a committee, may include as many as three TBAs. In 1973–74 the decision was taken in principle to give existing TBAs training so as to increase their knowledge of the process of birth. A pilot project was completed and 32 TBAs were trained in late 1975 and early 1976 and the project was evaluated in early 1977.

13. Subsequent to this evaluation, the Government of Western Samoa accepted the policy of providing training courses for TBAs during 1977 and 1978 in the districts. The Government stresses the fact that it provides delivery facilities in the district hospitals and the National Hospital, but recognises that a significant proportion of Western Samoan women express a preference for the *faatosaga*. To facilitate safe delivery, therefore, the Government invites the TBAs to participate in the training courses, but stresses further that this is a voluntary participation which does not entitle the participant to government remuneration following completion of the course, other than the gift of a TBA midwifery kit provided to the Government of Western Samoa by the United Nations Fund for Population Activities.

14. A total of approximately 120 out of 300 TBAs had been trained by August 1977; the remainder should be trained before the end of 1978. A manual has been prepared which the TBAs keep for reference. They are trained by a nurse midwife under the overall supervision of a medical officer.

15. A more recent development is the training of primary health care workers (village health workers). Based on concepts developed by the World Health Organisation (encouraged by the success of the People's Republic of China's "barefoot docotors"), the primary health care workers in developing countries are seen as a link between (all-too-often) remote district health services and the population at large. While Western Samoa, with a fairly satisfactory road network and transportation system, is better off than many other countries in similar circumstances with respect to overall development, the social structure of Western Samoa is possibly unique in its capacity to adopt community-based concepts without great problems. Consequently, Western Samoan society is able to adapt these concepts to the needs of their own village communities.

16. Although the concept as such has as yet not been fully developed in Western Samoa and although an official government policy with respect to the development of primary health care workers has yet to be decided upon, several medical officers have taken the initiative in their districts of encouraging women's committees to nominate individuals to be trained as primary health care workers. Primary health care, in the present context, is seen as basic first aid and basic knowledge of hygiene and environmental sanitation – knowledge geared to the provision of assistance to the district nurse on her visits to the women's committee and possibly help for the TBA in the village. A recent national seminar on primary health care has generated greater interest in the subject and it is expected that further debates on primary health care by villagers will create further ideas. Here again, it has been stressed that any teaching is attended voluntarily and that no government remuneration can be expected. Early signs indicate a great degree of interest in the further development of these workers.

Conclusion

17. An overview has been given of the involvement of Western Samoa communities in the provision of health care. It is believed that, although improvements can be made, Western Samoa is in the unique position of being able to make optimal use of her existing social structure in the provision of health and medical care services as communal participation in all activities in daily life is an inborn reaction to the solving of problems.

November 1977

CMC (77) 11/B15

COMMUNITY PARTICIPATION

Background paper prepared by the Government of Seychelles

Seychelles is following the experience of other countries in recognising the importance of community participation and education and motivation in the effective promotion of community health. It must be admitted that the present level of participation leaves a lot to be desired and a great deal more could be done. The Government intends to give more attention to community involvement and education/motivation in its national health programme which it is in the process of formulating. What must be aimed at is sustained participation, as all too often public interest in a particular project falls off rapidly.

EDUCATION AND MOTIVATION

2. In educating and motivating the population use is made of the existing Government media, namely Radio Seychelles; The Nation, a government-owned newspaper; and the government film unit. Of these, the radio is probably the most important as virtually every household has one.

3. Not to be underestimated is the value of person-to-person communication, which in Seychelles is facilitated by having the population concentrated on the main island of Mahe and two other islands (Praslin and La Digue) not far removed from Mahe. Many regard the mass media as being anonymous and impersonal and are suspicious of information emanating from them as they believe such information is processed. Opportunities for personal contact occur at the hospital level between nurses, midwives, doctors and patients; at the level of the rural clinics between nurse and patient; and in schools between the schoolchildren and the public health nurses running the school health programme.

4. In its proposed national health plan, the Government will be strengthening its maternal child health and family planning services, which form an integral part of the public health sector. Unlike curative medicine, to which people are generally driven by the aches and pains of illness, any preventive activity such as is inherent in a maternal and child health service requires a concerted effort towards information and education to attract "clients" and ensure that they will apply in their own lives the knowledge they have gained. The success of any maternal and child health and family planning programme depends largely upon what people themselves do after they leave the clinic and not merely on what is done for them at the clinic itself. People must not only be motivated to come forward to the clinic in the first place but they must also be adequately informed and motivated to return to the clinic regularly for fresh supplies, for additional immunisation and to discuss with the nurse or doctor at the clinic any problems they may have, and to continue practising thereafter what they have learnt about such things as good feeding practices and personal hygiene. The initiative lies to a large extent with the people themselves, although the quality of service provided will certainly have an impact. Incentives like the provision of free food influence attendance. The nurses at those clinics are encouraged to build up personal relationships with patients and gain their confidence. A mother is more likely to confide in, and discuss her problems with, someone whom she has come to know well and to trust.

5. A family planning service is for the first time this year being offered by the Government through its existing maternal and child welfare clinics. Prior to this, family planning was provided exclusively by the International Planned Parenthood Federation which has been operating in the Seychelles for the last ten years. Complete integration of family planning into government services will be effected over the next few months.

6. An important component of a family planning programme is the introduction of population education – e.g. population dynamics, family life education and sex education – to certain groups like secondary schools, students of higher education, and teacher training institutions. In addition, community centres in rural areas will be utilised to carry out non-formal education activities.

7. The Ministry of Education and Culture will have a prominent part to play in this aspect of the programme and it is intended to set up within this ministry a population education unit which will work in close liaison with the staff of the Ministry of Health and Welfare in the development and implementation of the educational and motivational component of the programme. To this end expert consultant services will be made available with assistance from the UN Family Planning Association (UNFPA) to undertake the following:

(a) investigation of problems concerning the health, family planning and family welfare of the community so that appropriate curricula and teaching techniques tailored to meet the needs of the community can be designed;

(b) the development and preparation of teaching, training and campaign materials;

(c) on-the-job training of local staff who are to be responsible for information and education activities – it is proposed to train two teacher/communication personnel and two technicians who will be in charge of the film unit and the operation of a mobile education and information van.

SPECIAL GROUPS AND ACTIVITIES

Action Familiale

8. This body provides couples with advice on contraception acceptable to Roman Catholics, namely the rhythm method. In addition it conducts training courses and organises discussion groups to motivate adults and youths to adopt a responsible approach to sex and family life.

The Seychelles Children Society

9. This voluntary organisation, which has now been in existence for seven years, is a very active one. Its areas of activity at present cover the following:

(a) the society originally initiated the crêche programme which has now largely been taken over by the Ministry of Education and Culture, save for a day centre in the city which it still runs – it supplies equipment and teaching aids to the various crêches on the island of Mahe;

(b) the society has had surveys conducted on those children who are handicapped, has financed the building of a handicapped school, and offers educational facilities to the deaf, the blind and the mentally retarded;

(c) under a scheme funded by the Save The Children Fund in Britain, the society makes monthly grants to low-income families with poorly-nourished children.

The Seychelles Cheshire Home (Dr Hermitte House)

10. Sponsored by the Seychelles branch of the Cheshire Home Foundation this house will become operational by the end of the year. It is meant primarily for the rehabilitation of paraplegics but will also provide medium-term facilities for the rehabilitation of undernourished and at-risk children. The response from the community in setting up the home has been excellent; its success will depend on continued community participation.

Société Feminine

11. This organisation, which is affiliated to the Association of Country Women of the World, is with the aid of a grant from the ACWW in the process of setting up a nutrition extension service. This will be concerned with the after-care of malnourished children in their homes.

Blood donation

12. Seychelles does not have a national blood transfusion service and for the size of the population it would be impractical to set one up. The national hospital, however, does keep a small

bank capable of storing up to 40 units of blood. Until recently there was a general reluctance to donate blood based on misconceived ideas, superstition and prejudice. Through the mass media this is gradually being overcome and people are being motivated to donate blood on a voluntary and non-renumerated basis.

Housing

13. A number of housing projects involving the reconstruction of shacks in certain poor housing areas are being undertaken by volunteer workers under supervision provided by the Public Works Department.

National health and welfare plan

14. Prior to the change of Government on 5 June 1977, a plan was in existence called the "national family and welfare programme", drawn up jointly by the Government and UNFPA. The new Minister of Health and Welfare on taking office felt the programme had been written without sufficient consultation with the rank and file and accordingly appointed a committee to re-examine and re-design the programme so that it would be more suited to local needs and circumstances. The revised programme was circulated to all medical officers, the Nursing Association, the Welfare Division, other Ministries and all non-governmental organisations, and there were comments invited. The feedback from all these sources will be considered in the formulation of the national health and welfare programme which will form part of a comprehensive social security system.

November 1977

CMC'(77) II/B16

COMMUNITY PARTICIPATION IN HEALTH SERVICES

Background paper prepared by the Government of Kenya

Health needs and community understanding

Community health, the subject of the Fifth Commonwealth Medical Conference, implies understanding the totality of recognition of health needs of a community and the positive commitment of the authorities to satisfy these needs comprehensively, as they relate to the individual, the family, the community and the environment. Some of these health needs are easily recognised, as for example when an epidemic strikes or when individuals complain of illness, pain or injury. Some other health needs, particularly those relating to promotion and maintenance of good health, are not so obvious. Those who work in these fields, whose efforts towards the promotion of good health and a sound environment and the prevention of disease are non-dramatic, have still an uphill battle to convince individuals, officials and society of the necessity of increasing investment in the community health sector.

2. The benefit to overall national development to be derived from emphasis on the various aspects of community health services has been increasingly recognized by successive government development plans since Kenya's independence in 1963, with resultant rising financial allocations to these services, particularly among the rural population. In considering the various aspects of health services, great emphasis is now placed on the promotive and preventive aspects, since the general public is already well-motivated in regard to curative aspects and demands are high, while it is less conscious of the need for general public health services which have to be promoted by centrally-organized effort. These include health and hygiene teaching in general education, health education for the masses, nutrition education, provision of wholesome water supplies and sanitation, immunisation, control of communicable diseases, and rehabilitation of the incapacitated.

Government health services

3. In general, the Government is responsible for providing health services to the whole population. This role is particularly significant in community health and motivating the community to learn and understand the essence of good health so that they can participate in helping themselves in their homes, villages and farms. Of particular significance in reaching remote populations are the rural dispensaries, health centres and mobile health units. New rural health workers from the community itself are being trained to work in these rural units and in the villages, and these have been found useful as motivators of the villagers, particularly in fields such as nutrition, maternal and child health, family planning education, and in communicable disease control. All these rural units are guided, assisted and supervised from the districts and the provincial health service level.

Community participation in planning

4. At all stages of planning development of health services and their implementation, the Ministry of Health consults and cooperates with other ministries and departments of the central Government, local authorities, voluntary organizations and local community organizations. Choice of new developments in any area of the country is largely influenced by the local district planning committees, whose recommendations are considered by the provincial development committees before decisions are taken at the Ministry headquarters level. The district development committee consists of members from all government departments at the district level, elected members of Parliament, representatives of the local county councils and prominent leaders in the community. This approach ensures a measure of community participation in development planning and decision-making.

Non-governmental health agencies

5. Other non-governmental agencies continue to complement the government effort by providing aspects of health services among the community in many parts of the country. Such agencies are churches and other voluntary organizations which provide health services, industrial hospitals or medical clinics, private hospital organisations and general practitioners. Their medical facilities form part of the work within the community and ease the load of patients in the often over-crowded government establishments, and at times work in situations where government facilities are not immediately available. These non-governmental health agencies are controlled by government guidelines in their practices and are accepted as part of community participation in the health services.

6. Church hospitals have been particularly valuable, providing about 30 per cent of the hospital bed capacity of the country, and these facilities are often placed among the communities in remote parts of the country. The Flying Doctor Service in Kenya is run by a voluntary organisation with small grants from the Government. This provides another link to the communities in inaccessible parts of the country, and has been useful in the control of communicable diseases and the evacuation of acute emergency cases to better-equipped hospitals for treatment.

7. Other voluntary agencies performing a very valuable health role in the community are those concerned with the care and rehabilitation of the physically or mentally handicapped. There are numerous voluntary societies dealing with disabilities such as those of the physically disabled, the blind, the deaf and the mentally handicapped. Such organisations receive government grants which cannot be adequate to meet the necessary expenses; the bulk of their funds have to be obtained from other sources such as endowments, contributions from philanthropic associations, individuals, and voluntary fund-raising activities such as organised self-help walks and sports.

Community self-help (Harambee) health projects

8. Community participation in aspects of development in all sectors of social activities is traditional rather than novel in most communities in Kenya. This tradition has been employed to very good effect in the extension of developmental programmes in practically all sectors of the economy – education, health, agriculture, the cooperative movement and even in commerce – to beyond what can be made available from governmental financial resources. In the field of health, local self-help groups have come together and contributed in cash or kind, or have volunteered their labour, to build dispensaries, health centres and, in a few instances, hospitals in areas where these facilities were lacking. Similar self-help spirit has been used in the provision of child care nurseries, water supplies and access roads in many parts of the country, all of which facilitate the provision of other aspects of health services.

9. The Government participates in these self-help efforts of local communities by giving guidance in planning so that they are in line with the overall development, by contributing some grants for the projects, and eventually by taking over the running of the projects as part of the government service when financial provision can be made centrally for them. The rate and ramification of aspects of health and other services to even the remotest of villages generated by the self-help effort in Kenya, which is a corner stone of government policy, confirms the essential nature of community participation in the planning and provision of health services. Part of this participation may be in the form of self-help projects which can be managed with a minimal government contribution, and which the people themselves consider to be of benefit of their local community.

8 November 1977

CMC (77) II/B17

COMMUNITY PARTICIPATION

Background paper prepared by the Government of India

Health education

In ancient India great importance was attached to education in cleanliness, appropriate diet, health and disease. Vagbhatta, an ancient physician, recommended that one should not sneeze, laugh or yawn without covering one's mouth. Nose and ears should not be picked with fingers. "The type of food, time of taking it, its quantity, combination, how it should be served, the material of the pots in which it was served were all given due consideration. Charaka and Susruta devote many chapters in describing the qualities and effects of different articles of food." The community was educated on different aspects of health in ancient India and people's participation was sought for preventive, curative and promotive aspects of health. People were educated regarding do's and don'ts to maintain fuller and happier life through "Dincharya" (routine activities for better health).

2. Our ancient physicians like Susurta and Vagbhatta laid great importance on people's active participation in prevention of disease and promotion of health resulting in increasing the longevity of life. According to Kautilya's *Arthasastra,* people were educated to keep their surroundings clean. It is worthwhile quoting from Kautilya's *Arthasastra:* "From each house a water course of sufficient slope at a distance of 3 *padas* (foot-length) or 1½ *aratnis* from the neighbouring site shall be so constructed that water shall either flow in a continuous line or fall from it into the drain".

3. Thus it is quite evident from the writings of ancient Indian physicians that the success of any health programme depends considerably upon the active participation of the community. This can be brought about by educating the people regarding various aspects of healthful living and creating situations in which people are directly involved in planning, implementation and evaluation of health activities at different levels.

4. Taking into consideration the modern trends in health, it is worthwhile mentioning that even the Bhore Committee which was appointed in 1943 found that "the low state of public health as reflected in the high mortality and morbidity (particularly among mothers and children) was preventable and was mainly due to the absence of environmental hygiene, adequate nutrition, adequate preventive and curative health services and intelligent co-operation from the people themselves". To seek co-operation from the people a Community Development Programme was launched in the year 1952 covering the rural population of the country. The principle behind the Community Development Programme was the active participation of the people for their growth and self-sufficiency, including better health.

5. The Bhore Committee also recommended that progressive improvement of public health depends largely on promotion of the hygienic mode of life among the people. In each village a health committee consisting of 5–7 individuals should be established for procuring the active participation of the people in the local health programme.

6. Based on the recommendations of the various health committees and experience gained during the process of planning and implementation of various health programmes, a network of health set-ups has been developed.

7. To provide medical and health services to our rural population, which is approximately 80 per cent of the total population, primary health centres have been established. For every 60,000 to 80,000 we have one primary health centre, and one sub-centre for approximately 10,000 population. The main functions of the primary health centres are to provide preventive, curative and

promotive health and medical services to our rural population. Besides these, one of the most important functions of primary health centre is to bring about a change in health behaviour of the people through community participation. A multi-pronged approach is being carried out to motivate people to accept various health programmes. According to the requirements of the situation, various methods of health education, such as mass meetings, group meetings and individual contacts, are used to gain better acceptance of the health services. Suitable media, such as radio, films, flash cards, film strips, handbills, posters, pamphlets and local drama parties, are being used for communication and motivation purposes. Special camps and campaigns are also organised to mobilise public opinion in favour of special programmes for eye camps, immunization, family welfare, malaria, smallpox, leprosy, etc. During the time of campaigns special efforts are made to mobilise the resources of governmental and voluntary organisations to make the programmes succeed.

8. So far as the sub-centres are concerned, they also carry out all the functions of primary health centres and are considered as mini primary health centres.

9. Besides the primary health centres and sub-centres at the grass-root level, we have the network of the health care delivery system provided through district and *taluka* sub-divisional hospitals. At the State level we have teaching hospitals and other big hospitals.

10. In all the big hospitals there are social service departments based on the principle of voluntary participation of the people for the welfare of the patients. Besides the welfare departments in each hospital, health education is also being integrated in the functioning of the teaching and district hospitals for:

(a) better acceptance of the services;

(b) making patients and their relatives understand the preventive measures to be taken to reduce the magnitude of preventable diseases;

(c) reducing the tension of the patients and their relatives and making the hospital experience a pleasurable one as far as possible;

(d) educating the patients and their relatives regarding causation, mode of spread, preventive and promotive aspects of the disease.

11. In the teaching hospitals, departments of preventive and social medicine are actively involved in the planning and implementation of training of interns in community medicine in rural areas. Thus, the whole of medical education is being reorganised so as to prepare doctors to cater for the needs of the rural population. In community medicine emphasis is given to helping people to help themselves through active participation in solving their health problems.

12. For better delivery of health services and better training of interns, each medical college has been assigned the responsibility of providing medical and health services to three primary health centres in neighbouring districts.

13. The success of any programme depends considerably upon the training of the various categories of personnel involved in the programme. To cater for the training needs of the health programmes, a training strategy has been developed so that all the categories of personnel are trained in shortest possible period of time. For this purpose a network of training institutes have been established. There are seven central training institutes and 46 regional health and family welfare training centres to train workers right from primary health centre and sub-centre levels to State level. Besides the in-service training programmes, which are followed with refresher and re-orientation courses, a one-year diploma course in health education is being organised by the three central institutes in collaboration with local universities. Increased emphasis on the health education component in basic training courses for medical, nursing and other para-medical staff is being given. Attention is also being given to the incorporation of health education in general education at various levels in schools and colleges.

14. All the health personnel working at the primary health centre levels are supposed to carry out health education activities so as to involve the community in active participation in the pro-

gramme. At the State and district levels we have health education specialists for the integration of health education in various programmes. The health education specialists plan and develop health-education strategy for better acceptance of the programme by the people. They are also involved in developing training strategies and evaluation plans for the successful implementation of health programmes. These specialists are also involved in developing educational aids – material, manuals and guides for health workers based upon research findings and their own experience of working with the community.

15. Recently the Ministry of Health and Family Welfare has formulated a new health policy which envisages the active participation of the people at all levels. The major emphasis is on people's participation in all the health programmes. Under the rural health services scheme, each village will select its own representative (on a population ratio basis of one per 1,000) who belongs to the community and enjoys its confidence, to provide on-the-spot primary medical care and at the same time to educate the community on the prevention of diseases and the promotive aspects of health. These representatives are known as community health workers.

16. The community health worker is a link between the community and the health agency. These workers are not government servants; they are voluntary workers responsible to the village council. Their training started from 2 October 1977 and the first batch of community health workers will start their work from January 1978.

17. These workers will be helped by the workers of primary health centres in carrying out preventive, curative and promotive aspects of health services through the involvement of community.

18. In short, it may be said that the network of the health care delivery system is being established in this country with emphasis on the implementation of health programmes through people's participation. Health education and community organisation are built in to all our health programmes for reducing the magnitude of our health problems, placing stress on the preventive and promotive aspects of health.

The Community Health Workers Scheme

19. A draft plan for health care services in rural areas was discussed in the Health Ministers and Health Secretaries Conference held on 28–29 April and 28–29 July 1977. As a result of the deliberations of this conference and with the approval of the Planning Commission and the Finance Ministry, a new rural health care scheme named the Community Health Workers Scheme (*Jan Swasthya Rakshak*) which is a part of the plan to involve the community in the delivery of primary health care, has been launched in the country with effect from 2 October 1977. It is open to all adult persons living in the areas of selected primary health centres to join the programme and serve the community in their spare time. The basic criteria for selection of a community health worker are: a permanent resident of the village, age preferably below 30 years, education or functional literacy, and a knack for social welfare service. The community will select one such worker per every thousand people.

20. In the first stage, starting from September 1977, the district health officers and medical officers of 777 primary health centres have undergone a training programme so as to equip them properly to undertake the training of community health workers. Four hundred and thirteen primary health centres in 28 districts of six States where the multi-purpose workers programme is being implemented have been covered under this programme, along with 364 other primary health centres (at the rate of one primary health centre from the rest of the 364 districts). Paramedical staff of the primary health centres have also been trained during September 1977.

21. The programme was inaugurated by the Prime Minister of India on 3 October 1977 in Haryana. It was also inaugurated simultaneously throughout the country by the respective State Chief Ministers or Health Ministers. The community have selected 20 workers for the first batch to undergo the training. During the training period the trainee will get a monthly stipend of Rs.200 for the entire duration of the training (i.e. 3 months). On completion of the training the

worker will receive a kit and packets of drugs as selected by the State Governments. The worker will continue to get an honorarium of Rs.50 per month and drugs worth another Rs.50. In addition, the services of the selected primary health centres will be further improved through the posting of an additional medical officer and the supply of drugs, stationery, etc. The scheme is 100 per cent centrally sponsored. A financial allocation of Rs.4.50 crores have been made during 1977–78 and 13.18 crores during 1978–79. The scheme will be reviewed in June 1978 so as to consider its extension to the remaining parts of the country.

22. A built-in evaluation system has also been included with the programme. The workers undergoing training will be evaluated initially during the course of training and finally while working among the community. A suitable pro forma for evaluation purposes is being designed by the National Institute of Health Administration and Family Welfare.

23. It is envisaged that the community health workers who are already undergoing training in the 700 primary health centres in the country will serve as a vital link between the community and the primary health centre. Each worker will function as a promotive and preventive health worker. He will also render first-aid in case of emergencies. He will be fit to provide elementary medical care. In addition to this work, he will be in a position to offer prompt advice and guidance to the people in the village who seek medical care. He will be able to notify the incidence or out-break of a communicable disease in the community and ensure that proper action is taken by the primary health centres staff to combat the infection. It is expected that the installation of a primary health worker and his or her proper functioning will awaken the community to take necessary measures for health promotion and prevention activities and serve as a vital link between the community and the health care delivery system.

24. The training programme is already in progress in the country. Manuals have been drawn up and are being supplied to the workers and suitable teaching aids and lesson plans have been prepared for their proper training. The States have indicated the drugs to be supplied to the community health workers and necessary action is being taken to meet the demand within this year. Excepting the States of Tamil Nadu and Karnataka, all the States have joined in this Programme.

COMMUNITY HEALTH WORKERS' PROGRAMME

Primary health centres selected for the Community Health Workers Scheme

State/Union Territory	*Districts*	*PHCs*	*PHCs selected for the programme*
1. Andhra Pradesh	21	416	101
2. Assam	10	146	10
3. Bihar	31	587	31
4. Gujarat	19	251	103
5. Haryana	11	89	25
6. Himachal Pradesh	12	77	12
7. Jammu & Kashmir	10	80	7
8. Karnataka	19	266	
9. Kerala	11	163	
10. Madhya Pradesh	45	457	45
11. Maharashtra	26	391	97
12. Manipur	6	17	13
13. Meghalaya	5	14	3
14. Nagaland	7	11	
15. Orissa	13	314	13
16. Punjab	12	128	25
17. Rajasthan	26	232	27
18. Sikkim	4	5	4

State/Union Territory	*Districts*	*PHCs*	*PHCs selected for the programme*
19. Tamil Nadu	15	382	
20. Tripura	3	27	3
21. Uttar Pradesh	56	875	182
22. West Bengal	16	315	15
23. A & N. Islands	2	2	1
24. Arunachal Pradesh	5	79	
25. Chandigarh	1	1	1
26. Dadra & Nagar Haveli	1	2	1
27. Delhi	2	8	
28. Goa, Daman & Diu	3	15	3
29. Lakshadweep	1	7	
30. Mizoram	3	4	3
31. Pondicherry	4	12	3
	400	5,373	