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- addresses PHC policy issues of national and international concern

- analyzes common problems in PHC program management, including planning, implementation and evaluation
- identifies gaps in knowledge about PHC and recommends research to fill those gaps
- provides up-to-date technical and policy information on PHC delivery.

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Reader comments are invited. They should be addressed to: the Director, APHA/IHP, 1015 Fifteenth Street, NW, Washington, DC 20005, USA.



In Thailand, community members and project staff work together to build a new well. PHOTO: AID 66-40-388

community participation

in primary health care

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ABBREVIATIONS

AID	Agency for International Development
APHA	American Public Health Association
CHC	community health committee
CHW	community health worker
CP	community participation
MOH	Ministry of Health
PHC	primary health care
PVO	private voluntary organization
TBA	traditional birth attendant
VHW	village health worker
WHO	World Health Organization

foreword

Community participation, a much discussed component of the primary health care (PHC) approach, is one of the most difficult elements to implement. While confident rhetoric concerning community participation abounds, in point of fact the international health community is only beginning to identify critical elements of the community participation process. The rhetoric of community participation is quite different from the reality: associated problems are numerous, and heat, more than light, characterizes most discussions on the subject among professionals.

Community participation stimulated by private voluntary organizations in charismatically directed, small-scale PHC projects has yielded exciting positive results that demonstrate community members' involvement in their own care. People have learned that they can organize healthier communities, as well as other areas of their lives. Successful community participation in health frequently results in general political consciousness-raising and the growth of awareness that, even in small ways, it is possible to take charge of one's own life and the life of one's community.

Considering the examples of successful community participation in some small programs, why is this strategy so difficult to implement on a large scale? One of the principal problems is that national bureaucracies and community-level participation are diametric opposites in a number of ways.

Because large-scale, national-level PHC programs are either exclusively or partially funded by tax monies, central, national-level bureaucratic structures must administer such funds. Central government departments are congenitally unwilling to share power even in those few instances in which a legislative basis for such power-sharing exists. Internal requirements for control and accountability and legal standardization of the means and methods by which such requirements are satisfied by functionaries and staff are generally legislated in national law and specifically detailed in legal regulations. By design, specific regulations usually diminish flexibility and decrease allowable options.

In such federal, national, state, and provincial-level statutes and regulations, bureaucratic norms are the rule. PHC projects and nationally-funded PHC programs are thus pressured in the direction of paying more attention to correct legal procedures than to results. The importance given to rank, hierarchy, and the roles of the actors in such systems also transcends the importance of tasks, though general lip service is given to "missions" or "mandates." Financial propriety — lit-

eral observance of regulations rather than flexible cost-efficiency — receives high priority whenever national tax monies are the source of program support. More than aberrations of any single system, these norms are attributes of all large, centralized, national-level bureaucratic organizations, departments, or ministries.

Clearly, small-scale, privately-supported projects and large-scale, governmentally-funded activities differ in the manner in which they approach problems and the acceptable means of solution. Out of these differences come conflicts of philosophy, priority, procedure, and means, even when common ends are sought. Such conflicts, however, should not be seen as a reason to abandon community participation approaches. They should be viewed as problems to be solved and obstacles to be surmounted.

In his philosophy of dialectical materialism, the German philosopher Hegel perceptively noted that man's history is a litany of great ideas in conflict. Throughout history, strongly-argued theses have stimulated strong opposing antitheses. Out of the conflict of opposing principles, new insights and valuable syntheses have emerged in time. The beginnings of this process are evident in the case of community involvement and community participation in PHC. Yesterday's radical, revolutionary concepts have become today's conventional wisdom. There is every reason to believe that this evolutionary process is slowly taking place, that bureaucracies are reluctantly modifying their terms of reference, and that the urge of their people to increase their self-determination has been gaining strength.

This report will not lay to rest the problems of community participation in PHC. It does present information and insights from the lessons learned in some 35 PHC projects that display community participation and community involvement elements. The intent of the authors is not to present "the final solution to the community participation problem," but to share the lessons learned to date. This process is a pilgrimage, and, as is true for any pilgrimage, the journey is as important as the destination itself. Certainly the journey thus far has produced worthwhile knowledge; at the same time it is clear that those of us in PHC have "promises to keep and miles to go before we sleep."

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Mexican children work in a school vegetable garden and learn lessons in self-reliance, cooperation, and nutrition. PHOTO: WHO/UNICEF 18327 by D. Mangurian

introduction

The purpose of this report is to clarify how community participation can help primary health care (PHC) programs and projects in developing countries achieve their goals and objectives. This report highlights major issues, presents strategies for achieving participation, reports on different ways communities participate, and draws conclusions about what has or has not worked and why.

Much of the extensive writing on community participation falls into two categories: theoretical overviews and studies of individual projects. These sources give little help to program designers or managers in answering such key questions as whether participation is appropriate, what kinds can be most helpful in furthering project goals, and how such participation might be encouraged. Questions addressed in this report that are likely to arise in the course of project design and implementation include:

- What is community participation?
- Why is community participation important? How can it help achieve health objectives?
- How can the community's objectives and priorities be reconciled with the objectives of the professional health staff?
- How can social, political, and organizational constraints to participation be dealt with?
- How do project design and structure affect participation?
- How do donor agency policies and operating procedures affect community participation?

The World Health Organization (WHO) defines primary health care as "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford." Although admitting that community participation "is understood and interpreted in different ways by different countries," WHO advocates extensive community participation—in assessing the situation, defining problems, setting priorities, planning activities, changing lifestyles, and contributing labor and money—in order to enable communities "to become agents of their own development instead of passive beneficiaries of development aid."¹

Rather than accept the WHO viewpoint as a *prima facie* truth, this report takes an empirical look at a topic

on which people tend to have preconceived ideas. It is not taken as given that maximum participation is desirable in all cases; nor is it assumed that encouraging community involvement unnecessarily complicates carrying out a project. On the whole, the underlying point of view is that of a health planner working for a large, governmental organization—a person not necessarily interested in promoting participation for its own sake. Thus, community participation is considered more as a means of supporting projects than as an end in itself. Consequently, participation is examined as an integral project component to be planned for, supported, monitored, and evaluated like other project components.

This report hopes to make clear that community participation is a complex process that affects and is affected by numerous constellations of factors, including country and community characteristics, general project implementation and management approach, and donor agency policies and procedures. The country and donor agency contexts in which the project and community activities take place often determine the success or failure of efforts at the community level. Good planning and results cannot be achieved without taking into account the effects of these external factors.

The Projects Studied

The authors analyzed participation in 35 PHC projects (see Table 1, page 11) and reviewed a substantial amount of literature on community participation (see bibliography, pages 50-53). A 1980 AID-supported workshop on community participation provided an analytical framework and point of departure for the analysis.

The 35 PHC projects studied cover a range of size and type: national-level, regional, and pilot projects funded by governments, USAID, and other donor agencies, including small private voluntary organizations (PVOs) and missionary groups. All projects selected contain some kind of community participation in their approach or objectives; are under way or have recently terminated; and offer a reasonable amount of information for study. The AID-funded projects were selected from projects examined in an APHA study of AID's active PHC projects²; PVO and other non-AID-assisted projects were identified from documentation available in Washington. Although most project information comes from documents and interviews, in a few cases information was also obtained in the field. Summaries of the 35 projects (Appendix A) indicate the sources of project information.

Methodology

In preparing this report, the researchers systematically reviewed community participation according to two major dimensions—level and breadth—in order to analyze factors associated with more or less participatory projects and to guide PHC planners. The level of participation refers to the intensity of community versus project staff initiative or decision-making in a particular activity. The breadth of participation refers to how many and which community members participate and whether major groups in the community are represented by those who participate. Other aspects of participation evaluated were the extent to which participation took place throughout the project area (Was participation evident in all or only a few of the communities?) and the

durability and growth of participation over time. Also examined were community structures or organizations through which participation was channeled and processes used to establish and maintain participation.

Participation and Health Impact

The question of how community participation relates to ultimate health impact is difficult to address, since few impact evaluations are available and even fewer analyze the impact of community participation on health status. Nonetheless, development literature and the experiences of the projects studied yield substantial empirical evidence that community participation improves such intermediate measures of health impact as service availability, service utilization, and changes in health behavior.

CENTRO COMUNAL



A community meeting in the Dominican Republic. PHOTO: AID, by K. Chernush

TABLE 1 PROJECT NAMES AND ABBREVIATIONS

<i>Project Names</i>	<i>Abbreviations</i>
Afghanistan/Basic Health Services	Afghanistan/BHS
Bolivia/Rural Health Delivery Services	Bolivia/Montero
Bolivia/Mobile Health Program	Bolivia/Chiquitos
Colombia/Research Project on Community Participation in Health Planning	Colombia/Research
Costa Rica/Community Medicine Program	Costa Rica/CMP
Dominican Republic/Health Sector Loans I and II	Dominican Republic/Health Sector
El Salvador/Rural Health Aides	El Salvador/RHA
Guatemala/Rural Health Services	Guatemala/Rural Health
Guatemala/Chimaltenango Development Program	Guatemala/Chimaltenango
Honduras/Integrated Rural Health Services	Honduras/Integrated
Indonesia/Dana Sehat	Indonesia/Dana Sehat
India/Social Work and Research Center	India/SWRC
Iran/Kavar Village Health Worker Project	Iran/Kavar
Kenya/Kibwezi Rural Health Scheme	Kenya/Kibwezi
Kenya/Kitui Primary Health Care Project	Kenya/Kitui
Korea/Yonsei Community Health Teaching Project	Korea/Yonsei
Mali/Rural Health Services Development	Mali/RHSD
Mexico/Project Piaxtla	Mexico/Piaxtla
Nepal/Integrated Community Health Services Project	Nepal/Integrated
Nicaragua/Rural Community Health Services	Nicaragua/PRACS
Nicaragua/East Coast Health Delivery	Nicaragua/East Coast
Niger/Basic Health Services Delivery/Rural Health Improvement	Niger/Diffa-RHI
Nigeria/Lardin Gabas Rural Health Program	Nigeria/Lardin Gabas
Panama/Rural Health Delivery System	Panama/RHDS
Papua New Guinea/Mogoro Fugwa Health Center	PNG/Mogoro Fugwa
Papua New Guinea/Nazarene Hospital	PNG/Nazarene
Peru/Extension of Rural Medical Attention	Peru/Extension
Philippines/Development of Peoples Foundation Health Program	Philippines/DPFHP
Philippines/Panay Unified Services for Health (PUSH)	Philippines/PUSH
Senegal/Rural Health Services Development	Senegal/Sine Saloum
Sierra Leone/The Eastern Clinic	Sierra Leone/Eastern
Tanzania/Hanang Ujamaa Village Public Health Program	Tanzania/Hanang
Thailand/Lampang Health Development Project	Thailand/Lampang
Upper Volta/Save the Children/Redd Barna	Upper Volta/Save
Zaire/Vanga Hospital	Zaire/Vanga

Appendix A (p. 55) contains pertinent information about the projects and summarizes their community participation experiences. The summaries are listed alphabetically by country.



At a rally near Lima, Peru, beneficiaries and officials of the various community projects express their enthusiasm and support for health and educational programs. Community participation can help earn the support of political authorities. PHOTO: UNICEF 8991 by Herencia

what is community participation and why is it important?

Community participation is often invoked as an essential tenet of primary health care; yet, despite the rhetoric, there is only partial agreement on the nature and advantages of participation, and even less agreement on ways to achieve it. Activities ranging from payment of fees to community planning have been dubbed "community participation." In the 35 projects examined in detail, community participation has taken many varied forms:

- Villagers in the State of Sinaloa, Mexico, run their own health clinic and village outreach program. Local people direct, supervise, finance, and provide all services. The role of outsiders became purely advisory after the first 10 years of project existence. (Mexico/Piactla)
- In Lardin Gabas, Nigeria, village health committees selected by the people are responsible for collecting drug and service fees and other donations, ordering new supplies, and paying and overseeing the village health workers they recruit. (Nigeria/Lardin Gabas)
- Members of a community health cooperative in Davao City, Philippines, volunteer their time to operate cooperative pharmacies that sell drugs at reduced rates. (Philippines/DPFHP)
- Women's weaving clubs in Chimaltenango, Guatemala, use profits from the sale of their products to help support their community health program. (Guatemala/Chimaltenango)
- Villagers in Sine Saloum, Senegal, have contributed labor and local materials to build village "health huts," and in some cases funds to buy special zinc roofing as a mark of pride in their own village health facility. (Senegal/Sine Saloum)
- Health councils in Kang Wha, Korea, select health workers, control the service schedule and location of facilities, and share responsibility with staff for deciding which services are offered. They also manage a health insurance scheme and credit union that provide funds to pay health workers and support the program. (Korea/Yonsei)
- Communities in San Ramon, Costa Rica, organize raffles and dances as a way of raising money to support local health posts and preventive health projects. (Costa Rica/CMP)
- Community members in Colombia carry out evaluation surveys on project health activities and on partic-

ipation in planning. Survey results are analyzed in community meetings.

BENEFITS OF COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

Ideally, community participation expands the impact of PHC programs by contributing resources, increasing service utilization, and facilitating preventive activities, while at the same time enhancing the community's self-respect and ability to control its environment. Specifically, community participation can:

Promote socioeconomic development. Community participation can build community will, skills, and self-confidence in undertaking activities which promote integrated socioeconomic development. Evidence indicates that this may indeed be essential for bringing about improved health.

- After beginning as a charity medical clinic, the Philippines/DPFHP program evolved into a medical cooperative. As community skills and confidence grew, income-generation and community-improvement activities were initiated, including cooperative drugstores and credit unions operated through the cooperative's neighborhood organizations.
- The Guatemala/Chimaltenango project began in 1963 by providing clinic-based curative care. In response to community-defined needs, it trained people from the beneficiary communities to provide health and agricultural extension services. At the request of the community, many different development activities ensued; community members help plan and support these activities by volunteering time and labor and by undertaking fund-raising activities.

Increase community self-reliance. Community participation is now generally recognized as being an essential component of activities designed to lessen community dependence on outside agencies, including government health systems. The movement toward increased community autonomy may be manifested, for example, by self-reliance in ideas and initiatives, in funding and control, or in materials and manpower.³ This increased self-reliance is considered a key requirement for success of PHC programs even though these are not usually planned to create completely self-sufficient communities or to absolve government from responsibility for the people's health. In fact, PHC programs assume referral and support, including supervision, from a larger system. Nevertheless, community participation is consid-

ered a necessary step toward this release of the creative energies that will enable communities and their constituent families and individuals to begin taking more responsibility in resolving community health problems.

Lower costs. Community contributions of human and material resources will almost always be required in order to assure sustainability of PHC programs, especially those begun with external assistance. Host governments' financial contributions are unlikely to increase materially, at least in the poorest countries, during the next ten years. Thus community contributions are crucial.

- In Afghanistan/BHS, use of unsalaried part-time health workers from the community made possible a total cost per patient visit of only 43 cents. Clients defrayed half this amount by paying service and drug fees.
- In the highly participatory Nicaragua/PRACS project, local contributions for such community projects as small water systems and latrines were four times higher than anticipated by the end of the project's first year and covered about 10 percent of total program costs.

Increase service utilization. Community participation in defining needs and priorities can help ensure that programs respond to felt needs and can thus facilitate utilization and support.

- In the Colombia/Research project, a controlled comparison between communities incorporating community participation in promotion and education and ones using only traditional health education by staff showed much better results in communities with participation. Communities with participation had better immunization coverage than others, due to outreach by health committee members. In one area of the project, 75 percent of the people patronized community health workers (CHWs). In the communities with the highest participation, health professionals showed more interest and provided higher quality care.

Facilitate behavioral change. Community participation in project planning and implementation can promote the attitudinal and behavior changes necessary for improved health conditions. The most participatory projects among those studied were also those that achieved the highest degree of community recognition of and responsibility for preventive health activities.

- The Nicaragua/PRACS and Nicaragua/East Coast projects noted significant changes in health attitudes and practices. Both projects had active health committees that conducted community needs surveys and planned and implemented such health-improvement projects as wells, latrines, and community gardens.
- In the Colombia/Research project, measurable

increases in health awareness and habit changes have occurred, and a sizeable decrease in diarrhea and general morbidity has been measured in the most participatory communities.

- In Guatemala/Rural Health, Panama/RHDS, Zaire/Vanga, Sierra Leone/Eastern, and many other projects, communities have helped construct latrines, water systems, and garbage disposal areas, and have then adopted the improvements into their daily life.
- In the Philippines/DPFHP project, use of toilets/latrines increased to 76 percent of the population by 1977. In 1976, a 90 percent decline in parasites in children was noted.
- In Bolivia/Chiquitos, some communities reported a significant improvement in sanitary conditions and in the use of latrines.

Encourage government support. Community involvement can help promote continued government support of PHC and the essential "political will" needed over the long term for project success.

- In Nepal/Integrated, community political leaders are involved in selecting CHWs. This has created mutual loyalties and given politicians a vested interest in the program. At the legislative level, such political interest has been manifested in willingness to provide the program with adequate resources.
- The Colombia/Research project has found that intensive community involvement brings about greater interest and responsiveness by government health personnel toward community health problems.

Contribute unique knowledge and resources. A participatory approach can result in much greater use of substantive community resources (e.g., traditional medicine) and knowledge (e.g., of the best time and place for service delivery), some of which may be unknown to people outside the community.

- In Honduras/Integrated, failure to consult the community resulted in unused health posts. The ones built were not located along the most direct and commonly traveled routes, which had fewer rivers to ford or mountains to climb.
- Sometimes staff determine service areas using political or administrative subdivisions that run counter to actual community groupings. This has been detrimental to both participation and service delivery. In Mali/RHSD, communities would not work together to support a common health center, and in Bolivia/Montero, forced grouping of communities within government programs stimulated rivalry and fragmentation.
- The Mexico/Piactla project encourages traditional healers and midwives to participate in CHW training classes. Instead of a lecture, the CHW students and

midwife or healer explore together what they know and can share with each other. For example, a midwife can tell health workers about common local beliefs and how to respect these; students learn to respond to the concerns of pregnant women in a sensitive, reassuring way.

Create more culturally appropriate services. PHC services provided by community people are often more culturally acceptable than those provided by outsiders.

- A survey in Honduras/Integrated indicated that rural residents have the most confidence in health guardians (CHWs) and auxiliary nurses from their own communities. Rural people expressed resentment toward the brusque, impersonal treatment often given by non-community personnel at health clinics.
- Interviews with villagers in Niger/Diffa-RHI revealed that they much preferred health services from village workers, in whom they had considerable confidence, to services offered at health centers outside the village.

Facilitate service coverage. Health workers selected and/or compensated by the community can facilitate coverage of PHC services at the village level.

- Use of community-selected and financed health workers in the Lampang/Thailand project increased the government health services' coverage from 20 percent of the population in 1977 to 70-80 percent by 1981. Use of CHWs has also relieved pressure on overcrowded hospitals, since people can make use of services available in the community.
- Village-selected health workers in Tanzania/Hanang have extended health services coverage from 25 percent of the villages in the district project to 95 percent in 4 years.
- Through CHWs, the India/SWRC project has provided affordable services to many people who otherwise would have none. Between 1973 and 1977, dispensaries treated 100,000 patients; CHWs averaged over 100 household calls per month.

LIMITATIONS/RISKS OF COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

While, as already indicated, participation is necessary for activities to be effective, community participation is not a panacea or a solution for all problems besetting PHC projects. As will be discussed in Chapter III, some kinds of participation are neither feasible nor necessary in certain circumstances.

In general, community participation requires an investment of substantial personnel time for motivation, training, and monitoring; moreover, it has political implications that may not be acceptable. Four of the

most common limitations/risks are outlined here. Community participation can:⁴

Absolve the government of responsibility. There is a risk that health agencies will use community participation to absolve the health system of responsibility by placing primary responsibility for health on communities that still need some outside assistance. It is particularly inequitable to ask rural residents to make financial contributions if urban dwellers receive free services.⁵

- In Afghanistan/BHS and other projects, many communities that were given the responsibility for paying community health workers felt the government should pay. The governments, however, felt that they could not afford to pay this cost, and that it had to be a community responsibility.

Threaten political authorities. Community participation is politically sensitive; it can lead to increased community demands and become threatening to authorities.

- A consultant visiting the Guatemala/Rural Health project found that community participation was seen by some as politically threatening. The authorities and the populace feared anything remotely resembling politics.

Support local elites. Working with community leadership — a common way for projects to tap into existing organizations and decision-making channels — risks supporting traditional patterns of exploitation by local elites. This occurs more easily if the agency relinquishes all control.

- In the Niger/Diffa-RHI project, according to an anthropological study, existing community structure made it impossible to achieve the type of community participation envisioned for the health project; therefore, the project inadvertently helped strengthen and concentrate the traditional power of the headmen, who recruited "participants" on the basis of personal loyalty.

Disillusion community members. Community participation may make great demands on the implementing agency to sustain a level of project management adequate to maintain popular credibility. Providing sufficient supplies, supervision, monitoring, and training are often problems for larger projects that may have to support activities in hundreds or even thousands of individual villages. Once communities have made contributions toward program objectives, the failure of the project to follow through with services and other support may lead to a backlash against further development programs.

- In Bolivia/Montero, communities showed great interest in the project and were motivated and organized, but participation declined dramatically as people became frustrated as a result of delays in providing promised services.



A community health discussion in the African countryside. PHOTO: UNICEF 8477 by Belknap

how can community members participate?

Supported by guidance that rarely goes beyond such directives as "projects shall incorporate community participation," project planners and managers are often uncertain about how to proceed. They may make a few ritualistic references to community participation in project plans and hope that participation will somehow occur despite scant effort to foster it. This need not be so. Although community participation cannot be planned in the same detail as a training course or construction of a hospital, systematic planning for encouraging participation is quite possible for PHC projects.

This chapter will discuss ways in which communities participate in primary health care projects and help projects achieve their goals. It also discusses how project staff can best encourage and complement community participation.

Although primary health care projects vary from country to country, their main goals generally are to improve the health of the population and to provide health services that are affordable to both the government or other sponsor and to the users. Projects seek to improve health status by:

- increasing service availability,
- increasing service utilization,
- modifying behavior, and
- initiating health-related community activities such as building water and sanitary infrastructure or establishing agricultural projects for cash crops and/or improved food crops for local consumption.

Three avenues through which projects can encourage communities to contribute to achieving these goals are:

- seeking contributions of resources from the beneficiaries of services;
- delegating some planning, management, and other functions to the community; and
- encouraging the community to participate in project evaluation.

Table 2 provides examples of ways communities can participate in project goals.

The following sections examine the kinds of inputs required from the project and from the community and how projects can encourage and assist community participation in achieving each of these major objectives. Project procedures and policies that impede participation are also reviewed.

INCREASING SERVICE AVAILABILITY

Over the centuries communities have developed their own sources of health care and traditions for dealing with illness. While these may be neither the most modern nor convenient, project planners should not take for granted that communities will wish to exchange them for new sources of health care or that people will appreciate the preventive aspects of PHC projects. This is one of the major reasons why it is essential to ascertain community interest and reach agreement on project and community responsibilities *before* the project makes any substantial inputs. A decision not to participate by some communities within the project area could fragment the service area, but such a risk is preferable to that of incorporating communities that are not interested.

Communities are frequently expected to play key roles in PHC projects by selecting community members to serve as village-level health workers, by building and maintaining health posts and water systems, and by assisting in immunization and other service activities. Project experience has shown that for community support to be strong, it is essential for communities to decide whether or not to be part of the project, a decision that is influenced by whether the project's health goals are among the community's priorities. Once this decision has been made, the community should have some voice in determining what obligations it will take on and how it will carry them out.

Community participation in the initial decision to participate in the project should be broadly based, providing all villagers and related power groups with an opportunity to approve or reject the project. This is especially important if, as is true in most cases, community members are expected to make contributions of money or labor.

To obtain this decision to participate, project staff in some cases consult only village leaders. In other cases staff first discuss the general plans with leaders and then have them arrange a meeting or series of meetings with the wider community to discuss the project. The amount of staff time required to obtain community approval is not necessarily extensive, but will involve at least several visits to each community. Projects have found that well-organized motivation and community education efforts by the project staff can substantially increase the demand for the project and thereby reduce the number of communities that do not wish to join.

The Nigeria/Lardin Gabas project has developed a way of screening out low-interest villages.

TABLE 2 WAYS COMMUNITIES CAN PARTICIPATE IN ACHIEVING PROJECT OBJECTIVES

<p>1. Increasing Service Availability</p> <ul style="list-style-type: none"> • deciding to participate • providing volunteer CHWs • building health facilities • lobbying government officials and politicians • assisting in immunization, family planning, and other service-delivery activities <p>2. Increasing Service Utilization</p> <ul style="list-style-type: none"> • setting priorities • determining services • selecting CHWs • establishing selection criteria for CHWs • deciding time of services • setting charges for services • deciding location of facilities or other service-delivery points • helping choose basic drugs • publicizing services <p>3. Modifying Behavior</p> <ul style="list-style-type: none"> • providing information on habits • providing social support • educating and motivating other community members • adopting new behavior 	<p>4. Carrying Out Health-Related Community Activities</p> <ul style="list-style-type: none"> • digging wells, constructing water storage and distribution systems • collecting garbage • draining stagnant water • constructing latrines • working in collective vegetable gardens, poultry-raising, and other food production <p>5. Contributing Resources</p> <ul style="list-style-type: none"> • contributing labor for construction of health posts, latrines, water systems • contributing materials for same • maintaining and cleaning facilities • paying for drugs • paying CHW salaries • paying for health services • paying for water use <p>6. Carrying Out Management Functions</p> <ul style="list-style-type: none"> • supervising CHWs • managing health posts • maintaining health posts and other facilities such as wells and pumps • managing resources to support CHW and services • managing drug supplies • organizing and conducting evaluation surveys • collecting information and vital statistics • discussing and acting on health survey results
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- If little interest is shown on the part of the villagers at a second meeting of project staff with the community, the program is not promoted. Since the success of the program is felt to depend upon strong village initiative and interest, the staff feel that to urge uninterested villagers to participate is to introduce a serious risk of failure. Interest factors that rank high include: the percentage of the village turning out for meetings; the extent of participation and planning in the meetings; and the percentage of younger adults present.

In a number of projects reviewed, service availability suffered because communities were not carrying out their responsibilities. Part of the reason was that they received insufficient initial orientation about what was expected of them and about the project and its goals. It may also be that community members had little opportunity to be involved in basic project decisions.

- In the first phase of the Senegal/Sine Saloum project, this situation resulted in large part because in its visits to villages, the agency responsible for community organization placed greater emphasis on the benefits to be derived from the health project than on the responsibilities village members had to assume.

- In contrast, the Nigeria/Lardin Gabas project makes sure that communities fully understand their responsibilities by using a contract with the community as a way of formalizing the relationship and making the responsibilities of each party clear and the agreement more binding.

INCREASING SERVICE UTILIZATION

Projects seek to improve the utilization of both preventive and curative health services. Information from the projects reviewed and literature on community participation indicate that involving the community in decisions about services can be an important factor in improving their use. Specifically, the following types of decision-making by the community are important: setting priorities for the project to address, determining services to be provided, selecting sites for health facilities, and selecting community health workers. (See Table 4, p. 28.)

Setting Priorities

Communities and technical health staff frequently have different priorities. A community's major priorities are often increased income and an improved standard of

living, while the project staff have health status as their prime concern. The dilemma posed by the differences in community and project priorities has been handled in a number of ways.

Some projects ignore or do not even try to learn about the community's non-health priorities. This discourages participation, or even utilization. Other projects go along with community desires to address non-health problems, at least until community members gain an appreciation for their health needs.

- In the Kenya/Kibwezi project, drinking water was the community's greatest "felt need." Using the community's crucial need for water as an entry point, project staff worked with the local development committees (which also covered health matters) to provide wells and construct dams.

Determining Services

The projects reviewed demonstrate that consulting community members about their needs and preferences regarding types of health services provided, sites, and service hours makes activities and services more acceptable and accessible. If communities are expected to help provide and finance health services, they must be given some voice in determining the services.

Community health priorities are usually for curative care, i.e., measures to alleviate immediate problems. Staff, on the other hand, are more concerned with prevention, and are likely to set health priorities on the technical grounds of epidemiological data, sanitation surveys, and the feasibility and costs of interventions. Communities may not even be aware of the issues considered by the technical staff.

Of the projects reviewed, only the Mexico/Pixtla project gave the community the entire responsibility for determining functions of CHWs, though a few other projects have gone quite far in including the community in such decisions. Most projects have found it desirable to take community preference (generally for curative services) into consideration, while at the same time promoting acceptance of preventive measures. A few projects (e.g., Mali/RHSD) began by providing only curative care, using it as an opening wedge in introducing preventive concepts and care.

The projects that attempted to focus solely on prevention usually were not successful since CHWs who do not provide care tend to lose credibility:

- A pilot project for El Salvador/RHA that gave the CHW only preventive functions was forced to add curative functions in order to gain community acceptance.
- Community desire for "substantive" services, as well as community health committee (CHC) members' desire to be more useful, caused planners to add emergency curative services (first aid) to CHC func-

tions in Colombia/Research as a supplement to CHW services.

The evidence suggests that the timing or sequence of introducing curative and preventive functions is key. In most circumstances, CHWs who begin with predominantly curative functions establish credibility and provide a basis for community acceptance. Preventive concepts and activities can be introduced gradually.

Selecting Sites for Health Facilities

Projects have found that utilization of health services is improved when the community is given a role in selecting the site. Individuals in a community know patterns of movement within and around the community, as well as social and political factors that should be considered in the placement of facilities. For project planners, consulting the community is often effective and less costly than conducting a formal study.

Failure to consult the community can result in poor utilization of facilities, as has occurred in Peru/Extension and Honduras/Integrated. Yet, as with other decisions, project staff must play an active role by presenting the technical considerations that must be taken into account in selecting sites (access to roads, proximity to other facilities, and other factors that affect the project's ability to support services), and by making communities aware of financial and other consequences of their choices. To leave the decision entirely to communities can have negative consequences.

- In the initial phase of the Senegal/Sine Saloum project, rural councils chose hut locations without any guidance. Consequently, council members usually secured one for their village, and a few larger villages were selected regardless of proximity to other health facilities.

Selecting Community Health Workers

Giving the community a role in selecting CHWs helps ensure community acceptance and support of these service-delivery agents, especially in projects that expect communities to pay their CHWs. Projects with government-paid CHWs, although less dependent on community participation in selection, must at least be sure of CHW acceptability.

Failure to involve the community in the selection process can have negative effects on service utilization.

- In Nepal/Integrated the CHWs (government rather than community-financed) were not selected by the communities; they were largely urban and high caste, and all male. As a result, they have had difficulty in working effectively with low-caste villagers and women. The program has since attempted to overcome these problems by introducing village-selected volunteers.

Leaving the decision entirely to the community has also been found unsatisfactory. For example, CHWs

may represent only one faction; they may be the less appropriate sex for reaching the primary target group; or they may be controlled by local elites and may therefore neglect the poor and low status members of the community.

- An evaluation of Mali/RHSD states that "even though it was apparent that lack of definite requirements would probably result in candidates who were all males and mostly illiterates, the principle of the villagers' making their own decisions was considered paramount . . ." Unfortunately, the male illiterates who were selected performed poorly and neglected women and children.

Community selection without staff orientation and guidance does not seem to work well; neither does imposition by staff without community input. Projects have an important role in working *with* the communities to define CHW selection criteria that are appropriate to local circumstances and needs. In developing selection criteria, project staff and the community should discuss four key factors.

Technical skills required. On the whole, the higher the level of skills required, the stricter the selection criteria must be and the narrower the range of community choice of CHWs. Therefore, to provide a meaningful selection role for the community, it is prudent to adjust initial CHW functions and activities to a rather basic level of skills and education and to increase skills gradually through inservice training.

Level of compensation offered. Skills and characteristics sought in CHWs should be commensurate with the level of compensation offered. In cases where communities pay CHWs, it is not practical to require qualifications that have a higher value in the market than the community can pay.

Personal characteristics. Certain personal characteristics of a CHW such as sex, age, caste, or social status may be influential in selection and may also contribute to CHW acceptability and effectiveness.

Community characteristics. Social, cultural, and political factions may exist that make it difficult to select a CHW who can actually serve (and be supported by) the entire community. Discussion of these issues with the community can help pinpoint potential difficulty and help the staff and community to work out solutions jointly.

The kinds of community decision-making that enhance service utilization—determining priorities, services, sites, and selecting CHWs—appear to be most effective if broad community representation is obtained in reaching the decisions. While leaders and committees can be delegated these responsibilities, it appears that projects benefit by obtaining a wider community input.

Neither communities nor project staff on their own are likely to make "good" decisions; the kind of dia-

logue required to reach joint decisions, however, requires considerable input of time and effort from the project staff. Each decision may involve one or more meetings in each community.

MODIFYING BEHAVIOR

PHC projects strive to modify the behavior of individuals and families in the community. Changes in dietary habits, child-feeding practices, sanitary practices, and fertility behavior are common project goals. While these are individual rather than community actions, the community can participate in carrying out health education and can also play an important role in establishing new social norms, thus increasing the impact of health-education efforts.

A few projects have tried to involve community members other than the CHW in undertaking health education.

- A carefully controlled experiment in Colombia/Research showed that health awareness and habit changes in villages that participated in health education (as well as in other aspects of project planning and management) were substantially greater than in communities that received only traditional health education by the staff.

Results from other projects, although not as clearly documented, also indicate that involving the community leads to greater achievements.

The kinds of health education procedures and activities vary. Some communities have organized special meetings and presentations; others have selected special groups of people to point out poor health and sanitation practices and motivate changes.

- In the Colombia/Research project, the health committees have taken the lead in promoting community participation in educational and other activities. With staff guidance, the committees set up "community vigilance" systems to identify personal and environmental health problems in the villages. This system appears to work well.
- In Lampang/Thailand, CHC members trained to carry out health education concentrate their efforts on publicizing and motivating acceptors for the mobile vasectomy clinics, helping with the nutrition surveillance program, promoting a safe household water supply project, and participating in a program of oral rehydration for control of diarrhea.
- In Costa Rica/CMP, CHCs, CHWs, teachers, and other community leaders work with project staff to organize an annual health education week in each community. The week features health-related talks, films, slides, dramatizations, exhibits, and contests, as well as discussions of health problems. These are well-attended, popular events.

A number of project policies and activities appear critical for obtaining community participation in health education. These include the following:

Planning. Project plans are often vague about how ongoing promotion and education are to take place in the community. It is very useful for project staff to determine with the community who is to carry out health education and how it is to be done.

Training. Projects have found it very helpful to provide training to CHWs and possibly other community members in preventive concepts, community organization methods, and promotional techniques. The lack of such orientation frequently leads to problems.

- The CHWs in the Peru/Extension project have not been very successful in motivating community involvement or in changing health attitudes and practices. A project evaluation indicated that training was too theoretical and curative oriented and apparently did not cover community development. As a result, the CHWs' emphasis is on curative care rather than community organization for new health activities.

Support. Continued guidance and supervision of CHWs and other community members is essential.

- After nearly six years of implementation experience, Thailand/Lampang project staff stress the need for overall impetus and backing from the health staff, pointing out that it is unrealistic to expect briefly-trained volunteers to keep up enthusiasm and initiate educational activities, given the current low levels of community awareness and interest.

Comprehensiveness. Health education carried out by the community should reach all segments of the population. If special efforts are not made to sensitize project and community personnel and to help them devise ways to include all groups, minority groups, low-caste people, or women may be excluded from the health education component of the project—obviously a serious omission.

Incentives. Finally, some type of incentive may be necessary for CHWs or CHC members to devote much

of their time to promotional or educational activities. Little information, however, is available on how projects have sustained such community promotional and educational activities as latrine construction on a long-term basis. Economic incentives are often prohibitive in cost; they are also frequently opposed on the grounds that people should not be paid for participating in self-help activities. Other kinds of incentives have been tried, such as public recognition by officials, but have not been systematically studied.

CARRYING OUT HEALTH-RELATED COMMUNITY ACTIVITIES

In many of the projects reviewed, communities have provided labor, materials, and even money for activities designed to improve health. Table 3 lists examples of the kinds of collective health and related activities planned or actually undertaken by communities.

Such activities are often the most visible aspect of participation. Unlike individual behavioral change, they constitute a communal approach to improving health, since they involve the community or groups of individuals in collective solutions to environmental, nutritional, and other health problems.

Communities do not often move beyond a supportive role—cooperating with project-initiated activities—to an initiative or decision-making role, such as identifying health problems, discussing solutions, and undertaking activities. In some projects, however, this desirable result has been achieved when the staff have served as a catalyst for a dynamic process of community resolution of health and related problems.

- In the Nicaragua/PRACS and Nicaragua/East Coast projects, people joined together to plan, build, and maintain wells, latrines, and community gardens. Significant changes in health attitudes and practices were noted.

As numerous authorities on community development have observed, many years of concerted effort by project staff may be required before self-initiated activities can be expected. Even then, communities are never

TABLE 3 COLLECTIVE HEALTH AND RELATED ACTIVITIES

—collective production of nutritious foods
—construction of pit latrines
—collective rearing of goats
—construction of water catchment and distribution systems and of dug or drilled wells
—protection of existing wells and water supplies

—establishment of day-care facilities
—group poultry farming
—improvement of housing conditions
—improvement of sanitary conditions in the market
—drainage of stagnant water
—construction of drainage ditches
—organization of garbage collection

completely autonomous, and while the initiative may come from the community, outside funding and technical support in management, supervision, and logistics is usually needed on a more or less permanent basis. For most projects, therefore, the necessity for a long-range input of staff time and other resources from outside the communities should be foreseen. Project staff can stimulate community participation in health-improvement activities in several ways.

Staff time. A considerable investment of staff time is usually required to educate the community about the need for sanitation and other group actions that attack the root causes of illness and death. A number of projects have found the use of community-conducted health surveys (to identify health problems), together with discussion methods, to be effective ways of initiating the changes in health attitudes that must precede action.

- In Kenya/Kibwezi, the project team helped community self-help groups identify the main health problems and diseases affecting the community and trace the causes of the problems. The community groups then decided on a course of action and developed specific plans to deal with each major problem, with assistance from the project staff.

Funds for community activities. The availability of funds to help finance local projects appears to play a crucial role. While certain health-improvement projects can be funded relatively cheaply (e.g., organization of community garbage disposal may require labor, but little technical input or capital investment), other kinds of projects (e.g., water systems) may require a considerable outlay of money as well as outside technical guidance and training in maintenance. A few of the projects studied have established special funds for communities to draw upon for health-related projects.

- The Philippines/PUSH project has set up a special fund that communities can draw upon to finance local projects. These funds have typically been used for health center repair and improvement, purchase of cooking utensils and garden tools, accessories for drainage, and chemicals and sprayers for insect and vermin control.

Intersectoral coordination. Better health may depend on increased availability of food, an improved water supply, availability of simple technology to process and store food, or even road improvements. To provide communities access to technical assistance and financing in these different areas requires close coordination with other government ministries and public and private agencies. While coordination is planned for in most projects, it has been difficult to achieve in many cases. Nonetheless, several projects offer examples of specific actions and organizational designs that seem to facilitate such coordination:

- In the Philippines/PUSH project, primary responsibility rests with the National Economic Development Authority (NEDA), a planning organization with no rural field staff. NEDA coordinates the activities carried out by the field agencies: the Ministry of Health, the Department of Roads and Public Works, the Panay Provincial Government, and other agencies. This arrangement appears to have worked quite well in supporting community projects.
- The Upper Volta/Sequenega Integrated Rural Development Project (not among the 35 projects analyzed in detail) has utilized the concept of intersectoral coordination and cooperation to provide the financial, nutritional, and logistical underpinning to a pioneer PHC project.

CONTRIBUTING RESOURCES

To keep project costs low and so help governments increase the number of communities that can be served, most projects have tried to mobilize community resources to support health activities. This form of participation stimulates community involvement and a sense of project ownership.

The most frequent kinds of community contributions include:

- labor and materials for construction and maintenance of facilities
- financial contributions
- local medicines and medical knowledge.

Construction and Maintenance

Community cooperation in construction is very common in PHC projects. Almost all the projects have some activity of this kind, usually organized on a one-time basis. Common tasks are construction of health posts, water systems, and latrines. The community is generally responsible for getting people to provide labor and local materials, while staff provide the technical expertise, supervise construction, and arrange outside financing.

Obtaining participation in actual construction does not appear to be a frequent problem. In projects that encountered difficulties, the project staff had poor knowledge of local conditions, and the community had not been sufficiently involved in the project from its inception.

When communities do not have a strong role in the project, they are unlikely to see it as a *community* effort, and are much more likely to see requests for labor and other contributions as impositions from outside—requests they do not cooperate with very willingly. For example, community labor contributions in the Bolivia/Chiquitos and Peru/Extension projects were seen by the communities as an obligation to outside authorities rather than participation in a community project.

Likewise, if project design is unsuited to local conditions or social and political realities are not taken into account, participation, or even cooperation, is unlikely (see discussion of pre-project assessment, p. 36). The local sense of "community" and "cooperation" may be quite different from that envisioned by the project.

- The Niger/Diffa-RHI project reported that community contributions have been uncommon for either construction of facilities or CHW support because the social structure is characterized by relatively small family groups who have little tradition of participating in wider communal groupings.
- Because of inter-village conflicts, the Mali/RHSD project experienced problems with getting communities to build pharmacies to serve several villages. This was due in large part to the inadvertent groupings of villages solely on the basis of proximity, without taking into account village rivalries. In addition, participants were not well oriented.

Inadequate maintenance of such facilities as health posts, wells, and aqueducts is a widespread problem. Experience indicates that projects can improve maintenance by working out with the communities exactly what their responsibilities are and by training the responsible persons or groups to carry out their tasks.

- The Panama/RHDS project has developed an apparently successful system for community construction and maintenance of water systems. Before approving water and sanitation projects, the Ministry of Health and each community negotiate an agreement that covers construction standards, technical assistance, provision of outside and local materials, a community pledge to collect and pay water user fees, agreement on a payment schedule, and community selection of a person to be in charge of routine maintenance. The Ministry handles major maintenance.

Many projects are designed on the premise that community involvement in construction projects will serve as a springboard to other kinds of projects and health-improvement activities. This, however, does not happen rapidly or automatically. None of the projects studied that limited participation largely to providing labor and materials achieved any significant degree of community decision-making—indeed, those projects were usually not entirely successful in eliciting cooperation in construction. This is another indication of the importance of community participation in decision-making from the very outset of a project.

Financial Contributions*

Compensation of community health workers. One of the major contributions communities make to financing

*Community financing is explored in another paper in this series, *Community Financing of Primary Health Care* (Stinson).

PHC projects is the selection and support of community members to serve as volunteer or community-paid CHWs. Besides contributing to actual financing of PHC projects, community support of health workers appears to be critical for developing community interest in the project and support for other activities. It crystallizes the community's relationship to the project by supporting the residents' perception that the project belongs to them rather than to outsiders. When CHWs receive government salaries, community members tend to consider them as government employees, and hence to perceive the program as a government program—one for which the government rather than the community should have prime responsibility.

In 5 of the 35 projects reviewed, CHWs serve as volunteers; in 23 they are compensated by the community; in 5 they are paid a government salary; and 2 projects do not use CHWs. Few of the projects worked well with totally uncompensated volunteers, and even paying CHWs a partial salary led to problems; after a few months, workers began demanding a more stable and sizeable salary. It appears unrealistic to expect people to serve as unpaid volunteers unless volunteer service is part of local cultural patterns and sufficient non-monetary incentives are provided. Even then, projects have found that unpaid volunteers must be selected with particular care to reduce turnover. With female CHWs—who are often chosen for volunteer work—involvement in volunteer service may work against the development objectives of enhancing women's status through increasing access to earning opportunities and of changing the perception of women as sources of free or cheap labor.

The most common methods communities have taken to finance CHWs include in-kind activities and cash raised through drug sales, income-generating activities, and prepayment schemes.

Community financing of drugs. In one-half of the projects reviewed, the community finances the drugs used at the village level and manages the drug funds. In the remaining projects, drugs are either provided free of charge or drugs are sold to individuals, without involving the community in the collection or administration of drug fees.

Examples of the types of schemes communities have used to finance drugs include the following:

- In the Costa Rica/CMP project, by raising funds through raffles, bingo, dances, and other activities, communities cover half the cost of drugs.
- CHCs in Bolivia/Montero collect drug fees and send these to the regional level, where staff purchase new supplies. Twenty percent is returned to the CHC to pay the CHW.
- The Colombia/Research project supplies the CHW with free drugs, but one community worked out its own system to provide first aid supplies to its CHC.

- The Philippines/DPFHP project works through a locally-run cooperative mechanism with considerable member participation.

Obtaining community financing of drugs, while not without problems, appears to be relatively less difficult than obtaining financial support of CHW salaries or health services. Because people already value drugs highly, little motivation and education are needed for communities to take over responsibility for this program cost.

General financial support. Several of the 35 projects reviewed have instituted financing schemes to raise funds to pay for local-level PHC services, including drugs, supplies, and salaries of CHWs. These general revenue-generating mechanisms pay for a wider range of items and are less specific than those discussed earlier for payment of drugs or CHW salaries alone. Five of the projects have established pre-payment schemes, which operate on a regular basis and are designed as the primary source of funding. Three projects have set up income-generating activities that are used to supplement funding from other sources. Examples of such activities are bingo games and sale of communal crafts.

Generally, the community, through a health committee or other cooperative organization, administers the pre-payment programs with considerable technical guidance from the project staff. The following examples illustrate the variety of pre-payment schemes:

- In the India/SWRC program, local committees in each village collect and administer monthly contributions from each family (the amount is set in a community meeting), which are used to pay the CHW.
- Township health councils in Korea/Yonsei have organized and are managing a voluntary, non-profit health insurance scheme with assistance from a team of insurance experts. In 1979 it was estimated that premiums covered 90 percent of local-level health services.
- The Indonesia/Dana Sehat cooperatives cover drug and service costs. Each family contributes monthly fees (paid in grain or cash) determined by the community. The program in each village is administered by a committee of village leaders.
- One community in the Colombia/Research project has created a community health association to cover hospital drug and treatment costs for low-income residents. All community members make monthly payments.

Income-generating activities are usually promoted by the CHC or other community group.

- The Philippines/DPFHP project has established a dressmaking and crafts workshop that employs about 100 people and generates funds for the support of other community services, including the health program.

- Women in Chimaltenango, Guatemala, have established weaving clubs and have used part of their proceeds to help support the health program.
- Communally organized dances, raffles, bingo, and other fund-raising activities cover equipment and medicines for health posts; per diem and work expenses for CHWs; and community projects in Costa Rica's Community Medicine Program.

One of the prime requirements for such financing mechanisms is a certain amount of group solidarity and participatory experience. All of the communities using pre-payment schemes participate in a variety of other activities and are considered highly participatory.

Project support for community financing. For projects to involve the community in financing drugs, CHWs, or other project elements, the following activities are essential:

Obtain community input. Project staff should encourage as much community discussion and decision-making as possible in planning and managing financing schemes. The greater the community's role, the greater will be the community's feeling of responsibility. For pre-payment schemes, for example, communities can help decide such things as who is eligible, who in the community will pay full rates, whom the community will subsidize, which services will be covered by the scheme, and which will be paid for on a use basis.

Delineate responsibilities. Community financial responsibilities must be made very clear at the onset of the project. Difficulties have often arisen if this responsibility is glossed over or explained inadequately by the project staff when the project is first presented to the community. Helping communities to understand and accept prime responsibility for funding appears to require a great deal of staff attention.

- In Afghanistan/BHS, for example, the community never took steps to compensate CHWs adequately, in the belief that since CHWs had been trained, supplied, and supervised by the government, eventually the government would take over responsibility for paying them.

For the system to run smoothly, community members need to understand the scheme, how it works, and what their role is. In pre-payment schemes, for example, individual families must pay regularly and understand that they must pay even if no one is ill. Such an appreciation comes only if time is devoted to educating the community and involving them in the design of the fund.

Select a financing mechanism. It has been found useful for project staff to help the community choose an appropriate mechanism for collecting or generating funds. When a specific mechanism is not selected and the decision on how to raise funds is left entirely to the community, the matter often remains unresolved. Project staff can help communities develop and maintain

systems for raising funds and can see that the scheme is financially sound and feasible for the community to implement.

Provide training. Project staff often must train selected community members responsible for administering a financing scheme. Lack of such training has led to poor results in some projects.

- Village pharmacies were set up in the Mali/RHSD project under the control of the "pharmacist" (a villager chosen to manage drug sales and supplies) and a village cashier to control funds. The system has suffered from a high rate of error in record-keeping and inventory (up to 63 percent) because of poorly designed bookkeeping and inventory systems and lack of adequate training and supervision.
- Problems arose in the Senegal/Sine Saloum drug supply system because the community management committees were never adequately trained to manage it. Consequently, the CHWs ran it, *de facto*. Records were poor and no one was actually in control and responsible. Problems were compounded because income from drugs sold in the health huts was insufficient to meet costs of both CHW salaries and drug supplies.

For financial mechanisms other than fee-for-service, staff should develop sufficient administrative capacity in the community to run the fund. In several of the projects reviewed, CHC members were given management training and long-term guidance and support from the project staff.

Local Health Care Knowledge

Existing health care agents in the community—traditional healers and birth attendants—are community health resources that are presently either not used or not fully utilized by PHC projects. Greater use of such resources could be expected to reduce costs to projects and open new areas for community financing of health services. Traditional practitioners are a trusted and well-utilized source of health care in many areas of the world, and villagers are accustomed to paying for their services. The fees that have been worked out over the years are high enough to support the practitioner and are paid in kind or in cash (at the time services are provided or later when the individual is more able to pay). The fee-for-service systems established in each community are thus adapted to local circumstances and are effective.

Of the projects reviewed, nearly one-half trained traditional birth attendants (TBAs) to improve their skills and hygienic practices. Less than one-fourth of the projects made an effort to select traditional practitioners to be trained as CHWs. And only five projects made use of traditional herbs and remedies (as well as Western drugs) as a way of reducing program costs and making health services more culturally appropriate. Informa-

tion is lacking, however, on how well these programs have worked, and on the kinds of project efforts that are required to support traditional practitioners and incorporate traditional medicines and herbs.

CARRYING OUT MANAGEMENT FUNCTIONS

Another way in which communities have contributed resources to primary health care projects, and thus assisted in keeping program costs low, is by undertaking management functions that would otherwise have to be carried out by paid project staff and/or other government personnel at various levels. Although communities participate in management in many ways, the functions for which they most often have major responsibility are those discussed above—management of drug supplies and financing schemes—and supervision of CHWs.

About one-third of the projects have tried to engage the community in non-technical supervision or evaluation of CHW activities. Community oversight and monitoring of CHWs can supplement staff supervision—which in many projects is infrequent—and can help improve morale of CHWs, serve to increase community confidence in these health care agents, and help communities remove CHWs who are not meeting local needs.

Although in most projects CHWs are theoretically accountable to the community and removal power of CHWs is vested in the communities, CHWs often feel more accountable to the formal health system because supervision and evaluation are staff responsibilities. Unless there is a strong mechanism for community involvement and continuing approval of CHW activities (including control over salary), the CHW tends to become solely responsible to the outside supervisor. Rather than replacing CHWs who are not meeting health needs, community members more commonly begin ignoring a CHW who does not satisfy them.

The following examples indicate how two projects have organized and carried out effective community supervision of CHWs.

- In the Nigeria/Lardin Gabas project, health committee members are trained to supervise CHWs and are responsible for seeing that CHW activities are carried out. The treasurer of the CHC provides general supervision, collects receipts, and checks to see that all treatment data are recorded properly. CHW logs are reviewed monthly by the CHC and the CHW. CHC members are encouraged to visit and advise the CHW at work; the CHC also investigates problems. The CHW together with the CHC treasurer and village supervisor complete a monthly report on CHW activities.
- In the Mexico/Piactla project, community paraprofessionals oversee CHWs, although CHWs work mainly on their own. Such community autonomy is the result of a lengthy process of community motivation and preparation begun by outsiders in 1963; community members have gradually taken on all major administrative and service-delivery functions.

Accountability and supervision cannot be assumed exclusively by either the project staff or the community. Both parties must play an active role, and the project design should reflect this need. Technical supervision and support from the project staff are essential for high quality health services and competent medical care. Technical accountability is, therefore, generally given to the formal health system. The community can best be responsible for making sure that CHWs perform their duties, are available when needed, treat patients courteously, and respect local social customs.

Projects have found the following factors to be important in planning and implementing effective supervision:

Clear definition of responsibilities. Although assigned the function of supervising CHWs, communities often do not have a very precise idea of what they are expected to do. As the following example illustrates, project staff can promote proper community supervision by clearly identifying responsibilities and by discussing with the community how the duties will be discharged, what kinds of action they can take when problems arise, and otherwise preparing them to deal with their responsibilities. Without this project support, community supervision suffers.

- CHC supervision of CHWs has not worked out well in the Peru/Extension project, according to an evaluation, because of a lack of clear definition of CHC functions and linkages with the CHW, and because the project-dictated composition of the CHC resulted in the selection of members who lacked authority and leadership qualities.

Training of community supervisors. The projects that have experimented with community supervision have found that a certain amount of training and orientation should be provided to CHC members or other individuals charged with supervision. Follow-up staff assistance in overseeing activities and resolving problems has also been found necessary. Lack of these project inputs can result in little community supervision taking place.

- Committees in the Senegal/Sine Saloum project were not notably effective in supervising CHWs because of several factors, including lack of training and support for CHC members in carrying out this function and lack of community control over CHW compensation.

PARTICIPATING IN EVALUATION

Communities participate in monitoring and evaluating projects to identify problems and areas requiring attention. Community involvement in evaluation fosters community awareness of problems and promotes communal action to resolve them. This does not happen when evaluations are carried out by outsiders and findings are not discussed with the communities. Community involvement in these activities helps projects meet community needs and contributes to a sense of commu-

nal ownership and responsibility for the project. It also can help managers understand the reasons for problems.

The approach of involving the community in evaluation differs substantially from an approach that relies exclusively on surveys conducted by outsiders to obtain information about the community. While reliance on surveys can provide useful data, such an approach has little potential for involving the community in problem identification or resolution.

Local people have participated in evaluation by helping to develop issues to be examined, conducting surveys, analyzing findings, discussing findings, and determining ways to improve the project. About 25 percent of the projects studied give the community some role in evaluation. An additional 40 percent conduct community surveys but give local people no role other than responding to survey questions, while 35 percent show no evidence of any community input whatsoever in evaluation. The following examples indicate how some projects have given the community a substantial role in evaluation.

- The Colombia/Research project has the most thorough system for community involvement in evaluation. Ongoing monitoring and evaluation is done through surveys carried out by CHCs and analyzed jointly with the local health team. An evaluation of the project was carried out by CHC members trained to use a simple form to note responses by household heads in their villages. This evaluation covered the structure, process, and impact of project health services, as well as the participatory process itself.
- In the Nicaragua/East Coast project, an annual survey of health status and needs was conducted by members of the CHC and project staff. Survey results were reported to an assembly of the community at large. On the basis of these results, the assembly decided to confirm or replace the CHWs.
- CHC members also carried out periodic surveys in the Nicaragua/PRACS project. The CHCs held quarterly evaluation meetings to review health problems and community actions and propose needed modifications. Project staff provide appropriate technical assistance to the CHCs.
- The Philippines/DPFHP project has no formal evaluative mechanisms, but does involve the community in informal assessment of project activities through neighborhood and general meetings.

All of the projects that reported active community evaluation provided the following inputs:

Training and guidance. Thorough orientation, training, and supportive supervision are needed to make community participation in evaluation work. For example, in helping to select the topics to be covered by the evaluation, the staff might stimulate community discussion

about the program to help identify areas of concern. To carry out the survey, community members require training and supervision. The educational qualifications and background of the community members selected will dictate the level of training, orientation, and supervision required.

Use of interviewers from the community. Surveys do not appear to be effective in furthering involvement unless they are carried out at least in part by community members. There are indications that information-gathering by outsiders alone can even discourage community involvement in resolving problems and in helping to make the project work. Evaluation by outsiders may simply reinforce the perception of the project as a government rather than a community project, a viewpoint that encourages the community to absolve itself from responsibility.

Feedback of results. One of the most important steps that staff can take to increase the utility of surveys is to provide direct evaluation feedback to the community. This tends to heighten the community's sense of control and involvement in the project and to augment its responsibility for undertaking support and health-improvement activities. Because the results of surveys conducted by outsiders are infrequently reported back to the community, the opportunity to recognize and prioritize the problems revealed is lost.

BUDGETING FOR COMMUNITY PARTICIPATION

Since participation-oriented projects stress use of community resources and often use volunteer workers, they are sometimes thought to be very low cost. Consequently, no provision may be made for the sometimes considerable expenditures a community participation approach can entail. While such an approach may be cost-effective, the cost of developing participatory primary health care projects may be much higher than expected for two reasons. One is the high dependence of CHWs on effective training, support, and referral services in order to maintain their credibility; the other is the extensive preparation and organizational work usually necessary to motivate and maintain community involvement in PHC programs.

Although no cost data have been identified on the participation component of PHC projects, some specific items that should be considered in budgeting for participatory health projects include the following:

1. Training of:

- community organizers to promote and maintain community participation (training in community analysis, community orientation, group dynamics, etc.)
- CHWs to promote and maintain community participation (in addition to health training)

- CHC committee members (in group dynamics, relevant management skills for carrying out their responsibilities, etc.)
- supervisors on why and how to support community participation
- staff to regularly monitor and advise on community financing and management functions
- local people to manage community finance schemes, conduct surveys, maintain water pumps, and carry out other responsibilities

2. Personnel Needs

- community organizers to undertake pre-project work in the communities and assess interest
- community organizers to work with communities during the course of the project to help plan and undertake community-level activities and generally encourage participation
- technical experts to provide ongoing training and support for new community activities, such as drug distribution and data collection

3. Support for Personnel

- salaries
- per diem
- transportation (vehicle and fuel)

In addition to making budgetary provisions, projects that encourage substantial community participation may have to proceed at a somewhat slower pace than projects without such a component. Building interest in the program and developing appropriate organizational structures takes time, as does involving the community in planning and structuring project components.

While the overall costs of incorporating community participation may be considered high, three long-term benefits must be taken into account: reduced community dependence, community resource contributions, and more effective PHC programs.

This chapter has examined some of the many ways that communities in 35 projects have helped achieve the objectives of PHC projects. The potential for community participation in achieving project objectives has been only partially realized, both because projects have not sought participation in some areas, and because projects have not put forth sufficient effort to encourage and support participation. Important ways in which the project staff can plan to obtain participation are summarized in Table 4. These include making the community clearly aware of its responsibilities; putting sufficient technical input into community or joint staff-community decisions; training community members to perform new, specialized functions; and giving long-term guidance to communities. The specific contributions required from the community are also presented in the table.

TABLE 4 PLANNING PARTICIPATION: PROJECT AND COMMUNITY RESPONSIBILITIES

A. Most projects seek:	In order to achieve this, projects may need to provide:		
1. Utilization of:	<i>Trained Personnel</i>	<i>Facilities</i>	<i>Drugs and Supplies</i>
a. Curative services (equal accessibility for all in need)	<ul style="list-style-type: none"> • For direct service provision • For supervision • For referral support 	<ul style="list-style-type: none"> • Clinics close to all population groups • Appropriate equipment 	<ul style="list-style-type: none"> • To supplement private sources • Forms/records
b. Sanitary facilities and water supply	<ul style="list-style-type: none"> • To design facilities • To oversee work • To educate public • To train a few people in maintenance 	<ul style="list-style-type: none"> • Latrines • Sewerage systems • Wells, water catchment tanks, water distribution systems 	<ul style="list-style-type: none"> • Piping • Cement • Tools • Pumps • Spare parts
c. Immunizations (completion of series)	<ul style="list-style-type: none"> • To deliver vaccines • To motivate public • To transport vaccines • To give injections • To maintain records 	<ul style="list-style-type: none"> • Clinics or mobile units close to all population groups • Cold storage facilities 	<ul style="list-style-type: none"> • Effective vaccines • Forms • Cold chain equipment
d. Prenatal care (early and frequent contact; tetanus immunization)	<ul style="list-style-type: none"> • For direct provision, including immunization • For health education 	<ul style="list-style-type: none"> • Clinics close to all population groups 	<ul style="list-style-type: none"> • Vaccines • Iron sulfate • Vitamins • Possibly powdered milk and other food supplements • Scales • Forms/records
e. Postnatal care	<ul style="list-style-type: none"> • For direct provision, including immunization • For health education 	<ul style="list-style-type: none"> • Clinics close to all population groups 	<ul style="list-style-type: none"> • Vaccines • Scales • Vitamins • Other drugs • Weight charts • Forms/records
f. Obstetrical care	<ul style="list-style-type: none"> • For deliveries • For health education • For referring complicated cases in an expeditious and reliable manner 	<ul style="list-style-type: none"> • Clinics close to all population groups 	<ul style="list-style-type: none"> • Obstetrical kits for TBAs • Drugs • Forms/records
g. Family planning services	<ul style="list-style-type: none"> • To educate public • To contact users (potential and actual) • To provide services 	<ul style="list-style-type: none"> • Clinics close to all population groups 	<ul style="list-style-type: none"> • Contraceptives • Forms/records

	Communities may help by:	Communities may participate more actively if involved in decisions about:	Comments
Information and Education			
<ul style="list-style-type: none"> • To ensure prompt and complete treatment • To upgrade traditional practitioners 	<ul style="list-style-type: none"> • Identifying problems • Constructing/renovating clinics • Providing a place for health activities • Paying for drugs • Paying health workers 	<ul style="list-style-type: none"> • Deciding to join project • Clinic location • Service priorities • Staff selection 	<ul style="list-style-type: none"> • Some communities may decide not to participate, thereby fragmenting the service area • Demand for curative services is high, but some people will prefer private sources or hospitals. This should not deter plans to serve the majority of the population with quality services
<ul style="list-style-type: none"> • About disease sources and transmission • About alternative measures • About available hydrogeologic surveys 	<ul style="list-style-type: none"> • Constructing facilities (labor, local materials, and even cash) • Maintaining facilities • Paying toward recurrent costs 	<ul style="list-style-type: none"> • Whether or not to build these facilities • What types of facilities to build • Where they should be located • Setting up a maintenance system 	<ul style="list-style-type: none"> • People often help build these facilities but without understanding need for them; facilities probably will be utilized more if community takes the initiative
<ul style="list-style-type: none"> • Regarding need for immunizations or to complete series • Regarding dates and times of immunization sessions 	<ul style="list-style-type: none"> • Providing immunization sites • Helping to "round up" those needing shots • Reporting disease outbreaks • Serving as volunteers at immunization sessions • Providing local cold storage for vaccines 	<ul style="list-style-type: none"> • Location and time of immunization sessions • Education of the entire community 	<ul style="list-style-type: none"> • Immunization programs tend to see participation in terms of utilization, but communities can also provide volunteers, help motivate parents, and furnish useful information on appropriate scheduling
<ul style="list-style-type: none"> • About importance of prenatal care • About nutrition, etc. 	<ul style="list-style-type: none"> • Contributing to costs • Encouraging all pregnant mothers to attend 	<ul style="list-style-type: none"> • Location and time of prenatal care 	<ul style="list-style-type: none"> • The difficulty is in motivating mothers to attend when no one is "ill"
<ul style="list-style-type: none"> • About importance of postnatal care • About nutrition, etc. 	<ul style="list-style-type: none"> • Contributing to costs • Encouraging all new mothers to attend 	<ul style="list-style-type: none"> • Location and time of postnatal care 	<ul style="list-style-type: none"> • The difficulty is in motivating mothers to attend when no one is "ill"
<ul style="list-style-type: none"> • About importance of personal hygiene for mother and baby, especially on cord hygiene • About importance of seeking services from <i>trained</i> personnel 	<ul style="list-style-type: none"> • Contributing to costs • Encouraging mothers to use trained personnel 	<ul style="list-style-type: none"> • Providing the services and referral system 	<ul style="list-style-type: none"> • The difficulty is in providing the needed trained personnel, supplies, and referral in a timely fashion
<ul style="list-style-type: none"> • About use and availability of methods 	<ul style="list-style-type: none"> • Educating and trying to convince potential users • Contributing to costs • Distributing contraceptives 	<ul style="list-style-type: none"> • Services to be provided along with family planning 	<ul style="list-style-type: none"> • In China, community groups discuss effects of population growth and pressure individuals to conform with norms; however, this is not an applicable approach in many cultures

A. Most projects seek:	In order to achieve this, projects may need to provide:		
2. Modification of:	Trained Personnel	Facilities	Drugs and Supplies
a. Dietary habits (especially for children)	<ul style="list-style-type: none"> • For health and nutrition education 	<ul style="list-style-type: none"> • Locations (perhaps MCH clinic) for education 	<ul style="list-style-type: none"> • Food supplements • Written information • Audio-visual materials • Seeds, fertilizer for gardens
b. Sanitary practices	<ul style="list-style-type: none"> • For health education • For skilled construction, supervision, and maintenance of necessary facilities 	<ul style="list-style-type: none"> • Latrines • Water systems • Sewerage systems (in urban areas) 	<ul style="list-style-type: none"> • Piping • Cement • Tools • Pumps • Written information • Audio-visual materials • Spare parts
3. Resource generation for:			
a. Worker compensation	<ul style="list-style-type: none"> • To train trainers • To train workers • To help community calculate costs and income • To help manage money 	N/A	<ul style="list-style-type: none"> • A reliable and adequate drug supply generally essential (people are reluctant to pay workers who cannot provide drugs)
b. Local management of drug distribution	<ul style="list-style-type: none"> • For inventory management • For financial management 	<ul style="list-style-type: none"> • Drug distribution network 	<ul style="list-style-type: none"> • Relatively inexpensive drugs (see above)
c. Facility construction and maintenance (clinics, latrines, water and sewerage systems)	<ul style="list-style-type: none"> • To design facilities 	N/A	<ul style="list-style-type: none"> • Some construction materials • Supervision • Tools

N/A = not applicable

	Communities may help by:	Communities may participate more actively if involved in decisions about:	Comments	
<i>Information and Education</i>	<ul style="list-style-type: none"> • About nutrition • About locally-feasible solutions, including gardens, fish ponds, small animal raising 	<ul style="list-style-type: none"> • Providing information on dietary practices • Producing more nutritious food for local consumption 	<ul style="list-style-type: none"> • Emphasis on child health • Ways to improve dietary habits • Ways to provide more nutritious food 	<ul style="list-style-type: none"> • Communities may not share professional concern for child health, and adults may eat supplements intended for children • Only highly motivated communities may overcome such constraints as drought, lack of funds, and poor soil conditions
<ul style="list-style-type: none"> • About links between sanitary practices and health 	<ul style="list-style-type: none"> • Discussing importance of sanitation and praising those whose behavior promotes group health 	<ul style="list-style-type: none"> • Location and design of sanitary systems • Maintenance • Financial support of facilities, e.g., designing scheme for water users' fees 	<ul style="list-style-type: none"> • Group pressure may be essential to get individuals to change behavior • Constraints may be great and a slow, methodical approach may be necessary 	
<ul style="list-style-type: none"> • About alternative ways of compensating workers 	<ul style="list-style-type: none"> • Providing information on ability and willingness to pay 	<ul style="list-style-type: none"> • Whether or not to have a health worker • Method of compensation • Who should be exempt from fees • How much patients should pay • How money should be managed 	<ul style="list-style-type: none"> • Communities need to decide whether or not they wish to have and pay for a health worker • Broad participation is highly desirable, especially for plans that require individual payment • Adequate community compensation of CHWs is rare, partly because communities have been left out of basic decision-making. This fault in project design should be avoided. • Community resources normally must be supplemented by the PHC system 	
<ul style="list-style-type: none"> • Drug costs • Inventory procedures • Financial management 	<ul style="list-style-type: none"> • Paying for drugs • Managing pharmacies • Transporting supplies from district level 	<ul style="list-style-type: none"> • Whether or not to participate in program • Selection of drugs 	<ul style="list-style-type: none"> • Community-operated revolving funds are common but only sometimes successful, often due to insufficient preparation of the community, to poor design assumptions, or to resupply problems 	
<ul style="list-style-type: none"> • Guidance about design • Alternative designs 	<ul style="list-style-type: none"> • Providing labor, materials, cash, land, or rentable space 	<ul style="list-style-type: none"> • Clinic location • Facility design • Steps required to secure land or arrange rental 	<ul style="list-style-type: none"> • Community interest often starts high but wanes quickly if services are not seen as desirable and reliable • Maintenance is often neglected 	

A. Most projects seek: In order to achieve this, projects may need to provide:

4. Provision of information about:	Trained Personnel	Facilities	Drugs and Supplies
a. Vital events, diseases, and other events of public health significance, e.g. interruption of water supplies	<ul style="list-style-type: none"> • To record events • To aggregate data • To analyze data • To disseminate results 	N/A	<ul style="list-style-type: none"> • Reporting forms and related supplies
b. Problems arising from health services	<ul style="list-style-type: none"> • To manage complaints 	N/A	<ul style="list-style-type: none"> • Forms/records

B. Cooperation and utilization may be greater if communities participate in: To facilitate this, projects may:

1. Basic decisions about:	
a. The community's participation in the project	<ul style="list-style-type: none"> • Give information on project services and any community responsibilities • Ask questions to get community to think about advantages and responsibilities • Answer questions
b. The health problems to be emphasized	<ul style="list-style-type: none"> • Indicate which problems are easiest to resolve • Explain professionals' opinions on health priorities • Ask questions to encourage people to consider various problems • Answer questions
c. Program design at the community level	<ul style="list-style-type: none"> • Explain alternative delivery models • Ask questions to solicit community participation • Answer questions
2. Selection of:	
a. Community health workers	<ul style="list-style-type: none"> • Give information on expected tasks • Give information on what characteristics have worked out well or badly in other, similar projects • Answer questions
b. Clinic location	<ul style="list-style-type: none"> • Explain amount of space required for various services • Encourage accessibility for all groups
3. Community analysis and problem identification regarding:	
<ul style="list-style-type: none"> —water and sanitation —health conditions —food availability —possibilities for integrated development 	<ul style="list-style-type: none"> —population pressure —dietary practices —financial support <ul style="list-style-type: none"> • Ask questions to solicit community discussion of these problems • Give information on the causes and possible solutions to these problems, to stimulate community solutions • Answer questions
4. Community planning and execution of projects to reduce problems in these areas	
	<ul style="list-style-type: none"> • Ask questions to solicit community discussion • Answer questions • Provide material resources and training as appropriate

	Communities may help by:	Communities may participate more actively if involved in decisions about:	Comments
Information and Education			
<ul style="list-style-type: none"> • Information about reporting procedures and their importance 	<ul style="list-style-type: none"> • Identifying reportable results • Providing requested information • Supporting the work of those collecting data 	<ul style="list-style-type: none"> • The need for reporting • Information collection and analysis 	<ul style="list-style-type: none"> • Community members are rarely asked to do more than provide information
<ul style="list-style-type: none"> • How to register complaints 	<ul style="list-style-type: none"> • Be willing to give feedback 	<ul style="list-style-type: none"> • Major aspects of program implementation • How to handle complaints 	<ul style="list-style-type: none"> • Service utilization may suffer if complaints are not quickly identified and resolved • Good communication between community and staff can reduce this problem. Creation of an active CHC may facilitate this
Representation of women and minorities is important if:		Comments	
<ul style="list-style-type: none"> • They will be asked to cooperate in significant ways 		<ul style="list-style-type: none"> • Community understanding of project is frequently lacking because staff did not take time and effort to explain adequately • Community commitment is essential if project depends on local financing or other contributions 	
<ul style="list-style-type: none"> • Their needs are to be met 		<ul style="list-style-type: none"> • Staff often decide training priorities, but workers will perform mostly duties that community values (especially if community pays for them) 	
<ul style="list-style-type: none"> • Their needs are to be met and services are to be convenient 		<ul style="list-style-type: none"> • Communities are usually unfamiliar with primary health care and make only marginal design decisions 	
<ul style="list-style-type: none"> • CHWs are to serve all community members 		<ul style="list-style-type: none"> • Community may nominate candidates, or may make final decision • Staff may suggest selection criteria, select from among community nominees, or leave full decision to community. Joint community/staff selection usually works out best 	
<ul style="list-style-type: none"> • The locations are to be accessible 			
<ul style="list-style-type: none"> • They are to understand the problems 		<ul style="list-style-type: none"> • Group discussions and self-analysis are likely to be more effective than health education lectures 	
<ul style="list-style-type: none"> • They are expected to utilize, manage, or help maintain something organized or built 			



Villagers near Nairobi, Kenya, lay a water pipeline. The health project provided the needed equipment and trained villagers to maintain their community water supplies. PHOTO: UNICEF 5397 by A. Matheson

what participation is desirable and feasible?

Not all projects will seek to foster all of the community activities and actions discussed in the preceding chapter. Project planners can decide in advance what kinds of participation are desirable for philosophical reasons or which will help a project reach its objectives. Moreover, planners can assess how likely it is that desired participation will actually occur. If this desired participation appears unlikely, the project design can be revised. In countries and situations where little community participation can be expected—for many reasons, including the government's lack of "political will"—external donors and other project sponsors should seriously reconsider project plans that require extensive and genuine community participation.

HOW MUCH PARTICIPATION IS DESIRABLE?

In determining how much participation is desirable in a PHC project, planners can be guided by the general orientation of the project and by its specific objectives. Decisions are required on the number and range of activities that the community might be willing to undertake; the extent to which it is desirable that the community rather than staff be responsible for activities; and the required breadth or representative nature of community participation.

Range of activities. PHC projects range from those that emphasize service delivery to those that aim to effect broader changes in health-related behavior and socioeconomic status. Projects that emphasize service delivery generally offer fewer opportunities for extensive community participation. The focus is usually on individual acceptance of specific health care services, such as curative care, family planning, and immunizations, rather than on activities that require collective decisions and actions. The kinds of community inputs needed to support such projects are limited, and may include consultation on facility locations, hours of operation, and fee schedules. Such community contributions to a project generally are concentrated during the initial period of project planning and may not require longer-term participatory activities and project support beyond service utilization.

Projects seeking broader community involvement, such as the selection of volunteer health workers or the contribution of resources to pay workers and offset other costs, generally benefit from an extensive community role. If the community is responsible for providing and managing crucial resources, accountability is essential. This entails establishing and maintaining a community infrastructure during the life of the project and

involving the community in decision-making about those aspects of the project to which they are expected to contribute time, money, and other resources.

Projects that seek to bring about more comprehensive changes in the socioeconomic conditions affecting health or that seek to involve the community as a whole in the initiation and support of environmental and sanitation improvement-activities require active community participation throughout the life of the project.

Level of participation. Participation can vary not only by the kinds and number of activities that are undertaken, but also by the degree to which community members—rather than project staff—are ultimately responsible for initiating and planning the activities. Community involvement can range from acceptance of the services provided to collective involvement in decision-making and initiation of health-related actions. The extent of participation that must be planned for can generally be gauged from the kinds of community activities being sought. Some examples follow:

—*Decision-making.* Projects that wish to involve the community in planning and management activities and in dealing with the underlying causes of poor health generally are more successful if community members take the initiative in identifying problems and work with the project staff in devising solutions and taking remedial action. Communities, however, may not have the experience and confidence to take on this level of responsibility by themselves. Time and project effort in working with the community may therefore be needed.

—*Cooperation.* Community cooperation with initiatives planned by an outside agency can be an acceptable level of participation for projects calling for contributions of time, money, or labor for such activities as building health posts, selecting volunteer health workers, or managing a revolving fund.

—*Utilization.* Simple acceptance and utilization of services may be a satisfactory level of community involvement in some projects; e.g., an immunization campaign's plans may need to place little attention on broad community decision-making, focusing instead on consulting the communities on key issues related to service delivery.

Breadth of participation. This ranges from projects in which only community leaders and other elite participate (narrow participation), to projects in which the entire community, including women and lower socioeconomic classes, participates (broad participation). In most cases *who* in the community participates is more

critical than the number of participants. Since most PHC projects emphasize maternal and child health services, participation of women has been found to be critical. If, as has happened in a number of projects, women are not involved in the selection of health workers, the community group may select male health workers whom the women may consequently be unwilling to consult. Other projects have found that because women were not involved in determining service hours at the clinics, the hours chosen were inconvenient to them. Similarly, projects with such target groups as ethnic minorities, certain castes, or landless poor need to be aware of the specific needs and situations of these groups. For many types of activities, therefore, broad participation must be sought.

WHAT PARTICIPATION IS FEASIBLE?

Good planning can help avoid the failure to reach desired community participation that occurs in many projects. Assessing the feasibility of participation helps determine whether project objectives requiring community decision-making or cooperation are achievable and helps identify appropriate ways to facilitate participation.

Assessing the feasibility of participation is particularly important when local people are to be involved in decision-making and when a country has few precedents for collaboration between the government and local communities.⁷ A feasibility assessment should be done during the earliest design stages, before a project's purpose and strategy are finalized.

In order to determine how viable the desired community participation is, planners should weigh the findings from a feasibility assessment against the level and breadth of participation envisioned. Projects requiring certain types of participation should not even be attempted if essential community and external support appears unlikely. A major commitment of effort and resources by the project may be able to overcome some constraints, such as lack of prior participatory experience or restrictive communication patterns, but it is unlikely to change basic political or cultural patterns. If sufficient resources are not available and constraints are great, it may be better not to try to stimulate a high level of participation.

Steps in a Feasibility Assessment

The steps in a feasibility assessment are described (in ideal terms) by Perrett and Lethem:⁸

- a review of project assumptions about the values, attitudes, behavior, and expected response of project populations;
- an assessment of whether the response of the intended project population is likely to develop as assumed, under what alternative (project) conditions, and with what consequences to benefits and costs;
- recommendations for changes or additions to project

technology or design that are needed to improve the social feasibility of the project;

- the design or modification of project information systems and related institutional arrangements that are needed to keep an eye on remaining social risks in the project and to let upper management know what is happening in the field.

The following specific considerations should be covered:

Country factors. *Political.* Because community participation can bring about changes in relative roles and power relationships by increasing the power of the poor, political commitment or at least tolerance at all government levels is an extremely important precondition. It is essential to determine to what degree the government will permit and support increased community control and modified power relationships within communities. The type of government, degree of stability, and the government's record to date can be considered as a guide to future prospects for supporting or tolerating participatory activities. Table 5 lists possible indicators of national-level commitment to community participation objectives.

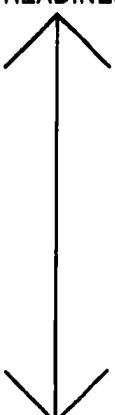
Organizational. Planners should also assess the ability of the government's organizational structure (or that of any other local host-country implementing institution) to support participation. Central government organizational factors that influence participation include the degree of centralization, attitudes and reward structures, management style, and specific institutional abilities to support community participation (see Chapter V).

The government's record in sponsoring participatory development projects should be examined. Is there a separate government organization with staff experienced in community organization (as in Senegal, Costa Rica, and El Salvador)? Or will the project have to train new or old staff to organize and monitor participation in communities? How successful have past organizational efforts been? Is it feasible to use alternative organizations that may be more effective than the Ministry of Health?⁹

Centralized agencies usually limit decision-making authority to high officials in the national or state capitals. These levels determine basic design, budget, and personnel policies. Such systems afford little opportunity for flexibility and responsiveness to local demands, even if official policy favors participation.

Project planners need to be aware of where and how government decisions that affect participation are made. Bossert stresses the importance of administrative commitment — the degree of significance that high government decision-makers give to PHC and to a participatory approach. The higher the priority, the more likely necessary resources will be made available and bottlenecks overcome.¹⁰

TABLE 5 INDICATORS OF NATIONAL-LEVEL READINESS TO SUPPORT COMMUNITY PARTICIPATION

<p>LESSER READINESS</p>  <p style="text-align: center;">↑ ↓</p> <p>GREATER READINESS</p>	<ol style="list-style-type: none"> 1. Acceptance by national government of basic literature and philosophy of community participation. 2. Permission for support of demonstration projects involving community participation. 3. Political party approval of community participation. 4. Inclusion of community participation in national health and economic policy. 5. Revision of educational curriculum to promote community participation. 6. Governmental publications supporting community participation. 7. Media releases supporting community participation. 8. Organizational/agency readiness to integrate activities and respond to community requests. 9. International agreements that promote community participation. 10. Legislative action or executive orders (statutes, rules, regulations) regarding community participation. 11. Budgetary/fiscal allocations or incentives for community participation. 12. Willingness/capability to decentralize planning and decision-making.
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Source: Adapted from Dr. James Sarn, Workshop on Planning for Community Participation in Primary Health Care Programs, APHA, Washington, D.C., November 6, 1980.

Attitudes of civil servants may be paternalistic. They may refuse to share authority with those who are less educated and less well placed socially, considering rural people to be "big children" who need constant watching. This attitude leads officials to underestimate local capabilities, and leads rural people to resent officials, refuse cooperation, and sometimes actively oppose official projects.¹¹

Such negative attitudes may be reinforced by evaluation and reward systems that stress rapid accomplishment of activities rather than more lasting results that might be achieved through building local capabilities. Additionally, a participatory approach simply takes too long when recognition and approval hinge on completing projects quickly. The potential impact of these characteristics of the administrative system needs to be taken into account; it may be possible for designers to build in some more appropriate incentives in larger programs.

A decentralized, flexible, and democratic administrative structure is the most favorable for developing participation. In this regard, planners should recognize that participation *within* government organizations helps facilitate participation at the community level.¹²

Community factors. Political, organizational, socio-cultural, economic, and physical characteristics of the specific communities within a project should be examined. Communities are rarely homogeneous entities, and planners should examine their internal structure, degree of stratification, and decision-making processes. Many villagers in developing countries include different tribal and other factions that find it difficult to work together toward the common end of community self-

reliance. However, by accentuating the positive elements in such situations, projects may help resolve many problems to the benefit of the community.

Political. Broad-based participation is more likely if authority and decision-making power rest with a representative body (a village development or community health committee). Participation is likely to be limited if the community is controlled by an elite group; and it is least likely to occur if the chief or headman is an absolute ruler who sees participation as a threat to his power.¹³ Planners need to be aware of power figures and elites so that measures can be taken to gain their support or at least to avoid their opposition. At the same time, the feasibility of including less powerful groups can be evaluated — women, low-caste groups, and racial, ethnic, and religious minorities.

If paternalism has been the prevailing pattern or if community suspicion of government efforts exists because of past failures, effective community participation will be much more difficult to achieve. These factors made successful community participation less likely in several of the projects studied, including Honduras/Integrated and Senegal/Sine Saloum.

Organizational. Communities' previous experience in organizing and managing resources greatly facilitates their participation in any new project. Existence of such groups as farmers' associations or mothers' clubs is evidence of a community's ability to organize around an issue or need and can provide a point of entry for the community organizer. Where village development committees already exist, e.g., in Kenya/Kibwezi, the likelihood of participation for health is greatly enhanced.

The lack of such experience and the high dependence on leaders to carry out project functions contributed to the problems experienced in the Senegal/Sine Saloum project, while a high degree of participation was observed in the Costa Rica/CMP project, which developed in a well-organized area along with broader development efforts.

Sociocultural. Just as the existence of a tradition of mutual aid seems to promote participation in communal efforts, factionalism and economic or social conflicts between groups will make broad participation difficult. The Indonesian tradition of reciprocal cooperation in communal activities was evidence of positive community solidarity. On the other hand, in Niger, where some ethnic groups have virtually no tradition of village-wide solidarity or any concept of community property, project actions had to be imposed from above or restricted to limited groups with shared interests.

Religion influences participation because some health matters may be considered unsuitable for intervention, beyond the scope of human decision or action. Taboos play a similar role in some areas. Also, some religions emphasize good works and service to the community more than others. The Thailand/Lampang project, for example, found that the Buddhist religion encouraged village self-sufficiency and communal cooperation in such activities as building or repairing homes, irrigation canals, temples, and other community facilities.

Extended families may be relatively self-sufficient entities, unwilling to engage in activities beyond their "borders." When one strong figure has to approve all decisions and activities by family members, s/he may limit participation by individuals.

In some cultures, it may be very difficult for women to participate in development efforts. Women may be much less likely to be chosen as members of community health committees and, to a lesser extent, as health workers. Even if selected as workers, women's relative lack of power means they have little influence in community decision-making. Women may not be allowed to make home visits or to leave their village for health worker training.

Illiteracy may preclude participation by many — especially women — as community health workers or health committee members. If health committee members are to manage money or drug supplies, numeracy is important. For these reasons it may be difficult to find persons in some communities to serve as CHWs, and it may be possible to involve only a few community members in certain kinds of management activities unless the project is willing to sponsor functional literacy and management training.

Communication patterns influence participation. In the Senegal/Sine Saloum project, the discussion of the project was restricted to a small group, so the majority of people knew little about the project. If village members are not encouraged to take an active part in discussing major issues in the local health care effort, they are

not likely to support its activities.¹⁴ In some cultural contexts women may have little or no access to radio or printed information and may be forbidden to attend meetings or receive visits from health promoters. Such situations create severe constraints to successful PHC implementation.

Economic. Family incomes, employment opportunities, and the seasonality of work limit the kind and amount of financial support communities are able to provide. Wealthier communities may be able to contribute money to infrastructure projects, but poorer communities may be able to do no more than pay toward the cost of drugs. It is essential to determine what the community can afford and to identify those goods and services for which people are willing to pay. Estimates can sometimes be made from census data, from such indicators as the type of home construction and the prevalence of radios, bicycles, and other consumer goods beyond the basic necessities, or from such other information as occupation, use of services, and expenditure patterns. Such information should be combined with findings from consulting with government or other appropriate officials.

Assessment of economic potential should include frequently neglected groups, particularly women. Only detailed investigation elicits information on marketing, agricultural, or animal-raising activities that are frequently overlooked components of the "housewife" role. Who controls the money that women earn and what it is used for are other commonly overlooked indicators of the community's overall willingness and ability to contribute toward health programs.

Physical. Such physical factors as climate, topography, dispersed settlement patterns, existence and condition of roads and physical facilities, and access to public transportation influence both people's access to services and their available time to participate as health workers or committee members. Some communities are compact villages, while others consist of families scattered over miles. If travel to meetings or home visits is difficult, costly, or time-consuming, participation will be reduced. During the times of the year when agriculture requires full-time attention, CHWs, health committee members, and other community members have less time for participation in the health project. It is not realistic to expect people to use scarce time, either to seek or provide health services (particularly preventive services), unless the time required for health activities is minimized, other burdens are reduced to free additional time, or incentives are provided so that health activities take precedence over others.

Assessment methods. Project designers can assess feasibility through general knowledge and through special studies or surveys. Private voluntary organizations (PVOs) with considerable experience working in a country or region often rely on general knowledge of the project area. Such knowledge is less available to outside donor agencies because of frequent personnel transfer

and the short duration of most projects. Greater efforts could be made to increase contact with host-country personnel and knowledgeable long-term residents. However, this kind of knowledge is difficult to systematize, since it is highly personal and often lost when the knowledgeable people are unavailable to project designers. A more systematic method of gathering and retaining information is necessary for large development assistance organizations.

Surveys can be used to assess feasibility, but they are often complex, time-consuming, and expensive, and there are often delays in tabulation and analysis. Furthermore, survey research may not be particularly useful in obtaining information about remote and disadvantaged persons and groups, since they are very hard to reach and may be passed over because of the survey team's ignorance or frustration.

In-depth anthropological studies may be more useful, particularly if they are done prior to project design and if they involve participant observation and community consultation. As part of a development organization's body of knowledge about the social structure in a given country, such studies may serve as a general background for all potential projects. More specific studies may then be undertaken as needed to illuminate and update the most pertinent aspects for specific sectors, programs, and projects under consideration. One approach proposed within AID is to develop national "profiles" of rural poverty in conjunction with the periodic preparation of the Country Development Strategy Statement.¹⁵

The most appropriate assessment method appears to be an ongoing or periodic process involving consulta-

tion at the national, regional, district, and community levels prior to and during the project, with in-depth sociological or anthropological studies as general background. An ongoing assessment should be an integral part of a project's monitoring and evaluation system.

Problems with Existing Feasibility Studies

Formal assessment may constitute a regularly scheduled component of project design, especially for such large development assistance agencies as AID and the World Bank. Feasibility assessments are usually carried out by social scientists under a detailed set of guidelines for specific areas of inquiry; these include socioeconomic characteristics, cultural patterns, and the role of women.

In practice, these formal analyses tend to be a rapidly accomplished "add-on" requirement rather than an integral part of design. They have been used mainly to assure planners that no obvious social harm will be done. In some cases they appear to be used only to buttress decisions already made. Social soundness analyses are required for all AID-funded projects, but it appears that in few of the AID projects reviewed were social soundness analyses actually used to assess the feasibility of community participation in the early design stage. It has been recommended to AID that such analysis should always be an *ongoing* dimension of project planning, implementation, and evaluation.¹⁶ It has also been noted that social feasibility analysis is probably the least used, although most immediately useful, technique for the majority of World Bank projects directly dealing with the rural or urban poor.¹⁷



Health workers in the Philippines lead a community discussion. WHO/18990. PHOTO: E. Ortin.



A community-built health post in Latin America. It is felt that community members are more apt to use such facilities if they contribute toward building them—even more so if the decision to build the facility was theirs. PHOTO: PAHO

how can participation be organized?

Once the need for community participation has been recognized and a decision made on what kinds of participation are desirable, a framework must be established through which community action can take place. Participation, once in motion, can become self-reinforcing, but getting it started is not simple. This chapter examines direct project efforts to promote community organization. The first section discusses the different village-level social structures and organizations that have been used as channels for participation — serving as catalysts for collective decision-making and action. The second section of the chapter examines how project staff have helped communities set up organizations; estimates of time and effort required are given. In the last section of this chapter, common problems in mobilizing communities are outlined, as well as project inputs that can facilitate the development of active and effective community organizations.

COMMON ORGANIZATIONAL STRUCTURES

Families and individuals in a community can carry out the responsibilities discussed in Chapter II through several different organizational structures. The most common organizational form is the committee. The second most prevalent is the community assembly, used in conjunction with a committee. In a few projects, recognized leaders and CHWs have prime responsibility for community activities.

Committees are used by all but two of the projects reviewed (El Salvador/RHA and Iran/Kavar). Most of the projects created special, new committees for health — generally referred to as community or village health committees (CHCs). A few used previously existing health committees.¹⁸ Five projects worked through existing village development committees.¹⁹ Committees are most frequently used to carry out day-to-day management, to implement decisions, and to mobilize the community for special health-related projects and activities.

Assemblies, general meetings open to all members of a community, are usually used in conjunction with committees. Of the 35 projects studied, 15 use initial or periodic assemblies to give the community a voice in planning and/or managing the health project.²⁰ Assemblies generally perform “policy” functions, particularly playing a major role in deciding whether to participate in a project and in setting priorities for the project — all decisions that take place when the project is being initiated. Sometimes assemblies also have a longer-term role and periodically (annually or semiannually) review project activities and progress.

Leaders are used as the sole means of involving the community in two of the projects reviewed (Iran/Kavar and El Salvador/RHA). In these projects community participation was limited primarily to selecting or nominating CHWs. In the other projects, leaders are consulted in the process of organizing the community to participate in the health projects, but broader representation is given to the community.

In addition, *community health workers* in a number of projects are delegated responsibility for carrying out administrative and management duties. Sometimes these health care agents are also expected to organize their communities and serve as prime organizers of community activities, leaving much less of a management role for health committees. About half the projects specifically mention training CHWs in methods of promoting participation.

Other organizations are also incorporated in a few health projects to broaden community representation and draw upon the strength of existing groups. Four projects mentioned working with women’s weaving and crafts groups and mothers’ clubs,²¹ although in most projects, major community responsibility is vested in a health committee or general assembly.

DECIDING WHICH ORGANIZATIONAL STRUCTURE TO USE

The choice of organizational framework is important. The review of 35 projects suggests that the extent to which all community members are represented is important, as is the appropriateness of the framework to the existing social realities of the community. The assembly/committee format is most frequently used in projects in which communities assume a wide range of responsibilities. Assemblies appear to be highly effective for achieving broad community awareness, interest, and participation in planning and management. Projects that use committees without open meetings tend to obtain less participation from the community. In terms of number and kind of functions undertaken by communities, projects using an assembly committee format undertake substantially more decision-making functions than those using committees or leaders alone—67 percent of the projects using assemblies/committees undertook five or more such activities, while only 17 percent of projects using committees and none using leaders did so. (See Table 6 below.) It seems logical that people are more likely to make substantial contributions of time, money, and effort when they are organized in structures that allow them some say in the project.

Yet the data from these 35 projects must be interpreted with caution, for although they suggest that the most democratic structures are most effective, judgments on the representative nature of an organization are difficult for outsiders to make. What appears as a democratic structure — i.e., an assembly open to and attended by the entire community — can be dominated by a single “charismatic” individual or the ruling elite. Similarly, a community leader, whether democratically selected or not, may represent the varied groups and interests in a community. Without an anthropological study, it is rarely possible for outsiders to evaluate these important subtleties.

Project experience also indicates that the organizational structure used to obtain participation should be culturally appropriate. Decisions are not made democratically in all societies, and to require this can be pointless.

- In the Afghanistan/BHS project, the process was adapted to the political reality of the Afghan village, which is not democratic in the Western sense. Although decisions in a village are made by consensus, the powerful landlords carry the most weight. Therefore, project staff first contacted the most important man in the village, who then called together other important members of the community to decide on CHC membership. Usually the same men who informally made such decisions were the ones selected.
- In the Philippines, where open assemblies have traditionally been used to make decisions on matters of concern to the community, the assembly structure was employed in the PUSH project to decide on what kinds of sanitation projects would be most appropriate and to choose sites for the projects.

SETTING UP COMMUNITY ORGANIZATIONAL STRUCTURES

In most PHC projects, health staff or organizers from community development agencies make initial contact

with village leaders, explain the project to them, and try to stimulate community interest. The projects using assemblies involve community members and leaders in organizing meetings and setting up committees to carry on further work. Projects using committees alone rely primarily on leaders to organize the committees, usually with guidance from the project staff. The process, as described in project documents, consists of three steps, all of which require time and effort on the part of project staff. Eliminating any of these steps generally results in more limited participation.

- 1) Project staff contact community leaders and explain the project; if there is initial interest, the leaders are asked to inform and consult the community.
- 2) The leaders then call a community assembly to discuss the project and ascertain community interest and willingness to participate.
- 3) The assembly or leader then creates a committee (or designates an existing committee) to plan and carry out activities.

The following examples illustrate the range and variety of ways projects have gone about initiating community participation.

- In the Nigeria/Lardin Gabas project, community participation is a prerequisite for a village to join the project. A staff member initially calls a meeting of all villagers to discuss local health problems, the program, and the villagers’ responsibilities if they decide to participate. The villagers then meet once or twice on their own to consider the program. If they decide to participate, they must contact the project staff, who meet again with them to discuss further details. A booklet developed on the project, *The Responsibilities of the Village Health Committee*, is read and discussed. If the commitment is reaffirmed, a village health committee — consisting of the village head, other officials, and elected representatives — is formed.

TABLE 6 ORGANIZATIONAL STRUCTURES AND COMMUNITY DECISION-MAKING FUNCTIONS*

Organizational Structure	Number of Functions Community Undertakes			Total
	5-7	3-4	0-2	
Assembly-Committee (15)	67%	26%	7%	100%
Committee (18)	17%	44%	39%	100%
Leader (2)	0%	0%	100%	100%

*Decision-making functions include: helping to determine needs, determining project services, selecting CHWs or CHW candidates, supervising CHWs, planning activities, managing resources, and evaluating project activities.

- In the Bolivia/Montero project, the Ministry of Health selected communities to be approached on the basis of a field study. At explanatory meetings in each community, villagers decided whether their community would participate. If so, the community organizing team worked with the community assembly to define problems, set up a CHC, and select a promoter (CHW).
- Project motivators in the Indonesia/Dana Sehat program spend a lot of time introducing and explaining the project to a group leader, who then explains it to other leaders, who in turn take it to a community assembly. The whole process consists of nine steps, each of which may entail several meetings.

PROJECT SUPPORT REQUIRED

Most projects do not indicate how much time was required to gain community acceptance of the project and set up the organizational structure for community participation. The Upper Volta/Save project mentions a two-meeting process to gain acceptance of the project by the village chiefs, but does not specify the time period. In Afghanistan/BHS, the recruitment team spent an average of two weeks per district setting up functioning health committees; about 15 villages per district were involved. The Bolivia/Montero project programmed five months for community organization, but later indicated that this was insufficient. A report by Management Sciences for Health states that, on the basis of the experience of the national primary health care project in Peru, the estimated time necessary to effect community organization is 3 to 6 months per community.²²

No information on the cost of setting up an organizational structure was identified. Such costs include 1) training community organizers to promote and maintain participation; 2) salaries, per diem, transportation for staff to assist in organizing community groups; and 3) training committee members to undertake new duties.

COMMON PROBLEMS

The review of projects reveals a number of areas where project efforts have often fallen short.

Inadequate Support of Community Organizations

Project planners seem to expect that assemblies or CHCs, once formed, will not only know what to do, but also how to do it. But experience clearly shows that it is highly unlikely that such community groups will spontaneously take on and effectively exercise appropriate functions. Well-defined tasks, training or orientation on how to approach them, and ongoing supervisory support are all needed. Failure of projects to provide such training and support clearly affected some of these efforts.

- An evaluation of the initial Senegal/Sine Saloum project found that the decay of village management

committees was at least in part due to inadequate supervision and support from government health and community development personnel. The document states that "the tasks of the committee . . . are new and strange. Without constant attention and reinforcement there is little likelihood that the structure and functions established during the motivation and training phases will be maintained."²³

A minority of projects provided specific training of health committee members for their expected functions.

- The Bolivia/Montero project's three-day leadership training session for newly-selected CHC members covers group decision-making, feasibility studies, management of community meetings, public speaking, problem-solving, and planning. While the CHW is being trained, the CHC receives an additional two days of training in CHW support, including managing community funds, budgeting, and procurement of supplies.
- The Colombia/Research project trained CHC members in project planning, implementation, and evaluation, and provided them with a manual. Specific training was provided at different times on how to collect information, conduct community surveys, and operate a community health surveillance system. At the community's request, CHC members were also trained in emergency first aid.
- The Nicaragua/PRACS project provided technical and administrative support for health committees from government health educators, CHWs, consultants, and other agency personnel, as well as radio and printed information. Philippines/PUSH indicates similar assistance.

The Nigeria/Lardin Gabas project noted that CHC members are trained for this function. A few other projects mention technical rather than managerial training for CHC members. The Upper Volta/Save project provides training in nutrition and growth monitoring to women CHC members; Thailand/Lampang has experimented with training some CHC members as health communicators (health educators). Lastly, the Panama/RHDS project gives CHC members training and technical assistance in agricultural matters to improve food production and nutrition.

Lack of Community Input in Determining Responsibilities

Problems in keeping community organizations active are common, in part because community responsibilities and the specific functions of the health committees are generally determined by the staff, rather than the community. (Exceptions include the Upper Volta/Save, Colombia/Research and Mexico/Piactla projects.)

Where there is a lack of community participation in determining responsibilities, they remain ill-defined and

imperfectly understood. Failure to define functions thoroughly leaves the community organization with no long-term role, often causing a marked drop-off in participation.

- In the Thailand/Lampang project, the CHC was expected to support the CHW, but specific functions and responsibilities were not made clear. Consequently, once the CHWs were chosen, the CHCs tended to lapse into inactivity.
- In Niger/Diffa-RHI, health committees were never given any specific function beyond selecting the CHW and occasionally securing contributions of labor and materials. These committees also became inactive.

Limited Breadth of Participation

Another problem that has affected participation has been excessive reliance on leaders and elites. While most projects recognize the need to win the support of leaders and influential persons in order to gain community confidence and support, sole reliance on leaders and elites has sometimes resulted in failure to mobilize the community. Better results occur when the broader community engages in discussion and decision-making.

The breadth of participation in most health committees may therefore be a problem in many projects. Since membership is usually limited to community leaders, women and disadvantaged groups may be poorly represented. Though not often perceived as a problem by communities, the generally low participation of women has had detrimental effects on projects, resulting in

inappropriate services and service hours, and in selection of male health workers who are often poorly patronized by women. Project planners should be aware of this and try to introduce changes favorable to greater female participation in ways acceptable to the community.

Some projects have made a special effort to incorporate women. A few projects specifically mention female membership on CHCs. The Nicaragua/PRACS project noted that about one third of the CHC members were women. The Montero project has found that the most successful CHCs are organized by women. The Upper Volta/Save project has separate women's and men's CHCs, since the two sexes will not work together on one committee. A report on the Niger/Diffa-RHI project notes that women's groups are represented on the Comité d'Action (Action Committee) — but also notes that such representation has done nothing to broaden participation since these committees are not functioning.

While project guidance in selecting CHC members can be helpful in promoting greater representation, such as encouraging selection of women and people from other often-neglected groups, it is important to respect community social patterns.

- The Peru/Extension project tried to impose on the community a preconceived scheme of CHC selection by excluding political leaders from membership. Without the presence of acknowledged leaders, the CHCs could not function well because the community did not recognize their authority.

At a village health assembly in Peru, a woman volunteers to become a CHW. PHOTO: WHO 17605 by Y. Pouliquen



how do project and donor agency elements affect community participation?

When planning or evaluating community participation, it is insufficient to look only at project/community interactions at the community level; project and donor agency factors in a broader context also affect participation. General project elements that influence community participation include flexibility in planning and implementation; scale and timeframe; organization and management; monitoring and evaluation; and coordination and integration. In addition, participation in projects assisted by external donor agencies is greatly affected by the structure and actions of these organizations. All of these extra-community factors should be examined during project design and their effects monitored during implementation.

PROJECT ELEMENTS

Flexibility

The degree of flexibility built into a project's design has important ramifications for community participation. Projects can be roughly grouped into those that follow a "blueprint" or detailed plan and those that pursue a "learning" approach to planning, whereby no detailed plan is used, and activities and schedules are developed during implementation, as experience dictates.²⁴

The theory of the blueprint approach is that planners can elaborate a cost-effective design for achieving a given outcome, that staff can then faithfully execute the plan, and that evaluators can measure actual achievements against those planned. Models for future projects are based on evaluation results.

In contrast, in projects following the learning model, activities emerge from a process in which community and staff share knowledge and resources to build a program that fits the needs and capacities both of beneficiaries and of outsiders providing assistance. The lessons are in the process.

The flexibility in project design characteristic of the learning model is essential if there is to be community participation in planning. Flexibility in the implementation of a project permits correction of mistakes and allows for community learning and increased responsibility. The more community responsibility for health activities is emphasized, the more important a flexible approach becomes. Learning or mixed models are characteristic of the most participatory projects; the least participatory projects more frequently follow a blueprint model.

It appears that considerable participation can be achieved by projects that combine the two approaches, building sufficient flexibility into basic blueprints to

allow for learning and change. A combined learning and blueprint approach entails four basic steps: assessment, planning, implementation, and redesign and evaluation. The distinguishing characteristic of the combined learning-blueprint approach is the programming of regular, cyclic learning adjustments that permit changes in the project design and expanded or extended action.²⁵

Scale and Timeframe

While this study confirmed the belief that smaller projects have a distinct advantage in successfully incorporating community participation, the review also indicates that participation is possible on a larger scale if projects are designed to foster and support it. Two national-level projects (Guatemala/Rural Health and Honduras/Integrated) have achieved moderate participation, while two large regional projects (Philippines/PUSH and Nigeria/Lardin Gabas) have attained substantial participation.

Project duration also plays an important role in determining what kinds of participation can be stimulated and take hold. High participation frequently takes several months or even years to develop. Consequently, a longer timeframe should be an advantage, although clearly time alone will not make a project participatory.

Organization and Management

The implementing agency's management capacity and style have caused problems in a number of projects — in some cases problems serious enough to affect community confidence and participation in the project.*

As mentioned in Chapter III, project and government acceptance of community participation in decision-making is easier if decisions within the agency itself are made in a participatory way. Although this management style is more characteristic of small, private projects, it can also help overcome some of the bureaucratic problems typical of government projects. Some private projects reviewed, particularly Mexico/Piactla and Philippines/DPFHP, had a participatory form of management as well as high community participation.

- The Mexican project was run in a very participatory way, with a strong attempt to treat everyone involved — outside advisors, local staff, and community members — as equals. The project seeks to demystify authority and the technical aspects of medicine.

*For more general discussion of management and logistics issues with regard to AID projects, see *Primary Health Care: Progress and Problems. An Analysis of 52 AID-Assisted Projects* (Parlato and Favini). Available through APHA.

- The Philippine project emphasized flexibility and free discussion among the staff, with health workers setting their own goals, based on community needs; the cooperative leadership provided the support necessary for achieving such goals.
- The Nicaragua/PRACS project found that a formal, structured project system was not effective in achieving its goals. Much better results were obtained through use of informal discussions between project and government personnel, and ultimately also with the community. A flexible system permitted needed modifications at all project levels including the community level.

Such project support systems as supplies, transportation, communications, training, referral, and supervision have an enormous impact on community confidence and involvement. Most of the projects reviewed experienced some adverse effects on participation because of support system deficiencies. In general, smaller, privately-run projects reported that administration and management caused fewer problems for community participation.

Some examples of how support system deficiencies can affect participation:

- Problems with regular drug supply have contributed to high CHW turnover in many projects (e.g., Bolivia/Montero, Honduras/Integrated, and Mali/RHSD), with consequent disruptions in participation, since the CHW is usually the organizer and focal point for community health activities.
- The lack of adequate supervision of CHWs and CHCs has lessened their effectiveness and credibility. In Guatemala/Rural Health, the dropout rate of CHWs was two to three times higher among unsupervised CHWs (1978-1979). Inadequate contact allowed CHCs to deteriorate in Senegal/Sine Saloum and other projects.
- Ineffective referral systems discourage CHWs and undermine community confidence and participation in the PHC program. In Honduras/Integrated, doctors and receptionists often disregard CHW referral slips and almost never give feedback to CHWs. Referred patients have sometimes been turned away for arriving at the wrong time or on the wrong day, often after travelling considerable distance.

Monitoring and Evaluation

Although the extent of community participation in development-oriented projects has frequently been noted in the literature as a determinant of success or failure in achieving stated goals, few projects systematically monitor or evaluate community participation. Existing evaluation and monitoring procedures often fail to reveal problems while solutions are still possible; moreover, very little attention is paid to community or

higher-level host country participation in monitoring and evaluating projects.

References in evaluation documents rarely go beyond global assessments of participation, with little emphasis on the factors that influence it or the kinds of indicators on which such assessments are based. The Colombia/Research project's experience with community self-evaluation of the participatory process was unique among the group of projects reviewed for the thoroughness of its assessment of participation. Other project evaluations, whether by communities or staff, tended to focus on general operations, service delivery, or achievement of targeted "outputs" rather than on participation itself.

The implicit purpose of many evaluations is to secure continued funding for current and future projects, with results often being shared only with funding agencies and government officials. Few evaluations are designed to help the community and project staff resolve problems and improve performance and participation. Yet monitoring/evaluation can be used to identify strengths and weaknesses and to take corrective actions.

In order to avoid the communication gaps that can easily develop between project or health system staff and community groups, thus undermining participation, ways need to be devised to identify factors affecting participation and to provide timely feedback so necessary changes can be made. The purpose of monitoring systems is to provide *usable* information to the project staff and community people involved in making project decisions. Periodic process evaluations serve a similar purpose, while final or impact evaluations provide guidance for future projects. Appendix B provides a brief review of several methods for monitoring and evaluating community participation.

There are two approaches to evaluating community participation. One is to compare participation in a particular project with "ideal" or full participation. The method devised by Pyle (see Appendix B) is one example of this approach and is one of the few examples of a quantitative methodology for evaluating community participation. A second approach, feasible for projects that have planned specific areas for participation, is to evaluate the current status of participation against the planned participation. For example, a project plan for improving drinking water should state what level and breadth of participation are desired and for what duration in how many communities. Either evaluation approach should delve beyond these specifics to explain why a particular extent of participation has been attained. All approaches need to be sensitive to the variation in participation among communities and to the changes in participation over time. Using either approach, evaluators can examine the following factors:

Number and kinds of activities. Enumeration and classification of activities and actions in which communities have participated can provide a measure of the effec-

tiveness of a project's community participation component. Activities directly related to project support may pose few problems in detection. To assess the great variety of possible community health-improvement activities, evaluators can develop checklists of activities that are commonly encountered. Table 2 in Chapter II presents such a basic list.

Level of participation. For evaluation purposes, the projects can be categorized by where they fall on a continuum of community involvement. Involvement can be ranked from simple utilization of services, through cooperation with project-initiated activities, to evidence of decision-making and community initiation of activities. The degree to which community members, rather than project staff, are responsible for decision-making is an indication of how well community participation has become established and a measure of its ability to be self-sustaining.

Breadth of participation. The extent to which a few individuals or the community as a whole contributes toward project objectives is an important measure of participation. Although only leaders' participation is sufficient in some activities or decisions, broader participation is very useful in others.

Coordination and Integration

Project experience shows a correlation between high participation and an integrated approach open to community priorities not strictly related to health care.

- The Guatemala/Chimaltenango project has focused on meeting community needs. While it began as a health care effort, the project has expanded into such areas as agriculture, water supply, reforestation, literacy training, and civic improvements. Recognizing that access to land is the paramount concern of people in the area, the project has organized a credit cooperative to facilitate land purchases.
- The Philippines/DPFHP project is an integrated effort in which sewing and crafts workshops help support the health programs and provide employment and income to member families. The project has also organized a credit union and has promoted community-improvement and recreational activities.
- The village development committees in the Kenya/Kibwezi project are involved in housing, road and school construction, literacy training, water supply, and agricultural development, in addition to health.

Critical for encouraging and maintaining community initiative and decision-making is the ability of sponsoring organizations to respond to community initiatives for projects that will improve the people's health and socioeconomic status. For example, without the aid of outside organizations, few communities can install a water catchment and distribution system. A community

initiative may end up in frustration if the project is incapable of responding to it.

A lack of coordination allows duplication of effort at the community level. This not only wastes scarce resources, but also confuses community members and may exhaust their patience with excessive demands for time and resources.

- The Honduras/Integrated project has attempted intersectoral coordination, but has had difficulties making it work. Each agency still has its own corps of promoters and field workers; most coordination is temporary and ad hoc, depending upon immediate needs and personal relationships. As a result, many related activities are carried out in isolation, wasting both program and community resources.
- In Thailand/Lampang, sustained links with local groups were lacking; villages appeared to be saturated with government programs making often conflicting demands for local participation in many areas of development.

DONOR AGENCY ELEMENTS

Donor agency policies and programming strategies are a final set of factors that affect participation in PHC projects. While agency characteristics — unlike the planning and implementation factors discussed earlier — are generally beyond the control of country-level project officers, recognition of their potential effects can be beneficial. Awareness may enable project officers to work around, influence, or change some unfavorable agency factors; at the very least it can help planners modify or avoid undertaking efforts that call for a level of effort and support inconsistent with agency conditions. This section examines how the overall development strategy, organizational characteristics, and project design and implementation procedures of large international donor agencies, such as AID and the World Bank, affect community participation.

Strategies

Donor agencies employ two major strategies for supporting PHC activities in developing countries. Assistance approaches can be characterized either as "institution building" or as "resource transfer." The institution-building approach emphasizes planning, development of local agencies and capabilities — including community capabilities — and coordination of activities with government and private agencies involved in health and related development programs. This approach relies primarily on technical assistance and management training to accomplish its goals.

A resource-transfer strategy focuses on more limited goals and on specific projects — often of an infrastructure-building nature. Activities undertaken tend to be of a limited range, such as training health workers or providing vehicles.

A major difference between the two strategies is that the resource-transfer approach emphasizes more immediate, concrete results, while the other approach focuses on long-range goals of developing local resources and capabilities. Also, resource-transfer projects usually involve only one or a small number of government units and may even entail establishing a special administrative unit outside the existing bureaucracy. This approach makes it easier to reach project goals and achieve measurable results, but gives little attention to involving the government or communities in the project.

The implications for community participation of a donor agency's assistance strategy for PHC are clear. The most participatory projects examined tended to take an institution-building approach. A resource-transfer focus generally is not conducive to the promotion and development of community participation for three reasons. First, promoting and supporting participation require investments in many different human development areas. Second, community participation activities take place at their own pace, so it is difficult to plan beginning and ending dates. Lastly, community participation is not as easy to measure and evaluate, particularly in the short run.

In institution-building strategy, on the other hand, does encourage general support for mobilizing a community and developing community resources; and the time schedules and evaluation procedures are more adapted to the fluid nature of community participation.

Organizational Characteristics

Such organizational characteristics of donor agencies as the degree of centralization, reward systems, and systems of accountability can have subtle but important effects on the amount of community participation that can be expected.

Centralization. A decentralized administrative structure allows for the flexibility so important in implementing a community participation component. Because communities themselves will shape some aspects of a project in which they are involved, all activities, costs, and project inputs cannot be planned for at the central level. Project officers at the country level need the authority to make decisions as the project develops.

Accountability. A key factor limiting AID's flexibility in the field is the plethora of "watchdogs" overseeing its operations. (While this discussion focuses mainly on AID, similar problems have been noted in other agencies.) Development analysts²⁶ have noted that, as resources have become scarcer, increasing pressures from Congress and other domestic overseers have significantly inhibited flexibility and innovation by AID country missions and have instead encouraged use of standard, proven responses in order to avoid criticism. Since such oversight functions concentrate on accounting and expenditures, they have also promoted a preoccupation with moving money²⁷ or with highly visible

"quick-fix" solutions, often at the expense of developing local institutions and capacities. The latter activities are rarely easily measurable and tend not to impress "bottom line" controllers. This strict accountability of an agency to its overseers discourages development of community participation and inhibits the innovative, flexible, and humanistic approach that is essential to the whole process.

Use of intermediaries. The use of such intermediaries as small, private voluntary organizations to implement projects can help in generating community participation. These agencies generally are characterized by flexible design and decision-making processes.

This study supports to some degree the belief that PVO projects have a comparative advantage in mobilizing community support. This does not mean that PVO projects are always participatory, that they are the only ones that can generate participation, or even that participation must be limited to small, village-level projects. Some of the most participatory projects reviewed — Nicaragua/East Coast, Kenya/Kibwezi, Tanzania/Hanang — were carried out using PVOs as intermediaries. Some other PVO projects, however, were far less participatory, e.g., Kenya/Kitui and Bolivia/Chiquitos.

Reward systems. While a decentralized structure is important for promoting an institution-building, participatory approach to development, it can only be effective if accountability and reward structures support it. Numerous analysts have noted that for staff of many donor agencies, rewards are for funds obligated and spent, rather than for institution-building and effective implementation.²⁸

It has been suggested that because of AID's decentralized structure, the responsibility for creative behavior is placed primarily on field staff; however, sometimes their experience level, rank, and isolation from the center of information and power, reinforced by the reward system, actually promote routine responses and avoidance of the risk, flexibility, and innovation required to foster participation.²⁹

Design and Implementation Procedures

A number of design and implementation procedures used by donor agencies have a bearing on community participation.

Implementation schedules. The three-year project period typical of AID projects is too short to allow for the process of initiating and developing community participation.

- The Philippines/DPFHP cooperative health system took ten years to gain full community support.
- The Mexico/Piactla project and the Guatemala/Chimaltenango project have been in operation nearly 20 years and have increased participation gradually over that span.

Unrealistic implementation schedules result in inevitable delays that seriously demoralize the community and clearly hamper further community participation efforts.

- In Bolivia/Montero, long delays in obtaining promised materials frustrated communities whose expectations were raised too long before services could be provided. Consequently, further efforts to obtain participation met with apathy.

Short time frames also put project implementors under considerable pressure to obtain results quickly. This tends to discourage development of community participation components because they take time to develop and because tangible, measurable results are not generally obtained quickly.

Flexibility of project design. The design processes of many donor agencies build in rigidity, instead of the flexibility needed for a participatory process to develop. Intensive, detailed planning — usually done by donor teams or short-term consultants — leaves little room for

community input and participant involvement. These elements are key for mobilizing community resources for financing, management, or even simple utilization of services. Projects are sometimes locked into an inflexible framework difficult to change.

In summary, the Alma-Ata Conference and all the long and careful thinking that went into it made community participation a sine qua non for the world's efforts to provide "Health for All by the Year 2000." Although virtually all PHC projects allege dedication to community participation, the extent of community involvement and of project efforts to foster it vary greatly. A substantial level of community participation is a challenging objective, and judging from the studies upon which this report is based, its achievement will take a lot more effort by sponsoring agencies and host governments. Finally, it appears that the cooperating agencies themselves may need some revision if their efforts in these directions are to represent anything more than a paper testament.

Community members in Colombia lay water pipes and build latrines in their community. PHOTO: WHO/UNICEF 18909 by H. Cerni



notes

1. World Health Organization, *Primary Health Care*, pp.2 and 20.
2. American Public Health Association, *AID-Assisted Primary Health Care Projects: Summary Reviews*.
3. For a more thorough discussion of these concepts, see White, Chapter 7.
4. Stephens and Kessler, pp.10-12.
5. See Stinson for further discussion of this issue.
6. Daulaire and Taylor, p.5.
7. Perrett and Lethem, p.19.
8. Perrett and Lethem, pp.35-36.
9. See American Public Health Association, "Expanding Primary Health Care from Projects to Programs: Report from a Workshop."
10. Bossert, p.95.
11. Uphoff, Cohen and Goldsmith, p.81.
12. Brinkerhoff, "Inside Public Bureaucracy: Empowering Managers to Empower Clients," quoted in Uphoff, Cohen and Goldsmith, p.81.
13. Shepperd and Martin, p.38.
14. Hall, p.51.
15. Morton, *Participation and Development*, Executive Summary, p.4. The CDSS, prepared annually by each USAID mission overseas, is a broad country development analysis and outline of the AID country strategy.
16. Morton, p.17.
17. Perrett and Lethem, p.64.
18. Colombia/Research, Panama/RHDS, Philippines/PUSH, Thailand/Lampang.
19. Costa Rica/CMP, Kenya/Kibwezi, Mali/RHSD, Niger/Diffa-RHI, Tanzania/Hanang.
20. Bolivia/Montero, Colombia/Research, Costa Rica/CMP, Guatemala/Chimaltenango, Honduras/Integrated, India/SWRC, Indonesia/Dana Sehat, Kenya/Kibwezi, Mexico/Piactla, Nicaragua/East Coast, Nigeria/Lardin Gabas, Peru/Integrated, Philippines/DPFHP, Philippines/PUSH, Tanzania/Hanang.
21. Guatemala/Chimaltenango, Philippines/DPFHP, Bolivia/Chiquitos, and Honduras/Integrated.
22. Bates and Hartman, p.21.
23. Weber, et al., p.11.
24. Korten, D., p.496.
25. Freymann, pp.28-29.
26. Tandler (*Inside Foreign Aid*), Ruther, and Bossert, for example.
27. As Tandler (*Inside Foreign Aid*) notes (Chapter 7), other development organizations (e.g., the IDB and the World Bank) suffer the same preoccupation with moving money, though often for reasons of their sense of accomplishment, the need for internal efficiency, and the effects of reward systems (see next section) rather than external pressures.
28. See, for example, Tandler (*Inside Foreign Aid*), Ruther, and Morton.
29. Tandler, *Inside Foreign Aid*, pp.24-25.

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Community/project collaboration in Sudan: The community provides labor and the government provides UNICEF-donated hand-pumps. PHOTO: UNICEF 9165 by M. Beyer

appendix A

PROJECT DESCRIPTIONS (In alphabetical order by country)

Afghanistan/Basic Health Services

Supported by an AID grant during 1976-1979, the project was a Ministry of Health pilot effort to extend services to rural areas. The expansion phase of the project, scheduled for 1978-1980, never took place because of civil unrest following the change in government in 1979. The project covered 830,000 people in four of Afghanistan's six health regions.

Purpose. To provide basic health centers (peripheral health facilities) in 50 jurisdictions and to develop alternative health delivery systems that could be replicated to reach the approximately 80 percent of the rural population without reasonable access to any health facility. The second phase was to expand and test further the most promising village-level health delivery alternatives.

CP* Component. The village-level delivery system utilized both CHWs and traditional midwives. Village committees (CHCs) were created to select, support, and oversee the CHWs. The CHCs were chosen by, and consisted of, influential village leaders. The CHC was to provide a clinic room for the CHW and make sure he performed honestly and competently. CHWs were permitted to sell drugs for a small profit as partial compensation; the CHCs were free to decide on any other form of financial support for the CHW. Traditional midwives were trained in primary care for women and children, as well as in midwifery; they worked on a fee-for-service basis.

CP Achievements/Problems. In general, the CHWs and trained TBAs were well accepted and appeared to be a successful innovation. Problems were encountered with financial support for CHWs; they began demanding a stable government salary. The CHCs were unwilling to provide additional support because they too expected the government to meet the costs. Use of drug fees caused an overemphasis on curative services. The CHCs also failed to supervise CHWs as planned. Since the trained TBAs were not allowed to dispense drugs, women and children had to be referred to male CHWs or health centers. This may have worked against effective coverage of women and children, who have never had more than minimal access to medical services because of the lack of accessible female health workers.

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Bolivia/Rural Health Delivery Services

This regional pilot effort of the Bolivian Ministry of Health and Welfare provides direct coverage to 35,000 people in the Montero region of rural Bolivia. The project was supported by AID during 1975-1981.

Purpose. To implement a pilot rural health delivery system and develop MOH planning and administrative capabilities. Objectives include development at local, regional and national

*community participation

levels of systems for planning, service delivery, human resource development, administration, logistics, information and evaluation, intersectoral coordination, and community organization.

CP Component. The project's community organizing team meets with the community at large. Communities meet to decide if they will participate in the project, to define problems and discuss solutions, to select CHC members, and to suggest CHW candidates. The CHC makes a pre-selection of suggested CHW candidates for MOH testing and final selection. The CHC and CHW define the work plan and CHW compensation, with the help of the organizing team. The CHC signs a work agreement with the CHW and is responsible for CHW compensation. The CHC receives specific training for its tasks. The CHW provides basic preventive and curative services, including promotion and health education, and is trained to encourage CP. Supervision is by auxiliary nurses. The community participates in decision-making and implementation by various means, including resource contributions. The role in evaluation consists of community response to staff surveys, as well as ongoing decision-making by the CHC.

CP Achievements/Problems. The CP process described above was not part of the original project, but was developed during implementation. While many gains were made in working out the process, some communities became frustrated when they were organized too long before service delivery began. Problems also arose with community compensation of CHWs. Some communities were too transient and unstable; others objected to signing a formal agreement with the CHW. Problems with supplies aggravated the situation, and contributed to a high CHW dropout rate. Professionals were not fully informed about the project and as a result resisted what they perceived as encroachment by CHWs in their area. Problems arose from an emphasis on promotion of program acceptance rather than promotion of community analysis of needs and desires. Plans to incorporate traditional midwives failed because of lack of interest and effort and of resistance by some midwives.

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Bolivia/Mobile Health Program

Catholic Relief Services, the Government of Bolivia, and an AID operational program grant provided funding for this regional project, targeted at 85 rural communities (100,000 people) in a remote area (Chiquitos Vicariate) of Santa Cruz

Department. Ultimately, the project reached only 22 communities. The period of AID support was 1976-1980.

Purpose. To provide a basic health services system for the unserved rural population by linking the Vicariate hospital with the rural communities by way of two mobile health teams, community-based auxiliaries and part-time unpaid community promoters (CHWs).

CP Component. Community volunteers motivated use of mobile team services and provided follow-up and interim services. Communities participated in building latrines and other facilities, and in housing and feeding the visiting mobile team.

CP Achievements/Problems. The 1979 evaluation indicated that community organization was very weak and that project benefits were perceived as gifts from above rather than as the result of community effort. Problems noted were a paternalistic orientation and a lack of mechanisms for participation in decision-making. Contributing factors were management problems stemming from poor coordination with government agencies and a division of funding and responsibilities between the project and the government. One consequence was the loss of one mobile team and a severe reduction in coverage. Equipment and supply problems were also noted, as were deficiencies in community development training and orientation.

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Colombia/Research Project on Community Participation in Health Planning

This pilot project was carried out by the research department of the Colombian Ministry of Health, using national and UNICEF funds and technical assistance from PAHO. It covered 6 rural and smaller urban municipalities in the departments of Caldas and Bolívar—approximately 60,000 people—during 1977-1980.

Purpose. To provide health planning agencies with experience-based criteria for decisions on CP in health services, and to demonstrate improved resource utilization and health services through the use of organized CP in health planning. Specific objectives included 1) determining in which stages CP is feasible; 2) developing CP methodology; 3) measuring the impact of health education with and without CP; and 4) evaluating CP in terms of coverage, community demand and satisfaction, attitudinal change in communities and health personnel, and costs.

CP Component. This project concentrated on fully involving the community in planning, implementation, and evaluation. General community assemblies carried out a diagnosis process and chose municipal planning committees to work with the health team in planning the program. These represented the different neighborhoods or villages in each municipality and incorporated existing organizations and leaders wherever possible. Subsequently, local assemblies, neighborhoods, and villages elected local committees to implement plans developed by the planning committees, maintain the health post, and motivate community attendance and involvement. All these groups helped evaluate the program in their communities.

Evaluation results were discussed and analyzed by the planning committees and community assemblies. CHWs were not emphasized as a participatory mechanism. Their role was to provide health information and services. The community selected CHWs in cooperation with the health team.

CP Achievements/Problems. Project reports indicate that CP in planning was feasible and contributed to health program success. More CP impact was noted in rural than urban areas. Comparison of health education with and without active CP revealed that educational efforts had more impact with participation and that community pressure as a result of CP resulted in greater interest and support from health personnel. Specific conclusions are: 1) Communities were able and willing to participate. 2) Training for community committee members is fundamental to CP. 3) CP crystallized during the implementation phase; tangibility is a motivating factor. 4) Coordination between the government health service and the community is crucial to success. 5) Adequate supervision is an important incentive for CP. 6) Greater community motivation exists for short-term actions—there is little willingness to take risks. 7) Greater participation was observed for those communities with prior participatory experience. 8) Community actions are a complement to, not a substitute for, institutional action.

Source

Estudio de Participación de la Comunidad en la Planeación de la Salud. Dirección de Investigaciones, Ministerio de Salud, Bogotá, 1980 (8 volumes).

Costa Rica/Community Medicine Program

This is an ongoing regional demonstration program funded through the Costa Rican Ministry of Health. Begun as an outreach program of Valverde Hospital, it is now administered as a separate program closely linked with the hospital. It began in 1970 and serves about 82,000 rural people in the San Ramon, Alajuela area.

Purpose. To extend the hospital's coverage out into the rural communities, and to achieve community participation in improving health. The program coordinates all public health activities in the region, trains and deploys CHWs, motivates and advises community efforts and projects, and carries out health education activities.

CP Component. CP is organized in a regional structure. Local health committees (CHCs) and school health committees are integrated with local community development associations (CDAs). The latter are part of a nationwide system that undertakes a variety of socioeconomic development work and are advised by government community organizers who spend about 75 percent of their time on health projects. Local CDAs send representatives to 4 canton-level health associations and an overall regional community health association. The CHCs are the most active parts of the CDAs. They have complete financial responsibility for local health posts, identify problems and undertake health projects, promote health awareness, hold community meetings, and work closely with the CHWs and auxiliaries. CHWs are elected by community assemblies and can be removed by the CHCs. Their role is promotive and preventive—they carry out no curative functions. Curative care is provided by auxiliaries, who are also chosen by the local community, at health posts and by professionals and auxiliaries at health centers and the hospital.

CP Achievements/Problems. Communities participate in planning local and canton-level projects, and play a considerable role in implementation, including financing health post construction and maintenance and half the drug supply. Communities also often pay CHW per diem during training and other work

expenses, but there is no direct compensation of CHWs. The system appears to work very well, due to the relatively high level of education and community organization. The dedication and charismatic leadership of the director has been a great advantage.

Source

APHA. *The Community Medicine Program, San Ramón, Costa Rica. A Case Study*, September 1979.

Dominican Republic/Health Sector Loans I and II

AID loans help fund this national program of basic health services covering a population of two million in the rural areas of the Dominican Republic. The program, carried out by the Dominican Ministry of Health and Social Welfare (SESPAS), began in 1975.

Purpose. To improve SESPAS' capacity to deliver basic health services by improving administrative and service delivery capabilities, by using part-time community promoters (CHWs), and by emphasizing preventive measures such as immunizations, contraception, and water and sanitation.

CP Component. CHCs select and oversee CHWs and are responsible for building and maintaining latrines and water systems. CHWs are paid by SESPAS. The community also helps identify needs.

CP Achievements/Problems. CP in this program was not emphasized and is limited mainly to implementing activities. No mechanism exists for CP in decision-making. Government salaries make the CHW primarily responsible to SESPAS rather than to the community, but the service delivery system appears to work fairly well.

Sources

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El Salvador/Rural Health Aides

Now covering about 300,000 people, this Ministry of Health program will eventually open up access for the entire rural population. AID funding began in 1978.

Purpose. To extend, improve, and integrate health, nutrition, and family planning services for the rural poor by expanding and improving the community-based Rural Health Aide (RHA) system. This includes training, deployment, and support of RHAs and supervisors, furnishing supplies, and conducting refresher training.

CP Component. Little participation exists beyond community nomination of RHA candidates (final selection is by regional MOH staff). RHAs are paid by the MOH, but there has been some discussion of at least partial support for RHAs by peasant agrarian cooperatives or private growers' associations. Traditional midwives are trained.

CP Achievements/Problems. The community has participated very little. Coordination with the government community development agency (DIDECO) is being strengthened; this may increase community involvement and participation. Alternative financing, if implemented, might also increase CP. The program as currently operated is highly centralized and top-down.

Sources

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Guatemala/Rural Health Services

AID loans for support of the Guatemalan Ministry of Health's national rural health program began in 1971. The program intends to reach the bulk of Guatemala's approximately 4 million rural people, though by 1979, 65-70 percent of the rural population still lacked access to modern health care.

Purpose. To improve rural health facilities and personnel and to link the preventive-oriented rural public health system with existing curative facilities.

CP Component. The community-based part of the rural health system consists of volunteer promoters (CHWs) and trained traditional midwives, supported and supervised by MOH-paid auxiliaries and paramedics, (TSRs = Rural Health Technicians) at the health post level. TSRs provide preventive, promotive, and limited curative outreach in the villages. The auxiliary provides curative care in the health post. Promoters are chosen by village health committees and provide preventive and limited curative service to their own villages and initiate and guide community health activities. CHCs are chosen by the community with the prior consent of political leaders and military officials. They help determine needs and mobilize funds and labor for community projects. Municipalities provide land, labor, and buildings for health posts.

CP Achievements/Problems. Community organization has been considerably hampered by rampant political violence. People are afraid to organize or engage in any activity that remotely resembles politics. There has been high turnover among CHWs, mainly because of the lack of compensation. CP has also been hindered by the government's top-down planning and paternalistic view of the community, though progress has been made and interest in a community-based approach has increased during the project period.

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Guatemala/Chimaltenango Development Program

An ongoing regional effort of the Behrhorst Clinic in Chimaltenango, this project is partially self-supporting and receives private external support through the Behrhorst Clinic Foundation, World Neighbors, and OXFAM. It began in 1963 and serves about 200,000 Indian villagers.

Purpose. To foment greater social and economic justices; to serve people on their own terms, respecting their culture; to

provide agricultural extension services and work toward secure land tenure; and to provide preventive and curative health services.

CP Component. At community meetings people discuss health and other needs. There is a local community betterment committee, of which the CHC is a part. The CHC selects the CHW, sets prices for health services and medicines, and assists with community projects. The promoters (CHWs) are also active in community motivation work, and work in agriculture and other development efforts in addition to providing preventive and curative health services. Women's weaving clubs have helped support the program. A credit cooperative helps villagers purchase land. Curative services are self-sustaining through drug and service fees; medicines are purchased by CHWs through a cooperative run by them. Some traditional healers have been trained as CHWs.

CP Achievements/Problems. The project appears to be highly participatory, with community involvement in planning and implementation. There has been no formal evaluation, but worker self-evaluation is encouraged. The program is responsive to community needs beyond health. One problem has been that drug/service fees have encouraged an overemphasis on curative care by the CHWs.

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Honduras/Integrated Rural Health Services

The Rural Penetration Program, begun in 1974 by the Honduran Ministry of Health, hopes to extend basic health services to a rural population of about two million. The current AID project has provided partial support during the period 1976-1981.

Purpose. To provide basic coverage through a pyramidal system, with community volunteers at the base and referral services of advancing levels of complexity. AID funding is intended to increase MOH capacity to train and supervise community and paraprofessional personnel to deliver basic health services.

CP Component. MOH promoters discuss needs and priorities with community members in assemblies. The community selects two types of CHWs: representatives, who work mostly in environmental sanitation, and guardians, who provide preventive and curative services. Health committees exist in some areas, but they are not effective mechanisms for community involvement since they are composed only of CHWs. CHWs are not reimbursed and drugs are free. The community provides labor and materials for community projects such as wells and latrines. Traditional midwives are trained and deployed.

CP Achievements/Problems. Although this project has emphasized CP, it has not achieved a great deal of participation. The lack of an effective mechanism for mobilizing continuing participation is the major reason. Inadequate training and

orientation of staff has hampered CP efforts. Lack of a mechanism for local financing has hindered community control, and non-payment of workers has resulted in high CHW turnover. Inadequate logistic support and referral have also contributed to the problem. Some remedial measures are being taken, such as an improved information and supervisory system, increased non-monetary CHW incentives, and media outreach to the communities.

Sources

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Indonesia/Dana Sehat

A number of similar projects in central Java are called "dana sehat"; this term means health fund. The earliest health project began in 1963.

The program strategy was modified during the early 1970s, becoming community-based rather than clinic-based, and was developed in a pilot project (Klampok model) in the village of Sirkandi (population 3,000) in the Klampok sub-district, under the auspices of the Foundation for Christian Hospitals. In 1974 the Foundation for Prosperous Indonesia was formed to support the program. Funding has also been provided by World Neighbors. Within two years the program had spread to about 50 separate projects.

Purpose. To provide simple, practical and inexpensive health care. Principles used: find the needs, problems, and potentials within the community; work out a simple but comprehensive program to meet needs, using existing community potentials; give priority to community participation in planning and implementation of the program; use existing health center staff more effectively through delegation of authority and redefinition of functions. The program covers agriculture, communication/transportation, nutrition, and education, as well as health.

CP Component. Village administrators act as a CHC, responsible for administering the program and calling regular community meetings to discuss health needs and program affairs. The village health cadres (CHWs) are selected by community leaders. They are part-time volunteers who provide basic health care and foment participation. While they receive no monetary compensation, in-kind compensation is common, and they are rewarded by increased social status. The financing mechanism is the "dana sehat" or village health insurance scheme. Each household pays a monthly contribution equivalent of one-half to one percent of its monthly income, which is collected by the block chief. This fund covers health center fees and the cost of medicines used by the CHW; any surplus can

be used for community health projects at the community's option.

CP Achievements/Problems. The program has been structured to encourage community participation and responsibility. The Klampok model appears to have been successful largely as the result of its organization in small, flexible units and its learning approach, which grapples with actual community problems. The system has spread rapidly to other villages and has proven viable.

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India/Social Work and Research Center

The SWRC is an indigenous, non-governmental pilot effort supported by a variety of agencies, including OXFAM, Catholic Relief Services, Christian Aid, several Indian state governments, and some ministries of the Government in India. The program began in 1972 and covers over 80,000 rural people in Rajasthan state.

Purpose. To make basic health care available in every village; to utilize all possible community personnel; to disseminate skills to the lowest possible levels to enable gradual village health unit self-sufficiency; to work towards increased education and awareness among villagers; to provide necessary guidance and supervision; and to incorporate health into the farmers' way of life. SWRC has active programs in ground water, agriculture, rural industries and crafts, education, and communication, in addition to those in community health.

CP Component. CHCs are organized through meetings between SWRC health staff and communities. The CHC represents all castes in the village and is responsible for selecting the CHW and determining and collecting village contributions for his/her support. The CHW, who is responsible for basic preventive and curative care, health statistics, and education, also conducts village meetings. The CHW is paid a small monthly salary out of regular community contributions. There is a small fee for drugs and injections. Traditional midwives, trained in improved midwifery, work with women to promote family planning and nutrition. They receive a monthly salary.

CP Achievements/Problems. Village response to the program has been favorable, although some problems have arisen. Some CHCs have not collected village contributions, shifting this burden to the CHW. Some people have not contributed as agreed, forcing SWRC to absorb some CHW salary costs. A high drop-out rate among CHWs has resulted from the heavy workload and low compensation. Recruitment has been difficult because of a high educational requirement; people with 8 years of schooling prefer better-paying, full-time jobs. The TBA program appears to work fairly well.

Source

Kale, Pratima and Philip H. Coombs. *Social Work and Research Center: An Integrated Team Approach in India*. International Council for Educational Development, December 1978.

Iran/Kavar Village Health Worker Project

This was a pilot project of the Pahlavi University Department of Community Medicine, with funding from Canada's International Development Research Centre. It began in 1972 and ran for three years, covering 9,000 people in 16 isolated villages near the town of Kavar, south of the city of Shiraz, in Fars Province.

Purpose. To provide a replicable model for village health care and at least a partial solution to Iran's shortage of health manpower, through the training and deployment of auxiliary health workers in rural areas.

CP Component. There are no formally constituted health committees. Initially, village authorities selected CHW candidates in those villages with a pool of literate persons from which to draw. Final selection was made on the basis of tests and interviews by staff. A later group of trainees was selected on merit only, by staff, with no community role. Group meetings were sometimes held to discuss health topics and plan preventive projects.

CP Achievements/Problems. Other than initial selection of CHW candidates, the community participated very little in planning of decision-making. Participation was largely limited to cooperation in supplying clinic space and equipment, constructing village projects, and accepting advice and services. An evaluation found that utilization of CHW services was independent of sex and village residence. Also, participation of village authorities in CHW selection often introduced factional issues. Assigning CHWs only to their own village made recruitment of women difficult: four of the five women CHWs came from other than project villages. Later CHW recruits were selected by staff only from among residents of the Kavar area or those who taught in village schools. Only 9 of the 16 lived in the village where they worked. These changes in recruitment and deployment were taken to remove the CHW from the influence and control of village authorities and minimize CHW involvement in political and family disputes.

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Kenya/Kibwezi Rural Health Scheme

This project is a national pilot program supported by AID, the Association of Swiss Civil Servants, Norwegian Church Aid, the Canadian International Development Agency, and the Government of Kenya. It began in 1979 in the Mankindu District of Kibwezi and should eventually reach 100,000 people. Implementation is by the Ministry of Health with assistance from the African Medical Research Foundation.

Purpose. To develop a primary health care scheme that can be replicated in 10 other underserved, remote rural areas. The project consists of a central in- and out-patient health center that can serve up to 300 people a day, the selection and training of CHWs, the ongoing training of project staff, and a mobile health unit to provide additional preventive and curative services and health education.

CP Component. AMREF staff visited villages and met with leaders and existing village development committees (VDCs) and

self-help groups to discuss the concept of primary health care and the role of the CHW. The project staff also tried to determine the villagers' perceptions of their own health problems so that these areas could be included in the program. Through baseline surveys, community health surveys, and numerous meetings, the project staff and communities identified health problems and attempted to work out collective solutions. The VDCs act as health committees; they select the CHWs, call community meetings, supervise health activities, assist in health post construction and maintenance, and coordinate with non-health development efforts. While CHWs are initially to be volunteers, the community will eventually assume responsibility for their remuneration. Community leaders and the VDC help determine areas in which the CHW is trained and also help supervise the CHW.

CP Achievements/Problems. Communities with active self-help groups decided themselves not to form separate health committees since the existing groups could serve this function. The planned number of CHWs have been selected by their communities and are in training. A baseline survey has been completed and health needs have been prioritized within communities. Methods of remunerating CHWs are still in the planning stage, although some communities have offered to donate labor and materials for construction of the CHW's health post. AMREF reports that the primary health care concept has been accepted with enthusiasm by communities. Considerable time and effort have been spent by AMREF staff in establishing rapport with local people and their leaders. AMREF has encouraged communities to initiate actions rather than merely respond to project guidelines.

Sources

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Kenya/Kitui Primary Health Care Project

This rural pilot project began in 1977 under the direction of the Catholic Diocese of Kitui and the Ministry of Health. The current project, which is being funded by AID and implemented by CODEL, began in 1979. The project contributes to the Government of Kenya's goal of providing health services to about one million people living in rural areas; the Kitui project covers 16 village centers totaling 230,000 people via mobile teams.

Purpose. To provide health care to people not presently served by existing government or medical mission facilities by creating a replicable, low-cost health delivery system. Four mobile health units and outreach from the mission hospital serve remote rural areas. Health teams are to provide prenatal care, immunizations, and simple curative care; offer health education; and give some training for community health workers and midwives.

CP Component. Baseline and community surveys to determine the impact of the project and appropriateness of the design are planned. Health education classes are often held on market days. Project staff recruit and select CHWs by contacting area women's groups and consulting with tribal leaders. CHWs provide health education and basic curative care. A nominal charge is levied for curative services, but CHWs are primarily volunteers.

CP Achievements/Problems. While CODEL reports that community response has been enthusiastic and improved

immunization coverage has reduced child mortality, community participation in planning, management, and evaluation has been limited. After 2 years, only 5 of the 100 targeted villages had active health committees. The Kitui project does not attempt to encourage the communities to contribute labor, time, or materials. CP has largely been limited to using services that are provided rather than initiating self-help activities. The most serious limitation seen in the project overall has been the minimal level of community-based work. The mobile health team is able to spend only a limited amount of time in each village, and the CHWs seem to have had only a peripheral role in supporting the efforts of the team. Little follow-up is done to determine the effectiveness of health education, and little has been done in prevention with regard to sanitation and nutrition. Kitui is less than 100 miles away from the Kibwezi project, but there has been little exchange between these two AID-funded projects, with the result that Kitui has not benefited from the experience of the Kibwezi project in CP activities.

Source

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Korea/Yonsei Community Health Teaching Project

Begun in 1974 by the Yonsei University College of Medicine in Seoul with private and government funding, this pilot project has been supported since 1978 by the University, the government, and Bread for the World. The project covers about 14,000 rural people in Kang Wha, an island district northwest of Seoul.

Purpose. To improve the health of the target population; to develop a culturally sensitive model for comprehensive rural health care; and to provide an educational experience in community health to medical students and students in other health disciplines.

CP Component. Township health councils have been established to select the Family Health Workers (CHWs), control the service schedule and location of facilities, and share responsibility with staff for selecting services. They also organize patient transportation and run the health insurance scheme, cooperatives, and credit unions that pay for the CHWs. The CHWs are village housewives who are trained in health and nutrition education, simple curative care, maternal and child health, family planning, tuberculosis care, and record keeping. As mediators between the traditional rural community and the modern health care system, they receive consultations at the health post and make regular home visits. They are paid a small, regular salary and may receive other rewards for excellent service. Financing is through the health insurance scheme and credit union.

CP Achievements/Problems. The community participates most actively in carrying out services and using them. Project documents stress participation, and there is apparently growing community involvement and responsibility and constant community feedback. The project appears to be well accepted and to have had a favorable health impact.

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Mali/Rural Health Services Development

Two rural regions of Mali totaling 60,000 people are the target of this pilot project assisted by AID and the Government of Mali during 1979-1983.

Purpose. To design, implement, and evaluate a demonstration rural health system that can be replicated on a national scale. The project intends to bring health services to the village level, emphasize promotive and preventive activities, and integrate with other community and economic development programs.

CP Component. Village management committees select part-time volunteer health workers with the assistance of the project staff. Workshops for local health and development workers are held to help them understand the project design and to build a health team that can train and support the VHWs. The curriculum for training VHWs was developed in the field. VHWs are to be paid from in-kind payments or revolving drug-fund profits, but thus far little or no compensation has been provided. A series of anthropological and baseline surveys were conducted at the beginning of the project, and Peace Corps Volunteers conducted additional background and needs surveys in the area before the project began.

CP Achievements/Problems. The National Center for Community Development has assigned a graduate of its training school to assist each project field team in training and supervising VHWs. Surveys have been conducted on the number and condition of wells in the villages, and plans for improving water supplies have been made. Labor has been provided by the communities for construction of various infrastructure projects. Delays in outside funding, however, have impaired the project's credibility in a number of villages that were promised assistance in water improvement activities. The majority of people in the regions to be served are being covered by the project, but the quality of health care services and record keeping have often been found lacking. There have been inter-village conflicts over pharmacies. Problems have also arisen from unguided village selection of CHWs: because they are all male, they treat mostly adult males and neglect women and children. One of the planned activities was to compare the relative success of the pilot projects in the 2 areas based on the degree of community development that had existed prior to the start of the program. Because of changes in several variables, this planned comparative study could not be completed.

Sources

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Mexico/Project Piaxtla

This ongoing regional effort began in 1963 as a private venture by David Werner and has since developed into a largely self-sustaining program, with some external support through its own organization, the Hesperian Foundation. It covers a population of about 10,000 in 100 rural villages in Sinaloa and Durango.

Purpose. To involve communities in meeting their own health needs in a humane, economically realistic, and ecologically sound manner. The program also encompasses other development activities, such as improving agriculture.

CP Component. This program is now entirely community-run. Villagers and trained local non-professionals operate, direct,

and supervise all services. Volunteer expatriates played an important role in initial service provision, organizing the project and training local people, but their current role is purely advisory. Local health committees flourish, and villagers selected by their communities are trained as CHWs by the local project team. They work in community organization and health education, as well as basic curative medicine. The program is largely locally financed through drug and service fees and communally worked agricultural fields that help support the clinic. The local project team also does some outside fundraising. The project tries to incorporate indigenous healers, medical knowledge, and remedies within the program.

CP Achievements/Problems. On the basis of available information, this project appears to be an excellent model of a learning-process project involving full local participation and control. When it was found that the initial use of expatriate volunteers to deliver services was fostering dependency on outside resources, their use was curtailed to a training and advisory role; it has been steadily shrinking. The project founder's enthusiasm and dedication has been an important factor in the project; although he is maintaining an ever-lower profile, it is not yet known whether the project would continue to prosper with no expatriate involvement.

Sources

"Health Care for the People, by the People: Project Piaxtla," *Development Communication Report*, July 1979.

Interview with Martin Reyes, Director of Ajoya Clinic, June 1981.

Nepal/Integrated Community Health Services Project

This AID-supported project provided support for Nepal's Integrated Community Health System (also known as the Basic Health System) during the period 1973-80; AID support is to be continued under another project entitled Integrated Rural Health/Family Planning. Conceived as a nationwide effort, activities are being gradually expanded over a period of years to achieve national coverage.

Purpose. To help the Government of Nepal organize and manage an effective integrated basic health service, using multipurpose home visitors to extend the coverage of rural health units. Two major outputs were planned: development of basic health management and control systems, and training of health workers.

CP Component. District and local health committees are expected to support health posts through contributions of land, labor, and materials. Outreach workers are apparently not selected by the communities; they are largely urban and high caste; all are males. They are paid by the government. Some effort has been made to introduce volunteer CHWs from the local villages as a still lower level of health workers, but information is scanty. Some use has been made of traditional ayurvedic medicine, but not of traditional practitioners.

CP Achievements/Problems. CP in this program is limited to implementing activities—provision of land, labor, and materials—and use of services. There appears to be no decision-making or planning role for the community. CHC responsibilities are not defined. The outreach workers have had difficulties in working with villagers because of differences in caste and origin.

Sources

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Nicaragua/Rural Community Health Services (PRACS)

The PRACS program was a regional pilot supported by AID and implemented by the health education division of the Ministry of Public Health. It began in 1976 and ceased activity prematurely in 1979 due to political turmoil. The program covered 45 villages in Esteli Department, a rural area northeast of Managua.

Purpose. To develop a community-supported primary health care model, using Ministry health educators, rural health collaborators (CHWs), and CHCs, reinforced by radio lessons.

CP Component. The CHCs participated in planning, assisted by health educators and a system of planning charts developed by the project. The CHCs surveyed health problems, evaluated resources available in the community, reviewed possible actions, determined priorities, assigned implementation responsibilities, and evaluated results. The CHCs also participated in the selection, supervision, and evaluation of the CHWs. CHWs were responsible for preventive and curative health services and worked with the CHCs in detecting problems and developing solutions. CHWs were trained in community organization and health analysis. The CHCs were responsible for mobilizing local labor, materials, and monetary contributions. Such local contributions covered about 10 percent of total program costs. It was reported that local contributions were four times higher than anticipated by the end of the project's first year. The program tried to use traditional practitioners as CHWs.

CP Achievements/Problems. Participation appears to have been quite successful. Response to the radio school was very good. An advantage was the flexible approach taken, which permitted the project to learn from its own experience as well as that of other similar projects. Another important factor was the development of a well thought out and tested CP methodology and the provision of training and continuing support and assistance to the community. (One source claims, however, that the project was very politicized and that mainly Somoza supporters participated actively.)

Sources

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Sarn, James E., "Popular Planning and Radiophonic Schools: Nicaragua's PRACS Program," *Development Communications Report*, July 1979.

Nicaragua/East Coast Health Delivery

AID provided an operational program grant during the period 1977-1980 to Partners of the Americas, the PVO that originally began this regional project in 1964. The program served approximately 35,000 rural people in the Atlantic Coast area of Nicaragua.

Purpose. To help refine a model regional community health program that would provide an alternative means of providing basic health services in similar isolated areas. The project stressed use of locally trained health workers, appropriate technology, and regionalization of health services.

CP Component. CHCs planned and implemented community health projects, conducted and analyzed annual surveys of health conditions, and selected and supported CHWs. There

were two types of CHWs: health leaders and nutrition leaders. Both were essentially volunteers, though health leaders received some minor compensation through drug sales. Health leaders had basic preventive and curative functions and received training in community organization. Communities provided labor and materials for building health posts, wells, and other community projects. They also undertook fund-raising efforts. CHCs were responsible for administering funds collected through drug fees. Traditional midwives are trained in preventive health education as well as in improved delivery procedures.

CP Achievements/Problems. Until a fairly advanced stage of project implementation, participation was hindered by external control—the project was partly administered from the Partners office in Wisconsin, which caused administrative problems such as delays in disbursements. This was changed, and administrative control later rested with a local board in Puerto Cabezas. A high service orientation by staff also impeded long-range planning to some degree. But in general participation at the community level was high in this project, with active CHCs involved in planning, implementation, and evaluation.

Sources

AID project documents.

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Interview with Marcia Griffiths, April 24, 1981.

Niger/Basic Health Services Delivery/Rural Health Improvement

The AID-assisted Basic Health Delivery Project (Diffa) began in 1978 and is currently being merged with the Rural Health Improvement Project, scheduled for implementation during 1978-1983. Africare has been the contractor for the projects, which are being implemented by the Ministry of Health to bring basic health services to 3,500 villages—about 1.9 million people or 39 percent of the rural population. Basic Health Services Delivery covered 152,000 people.

Purpose. To strengthen the government's ongoing primary health care program by training village health workers, retraining health professionals, and setting up sanitation programs. The Basic Health Services Delivery Project concentrated on developing the health infrastructure in Diffa, one of the country's seven departments. Improving Rural Health Services is developing human resources and institutional support for village-level workers, in addition to improving potable water supplies, environmental sanitation, and nutrition.

CP Component. A nurse and rural development officer visit each village to discuss the program and the village health team approach. The health system depends upon a village health team that consists of a midwife, a *secouriste* (CHW, usually a male village leader), and a village administrative committee. The village health teams are selected by their communities and are trained and supervised by dispensary nurses. CHWs are volunteers, but non-monetary compensation is common. *Secouristes* sell medicines at a small profit, but must still maintain other sources of income. Broadcast radio has begun for health education, and there are plans to use television.

CP Achievements/Problems. While emphasis has been given to community self-sufficiency in the project design, there is little evidence of community-initiated activities. Participation is mainly in use of services and in some implementation activities. Although considerable progress has been achieved in training CHWs, the training methods need to be revised. According to the Ministry of Health, villages appear to be reacting favorably to CHWs; people in villages with health teams are more health conscious, demand more services, and have better health habits.

A major difficulty has been the failure to take the local social structure into account in designing for participation; the design assumed that all villages had communal structures in place, when in fact many had no concept or tradition of broad community cooperation.

Sources

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Nigeria/Lardin Gabas Rural Health Program

An ongoing rural pilot project that began in 1973, the Lardin Gabas project is sponsored by the Church of the Brethren, the Church of Christ, and the Protestant Central Agency for Development Aid of the Federal Republic of Germany. The project serves a population of 500,000.

Purpose. To prevent disease through the use of traditional health education methods (parables, songs, drama, and riddles) presented by CHWs to improve individual health behavior.

CP Component. The program director initially contacts a village through the village chief. Meetings are held with villagers to explain the project, enlist their support, and explain the duties of the CHC. Health committees are formed of leaders and villagers; a booklet outlining health committee responsibilities is presented to the members. The CHCs select the CHW, based on recommendations from the villagers; pay the CHW's salary and training costs through fees for drugs, services, and donations; and oversee the CHW's work.

CP Achievements/Problems. Participation appears to occur in planning and implementation of activities. Many villages are providing time and labor to build village health clinics and clinic furnishings. Some villages also build their own wells. The CHWs have coordinated their efforts with the community development workers and agricultural instructors so that the program is able to address other community needs in addition to health. It has been difficult to change health behavior based on taboos and traditional health beliefs. Some villages are too small to support the CHW adequately, or too isolated to permit adequate supervision. The CHW selection criterion requiring literacy has made it difficult to recruit women CHWs (each village has a male-female team).

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Panama/Rural Health Delivery System

This AID-assisted project is a continuation of an earlier effort to assist the Panamanian Ministry of Health in extending rural health services. Though national in scope, the project is currently targeted at 150,000 people in 225 rural communities. Current AID funding covers fiscal years 1976-81.

Purpose. To strengthen and expand the rural health system by constructing health facilities, training additional personnel, constructing wells, aqueducts, and latrines, and improving nutrition.

CP Component. CHCs work with health assistants (CHWs) in planning and implementing solutions to health problems. CHCs encourage community attendance at clinics, cooperate in immunization and other preventive campaigns, and assist with nutrition surveillance. CHCs are also responsible for organizing community contributions for projects and for overseeing and maintaining community projects. The community selects CHW candidates; final selection is by staff. CHWs are paid by the Ministry, and receive community development training. They have preventive and curative functions and help organize communities to undertake projects. Community resource contributions include labor and materials for projects and special fund-raising efforts. CHCs administer money from drug fees and supply CHWs with drugs. Some traditional healers are trained as CHWs.

CP Achievements/Problems. Community participation has been mainly in the area of implementation of water systems and latrine construction, and appears to have worked well. No information is available on the degree of CP in project planning.

Sources

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APHA. *AID-Assisted Primary Health Care Projects: Summary Reviews*, 1981.
Telephone interview with Abby Bloom, former USAID/Panama Health Officer, April 27, 1981.

Papua New Guinea/Mogoro Fugwa Health Center

The Mogoro project is a missionary effort funded from church and local government sources. It began in 1962 and serves about 6,000 people in a rural area.

Purpose. To provide health services and education to the local population.

CP Component. The community, through a CHC, participates with staff in decisions on type, time, and location of services. It also proposes CHW candidates; final selection is by staff. The community is responsible for building and maintaining infant welfare clinics. Women from the villages are trained to work as volunteers in the central clinic and the infant welfare clinics in the villages, but no information is available on specific functions. It appears that traditional medicine is used somewhat.

CP Achievements/Problems. Information on this project was sparse, but participation appears to be mainly in implementing activities and using services. Little indication was found of an effort toward self-sufficiency and effective use of community resources.

Source

- APHA State of the Art questionnaire.

Papua New Guinea/Nazarene Hospital

This pilot project is run and supported by missionaries. Begun in 1967, the project covers over 45,000 people, 90 percent of them rural.

Purpose. To promote community self-sufficiency in health care, and to train health and administrative support personnel.

CP Component. Community members participate through a health committee with responsibility shared with staff for

deciding type, time, and location of services; for selecting CHW trainees; and for maintaining buildings. The CHC has input into planning, implementation, and evaluation. CHWs, who are volunteers, have a primarily motivational and educational role. Communities give time, labor, and materials for construction of facilities. Fees for services cover about a quarter of project costs. The project is now being integrated into the national health care system.

CP Achievements/Problems. Information on this project was scanty; it appears to be quite participatory, though mechanisms are not described in any detail. There is an emphasis on achieving as much local self-sufficiency as possible, as well as on coordinating with the national health network for necessary extra-community support and referral services. Missionary staff aim to "work themselves out of a job" to ensure long-term survival of the program.

Source

APHA State of the Art questionnaire.

Peru/Extension of Rural Medical Attention

Funded by the Swiss Government and UNICEF, this regional pilot project is implemented by the Puno regional office of the Ministry of Health. The project, which began in 1972 and will run until at least 1986, serves 35,000 rural people in the Peruvian highlands region.

Purpose. To improve health status, raise the consciousness of the peasant population, and promote active participation in the solution of health problems through the use of trained auxiliary nurses, promoters (CHWs), and midwives.

CP Component. CHCs are selected by the community in accordance with project criteria. They are responsible for supporting and supervising CHWs; handling drug supplies; constructing and maintaining health posts; and completing other projects such as wells and latrines. CHWs are selected by the community or CHC and project staff. They are volunteers, though some of them apparently get some compensation from drug sales and service fees. CHWs provide mostly curative services; they have no important community development role. Traditional birth attendants are trained, and some effort is made to encourage use of beneficial home remedies.

CP Achievements/Problems. Although the project set out to be participatory, it has failed to achieve this goal to date. The CHCs have not been very effective as a CP mechanism because of inappropriate selection criteria, i.e., elimination of political leaders. The CHCs lack authority and have not been effective in overseeing CHWs. Changes have recently been made to permit free community determination of CHC membership and to reduce the curative bias of CHWs. The community did not participate in planning the original project; efforts are now being made to get more community input into needs identification and planning.

Sources

APHA State of the Art questionnaire.

Project Annual Reports for 1978, 1979 and 1980.

Swiss Government Technical Cooperation, ORDEPUNO Region and MOH. "Evaluación del Proyecto Extensión de la Atención Médica Rural en el Perú," October 1980.

Philippines/Development of Peoples Foundation Health Program

The DPFHP began in 1967 as a church-supported charity medical clinic in a squatter settlement in Davao City, Mindanao. It gradually evolved into an integrated development and health

program largely supported by local resources through its own non-profit foundation, with additional support from other private donors and UNICEF. The program covers about 17,000 people in urban fringe settlements.

Purpose. To provide primary health care services to low-income squatters. The broader objective is to foster community competence, self-reliance, and development. The project was designed to demonstrate how education and organization can activate communities to take effective health actions and make major health improvements.

CP Component. Community members participate through the health cooperative and its neighborhood sections. There is no separate health committee. Participation is a function of membership in the cooperative, which is open to low-income residents of the Bajada area of Davao City for a nominal membership fee and monthly dues. A representative from each member household must attend three orientation sessions. Member households cooperate in preventive health programs and operation of cooperative pharmacies, which sell drugs at reduced rates. A community-based workshop helps support the program and provides employment. The CHWs (*Katiwala*) are selected and supported by the neighborhood groups and serve as conduits to convey community wishes to the cooperative staff, in addition to providing preventive and curative health services. They are paid the equivalent of US \$0.30 per case as an incentive for reporting diseases and vital events; incentives are financed from cooperative fees, dues, and drug sales.

CP Achievements/Problems. The program, presently serving over 2,000 households, has apparently been quite effective in providing low-cost health services through community involvement. Some donor support is still necessary to make up deficits. Designed as a service rather than a research project, the program lacks a formal evaluation mechanism. Available evidence indicates the project's success and replicability hinge on community involvement. *Katiwala* have begun to work in other areas of the Philippines.

Source

APHA. *The Development of Peoples Foundation Health Program.* (Davao City, Mindanao, Philippines) Case Study, Fall 1979.

Philippines/Panay Unified Services for Health

PUSH, begun in 1978, is a regional project coordinated by the Philippines National Economic and Development Authority (NEDA) and the Region VI Development Council, with funding assistance from AID. The Ministry of Health is responsible for technical health aspects. PUSH covers 600 *barangays* (villages) in four provinces of Panay Island, a population of 600,000.

Purpose. To improve health status by providing basic preventive, educative, and health promotional services, and by installing essential environmental sanitation infrastructures.

CP Component. Community health committees (CHCs), closely identified with the Barangay Councils (local governments), are established with the assistance of community organizers. The CHC nominates barangay health workers candidates (BHWs), who must be endorsed by the mayor. The BHW is finally appointed by the provincial government on the basis of tests and/or interviews. The CHC also identifies problems and assists in project implementation. In addition, there are 2-12 general community assemblies each year in which decisions are made on project options and on maintenance and funding of local projects. The BHW is responsible to the CHC and Barangay Council, and is a paid employee of the Provincial Government at the minimum civil service salary (US \$50.00 per month). The BHW is responsible for preventive and promotive health work

and community organization for health activities. Village pharmacies are also planned; they are to be owned, operated and managed by each barangay. Funds derived should cover operating expenses and drugs and help finance community projects.

CP Achievements/Problems. It appears that the community participates quite a bit in decision-making at the village level, and project structure stresses incorporation of political leaders on all levels and extensive inter-institutional coordination. CHWs work with clubs and other local organizations to promote community projects. Communities donate labor and materials, though some are reluctant to do so more than once. The project appears to be quite dependent on external financing and does not appear to be directed toward funding self-sufficiency.

Sources

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Senegal/Rural Health Services Development

This regional rural health project in the Sine Saloum area is funded by AID, the Peace Corps, and the Government of Senegal. The project, designed to reach 800,000 people, was implemented from 1977 to 1980 by the Ministry of Health and *Promotion Humaine*, a cabinet-level organization concerned with rural development. AID contracted a consulting firm to redesign the project after evaluations found serious management problems. This summary covers the project until June 1980 when the contractor began work.

Purpose. To create a self-sustaining, village-based health care system that could be replicated at a manageable cost. A network of village health posts staffed by community health workers was planned, and the government's support system for health post services was to be strengthened. Existing health posts were to be renovated and new posts built.

CP Component. *Promotion Humaine* held village-wide meetings or ward meetings to discuss the project and help organize Village Management Committees responsible for selecting CHWs, monitoring health hut receipts, maintaining drug supplies, organizing the building of health huts, and managing the health teams. Villages have contributed labor and materials for health post construction. Drugs and service fees are supposed to cover health post maintenance, drug supplies, and CHW salaries. Three types of community health workers are utilized: the *secouriste* (CHW), *hygieniste* (sanitarian), and the *matrone* (midwife).

CP Achievements/Problems. Planned CP in decision-making and management has not materialized. The management committees were unable to carry out many of their planned functions, including managing the health team, because of lack of training and prior experience. While committees were set up in over 100 villages, follow-up, supervision, and support by government health and community development personnel have been inadequate. Technical supervision of CHWs was also a problem; department supervisory teams were never organized, and time and transportation problems made it difficult for project and health center staff to provide needed supervisory support. Villagers did not appear to have a clear understanding of project objectives and their responsibilities as members of the community. Decisions were often made by a few leaders, rather than by the entire community. Because outside authorities

allocated a high proportion of income from health huts to pay CHWs, money was insufficient to buy drugs. Insufficient guidance was given to village leaders in locating the huts. As a result, many were too close together to earn enough income to cover costs. Consequently, many huts had to close. This resulted in frustration and disappointment for villagers who had given time and labor to build the huts. A high turnover among CHWs resulted partly from initial requirements for French literacy, which led to choosing well-educated people who were easily attracted to higher paying jobs in the private sector.

Sources

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Sierra Leone/The Eastern Clinic

The Eastern Clinic is a regional project funded by European governments, the Government of Sierra Leone, and university and religious groups. The project began in 1967 and is to reach 70,000 rural people.

Purpose. To improve people's health and standard of living.

CP Component. The project is hospital-based, with extension work done via health posts and community health workers in the areas of agriculture nutrition, maternal and child health, and health education. Community elders from the 5 chiefdoms served by the hospital and its outreach program are members of the hospital committee. The committee is involved in planning and evaluation, and the elders advise the hospital staff, in addition to motivating and representing their respective villages. The CHWs are proposed by the CHC; final selection is by staff.

CP Achievements/Problems. Although information on this project was sparse, it appears that the community participates in planning, implementation, and evaluation. Special village classes are held in local dialects, films are shown, and rural health bulletins keep health workers and teachers better informed. Several agricultural income-generating programs have been established to support the clinic. Traditional health practitioners can come to the hospital to treat patients, and traditional midwives work as project volunteers.

Source

- Health Project Capsule. "The Eastern Clinic." APHA, Summer 1979.

Tanzania/Hanang Ujamaa Village Public Health Program

CODEL (Coordination in Development) is the principal contractor and implementing agency for this project, supported by an AID grant since 1977, which serves a rural population of 200,000.

Purpose. To develop a model primary health care program to reduce the incidence of infectious and other preventable diseases by emphasizing maternal and child health services. Health manpower training and a management information system are being designed to strengthen national capability to implement larger projects. Two village health workers, one male and one female, are to be trained for every area village without an established health-care facility.

CP Component. Staff contact the villages to explain the project. Villages to be included in the project are selected on the basis of interest and willingness to support their CHWs during training. Village meetings are held to encourage participation in planning the health programs. Existing village development committees (VDCs) take on the function of community health committees. Volunteer CHW candidates (male-female teams) are nominated in village meetings for final selection by staff. They are trained to promote CP as well as to provide health education and basic services. The VDCs supervise non-technical CHW functions. Besides supporting CHWs during training, the villagers provide funds for the first-aid box and a site for the mobile clinics. A technical advisor makes ongoing visits to the villages to monitor progress and give support to committee activities.

CP Achievements/Problems. About one-half of the committees are active. The community is financially supporting the CHW team during its 10-month training program. Although it was planned that CHWs would be volunteers, complaints by the CHWs have led to payments and/or their being excused from otherwise required communal labor. About one-half of CHWs receive some form of remuneration from their communities. Baseline surveys have been conducted by village health workers as part of their training, and sanitation and water-improvement projects have been initiated in a few villages. Villagers have also provided labor and materials for constructing health posts, dispensaries, water systems, latrines, and rubbish dumps. Attempts to involve community leaders as health educators have had only limited success; the teaching methodology was too sophisticated for their level of literacy and is now being modified.

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Thailand/Lampang Health Development Project

The Lampang project is a regional demonstration project of Thailand's Department of Health. Planned in collaboration with APHA, the project receives funding from AID and technical assistance from the University of Hawaii School of Public Health Medex program. The project period is 1974-82. The target group is the 666,000 rural inhabitants of Lampang Province.

Purpose. To expand health coverage to at least two-thirds of the area's rural population, especially women and children; and to establish a cost-effective model of an integrated health delivery system, replicable nationwide, that can extend curative, preventive, and promotive services to sub-district health centers and to villages through the efforts of trained village health workers.

CP Component. Health center staff help reorganize existing CHCs or organize new ones; these consist of influential leaders (all male). CHC responsibilities include selection of and support

for the local village health volunteers (CHWs). There are two types of CHWs: Health Post Volunteers (HPVs) and Health Communicators (HCs). HPVs (1 or 2 per village) provide basic curative and preventive services, coordinate government health activities in the village, and supervise HCs. HPVs derive a minimal income from drug sales, and they and their families get free medical care. HCs (one for every 10-15 households) provide health information and promote use of the HPVs and health centers. Although not paid, they receive free medical care. Traditional midwives are trained in improved delivery practices and basic maternal and child health and nutrition. They receive free medical care in addition to customary compensation from clients.

CP Achievements/Problems. Although the community is very little involved in planning and evaluation, the CHWs have a great deal of responsibility in carrying out project activities. Local financing appears to be limited to paying drug and service fees. HPVs have complained about inadequate compensation. Since CHC functions have not been clearly defined, the committees have tended to become inactive after initial selection of the CHWs. The HCs have not been as useful as anticipated because of supervision deficiencies (this also applies to the HPVs), but they have been helpful in surveillance and special campaigns. It has been suggested that the HC function be given to the health committees, and this has been tried with some success on an experimental basis.

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Upper Volta/Save the Children/Redd Barna

This is an ongoing pilot project, funded by private donations and Save the Children/Norway, that began in 1976 and serves a population of 22,000 in a rural area of Upper Volta.

Purpose. To increase the capability of communities to solve their own health problems through their own efforts and initiatives.

CP Component. CHCs are composed of local leaders and interested villagers. Since men and women will not meet together, both male and female committees were developed. The project staff meet with village chiefs and leaders and informally talk with people to identify health committee members. Specific responsibilities develop as projects emerge, but generally members represent their group and solicit ideas and concerns on health, meet regularly with staff, and help organize the community to implement projects. They also have a role in informal ongoing project evaluation. The committee is responsible for selecting and evaluating the CHW. The "bush pharmacist" (CHW) is generally male; female TBAs are also trained. CHW responsibilities include setting up a health center with the CHC, curative work, and health education. The CHW is paid with profits from drug sales and receives some in-kind support; however, funds are not always adequate.

CP Achievements/Problems. The project design does not take into consideration the two tribes represented in the villages. These two tribes do not traditionally work together, and so CP has been difficult to achieve. CHCs have had a role in working out project plans, and communities have provided time, labor, and materials to build community health centers. All the communities are involved to some extent in project planning and implementation. CHC members have collected money and organized income-generating projects to support program activities. Some areas are overly supported by the staff, diminishing the self-reliance of the communities.

Source

Bonnie Kittle, former Health Project Coordinator and Interim Director, Save the Children, Upper Volta.

Zaire/Vanga Hospital

Sponsors for the hospital outreach program are the Baptist Church of the United States, OXFAM, and the Ministry of Health of Zaire. The program began in 1967 and serves a population of 300,000.

Purpose. To extend and integrate hospital services at the village level through the efforts of a mobile clinic team that emphasizes preventive services.

CP Component. CHCs are made up of members selected by the community and are organized by hospital outreach staff. They are responsible for implementing sanitation projects. CHWs do not appear to be used in the project. CHC members appear to have some input into determining hours of services at the health post, location of health post facilities, services offered, and allocation of funds. Health posts are coordinated with Vanga Hospital and financed by drug sales. An outreach team travels by bike or on foot each month to the villages and delivers educational, curative, and preventive services.

CP Achievements/Problems. The community is asked to help, but does not appear to have much decision-making power. Communities provide time, labor, and materials for sanitation projects.

Sources

APHA State of the Art questionnaire.

Health Project Capsule. "Vanga Hospital Community Medicine Program." APHA, 1979.

appendix B

METHODS FOR MONITORING AND EVALUATING COMMUNITY PARTICIPATION

✓ In a WHO working paper on evaluation of primary health care programs, Cole-King outlines a framework for evaluating primary health care, including community participation. She provides some sample questions for evaluating community participation, together with an outline of the information required and the methods of obtaining the information. She also discusses a wide range of different evaluation approaches, reviews existing studies, and analyzes the context and process of evaluation for primary health care projects. (Cole-King, *Care in the Context of Primary Health Care*, Appendix 9.) See table 7.

✓ The process involved in participatory evaluation has been described by Feuerstein in several published articles. Feuerstein examines the nature of participation, examples of participation in practice, the implications of a participatory approach in evaluation, and participatory evaluation as an appropriate technology for community health programs. She discusses the methods used in participatory evaluation, the role of external agents as facilitators of the evaluation process, the goals of evaluations, and the use of evaluation findings. (For a brief summary, see *Contact*, No. 55, Christian Medical Commission, Geneva, February 1980.)

✓ The Colombian project developed a series of three questionnaires that CHC members used to evaluate the participatory process as well as project service delivery. Eight volumes have been issued describing the methodology and results of this project, including one on evaluation. (Dirección de Investigaciones, Ministerio de Salud, *Estudio de la Participación de la Comunidad en la Planeación de la Salud, Documento sobre la Etapa de Evaluación.*)

✓ The Pan American Health Organization (PAHO) has issued a series of documents on evaluation methodology for community participation in health programs. One volume describes a conceptual framework for investigating community participation by looking at the relationships between traditional and modern concepts of health and treatment. The method proposed seeks to identify, for both the community and the health system, the psychological, social, and historical factors that influence community participation. Once these factors are identified, representatives of the traditional community health system and the modern health system are brought together to reconcile their points of view; the factors identified in this dialog are then investigated in depth. All components of the investigation are described in detail in the document, as is use of the results. An appendix provides examples of factors to be analyzed, data collection methods, and questionnaires. (PAHO, *Esquema Metodológico Simplificado*)

✓ Another PAHO volume outlines a model for national studies of community participation in health programs. Relevant factors affecting community participation are discussed and a detailed model with two options — a case study or sample survey — is described. A participation questionnaire with suggested indicators is included. Appendices describe field study methodology. (PAHO, *Modelo de Estudios Nacionales*)

✓ A third PAHO volume consists of a compendium of reference articles on applied social research in community participation and service delivery in health programs. Included are articles on social science classification schemes, research design, social surveys, bibliographic research, and sample

TABLE 7 QUESTIONS FOR EVALUATING COMMUNITY PARTICIPATION*

Questions for evaluation: suggested framework for development of evaluation guidelines
Community Participation and Development

<i>Main Questions</i>	<i>Sub-Questions</i>	<i>Information Required</i>	<i>Methods of Obtaining Information</i>
1. What is the nature and extent of community participation?	1) Is the community involved in planning, management and control of the health program at community level?	1) Nature and effectiveness of local decision-making institutions (e.g. health committee). No. of meetings held where health issues discussed. Participants at meetings.	1) and 2) Observations at meetings, interviews and questionnaires with local personnel and health community development extension personnel.
	2) Are local resources used? What kinds of resources? (labor, buildings, money, mass activities)	2) Means of raising revenue, how much raised. Degree of financial control of health activities, Other resources contributed.	
	3) Is there a community health worker (or workers?)	3) Selection procedures for CHWs. How paid/supported. CHWs' role in health development committee. Functions and activities of CHWs.	3) Interviews with CHWs and community members and leaders.
	4) What percentage of the community participate in health activities? (e.g. immunization, use of child clinics, antenatal care, latrines, clean water)	4) No. of people with or using clean water, attending organized health activities etc. (see coverage)	4) Surveys, household questionnaires, health service statistics.
	5) Have community projects been implemented? (e.g. setting up a day care/child feeding center, water protection)	5) Existence of community programs or evidence of ongoing or completed projects.	5) Observations.
2. Is there a mechanism for the integration of community activities at local level with outside agencies?	1) Is there a mechanism for dialog between health system personnel and community leadership?	1) No. of meetings between health system and community representatives. Topics discussed and characteristics of participants.	1) Observation and interviews at community level.
	2) What other agencies are involved at community level and what socio-economic development activities are being implemented?	2) Other sector activities at community level. No. of visits to community by other agency personnel.	2) and 3) Interviews with personnel from other agencies, health and community leaders.
	3) Does the mechanism for dialog with the health system (if it exists) include involvement of other agencies?	3) Level of other agency participation in community meetings.	
	4) Is there a mechanism for intersectoral co-ordination at higher levels? (e.g. district or region). How much control of resources and autonomy does it have?	4) Institutional administrative mechanisms at district level. Nature of decision-making bodies and their membership. Intersectoral representation. Access to resources.	4) Interviews and possible observations at district level.

<i>Main Questions</i>	<i>Sub-Questions</i>	<i>Information Required</i>	<i>Methods of Obtaining Information</i>
3. Are health activities coordinated with other sector development programs?	1) Is there evidence of coordination between health activities and other sector programs?	1) Health activities in schools. Role of health workers in agricultural extension - promotion of gardens, poultry, etc.	1) Visits to schools, interviews with school teachers, observations and interviews with health workers and CHWs.
4. Is there a mechanism for community representatives to be involved in decision-making at higher levels and is this effective (are their interests adequately met)?	1) Are community representatives involved at district and regional-level health planning and program management bodies? How much power do they have?	1) Participation of community members in district and regional-level health planning and management bodies. Who from the community participates, and do they have an effective vote?	1) Interviews and observation, study of minutes of meetings, etc.
5. What forms of social organization exist in the community and how effective or powerful are they?	1) Are there women's groups, farmers' cooperatives or clubs, church or religious organizations, young people's clubs, political organizations, trade unions, etc.? How active are they? How are they represented in the community leadership?	1) Identification of social groups, numbers involved in each, and representation of groups in community leadership. Information on activities of groups and influence on members, etc.	1) Questionnaires, interviews and anthropological in-depth studies.
6. Are traditional practitioners integrated into the PHC program?	1) Where do traditional health practitioners exist in the community? How frequently are they used for what purpose? Are they involved in health committees? Is there any contact between them and health system personnel (have they had training)?	1) No. and type of traditional practitioners and their workloads and patients. Utilization patterns of traditional practitioners. Membership of health committee. No. of contacts with health system personnel. Nos. trained, etc.	1) Interviews with traditional practitioners, and patients. Household questionnaires (see health needs agreement). Health system records and interviews with health system personnel.
7. What is the potential for increased community participation and more democratization at local level.	1) Are deprived groups adequately represented in decision-making institutions? How can their interests be more adequately represented in centers of power? Are there activities for consciousness-raising, improving knowledge and skill of deprived groups?	1) Identification of deprived social groups (e.g. access to land, jobs, low income, etc.) Participation in community meetings, etc. How effectively organized and possibility for cooperative formation based on economic activity.	1) Questionnaires, interviews, anthropological studies.
8. Is the community being adequately informed about health matters?	1) What methods of communication are being used and how effectively are they reaching people? 2) Is the information relevant, appropriate, and accurate?	1) Evidence of mass media educational programs. Health education activities through health system. Health information provided through other sector extension programs. Percentage literacy and use of mass media coverage by extension programs. 2) Content of educational programs and comparison with agreed standards and priorities.	1) Survey of health education programs. 2) Assessment of the quality (methods, e.g., visual aids used and content. Subject matter correct and related to stated priorities). Household questionnaires.

reports on some research studies conducted. A bibliography on different aspects of social research is included. (PAHO, *Técnicas de Investigación Social*)

✓ AID/Washington's Bureau for Program and Policy Coordination has developed some research and evaluation instruments. Examples include questionnaires used in Thailand and Peru on villagers' attitudes toward and participation in rural water projects. These survey instruments deal with many other aspects of water projects besides community participation and are apparently applied by outside interviewers. (Contact PPC, AID, Washington, D.C. 20523 for further information.)

✓ The Rural Development Committee at Cornell University group has done a great deal of work in developing an analytical framework for investigating community participation in project design, implementation, and evaluation, and has carried out a number of field studies of participation and use of community workers in development projects, including at least two health projects, in Senegal and Guatemala; the broader development projects studied in Sri Lanka, Upper Volta, and Bolivia also include some health activities. (See bibliography for specific publications of interest by Cohen and Uphoff; Uphoff, Cohen and Goldsmith; Esman, Colle, Uphoff, and Taylor; Hall; Colburn; and Taylor and Moore. Documents can be obtained from the Rural Development Committee, Center for International Studies, 170 Uris Hall, Cornell University, Ithaca, New York 14850.)

✓ In a paper prepared for AID's Bureau for Food for Peace and Voluntary Cooperation, Pyle outlined a monitoring/evaluation scheme for quantifying the extent of community participation in health programs. The method calls for participation in a community or project to be scored on seven attributes of effective participation efforts:

1. *Diagnosis*—the community members' participation in assessing their general health needs, the health needs of disadvantaged groups, and their awareness of resources they might contribute to solving health problems.

2. *Consciousness*—an awareness and orientation of change (toward self-reliance) and sense of community (cooperation) among all social, economic, religious, and political groups.

3. *Programmatic involvement*—the willingness and ability of community members to be involved in the planning, implementation, and evaluation of program activities in their community.

4. *Organization*—the effectiveness of community organizational structures to make decisions, arrange for the transfer of power, handle financial matters, etc.

5. *Comprehensiveness*—the breadth of participation in activities as well as in program benefits.

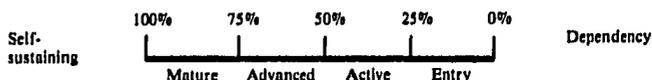
6. *Financing*—the community members' willingness and capacity to contribute in monetary terms to the fulfillment of program objectives.

7. *Linkages*—the community members' confidence and capacity to assist in community health improvement.

Each of the seven aspects of community participation is scored on a scale from 0 to 4 points: none of the aspects found = 0; some = 1; moderate = 2; considerable = 3; and complete = 4.

While comprehensiveness and financial components lend themselves easily to quantification, the judgment of the other attributes will be qualitative and arrived at through interviews and observations. A community's or program's participation is calculated by taking the total score, dividing by 28 (maximum score attainable) to arrive at a percentage. This makes it

possible to place the community or program on a continuum that extends from dependency on one end to self-sustaining development on the other.



It is suggested that this method for reviewing progress in participation be implemented annually by an evaluator, together with community members themselves, and that it be used as the basis for planning participation in the next year's activities. (David Pyle, "Framework for Evaluation of Health Sector Activities for Private Voluntary Organizations Receiving Matching Grants," May 1981.)

✓ In a recent publication, Tendler makes suggestions to evaluators of PVO projects. Slightly modified, several of these suggestions are useful for evaluating participation in PHC projects.

1. Locate the participants and the beneficiaries of the PHC activity in the income distribution of the community, approximately by thirds. Elaborate on how the benefits and results of the PHC activity are distributed among dwellers in the area.

2. Learn the history of community decisions and acts that took place up to and during the PHC activity. Find out to what extent existing community groups were included in project decision-making, and to what extent the poorest groups participated — the landless, women, ethnic or social outcast groups, temporary (vs. permanent) workers, land tenants (vs. owners), small (vs. large) owners, etc.

3. Did indigenous organizations exist prior to the project? Among the poorest, too? How were they included in project decision-making? If not, why?

4. If decision-making is not particularly participatory, are there ways of making it more so? Does project history show that decision-making is more participatory now than it was originally? How was this accomplished?

5. Are there certain project tasks or activities that are not as suited to participatory decision-making as others? That is, does participation result in less effective project outcomes in some cases? What are the tasks that seem better suited? Less well suited? Why?

6. When decision-making is in the hands of local elites and therefore non-representative, do the excluded groups nevertheless benefit? In situations of elite control, are there some activities where excluded groups benefit regardless of elite control, and other activities for which elite control results in mainly elite beneficiaries?

7. Do some activities seem more appropriate by elites than others, e.g., fertilizer supply vs. health-clinic services?

8. Does the project exclude elites from decision-making or benefits in any way? If so, how were they bypassed? Some examples are activities in which the elites have no interest, low-status activities, class-based organizations from which elites are naturally excluded — like women's organizations, tenants' unions, labor unions, etc.

9. What aspects of the project, if any, seem to be reaching the poorest stratum of the population? Why are these activities, as distinct from the others, able to reach the poorest? What is the nature of the relation between the project and the poorest in these particular activities — participatory, "enlightened" top-down?

10. By reading country-specific studies on income distribution, and by talking with local people, find out how to identify

the poorest groups — e.g., lowest caste, casual laborers, women. Seek them or their representatives out to ascertain how they are being affected by the project.

11. Watch for examples of, or opportunities for, targeting on the poor by type of activity — e.g., low-status activities and goods, absence of elite interest in participation in the activity, class-based organizations. Are these opportunities being exploited, and, if not, how might they be?

12. To gauge the degree of representativeness of local participation in the project, find out about the history of some important issues and how they were resolved.

13. Where there is a community contribution to projects, ascertain its distributional burden. For example, voluntary labor might fall disproportionately on the poor, while contributions in cash or kind might fall disproportionately on the rich. (Judith Tendler, "Turning Private Voluntary Organizations Into Development Agencies: Questions for Evaluation," April 1982.)

✓ A methodology for assessing factors that affect community participation in health projects has been developed in conjunction with this paper. This method has an operational focus; it is designed for rapid identification in ongoing projects of problems that impede community participation. The approach is flexible and qualitative, making use of documentation, interviews, and direct observation at five program levels in order to examine the interactions of the entire project-community system: central planning and administration, personnel training, field supervision, community health workers, and the communities served. Model questionnaires for each level are provided, to be adapted to specific circumstances as necessary. ("A Method for Assessing Factors Which Affect Community Participation in Primary Health Care Projects" by Patricia Martin is available upon request from the American Public Health Association, International Health Programs, 1015 15th St., N.W., Washington, D.C. 20005.)



Community members in Colombia lay water pipes and build latrines in their community. PHOTO: WHO/UNICEF 18909 by H. Cerni