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**COMMUNITY PARTICIPATION IN HEALTH
PROGRAMS: EXPERIENCES FROM THE
MAASAI HEALTH SERVICES PROJECT,
TANZANIA**

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ABSTRACT

The Maasai Health Services Project in northern Tanzania is a primary health care undertaking in which individuals chosen by their communities are trained as providers of selected preventive and curative services, including family planning, and as facilitators of change in their areas. The communities, through the selection, support and supervision of these community health workers (CHWs), are actively involved in every stage of project activities.

This paper examines in detail the process through which community management of the project is promoted. Important elements within this process include 1) holding several unhurried meetings with community members and leaders to discuss health problems and solutions fully; 2) cultivating leadership and management from within the community while providing technical assistance from the outside; 3) working with CHWs who are selected by their communities; 4) conducting the training of CHWs in their own communities instead of at a distant site; and 5) integrating community organization skills and activities into CHW training.

Some of the lessons learned are that 1) project staff must resist the role of expert and maintain that of facilitator; 2) the pace of the project must be in step with the communities' understanding and readiness to accept it; 3) the role of the CHW must respond to the urgently felt need for curative services; the real need for preventive services, such as family planning; and the long-range need for social change; and 4) the project must respect the traditional social structure of the Maasai and Waarusha groups served and must also recognize and adapt to the differences between them.

INTRODUCTION

To meet the health needs of the underprivileged in developing countries, health service systems must assist communities in identifying their problems and in assuming the responsibility of alleviating them. This approach, rather than the established one which holds that responsibility for health care lies with the professionals, is consistent with the concept of primary health care (PHC).

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 both the community and country can afford."¹ In the years since the Alma Ata conference on PHC, there has been growing recognition that communities' full participation is a critical element of successful programs. Tanzania is one of the many countries trying to achieve the WHO goal of "health for all by the year 2000," in part by encouraging community involvement in PHC.

Since independence, Tanzania has consistently followed a socialist policy with a strong emphasis on the development of rural areas, equal distribution of goods and services, and self-reliance. The national rural development and health policy stems from the Arusha Declaration of 1967. The policy's principal health objective is to raise the living standards of the rural population by developing health programs to control the major diseases of the rural sector, by training health personnel, and by concentrating health resources in the rural areas. The rural

program was implemented with substantial self-help elements from the people, who sometimes contributed up to 50 percent of the building costs by providing free labor and local building materials.

Community support of health programs offers considerable tangible benefits, including lower operating costs and improved coverage, particularly as input from outside sources is reduced over time. The intangible benefits, however, must not be overlooked. Community members sense an intrinsic value in controlling the processes and making the decisions that affect them. Participation ensures that activities are implemented in a culturally and socially acceptable way, thereby promoting utilization and effectiveness.

The community's role in the Maasai Health Services Project is that of manager, responsible for the selection, support, and supervision of the local CHWs. The purpose of this paper is to add to the existing body of knowledge by sharing the process used by the project to achieve active community involvement.

BACKGROUND

The Maasai Health Services Project is a primary health care delivery and operations research undertaking based in the Arusha region of northern Tanzania. It operates under the auspices of the Lutheran Church Synod in the Arusha region with technical assistance from the Center for Population and Family Health of Columbia University. Funded initially by the U.S. Agency for International Development and the Lutheran World Federation, it is currently funded wholly from the latter source. Population

and Family Health of Columbia University. The goal of the project is to train 72 CHWs to deliver selected PHC interventions in the communities surrounding seven Lutheran Synod dispensaries. The role of the communities is to manage the program while the project provides managerial advice, training, and technical supervision.

The project covers a population estimated to be between 55,000 and 200,000, the former figure representing those within a five-mile radius of the dispensaries and the latter, those within 20 miles. Two related groups are encompassed: five dispensaries serve the Maasai, who are seminomadic pastoralists, and the remaining two dispensaries serve the Waarusha, a settled people who practice farming as well as herding. The two groups share a common language and many traditions, though their present lifestyles differ considerably.

The Maasai's daily life is centered on the care of their cattle. Today (as they did not in the past) many Maasai remain year-round in scattered, semipermanent settlements (bomas) while some family members move with the cattle in search of pasture. Entire bomas will sometimes relocate, particularly when faced with a severe shortage of rain. Nevertheless, most Maasai in Tanzania now have an identifiable home area to which they return each year.

Each boma is made up of from two to five married men and their wives and children. One of the men is mwenye boma, or headman. He acts as the ultimate traditional authority in his boma and also as liaison with other bomas and authority figures. Any approach to a boma by outsiders must be made through the

headman. Civil representatives for the community are selected from among these traditional leaders.

The Waarusha live in more densely settled villages near their farms. Their social unit is a cluster of 10 houses, presided over by an elected representative who fulfills much the same duties as the mwenye boma but whose source of authority is more civil than traditional.

THE PROCESS EMPLOYED TO PROMOTE COMMUNITY INVOLVEMENT

To achieve community management, the project promotes the active participation of local residents and government officials. (In Maasailand, these civil positions are held by traditional leaders.) This process includes the community's involvement in discussions of project goals and design, in CHW selection, and in training.

Community Meetings and CHW Selection

The project's first contact is with a few leaders of the community, who are asked to schedule a meeting with the local government to discuss health problems and possible solutions. On this first visit, which lasts several days, staff members gather quantitative and qualitative information on village resources, available goods and services, diseases commonly seen at the dispensary, common causes of morbidity and mortality, and traditional values and practices, particularly as related to health and family planning.

The second meeting is held with the 25 local government members, who define and discuss the severity and prevalence of

local health problems. A meeting of the whole community is planned to discuss these problems further and to develop a strategy for handling them. The project staff members, serving as facilitators, suggest that mothers be especially encouraged to attend, since early childhood diseases are among the most important causes of morbidity and mortality. The leaders, who are all men, agree, though it is difficult to assess their true commitment to the idea of involving women. Women do, in fact, attend the general meetings, although they are usually fewer and always less vocal than their husbands, sons and brothers. This encouragement of women's involvement is one way in which the project affects spheres outside the narrowly defined health sector.

The third contact is the community meeting. To achieve contact with a sufficiently large proportion of the population, several meetings are often required. The problems named by the leaders are reviewed, others are added, and their relative importance to the community assessed. As potential solutions are considered, the facilitator stresses those that can be accomplished and are sustainable by the community.

The problems brought up often focus on the lack of services, such as immunization, curative care, and health education. In an effort to make such services more accessible to their widely dispersed and/or underserved communities, the residents usually suggest that more dispensaries be built. The facilitator encourages discussion on the relative values of treatment and prevention, on the impact of dispensaries on treatment and prevention, and on how services might be made more accessible to

those who would benefit most from them, such as mothers and children. As discussion flows along these lines, the concepts of outreach services and community health workers often arise. The facilitator strives to have the idea originate with the community; this fosters a sense of ownership and responsibility toward the program. Once the idea is established, the facilitator explains that the project can assist the community in training these workers and providing technical support, but that it will remain the community's responsibility to select, support, and supervise them.

A full discussion of the CHWs' responsibilities and desired qualities ensues, during which the facilitator may make suggestions based upon previous experience. For example, since the dropout rate has been high during training, the community is encouraged to select more CHWs than are actually needed. It is also recommended that the community divide itself up into service areas and that each such area choose two or more CHWs. This ensures an even distribution of workers over the entire area and also ensures that selection is done by neighbors who best know each other. The community should also discuss the issue of support for the CHWs during and after training. This support, if it is to be provided, may take the form of payment, provision of food supplies, or assistance with domestic responsibilities.

The CHWs are selected only after the issues of characteristics and support are thoroughly discussed, which may take many meetings and several months. In determining the criteria and making the selection, the community members assume

the role of manager, thereby strengthening their responsibility to the future support and supervision needs of the CHWs.

Training

In the Maasai Health Services Project, training takes place in the CHWs' home areas. This is desirable in part because CHWs' domestic and community responsibilities prevent them from leaving for weeks at a time and in part because of the significant advantages local training affords in the area of community participation.

Local training increases the visibility of the program in the community. Frequent informal discussions take place when community members have the opportunity to come around and inquire about the program. A considerably greater proportion of the population receives accurate information about the role of the CHWs because of the exposure received during training.

Another advantage of local training is that the fieldwork is directly relevant to the CHWs' training and provides immediate assistance to this underserved population. For example, since the treatment of conjunctivitis and diarrheal dehydration is taught in the first training module, CHWs are able to recognize and treat these highly prevalent and preventable diseases early in their training. Thus, the community receives treatment and education they would not otherwise receive and the CHWs build up trust and self-confidence.

Training in the CHWs' home areas also allows various individuals who will subsequently play important roles in the CHWs' work to participate in the training itself. The dispensary

workers, who have attended Training of Trainers workshops conducted by central staff, are a major part of the training team. This link between the dispensary workers' role as trainers and their subsequent role in technical support and supervision provides a valuable continuity in the CHWs' learning process. Others in the community also take a part in training: elected officials, teachers, and traditional leaders have participated. Community members were originally invited as visitors but are now encouraged to become involved in all aspects of training, including lesson plans, schedule determination, and evaluation. In one area, the chairman of the elected village government attended the entire first training module. Consequently, he has an excellent understanding of the goals and purpose of the project and of the expected roles of the CHWs. He has proven to be an active advocate of the project.

One disadvantage of the participation of local officials, teachers, and other community members as trainers is that they tend to present long lectures with little opportunity for dialogue. This is in contrast to the training techniques employed by the trained trainers, which encourage full participation through discussion, role-playing, demonstration, and teamwork. The latter techniques are more conducive to learning, and the local officials are encouraged to use them. However, even if they do not, it is felt that the advantages of the officials' involvement outweigh the disadvantages of their didactic techniques.

During their practical training, CHWs gain experience in

facilitating village government and community meetings. These meetings serve the practical purpose of increasing the CHWs' communications skills while promoting active contact with, and providing information to, the community. Project experience shows that frequent meetings during training are valuable in promoting community management and in preparing the CHWs for their critical role as agents for change.

Because educated persons are respected in Maasailand, the CHWs gain credibility from the mere fact of attending a training course. That credibility is heightened by the fact that the trainers, who evidently believe in the program and the CHWs, spend large amounts of time in the community and become respected and trusted. This factor may assist the CHWs in gaining acceptance in situations that would traditionally be closed to them because of their sex or age.

This heavy emphasis on community management during training paves the way for activities after the completion of training. The dispensary workers, the CHWs, and the community are then fully responsible for the project. The role of the central project staff diminishes considerably and becomes one of supervising the dispensary workers, conducting training workshops, and providing assistance as requested according to needs identified by the community. Overall project evaluation and operations research activities also remain tasks allotted to central staff, although dispensary workers, CHWs, and community members are responsible for monthly monitoring of reports and local activities.

DISCUSSION

As the project progressed, it became evident that community participation was a crucial factor in CHW performance and program continuation and success. This necessitated modifications in the original project design to reflect increased community responsibility and sustainability. Some of these modifications are described below.

The Role of Project Staff

Ideally, the community should take the leading role in the CHW program. At this stage, however, it is still central project staff who initiate the meetings and discussion of health problems. This role is viewed as a temporary one, necessary in the project's early stages. It is imperative, however, that the staff not assume the role of "expert" as a consequence of their early activities. The basic premise of the project is that the communities understand their affairs best and must therefore make the decisions that affect them. What others perceive the community to need must not take precedence over what they, themselves, feel they need, although those from outside may make suggestions, give advice, and support and nurture them as they gradually assume the management role. It is hoped that as the CHWs begin to provide needed services, neighboring communities will see the advantages and demand similar services, thereby initiating the process themselves.

The Pace of Project Activities

The pace at which the project proceeds in the community must match the readiness of the community to understand and accept it.

Visits by staff, which were longer and more frequent than originally planned, increased their familiarity with the area and residents and the residents' knowledge and trust of them. The longer time frame afforded more opportunity for discussion on the overall purpose of the project as well as on the specific issues relating to the CHWs, including desired qualities, responsibilities, support, logistics, and selection process. A project such as this one requires an informed, committed community; undue pressure exerted on the community to act before it is ready may undermine the long-term success of the project.

The Role of CHWs

The balance in CHWs' activities between curative and preventive services is an important issue. Curative care is often the greatest felt need of a community; to ignore it is to risk losing the communities' interest from the start. Preventive care is desirable because it can produce permanent change, but it is not often requested at the outset because the communities are rarely well informed regarding its benefits. The project has experimented with different levels of each type of service and has found that because the preventive skills are more difficult to teach and to learn, more time must be dedicated to training and supervising the CHWs in these skills. The extra effort is worthwhile because the impact of preventive activities is great.

Thus, the CHWs are prepared with treatment skills that will respond to the felt needs of the community, engender appreciation, trust and respect for the CHWs, and bolster their morale and self-confidence. However, preventive skills, such as

family planning and health education, are more strongly emphasized to enable the workers to affect the roots of ill health.

Originally, the project aimed to prepare the CHWs as prominent nuclei of activity for health action. This is now viewed as inappropriate, because placing all the responsibility for activity with the CHWs may negate the responsibility and inhibit the participation of others in health and social change. The modifications made in the CHWs' training reflect their responsibilities in community organization; increased emphasis is placed on the skills necessary to be effective facilitators and agents for change to enable them to function on a broader range of development activities.

In their role as agents for change, the CHWs must increase the community's awareness of the true causes of ill health and motivate community members to address them. This sometimes requires confrontation with powerful local or outside individuals or groups who, either through neglect or design, prevent the community from realizing desired improvements. They may do this by diverting kerosene or foodstuffs for private gain, by selling medicine that should be provided free of charge, by preventing women from taking an active part in development projects, or by performing their jobs in a desultory fashion. Those who are hurt by these practices must stand together and demand change; the CHW can not and should not act alone. This again underscores the importance of the program's strong foundation in the community; a program desired, owned, and supported by the community will not

be easily thwarted by a few profit-seeking individuals.

The Site-Specific Approach

The importance of working through the recognized community leaders cannot be overemphasized. The Maasai and Waarusha are traditional cultures, and the headmen, elected representatives, and elders wield tremendous influence. They are well informed regarding the community and its members and feel a strong sense of responsibility toward them. Their favorable outlook and support prepare the way for the project's strong foundation in the community.

Despite traditional similarities, the semiurbanized Waarusha differ significantly from the Maasai in occupation, social structure, and environment. These differences call for modifications in the approach to community involvement used with the respective groups. For example, the Maasai communities can be approached via the very clear traditional lines of authority, while the traditional leaders among the Waarusha share their authority with civil and economic leaders. Meetings called by the elders in Maasailand are generally well attended; scheduling and holding meetings with the Waarusha has proven to be problematic. The level of urbanization is clearly a factor: the Waarusha are involved in many and varied activities outside their immediate community. In addition, the curative services provided by CHWs, which are so appealing to the underserved Maasai and often whet their interest in the project initially, are less attractive to the Waarusha, who have dispensaries and a regional hospital within reasonable distances. Promoting interest based

on the preventive services requires a different approach. Thus, although the overall structure of the project need not change, the needs and resources specific to the Waarusha must be considered in determining activities in those project sites.

Examples of Community Support

In the more isolated sites, tangible examples of community support have been encouraging. CHWs in three sites are receiving regular monthly stipends from their communities. In one particularly large area, community residents have provided food for the CHWs during training when they are away from their bomas for several days at a time; in another area, CHWs have received assistance with their domestic responsibilities while they are in training. Kerosene for the vaccine refrigerators has been purchased by the communities on several occasions when the district medical office, officially responsible for supplying it, has been unable to do so. This is noteworthy because kerosene is extremely scarce and the price exorbitant.

Although it has been resolved in three sites, the question of remuneration during and after training has been a stormy one. Changes in attitudes are needed on two fronts in this issue. On the one hand, the question of support must be introduced early in the community's discussion process and a consensus formed as to whether and how support will be forthcoming. On the other hand, it may be unrealistic for the CHWs to expect support before they prove their worth through performance, even if the community has agreed to support them in principle. The tangible financial support so far demonstrated is evidence that the communities

value the CHWs' contributions and feel responsible for them, and it provides a considerable boost in morale to the CHWs themselves.

Conclusions

The communities with which the project has worked have demonstrated the enthusiasm and capability necessary for managing a local CHW program and have assumed the responsibility for doing so. This was facilitated by the project's strong emphasis on active community involvement. The communities' continued activity, encouraged and supported by government health authorities and the Lutheran Synod, will promote improved health status for their residents.

REFERENCES

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