

COMMUNITY PARTICIPATION IN THE DEVELOPMENT OF PRIMARY HEALTH SERVICES

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Improving the quality of life—by changing the structure of society and sustaining and irreversibly increasing resources so as to more equitably satisfy the needs of component groups—constitutes the essence of socioeconomic development. This process assumes not only an increase of resources, but also their improved utilization and distribution to satisfy those needs which are considered the most urgent and important. The type of development varies according to the importance assigned to various component areas of development, and this in turn reflects the developing society's prevailing system of values. In this regard, the values that represent progress in the component areas of development—areas such as industry, agriculture, health, and education—should be considered apart from values which affect full participation by different population groups or regions and those which hinder the reduction of environmental and social hazards. This approach is explained in the United Nations document entitled *A Unified Approach for Development Analysis and Planning*.

Until very recently, there was a tendency to believe that, if development were focused mainly on rapid economic growth, not only could economic development be achieved, but participation by the community, reduction of poverty (the central problem of underdevelopment) and other desirable results could also be attained. As we all know, this has not happened. If development is to be achieved, it is essential to induce changes in institutions and in social systems and subsystems—as well as to motivate individuals for the assumption of new functions and responsibilities while improving their ability to promote their own development. This can be done by enabling society and its components to identify problems and plan structural changes in social and institutional systems and subsystems that are essential for development.

From this standpoint, development planning is an undertaking aimed primarily at inducing changes in the attitudes and values of society, changes which are produced by a process of dialectical interaction that parallels changes in the systems and institutions operated by the individuals themselves. In essence, this process is one of educating individuals and society with a view toward increasing the capacity of the population to identify and solve its own problems—an end achieved through responsible and purposeful community participation.

Extension of Primary Care

In 1975, the Twenty-eighth World Health Assembly declared that primary health care is the point of entry for the individual to the national health system, asserting that it should be an integral part of the health system—one related closely to the life patterns and needs of the community served, and that it should be fully integrated with the other sectors involved in community development.

The Governments of the Americas, assuming a joint commitment, have established as their primary goal the extension of health service coverage to the entire population of the Hemisphere. To achieve this objective, they have decided to establish minimum health services, properly coordinated with more complete care levels within the national health systems, so as to respond more effectively to the priority needs of all their inhabitants with maximum utilization of available resources. Community participation is considered an essential part of this strategy.

Health Priorities

Health services, dedicated to providing maximum population coverage in rural and urban areas of Latin America and the Caribbean, should give priority to the following activities:

The first priority activity is reduction of morbidity and mortality caused by the prevalent communicable diseases, especially malaria and diseases preventable by vaccination.

The second priority activity is health care for mothers and children—who are felt to constitute the most vulnerable group and the critical component of the family unit.

The third priority activity is reduction, within the framework of national food and nutrition policies, of protein-calorie malnutrition—the principal cause associated with infectious and gastrointestinal parasitic diseases, especially in children under five years of age.

The fourth priority activity is provision of primary health care and the systematic referral of patients, according to their needs, to specialized levels of the national health system.

And the final priority activity is basic environmental sanitation, primarily involving water supply and sewage disposal.

Revision of Health Policies

To achieve these objectives, the Governments have decided to formulate and implement realistic health policies, both sectoral and intersectoral, which will serve as guidelines for carrying out their health programs and, in particular, for increasing their programs' operational capacity.

For these purposes, it is essential to define national health service delivery systems at various levels of complexity, in order to coordinate the various components of the sector. It is also necessary to improve the programming, administration, control, and evaluation processes, so as to ensure the maximum productivity and efficiency of available resources while promoting and improving effective community participation.

Because of the varied nature of communities, and therefore of possible alternative solutions to community problems, each community must be treated individually. Nevertheless, the experience gained in the Americas indicates that systematic efforts must also be made to enable the communities to develop their capacity to provide health services, appropriately supported by technical and logistic systems—including programmed community training. As a further requisite, the communities need to be assured that they will have access to health services at all levels of the institutional system.

This implies revision of health policies, development of appropriate technologies, and careful programming of services and investments, as well as preparation and adaptation of health personnel and training institutions. Health personnel should be motivated to contribute ideas, experiences, and creative and innovative thought processes to bringing about the changes in the health situation that they desire. This calls for a multidisciplinary approach, active participation of related individuals and institutions, and coordination of the actions of other social and economic sectors currently engaged in integrated community development.

Health and Community Development

Considering the normal living conditions of communities that lack health services, the isolated extension of these services only means a temporary solution—one which is rapidly neutralized by the pressures of poverty, malnutrition, poor environmental conditions, inadequate housing, and inability to make rational use of the scanty resources available. If the unified approach to development is to be successful, health programs must be closely linked with activities in other developmental sectors. Therefore, health goals must be based on and supported by appropriate policies of other sectors, as well as by the direct activities of health services. In turn, the emphasis on health services must be reoriented to support programs aimed at increasing the productivity of low-income groups, creating new areas for human settlement and agricultural production, and providing a social environment more conducive to general development. Consequently, primary health services must be made an essential component of total community development.

In this regard, efforts must be centered on meeting the most pressing health

needs of underserved communities—through imaginative solutions based on multisectoral approaches. These solutions must enable individuals and community groups to aid themselves and to meet their immediate needs by making rational use of the community's substantial available and potential resources.

The importance of obtaining additional financial resources from international credit agencies has also been recognized. These resources, when properly programmed and used, will help to supplement national and Hemispheric efforts to extend health service coverage and, in particular, to support communities in organizing themselves for that purpose.

The educational component implicit in community participation serves not only to provide information, but also to promote continuing self-education and training of individuals, thus helping the individuals to improve themselves while contributing to overall socioeconomic development.

Accordingly, if the population is to be in a position to participate effectively in the extension of primary health service coverage, the following conditioning factors, among others, must be taken into consideration:

- 1) The community should be organized so as to facilitate the conscientious and sustained support of individuals, groups, and institutions whose attitudes, purposes, and structures must be adapted to meet the program's objectives. This organization should be conditioned by the sociopolitical situation in each country.
- 2) Training should be provided for community groups that serve as instruments of change or as recipients of program benefits. Not only would this enable them to better understand their own problems and to relate their socioeconomic status to that of other communities in their country, but it would also permit them to assume responsibility as promoters of this development and to become motivated to solve their common health problems.
- 3) Multisectoral coordination of activities carried out by public, private, national, regional, and local agencies should be promoted—as a means of creating comprehensive systems of joint action for providing coverage.

Community Motivation

One of the characteristics of communities is the existence of common needs and interests. As a result, every community adopts a specific plan of action and is able to mobilize and use its own resources when duly motivated and oriented toward solution of its priority problems.

But experience also shows that in the past communities have been used mostly as a means of achieving objectives preestablished by the development program's technical personnel—objectives disregarding the needs and expectations of the communities, ignoring the attitudes and behavior of their members, and thus omitting things which are essential to the improvement of those members' living conditions. In addition, the failure to fulfill promises made has created a sense of distrust and frustration in the

communities which is normally interpreted by the experts as community apathy or indifference to progress.

It should also be remembered that programs seeking the extension of coverage with community participation will be more effective if they are linked to other sectors of development and to regional and national plans for socioeconomic development. In other words, the efforts and resources of the communities must be supplemented by those of the Governments.

The term "community development" must be construed to imply the use of specific approaches and techniques in each particular case, combining the assistance of the State with organized self-determination and local efforts. Such community development would deliberately stimulate local initiative and leadership as primary instruments of the process of social change.

The Need for a New Approach

In the Americas, community participation in health services for rural areas is not new. But despite the commendable efforts made in this regard by the Governments, with the assistance of PAHO/WHO and other international agencies, the results have not been satisfactory. This is due, among other things, to the adoption of methods used by developed countries that are not suited to the cultural, social, and political conditions of developing countries. Communities have been used as instruments—either to implement health services or to carry out test programs confirming the effectiveness and efficiency of specific techniques—without giving proper consideration to the fact that human beings are the subjects and objects of development.

In every community there is a health system that may be called the informal health system, whose resources and modes of operation are integrated into the life-style of that community. Research findings need to be revised and efforts ought to be concentrated on operational studies aimed at identifying the internal dynamics of this informal system, in particular its organization and operation and its interrelations with other aspects of community life. This will enable the coordination of the informal system with the institutional health system, as well as the utilization of traditional health personnel to promote greater community participation in the programs involved.

We have thus endeavored to emphasize the value of an analysis of community characteristics as the starting point for training both health personnel and the population to be served. This training would induce a change in attitudes and behavior which is essential for the effectiveness of their joint efforts. In addition, an interchange of ideas should be encouraged in order to consolidate points of view and activities in favor of the program. Such a dialogue would enable local personnel to be constantly aware of the needs of the community and to gain a better understanding of its motivations, life-style, and expectations.

This process, in which both the health personnel and the community should participate actively, would bring about the structural reorganization and other changes required to meet the communities' real needs. And that is essential if the final goal of development—the well-being of the individual and the community—is to be achieved.