

28102



Technical

Discussions

Washington, D. C.  
October 1973



RA  
10  
.A4  
1973  
v.2

Provisional Agenda Item 15

CD22/DT/1 (Eng.)  
13 September 1973  
ORIGINAL: SPANISH

*Pan American Health Organization. Directing Council.*

COMMUNITY HEALTH SERVICES AND  
COMMUNITY INVOLVEMENT

LIBRARY  
PAN AMERICAN SANITARY BUREAU  
WASHINGTON, D.C.

## INTRODUCTION

The aim of this working document is to stimulate discussion on permanent community participation as an essential means of achieving objectives in the health sector. It refers to Resolution XXIX of the XX Meeting of the Directing Council of PAHO, which selected "Community Health Services and Community Involvement" as the topic for the Technical Discussions at the next meeting.<sup>1</sup>

Since enlisting community participation in any program for social action is an extremely complex process, this document does not pretend to analyze all aspects of the subject, nor to cover all the many ways of achieving community involvement. It is hoped that appropriate methods will be worked out and perfected by experiment, in accordance with the special characteristics of the countries in the Region.

The document is composed of four parts: the first is devoted to the scope and content of participation in health programs; the second refers to the responsibility of ministries of health in the field of education for participation; the third deals with the role of the universities in the promotion and orientation of participation in the development of health services; and the fourth covers the contribution of other national institutions in this connection.

The human being as a member of society should be seen in a dual capacity in relation to health activities: he is both the fundamental object and, at the same time, the protagonist. This explains the constant concern of the Pan American Health Organization/World Health Organization to promote more effective participation by the population in the development of health services.

The preamble to the Constitution of the World Health Organization states: "Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people."<sup>2</sup>

The II Special Meeting of Ministers of Health of the Americas recommended in 1968 "that, in determining activities in health programs, attention be paid to social and cultural conditions, especially in traditional rural societies." It was further recommended that "health education activities be strengthened in all programs that contribute to the economic and social development of the rural community."<sup>3</sup>

---

<sup>1</sup>Pan American Health Organization (1973), XX Meeting of the Directing Council of the Pan American Health Organization. Final Report. Official Document No. 111.

<sup>2</sup>Basic Documents of the Pan American Health Organization, 10th ed., Official Document No. 112, 1972.

<sup>3</sup>Pan American Health Organization (1969), Special Meeting of Ministers of Health of the Americas. Final Report. Official Document No. 89.

In its 51st Session, the Executive Board of the World Health Organization stressed the importance of community participation as an essential factor in the pursuance of any health policy. Without the participation of the local population, the health services will not be in a position to meet the needs of that population; the "national will" would not be enough to ensure that the necessary decisions were taken.<sup>4</sup>

In Resolution WHA23.61, the Twenty-third World Health Assembly established as one of the basic principles for the development of national health services: "the health education of the public and participation of wide sections of the population in the carrying out of all public health programs, as an expression of the personal and collective responsibility of all members of society for protecting human health."<sup>5</sup>

Every individual in his capacity as a member of a community is interested to a greater or lesser degree in matters concerning the social group to which he belongs. Social participation is a means of developing personality and of making achievements which satisfy the basic needs of the individual. It should therefore be promoted through education.

This is why community development should be seen as an essentially educational process, aimed at strengthening in the individual a feeling of responsibility vis-à-vis the community to which he belongs and at directing his interest and his actions towards the collective benefits which can be obtained through common endeavor.

The idea of enlisting the active participation of individuals, families and the community to help solve priority health problems is not a new one in the Region.

For several years the Pan American Health Organization, together with certain national authorities, has advocated the stimulation and enlistment of full participation by wide sections of the population in all health programs as an objective of health education, and has considered such involvement as one of the surest ways of achieving community development.

The Ten-year Health Plan for the Americas, drawn up at the III Special Meeting of Ministers of Health of the Americas, states: "Community participation has proved to be an effective reply to this new approach to health care and disease, inasmuch as the motivation, education and organization of communities is enabling them to participate in programs in the interest of their own health."

---

<sup>4</sup>Off. Rec. Wld Hlth Org., 1973, No. 206

<sup>5</sup>Off. Rec. Wld Hlth Org., 1970, No. 184.

The same document stresses, as one of the requirements for achieving the objective of extending health service coverage, the importance of enlisting the active participation of the community - which represents a more productive health resource - throughout the whole process of organizing the health system, using various techniques such as establishment of health committees, which bring together the agricultural, educational and housing sectors, depending on local conditions in the countries.<sup>6</sup>

## 1. COMMUNITY PARTICIPATION IN THE ORGANIZATION AND RUNNING OF HEALTH SERVICES

### 1.1 Evolution of the Concept of Participation

Experience in the countries, particularly in Latin America, has shown that judicious decisions may be taken by the governments and technically sound plans and programs may be drawn up, including possibilities of external and internal financial and technical assistance. Nevertheless, all this may be done regardless of whether the population and influential groups are willing and prepared to bring it into practice or whether the appropriate mechanisms exist to channel the individual and collective will and capacity in that direction.<sup>7</sup>

There have been several stages in the evolution of the concept of popular participation.

In the fifties, the United Nations associated population involvement with community organization, in the hope that the people and the government jointly would try to develop solutions for the many problems of each locality. This decision became operational when the governments established community or local development programs. At that time some governments were implementing the first major nationwide programs.\*

---

<sup>6</sup>Pan American Health Organization (1973), Ten-year Health Plan for the Americas. Official Document No. 118.

<sup>7</sup>ECLA (1964) La participación popular y los principios del desarrollo de la comunidad en la aceleración del desarrollo económico y social, Boletín económico de América Latina, Vol. 9, No. 2.

\*The view has been expressed at the United Nations level that community development represents a valuable and effective instrument for economic and social development. On this basis Member States were invited to use and benefit from community action to the maximum as a factor of economic social development, particularly in sectors where the population is not fully employed and in conjunction with agrarian reform. The states which adopted those recommendations would work out on that basis social policies aimed at organizing and directing popular participation.

During the same decade and coinciding with the events mentioned above, the planning process was initiated in Latin America as a means of rationalizing the process of social change. At that historic moment, world experience was showing that the planning method, as used in the development model of socialist countries, was capable of bringing about a rational transformation of society.

Together with the concept of planning came the idea that these transformations could be brought about at a low social cost, in contrast to the high cost of change when brought about in an uncontrolled manner.

Moreover, some international organizations favored the creation of planning systems at the national level as a means of achieving development through a political and administrative system which, after determining priorities, would establish realistic objectives and aims. In this way, international assistance would be put to better use. The purpose of the process was to achieve an economic development in which the social sectors (education, health, housing) would remain rather marginal.

In the sixties, considerable efforts were made to incorporate both social and political dimensions into the development process. Thus the following concepts, among others, emerged: overall planning, development of human beings and for all human beings, social and cultural planning, mobilization, participation, promotion and awareness, which are all part of the vocabulary of development planning.

The concept of participation varies according to whether it is used as an instrument, according to the Anglosaxon point of view (community organization and development), whether one tries to give it a political content based on the object of mobilization of the population for development, or whether it is adopted as a central objective of social policy.

In the Region, the programs using the concept of participation have evolved as follows:

- Programs whose central objectives concern the promotion and organization of a group of participants, with the aim of meeting a felt need, for which the material and financial assistance of public or private institutions is required. The scope of such programs is limited to the local level and/or to certain sectors.

- Programs to which the previous description applies but covering a larger number of communities and therefore a wider section of the population. These use coordination between institutions and the participation of the population as basic means of achieving the objectives of community development programs. Their scope is nationwide and their aim in the first stage is to mobilize the population, thus ensuring its permanent involvement.

- Programs drawn up in the framework of the social policy set out in the national development plan. The objective is to obtain popular support through participation and to improve the effectiveness of activities carried out at the local level, through coordination at the national or regional level with other measures used to promote national development.

The seventies have added a new dimension to the concept of community participation. Development plans include a definition of social policy,\* based on the hypothesis that the development process is essentially a social process and that planning for development must be a rational program for social change. In that framework, the policy pursues three basic objectives:

- i. The incorporation of all sectors of the population into the processes of production and distribution of wealth;
- ii. Popular participation in all tasks connected with the organization and furtherance of development; and
- iii. The organization and running of services responsible for social welfare.

In this way, social policy acknowledges that the process of participation is a comprehensive one which should cover all the activities of society. Consequently, participation implies that society as a whole should play a part in decision-making; decisions should not result from the participation of certain groups only. There should be an equal opportunity for all to participate critically and consciously in decision-making.

From the above it can be inferred that it is the population, with all its strata and sections and through its multiple and complex relationships, which should design, implement and benefit from the plans intended to raise its standard of living, particularly if such plans call for structural changes or changes in the way of life of the sections of the population concerned, e.g., the modernization of rural life.

## 1.2 Elements of Participation

The following matters must be considered in an examination of the process of participation:\*\*

---

\*e.g., CORDIPLAN, IV National Plan 1970-1971, Vol. II, El Desarrollo Social y cultural, Caracas, 1970.

\*\*A distinction should be made between mobilization and participation of the community. In this connexion it has been stated that mobilization is a precursor of participation and supposes a process directed towards social change, as opposed to static preservation of the social system. It is based on social movements which make concrete and rapid achievements possible and which, at the same time, enable the population to organize itself and to participate in the making of wider ranging decisions.

- Who should participate
- The form this participation should take, and
- The type of development to which the participation should lead.

With regard to the first element, it has been pointed out and is usually accepted that participation must involve the majority of the population, particularly including marginal groups. Pursuance of this objective will impose certain conditions regarding systems of representation, to establish ways and means of achieving participation within society, and it has been suggested in this respect that it should be channeled through formal or informal organizations (government-sponsored organizations, political groups or spontaneously formed groups). This would make true participation possible, leading to modification of the development process and, eventually, to the sharing of its benefits by all.

As for the form that participation should take, it has been proved that the majority of the strategies suggested for achievement of true involvement adopt the concept of organization, based on the notion of a coherent social structure which facilitates individual access to the community and the nation. These forms of organization for participation are not limited to a single, typical pattern; on the contrary, they vary according to certain factors (motivation, interest, activities, values, etc.). This led to a classification system into which it was attempted to fit each type according to its characteristics, as described further on.

The third element to be taken into account is the type of development to which participation should lead.<sup>8</sup> As has been seen, the purpose of participation is to enlist the cooperation of the population and reduce individual or collective resistance to the process of change. In general terms, this means that participation will lead to a speeding up of the modernization process, facilitate social mobility, maintain the level of social welfare and, finally, guarantee an economy and economic policy encompassing all sectors of the population, since the involvement of majority groups will have a salutary effect on economic growth.

Seen in this perspective, participation counteracts underdevelopment, which implies on the one hand a lack of popular involvement in development programs, hence a failure to make use of key resources in the population; and, on the other, the absence of mechanisms for dealing with resistance, lack of political support and the channeling of vital resources to unproductive sectors.

For the purposes of the elements described above, participation must take a concrete form and be expressed by systematic activities, so that its achievements can be measured. Involvement, regarded as a means of speeding

---

<sup>8</sup>United Nations (1969). Second United Nations Development Decade. Document No. E/CN. 12/826.

up social change and a factor working for the integration of society and providing support for government measures, calls for the establishment of programs whose objectives, aims, scope, instruments and resources must be clearly specified. Preferably, most of the programs should take the form of concrete projects. A study should be made of the organization needed to reach the different national, regional and local levels, outlining the strategy corresponding to each level.

Various conditions are required for the implementation of this type of program, e.g., decision-making and executive abilities allowing for flexibility and speed in making the necessary adjustments to programming of activities; ensuring consistency between the needs and aspirations of the population and the feasibility of the policies as interpreted and worked out on the technical and decision-making levels; and the development of systematic training for staff responsible for running the projects.

Organization of participation in the form of systematic projects means that it must be directed towards a specific purpose, for example, improving the efficiency of services or achieving structural reforms in society. Moreover, it should be borne in mind that the population involved is made up of heterogeneous groups in terms of sex, age, interests, motivation, cultural level, etc., and that their contribution will introduce modifications in society. It follows that the promotion of participation calls for organization at the institutional level. Since institutions promote involvement they must be prepared to accept it, pending consolidation of the required changes; they should organize the population so that it can participate and, in due course, become incorporated into the proposed objectives.

There are many examples to show that in practice this does not happen. In principle, the objectives of the institution express a wish for community involvement, but it can be seen that in fact there is none, since resistance to critical participation is such that it systematically blocks any attempt to establish effective participation. For example, it is sometimes forgotten that the activities determining health programming are conditioned by the social reactions of the beneficiary community and are a product of the combined efforts of the groups making up the administrative structure. Consequently, the health planning process cannot achieve its objectives because it did not first ensure that there was a genuine wish for change and a favorable attitude towards the process and its consequences expressed by the human groups concerned.

### 1.3 Forms of Participation

The concept of participation implies a model of society in which this element has a positive value. Thus the ideology which defines the terms of reference for decisions made must necessarily postulate the principle of involvement.



However, the problem of lack of consensus as to the definition of participation has aggravated difficulties to some extent. A need has arisen for definitions leading to more profitable achievements on the practical level. One attempt to remedy the situation was made by ECLA, which suggested that participation means the capacity of members of groups and communities in society to obtain from the dominant groups of that society the reactions that will satisfy the needs and aspirations of members of the social units. The types of reactions obtained will determine the individual's access to the opportunities or assets distributed among members of society.<sup>9</sup>

Thus the involvement of each person in his capacity as beneficiary of and contributor to the social system will depend on its application to one or more social units\* sharing those benefits. Participation as an instrument for development refers, in the last analysis, to the attempt to achieve integration of all sectors of the population and is one way of undertaking rapid integration of marginal groups.

Lack of integration can be overcome in two ways; on the one hand, the phenomenon can be seen as a product of the structure of society, and modifications in the structural relationships will be necessary to eliminate marginality. Another approach is based on the concept that marginality can be eliminated without social modification, by measures taken within the marginal sectors themselves to encourage their integration into the rest of society.

As already seen, organization of the population can take different forms. ECLA<sup>10</sup> states that the various types of participation can adopt the following organizational modalities:

- According to common interests of members;
- According to types of activity and/or involvement;
- According to political, economic, social or religious roles played by the members who, in their turn, facilitate analysis of those roles and their use in the development of social programs.

---

<sup>9</sup>ECLA (1969) Second United Nations Development Decade. E/CN. 12/826, pp. 203-204.

\*Social unit is the generic term to designate large, complex units or small, simple units capable of direct interaction.

<sup>10</sup>ECLA (1964) La participación popular y los principios del desarrollo de la comunidad en la aceleración del desarrollo económica y social, Boletín económico de América Latina, Vol. 9, No. 2.

Similarly, analyses of participation have led to the establishment of a classification system designed to differentiate between the various modalities that may be adopted. For example, Alberto Meister<sup>11</sup> suggested five types of participation which can be summarized as follows:

- Actual participation, characterized by the fact that it is not voluntary and that it is based on tradition and favors the preservation of established habits.
- Voluntary participation for which, as the name indicates, recruitment is voluntary. It tends to satisfy new needs and to create new forms of behavior, thus speeding up social change.
- Spontaneous participation, meaning the forming of new groups without proper organization. Its social role is therefore insufficiently clear.
- Induced participation, which is stimulated by external agents and tends to produce forms of behavior considered desirable.
- Imposed participation, which is compulsory, also instigated from the outside, and considered essential for group action.

It should be pointed out, however, that although social programs are obviously designed to encourage participation, it is difficult to evaluate its impact since such programs often lack a coherent policy for all sectors of economic and social development. It has been stated frequently that efforts in this field have been directed mainly towards meeting immediate needs. Consequently, individuals participate actively but only on a temporary basis, and there is evidence that in such cases the activities undertaken usually tail off once the need has been met. The importance of achieving conscious and permanent population involvement should therefore be stressed.

#### 1.4 Community Participation as a Factor of the Health Plan

If we start with the principle mentioned above, i.e., that society as a whole shares a desire and need for participation, the health plan must contain the assumption that community involvement is essential to improve the health of the population and that the operational mechanisms making such involvement possible, must be studied.

A survey of the present situation reveals the existence of programs for participation in the health sector, organized and executed by various institutions responsible for operations in the sector. In these organizations, the methodology of community development has been applied with the

---

<sup>11</sup>Meister, A. (1971) Participación social y cambio social, Caracas, Editorial Monte Avila.

aim of enlisting the participation of the population to support the activities programmed for the sector. The degree of success achieved depends on:

- clarity of objectives,
- precision in the planning of the program,
- quality of the human resources used,
- institutional support for the experiment,
- coordination in the field with other ongoing sectoral programs.

This approach involves the selection of participation as a means of achieving concrete ends connected with the sector. The experiment does not seem sufficient. If the phenomenon of involvement is really to materialize in an effective form, at least two further conditions must be fulfilled: there must be a desire to participate in the political system, and that will must be reflected in a plan for a true participation policy, affecting all sectors involved in the planning process equally.

The process would be composed of the following elements:

- The population of a community, region or country;
- The health services, composed of professional health staff, premises and equipment and of the persons who make the decisions at the highest level of the organization(s);
- The social, physical, economic, cultural and political environment in which the individual operates;
- The content of participation, for the phenomenon does not take place in a vacuum; there must be concrete actions to constitute participation;
- The different levels of participation (national, regional, local). Decision-making should be shared horizontally as well as vertically;
- The mechanisms of participation, which will be generated by both health institution and population, so that involvement can be encouraged and properly channeled; and
- The human, financial and other resources needed to give effect to the principle of participation.

These components are interrelated for, as in all processes, dynamics impose a complex relationship between them, in this case directed towards the achievement of true participation.

The following components relating to the health sector call for more detailed examination: the content of participation; the mechanisms of participation; and the resources used.

In regard to the content of participation, the following actions must be distinguished:

- i. Actions directed towards achieving the objectives of the health programs.
- ii. Those connected with administrative and political management based on provision of services, financial matters, equipment, personnel, geographical location, etc.
- iii. Actions related to the formal health care system at all levels and those which promote the establishment of criteria or standards for maintaining sound interaction between the population and the health team.
- iv. Actions intended to improve inter- and intra-institutional communications in the health sector.
- v. Actions undertaken to deal with emergency situations and public disasters, e.g., earthquakes, floods, hurricanes.
- vi. Actions intended to preserve and improve environmental conditions and the quality of life.
- vii. Actions which enable the population to make known its opinion of the services provided, schedules, quality, costs, fees, etc.

Among the mechanisms of participation the following may be mentioned:

- Motivation, in the sense of a mental inclination to adopt new attitudes and behavioral patterns, a prerequisite to participation.
- Organization seen as a structured system of relationships between the various parts making up the sector, facilitating the activities of institutions and promoting the population's capacity for intervention.
- Coordination considered as the joint will and endeavor of various organizations, which fulfill different but complementary functions.
- Education in the sense of the acquisition of new values and attitudes and the development of aptitudes, thus ensuring the timely and appropriate development of the available health services, the

stimulation of rational demand for services and the informed and motivated participation of the community, which facilitates proper use and management of its resources.

Here stress should be laid on the importance of completing investigations aimed at finding new techniques and improving existing ones to ensure sustained community participation in the development of the health services.

In regard to the resources used, mention should be made not only of the means of financing community work but also of the need for professional staff specialized in community work, in accordance with the new approach to participation. Usually ministries of health employ health education specialists, one of whose duties is to analyze and facilitate proper channels of communication to improve the operation of the administrative structure of the health services and communications between the health services and the communities. The role of the health education specialist is to orient health staff in the educational aspect of their work with the community, since the different categories of staff have the opportunity of and share responsibility for working with various community groups, to promote and encourage their participation.

Experience in the health field varies with social and political context, so it is difficult to establish a "model" policy for participation. However, the experiences of some countries in the Region are described below as examples. It is hoped that public discussion of the various modalities being practiced at present will complement this paper by establishing a more concrete view of participation in support of health programs in Latin America.

## 2. RESPONSIBILITY OF MINISTRIES OF HEALTH IN ORGANIZING AND GUIDING COMMUNITY INVOLVEMENT IN THE DEVELOPMENT OF HEALTH SERVICES

With a view to elucidating the role played by ministries of health, we shall take as an example the experience gained by Panama in the organization of health committees.

### 2.1 The Panama Experience

The efforts of Panama to enlist community participation in health programs have resulted in a new plan, to be implemented through the integrated health program. The aim of the latter is to coordinate all the Ministry's basic programs at the level of each of the communities covered, using the Health Committee as the point of departure. The active and organized involvement of members of the community is regarded as essential to raise the level of health of the individual. The program also seeks to combine community action with the activities of health teams.

The concept of community health involves the integration of health programs into organized communities. Consequently, community participation depends on the ability of the community to manipulate the factors required to produce health. The efforts made by the community will show the extent of its interest in participating and the degree of organization reached will indicate the level of "health production" that it is capable of achieving.

The characteristics of the programs correspond to different stages of community development. Involvement of less developed communities in health programs calls for preparation of a methodology aimed at an almost total transformation of the existing social organization. This endeavor goes beyond the health sector because of its scope. Nevertheless, health programs represent a challenge to communities and are important means of achieving awareness and organization.

The health of the population is closely related to social and economic conditions. The strategy to be developed in the health field is therefore linked to the national economic policy and social development plans in general.

The organization of a community is a prerequisite to enlisting the population's participation in health programs. The integration of programs in organized communities is a process calling for both structural changes and education.

The Panama Ministry of Health instituted a form of popular organization aimed at enabling communities to organize themselves: Health Committees.

This idea originated at the International Seminar on Health Education held in Chitré, Panama, following which five Health Committees were set up by community leaders in Chitré.

Later, in 1962, the Ministry of Health (then called the Ministry of Labor, Social Welfare and Public Health) gave great encouragement to the creation of such committees throughout the country. This significant step was due to the need for community participation in the program of mobile units for rural areas (Programa de Unidades Móviles en Areas Rurales: PUMAR) and to the fact that the Controller General of the Republic had ordered that the proceeds of delivery of medical and paramedical services in state health institutions be paid into the common national fund, although still managed by the staff of those institutions.

The Ministry gave instructions that this type of group be set up in all communities of the country where medical services were provided and that they assume responsibility for administration of the funds obtained from the delivery of services in state institutions, in addition to cooperating with all health activities undertaken in their communities.

In accordance with these ministerial measures, the principles of community participation in health programs were incorporated into the National Health Plan. The General Directorate, together with the Health Education and Social Service Sections, prepared regulations for the establishment and operation of Health and Welfare Committees, giving the committees wider responsibilities permitting them to engage in activities other than the management or administration of funds.

On 29 December 1970, Cabinet Decree No. 401, establishing Health Committees by law, was passed.

The basic objectives set for Health Committees reflect the common desire for integration that must unite the community and the health services operating in it. The objectives are as follows:

- (a) To make the community aware of its health needs and problems and encourage its participation in their solution.
- (b) To achieve more efficient and coordinated participation by members of the community in Ministry of Health programs and campaigns.
- (c) To administer the proceeds of the medical and paramedical services and to develop activities to collect and augment them.
- (d) To keep the public informed about activities undertaken by the Health Committee in managing its funds.

Over the years, the Health and Welfare Committees have demonstrated their usefulness in the development of programs and measures instituted by the different ministerial health institutions. Some of their activities are: (a) helping to construct health premises through provision of labor and funds; (b) buying medical supplies and equipment; (c) buying mobile units for the institutions; (d) paying the salaries and expenses of service personnel; (e) carrying out repairs to buildings; (f) giving blood to needy patients; (g) providing latrines for the poor; (h) purchasing vaccines; and (i) providing volunteer workers for the activities, etc.

The principal task of the team working according to the concept of community health or medicine is to construct a comprehensive health program for a group of communities with similar needs and common problems. This objective cannot remain abstract; it must take the concrete form of procedures leading to activities, i.e.:

- The health team is responsible for giving advisory assistance to the communities in its area. For this purpose it is essential to establish a system by which the requested advice can be given.

In this case it takes the form of a sectoral coordination commission at the level of each sector (determined by the existence of the team working in a Health Center).

- The Health Committees appoint working commissions needed by the community to solve specific problems, e.g., safe water or food production commissions.
- The Sectoral Coordination Commission brings together all the health committees in a sector by arranging meetings attended by one or more representatives of each. Discussions are held on common problems, decisions are made affecting all equally and activities promoted for the benefit of all.
- The community health seminar is held in a community and discussions take place on the most important problems of that community. Working groups are formed to make recommendations on the basis of the conclusions reached. This type of communication is most valuable since the community as a whole feels that it is part of a plan of work. The health team of the sector contacts several communities at the same time, and neighboring communities are also invited to attend with a view to arousing their interest in organized work for health.

In a period of two and a half years, 600 Health Committees have been set up in the same number of communities.

It is planned to extend coverage to 300 communities, each with about 500 inhabitants, over the next three years, and special attention will be given to the solution of nutrition and water supply problems. The health teams directly responsible for the communities selected will also give priority attention to other basic programs of the Ministry: environmental health and conservation and administration of community health resources.

The communities concerned are, of course, carefully chosen on the basis of specific criteria to ensure that, within a reasonable margin of safety, each will be able to participate in an organized fashion and that such participation will lead to achievements of the objectives of the program.

An initial study on the socioeconomic and health status of each community will be carried out. It will be complemented by periodic assessments during development of the program and compared with a final evaluation in relation to the general objectives of the Health Plan.



### 3. ROLE OF THE UNIVERSITIES IN THE PROMOTION AND ORIENTATION OF COMMUNITY PARTICIPATION IN THE DEVELOPING OF HEALTH SERVICES

The functions of the university have been outlined in connection with the different sectors, or aspects of knowledge, representing the former as the institutional reflection of the latter. Thus the acquisition of knowledge is the mission of "research," the communication of knowledge the mission of "teaching," and the application of knowledge the mission of the "public service." There is a constant need to maintain a balance between the three parts, since they are necessarily interrelated, and it is said that the integrity of the university will be destroyed if decisions are taken in one of these areas without considering their possible impact on the other two, or if one is strengthened without strengthening the others.

According to these principles, the university is an agent of change and the fulfillment of this important function is a factor contributing to development; its role is a wider one than that of merely communicating or preserving knowledge. What are known as university extension programs have thus been regarded as a public service rendered by the university to the society which maintains it.

In regard to medical education, the three objectives of the university have been recognized by various expert committees as being functions of medical schools also. It was pointed out that those functions should be considered in terms of the needs of the community, which should be the basic concern of the university. This was justified by the negative effects attributed to hospital teaching, for example, the excessive specialization of hospital work and the special characteristics of hospital patients, who are considered as individuals without a social context.

Considerable encouragement was therefore given to departments of preventive and social medicine whose development, it was hoped, would ensure the training of professionals more aware of the needs of the countries. Many so-called "integrated medicine" courses were then initiated, which can be classified as follows: (a) extramural courses; (b) intramural courses; and (c) integrated medicine courses given during internship. A review of the development of such programs can be found in a study sponsored by PAHO/WHO and recently published by the Department of Human Resources.

The extramural courses are also called "community medicine" programs, ranging from family health programs to others aimed at organizing communities for self-help in the field of health. In fact, these can be compared with the courses which have always been given in schools or departments of preventive and social medicine under the old concept of public health expressed by Winslow in 1920: "The science and art of preventing disease, prolonging life and stimulating health and efficiency through a common, organized effort . . . ."

Among the advantages of such programs are the following: (a) the patient is seen as a member of a family and of a district and not as an isolated entity, and (b) preventive measures are regarded as an integral part of medical practice. The student learns to help maintain health through education and advice given to families, the application of specific immunization procedures and the practice of medical examinations. This is emphasized in medical school programs.

Another approach was the concept of the community as a laboratory. According to this philosophy the student has to learn to consider the health of the community as a whole and to make the correct diagnosis, just as he makes a diagnosis based on an examination of the health problems of a single patient. It can be said that this stresses the investigative aspects for application to teaching.

After the meetings of the expert committees mentioned above, the need became evident to establish relations between departments of preventive and social medicine and the community health services, since usually such relations were either superficial and very limited or non-existent. Recently, however, the communities' expectations with regard to the health services and even medical schools have had to be taken into account, and it has been stated that medical schools should carry out studies on the way in which medical care is given to patients, since the university is in the best position to study effective ways of providing services and effective methods of ensuring their accessibility, with the aim of developing sound plans for the organization and provision of medical care.

Thus the need for improved relationships between traditional teaching institutions and traditional service institutions has been increasingly felt; and in some countries "regionalization of teaching and care" is seriously being considered as part of the concept of "community medicine" and as a mechanism for training health professionals. This is a new concept offering great possibilities, in that it will bring together, in a most effective way, the four functions - teaching, research, medical attention and service to the community - now recognized to be the responsibility of medical schools, keeping them properly balanced in line with the special needs of each country or region.

To illustrate this, examples are annexed of what is being done in an English-speaking Caribbean university and in a Spanish-speaking country, showing the efforts made by faculties of health sciences to enlist community participation in the promotion and development of health programs.

#### 4. CONTRIBUTION OF OTHER NATIONAL ORGANIZATIONS IN THE DEVELOPMENT OF HEALTH SERVICES WITH COMMUNITY PARTICIPATION

A population's level of health reflects its degree of development and health promotion cannot be considered separately from the community's economic and social circumstances. The diseases predominating in underdeveloped areas are a problem related to standards of living; its solution calls for measures that go beyond the responsibility of health ministries, involving the planning of policies and strategies which can only be envisaged in the framework of intersectoral planning activities at the national level.

The fact that health care cannot be separated from the general level of development in relation to existing problems and achievements of the programs means that the health sector must become a subsystem of the social sector for the solution of certain problems and must coordinate its activities with those of other national organizations in a joint effort to meet common objectives.

The problem of rural areas is one of the most difficult, affecting a large sector of the population in the Region. The fact that there are very few possibilities for employment, production and revenue denies this population access to institutional services, and the low level of education of rural inhabitants prevents them from improving the living conditions that have a harmful effect on their health.

Radical changes are needed in the agrarian sector; efforts in this direction are being made through programs for agrarian reform and rural organization.

Ministries of health must take part in this process by agreement with the organizations operating in the rural environment. Their action should be based on concrete, comprehensive and interdisciplinary projects and involve the active participation of popular groups.

An example of this is seen in the experience of the Brazilian Rural Credit and Assistance Association (Asociación Brasileña de Crédito y Asistencia Rural: ABCAR).

##### 4.1 The Contribution of the Brazilian Rural Extension System. Expansion of Health Services in the Rural Sector

###### Rural Extension Activities

The activities of the Brazilian Rural Extension System take two main forms: the first, centering on the modernization of agriculture, has the objective of increasing productivity in the land and cattle sector; the second, more concerned with social welfare, is designed to help families and communities to improve their living conditions.

In implementing activities directly related to agricultural modernization and social welfare programs and carrying out measures intended to give support to or provide means for doing this work, the system consists of a strategy based on the combination of human, technical and financial efforts in the fields of agriculture, education, health, nutrition and housing. The strategy is based on the following means and objectives:

1. Through coordination of research and experimentation: the establishment of a flow of technological information derived from applied research that can affect levels of agricultural productivity and improve health and nutrition.
2. Through activities undertaken jointly with the rural credit system: the organization and expansion of rural credit with a view to achieving an optimum combination of resources and to make the new technology feasible at the level of the producer, thus creating conditions tending to increase the income of rural properties.
3. Through integrated management with the service delivery organizations, with the aim of achieving maximum utilization of the benefits offered, particularly those connected with marketing of produce and welfare of the population, to improve the coverage and quality of attention to the basic needs of the rural family.
4. In permanent and close contact with official and unofficial authorities: mobilization of available resources, means and talent for the benefit of the community.
5. Integration with the coordinating bodies of rural development policy: maintenance of a bilateral flow of data and information collected or produced during the development of activities and emanating from studies of models and evaluation of the results observed in the execution of programs.

The activities of the agricultural modernization and social welfare system take effect through implementation of a strategy worked out on the basis of specific objectives, determined by the special characteristics of each region, particularly those related to land and cattle. To meet these objectives, goals have been set for the work done each year, not as final and complete results of extension activity but as "demonstration nuclei" for spreading the information required to achieve the objective, thus leading to increased use of the recommended practices.

The system is brought to the various population groups which are its clients and beneficiaries of its activities through essentially educational methods based on the principle of "learning what to do while doing it." Such methods produce living and tangible examples which encourage and stimulate the participants' capacity for observation, analysis and decision.

Participation of the Rural Extension System in Health Programs

The extension system affects health programs in that it mobilizes communities and motivates them to participate actively in public health programs designed for rural populations. In this respect the activities of the Extension System are educational in nature and oriented principally towards basic sanitation, health education and participation in programs for the prevention and control of epidemics.

Through complete integration with the state health bodies and through a joint effort, the following results were achieved during the period 1969-1971:

	Results Achieved		
	1969	1970	1971
Bodies participating in the program	20	21	21
Municipal offices	685	1,126	1,053
Families receiving health education	210,943	271,927	218,846
Families improving their water supply systems	34,921	62,547	53,615
Families improving domestic hygiene	18,512	29,570	28,262
Families installing latrines	16,409	32,977	25,353
Mothers receiving guidance in maternal and child health	10,099	18,982	14,545
Number of persons attending meetings on the value of campaigns against epidemics and benefitting from the activities of health authorities with regard to:			
- Control of parasitic diseases	120,542	151,685	209,259
- Vaccination	1,006,424	832,011	932,544

The following table shows the number of persons who benefitted from the continuous training program in health education and basic sanitation over the three-year period:

Category of Staff	No. of persons trained		
	1969	1970	1971
Teachers	1,383	9,723	7,899
Community Leaders	2,203	8,456	5,474
Total trained	3,586	18,179	13,373

In regard to health, the activities of the Extension System in rural areas are undertaken in agreement with the health technicians, who give assistance to the program in the form of technical support, supervision of health education and basic sanitation measures, and specific activities (vaccination, distribution of antiparasitic drugs, etc.).

#### Coordination with Health Bodies

Conventions or agreements for the joint execution of activities have been established between the Extension System and the following health bodies: the Special Public Health Service Foundation (Fundación del Servicio Especial de Salud Pública: FSESP); the Health Secretariats of the states of Acre, Maranhão, Piauí, Ceará, Rio Grande do Norte, Paraíba, Pernambuco, Bahia, Minas Gerais, Santa Catarina and Rio Grande do Sul; the Brazilian Assistance Legion (Legión Brasileña de Asistencia: LBA); UNICEF/FAO/WHO (special agreement: municipal administrations, Ministry of Health, Campaign Supervision Office (Superintendencia de Campañas: SUCAM); although no agreement has been signed with the latter, the relevant activities are being carried out jointly).

#### Simplified Health Unit

As a result of coordination between the extension services and health agencies, "simplified health units" have been established at the state level since 1968 with the aim of bringing the benefits of health programs to rural families.

The purpose of these basic dispensaries is to arouse the community's interest in its own health. By December 1972, a total of 246 basic dispensaries had been set up in 16 states.

### Establishment of a Basic Dispensary

#### Minimum Conditions:

- Presence in the area of a health unit run by the SESP Foundation or the Health Secretariat;
- Presence of a local Rural Extension office;
- Existence of a health society;
- Participation of the municipal administration;
- Health advisor;
- Premises.

#### Operative Supporting Structure for the Basic Dispensary

- Coordination at state level (health agency);
- Municipal coordination (Rural Extension);
- Health society;
- Health adviser (trained to run the basic dispensary).

#### Health Societies or Commissions

The Rural Extension technician is responsible for organizing, supporting and guiding the health society or commission, which is composed of elected offices and governed by statute. Most of them have legal status as a public welfare association.

There can be an unlimited number of associates and the average fee per family is Cr. 0.50.

The functions of the society are as follows:

- To hold meetings of representatives of the health agency and the Rural Extension Service and the health adviser to plan the activities of the basic dispensary;
- To familiarize public and private organizations with the activities of the basic dispensary;
- To keep the community and the executive and legislative branches of the municipal government informed about the activities of the health adviser;

- To inform the community about work carried out, collect data and assist with the planning of health activities at the local level.

#### The Health Adviser

The health adviser working at the basic dispensary has a primary education, is between 18 and 35 years of age, and is appointed by the community in which he works.

He receives a monthly salary from the municipal administration and undergoes at least 90 days' training in FSESP or Health Secretariat units.

#### Activities of the Basic Dispensary

- Administration of BCG, DPT, Sabin, smallpox, tetanus and typhoid vaccinations;
- Collection of specimens for parasitology examinations, syphilis tests and BAAR investigations;
- Giving nutrition and health education to families;
- Carrying out chemotherapy and chemoprophylaxis of pulmonary tuberculosis;
- Carrying out health surveys;
- Undertaking basic sanitation measures (latrine construction, water supply, etc.);
- Giving emergency treatment;
- Referring patients to health units or hospitals.

#### Functions of the Various Bodies Participating in the Program

- Special Public Health Service Foundation (FSESP):
  - Providing technical support
  - Training health advisers
  - Preparing teaching materials
  - Assisting with supervision and evaluation



- Health Secretariat:
  - Providing technical and financial support
  - Providing vaccines and drugs
- Rural Extension Service:
  - Selecting areas for the establishment of basic dispensaries
  - Mobilizing the communities and organizing the health society supervising, evaluating and publicizing the results
  - Providing basic equipment under the UNICEF/FAO/WHO agreement
- Municipal Administration and Communities:
  - Installing and maintaining the basic dispensary
  - Paying the salary of the health adviser
  - Providing support for immunization campaigns carried out in the area.

Annexes

DEPARTMENT OF SOCIAL AND PREVENTIVE MEDICINE  
UNIVERSITY OF THE WEST INDIES

Report on Experience in the Caribbean Regarding the Role of the  
Universities in the Promotion and Orientation of Community  
Participation in the Development of Health Services

Brief History of the University of the West Indies

The University of the West Indies started as a University College under the supervision of the University of London (following its curriculum and administrative structure and awarding its degree). The first students to enter in October 1948 were 33 medical students drawn from territories of the English-speaking Caribbean.

In 1962, the University received its charter as the independent "University of the West Indies." Also in the summer of 1962, despite the disbanding of the Federation of the West Indies, the governments of the individual territories agreed to maintain the University as a joint service. In addition to the support of the governments of the region, the public and the private sectors provide support for the University in a variety of ways, through the provision of funds for fellowships, facilities and in personal time.

Faculty of Medicine

The Faculty of Medicine has had the responsibility for training medical students. Until fairly recently, these were the only health personnel being trained in the University. It was soon recognized that the Faculty of Medicine must become more involved in the community health problems of our Region. In 1954, the Dean of the Faculty of Medicine sought and received support for five years from the Rockefeller Foundation for the establishment of a subdepartment of Social and Preventive Medicine "whose functions would include efforts to improve the facilities of undergraduate teaching to enable them (the undergraduates) to study patients in their homes and social environment, and to introduce students to the wider aspects of illness."

This department has played a leading role within the Faculty of Medicine in the promotion and orientation of community participation in the development of health services. Almost from its inception the staff of the department has been working closely with the nearby village of Hermitage (population 1,700), organizing and delivering a health service through community involvement. This community program has been extended to include another nearby community, August Town. The residents were

involved in the initial planning of the program. Community leaders have worked on a voluntary basis in the clinic and also in establishing links between the clinic and the community.

From time to time, the department has collaborated with other departments and agencies in carrying out surveys and/or epidemiological studies focussed on community health problems, not only in Hermitage and August Town, but in other areas, including the hilly rural community of Lawrence Tavern.

As early as 1963, health education was introduced as a specific subject in the teaching program of medical students, through the generosity of the Ministry of Health, Jamaica, and the cooperation of their health education officer.

The Department of Social and Preventive Medicine, U.W.I.

The Department of Social and Preventive Medicine has outlined as its overall aims the following:

1. To assist in the training of health personnel; to initiate and participate in research, especially operational research; to develop and assist in operating demonstration programs, and to provide consultation so that relevant programs may be planned to meet the health needs of our several communities.
2. In collaboration with ministries of health and other agencies in the Commonwealth Caribbean, to help identify problems of public health importance, plan and propose ways of solving these, and evaluate the effectiveness of remedial programs.
3. To plan, develop and evaluate programs of health care, including environmental health.
4. To assess the needs of health manpower in the Commonwealth region, and to assist in organizing and evaluating programs to meet those needs.
5. To provide leadership in the development of action programs and of evaluation in population dynamics, including family planning.
6. To assist the Faculty of Medicine in the planning and development of a general practice or family practice unit or department.

While the teaching program for medical students includes teaching, both in the preclinical and clinical years of the course, the highlight of the course is the five-week rotational clerkship in which one-tenth of the class (about 12 students) rotate through the department every five weeks over a 50-week period. An important aspect of the clerkship is a two-week rural field experience introducing students into broader facets of community medicine.

The clinical clerkships in Social and Preventive Medicine have been instrumental in establishing links with outlying communities, not only in Jamaica but also in other territories of the English speaking Caribbean. These outpost teaching sites have provided an important nucleus around which an expanded program in community medicine may be developed and improved as we try to train professionals and leaders to assist in organizing communities in the health field.

The department believes strongly in the concept of the team approach to health and is conscious of its responsibility for training of personnel at various levels and in various disciplines.

Teaching is given by the staff to social work students, social welfare students in community development, student nurses, student midwives and community health aides; and at the West Indies School of Public Health, Ministry of Health, Jamaica, to public health nurses and public health inspectors.

Since January 1972, a postgraduate diploma course in public health has been conducted for medical graduates. Plans are now being made for a similar course for other health personnel, so that members of the health team may be trained together in certain core subjects.

Support from PAHO/WHO in various ways has enabled the University of the West Indies to undertake important regional training activities in furtherance of the team concept, e.g.:

(i) Staff Conferences in Eastern Caribbean

In the summer of 1963, staff conferences of a variety of health personnel were held in six islands of the Eastern Caribbean. These conferences were unique in that there was a team of U.W.I. and PAHO/WHO personnel representing pediatrics, social and preventive medicine and including nurses, physicians, a health educator and a sanitary engineer. The team worked with local personnel in each territory and considered the problem of gastro-enteritis and malnutrition. Public meetings were held in each territory involving a wide cross-section of the community.

(ii) Survey of Health Needs

In summer 1964, another joint PAHO/WHO and U.W.I. project was undertaken in which an assessment was carried out on the health needs of the British islands in the Eastern Caribbean. The data gathered were used for social and economic planning and in the training programs of the U.W.I.

(iii) Health Statistics Courses

Three short courses in health statistics of three and four months duration were held for medical records officers and statistical clerks from the Caribbean region during the period 1965 to 1968.

These three projects demonstrate not only the team approach in tackling community health problems, but the role of a university and an international agency working together in encouraging community participation for the development of health services.

Family Planning and Epidemiology Unit

In the context of social change, priority consideration must be given to the problem of rapid population growth. A Family Planning and Epidemiology Unit has therefore been established within the department, with the financial support of the United States Agency for International Development. The Unit has responsibility to respond to the needs of the National Family Planning Program in Jamaica, particularly with regard to aspects of training, research and evaluation. It also provides consultation to other family planning programs in the area on request.

Survey to Determine the Role of the U.W.I. in Attempting to meet Health Needs of the Region

In 1971, the University of the West Indies set up a special committee to investigate and report on the feasibility of expansion and/or duplication of its Faculty of Medicine. The committee's report - the I.A.D.B. Report - states inter alia that "the health needs of the people in the Caribbean area are numerous. The University can play a considerable part in making efforts to fulfill them. Innovation both in the delivery of health services and in the education and training of health personnel is urgently needed."

The committee stressed the need to train in increasing numbers all types of health manpower in the Caribbean and recommended a doubling of the output of medical doctors. However, to achieve these objectives, there would have to be an input of new money. This poses a challenge to seek new methods of utilizing existing personnel so that their knowledge and skills may be used to the maximum advantage.

### Community Health Aides and their Recognition

The need for innovations in the delivery of health services had already been recognized. In 1967, an experimental training program for community health aides was started in Jamaica by the Department of Social and Preventive Medicine, U.W.I., in a low-income suburban district in which there was no resident doctor. The aim was to train local residents to work as auxiliaries in a health team under the direction and supervision of established health professionals.

In 1970, the Ministry of Health, Jamaica, became interested in the results of this project and joined the Department of Social and Preventive Medicine, U.W.I., and Cornell Medical School, in establishing a second project, this time, in the isolated rural community of Elderslie in St. Elizabeth. The Ministry of Health included the salary of these auxiliaries in its regular health budget.

The results of these two projects encouraged the Ministry of Health and Environmental Control, Jamaica, to train and employ in 1972-73 about 350 community health aides. The present projection is to train 2,500 aides for the entire island.

Other Ministries of Health in the Caribbean have expressed interest in training auxiliaries to augment their health force.

### Training Program and the Use of the Manual

The training course included lectures, seminars, practical work in clinics, field visits, projects, working with community groups, tutorials and demonstrations. The basic material used in the first training course was edited and compiled in the form of a manual. This manual has been used in the training of the community health aides in Jamaica.

The community health aide training program and the manual together have demonstrated the role a university may play in promotion and orientation of community participation at all levels for the development of health services. It clearly combines the functions of the university in training, research, and service.

### Research

Research projects undertaken by the University of the West Indies have contributed significantly to the improvement of health and the development of health services in our several communities. The findings of several research studies have been the basis for the definition of policy and the development of realistic programs by several ministries of health within the region, e.g., immunization schedules and the management of hypertension.

Further, the various research programs have provided training for health personnel in the epidemiological approach to community health problems and developed an understanding of the various environmental factors, including attitudes which affect health and the delivery of health care.

One of the major research projects carried out by the Department of Social and Preventive Medicine has been the Inter-American Investigation of Mortality in Childhood, sponsored by PAHO/WHO. This was an interdisciplinary project, and the team of research workers included statisticians, nurses, social workers and physicians.

A pre-operational survey of knowledge, attitudes and practices in family planning has been carried out recently in Dominica, West Indies, for use of the Government in planning and organizing a national family planning program. Research is continuing into the social, cultural and psychological aspects of family planning and in various aspects of the delivery and use of family planning services in the region.

A Health Education Study to ascertain various sociocultural factors associated with child health and care is at present being carried out by the Department of Social and Preventive Medicine as a basis for the development of efficient health education programs within the hospital and community setting.

A critical problem in securing participation is that of reaching people with the information they need and in ways that will stimulate necessary action. Inaccessibility of people due to difficult terrain, poor roadways and low levels of literacy, among others, make it important to devise ways of reaching people through readily available resources. Today, the widespread use of battery-powered transistor radios has overcome the lack of electrical power in rural areas. Capitalizing on this fact, a special study of the use of radio in communicating health information is now under way within the Department of Social and Preventive Medicine. A doctor in the clinic setting selects patients and focusses on problems which they present, using the patient's manner of communicating and treatment of their conditions. He assists them to acquire the information and understanding they need and to know what preventive measures are possible. This conversation is recorded on tape and broadcast over radio at a specific time each week, thus sharing with the community pertinent health information.

The villages of Hermitage and August Town have been used as the "laboratories" for developing community health studies. In collaboration with other clinical departments and with the M.R.C. Epidemiological Research Unit, studies have been carried out on clinical growth, nutrition and specific diseases. Medical students and young physicians, nursing students, social work students and social welfare students are all receiving some of their training in Hermitage and August Town communities.

In addition, medical students, during their clerkship and elective study periods, have conducted community health studies in some of the Eastern Caribbean islands, such as:

- "The Organisation of Medical Services in Jamaica"
- "Aspects of Health in Jamaica 1968-1969"
- "Community Medicine in Barbados"
- "The Working of a Voluntary Child Health and Welfare Clinic"
- "A Perspective of Medical Practice in a Rural Hospital"
- "Study of Hospitalisation and Deaths in a Hospital of Children under Five Years of Age."

#### An Interdisciplinary Project

Through the initiative of individuals representing social welfare, sociology, and social and preventive medicine, proposals for the development of an interdisciplinary project in health, education and social welfare were made in 1964. The project included three main functions - teaching, research and service - and had as its objectives:

1. To provide the University with facilities for cultivating an interdisciplinary approach to social, educational and medical problems.
2. To give information which would enable governments to develop programs that would utilize available resources to better advantage.
3. To help the community to play an important role in improving its health and socioeconomic and educational levels.

As a demonstration and research center, the project would play an important role in training undergraduate and postgraduate students from different disciplines.

Many persons within the University were motivated to work with the community and the government in developing a model that may be useful for other communities. The development of the project was greatly hampered by lack of resources. However, some progress was made and various programs have since been developed in education, social work and health, which have involved the participation of the community at several levels.



### Social Welfare - New Roles and Functions

In recent years, revolutionary changes have been taking place in the concepts and functions of social welfare. In the developing countries, especially, increasing attention is being given to the developmental functions of social welfare as distinct from its preventive, remedial and supportive functions.

The International Conference of Ministers Responsible for Social Welfare in 1968 described social welfare as being "fundamentally engaged in the development of human resources, including the strengthening of family life and the preparation of people, especially children and youth, to improve their own lives as they contribute to national development."<sup>1</sup> It has a "further responsibility to help to create a milieu suitable for the development of potentials and the conditions for improved social functioning."<sup>2</sup>

In its holistic and integrated approach to human needs and the development of human resources, social welfare must of necessity have a close relationship with the important sectors, such as health and education, whose contributions are essential to social functioning.

On the other hand, it is considered that social welfare has a particular knowledge and expertise to contribute to the formulation of those policies and plans of other sectors which rely for their success on the support and involvement of the people of the community.

It is recognized, however, that in the field, social welfare is not the monopoly of the fully trained professional social workers who are, in any case, in very short supply. The International Conference of Ministers Responsible for Social Welfare urged that "certain skills, knowledge, and attitudes developed by social work and community development for the involvement of people in the solution of their problems should be incorporated in the training of all personnel in the social fields, including health," and that "wherever possible interdisciplinary cooperation and team efforts, starting with joint training, should be undertaken."<sup>3</sup>

The concepts outlined above are reflected in the following examples of programs in which the University of the West Indies is currently involved.

---

<sup>1</sup>Proceedings of the International Conference of Ministers Responsible for Social Welfare. United Nations Publication, Sales No. E. 69, LV.4, p. 6.

<sup>2</sup>Training for Social Welfare - Fifth International Survey. United Nations Publication, Sales No. 3. 71, IV. 5, p. 3.

<sup>3</sup>Proceedings of the International Conference of Ministers Responsible for Social Welfare. P. 13.

## 1. Training

Social work training in the University is conducted in two departments:

- (a) The Department of Sociology offers a Two-year Certificate Course in Social Work, and a Three-year Bachelor's Degree in Applied Social Studies.
- (b) The Extra-Mural Department conducts an ongoing program of short-term courses, conferences, seminars, etc., at various levels, for persons in the broad field of social welfare. Much of this work is done at the Social Welfare Training Center, a residential center located on the Mona Campus.

The Two-year Certificate Course offers generic training. Students come from many fields, including Public Health. The curriculum includes a course in public health for all students. Students have done research projects in the field of health, and have done field work assignments in the National Family Planning Board and the Bureau of Health Education, Ministry of Health.

One of the main programs conducted by the Extra-Mural Department is a Regional Four-month Course in the principles and practices of social work. Students are drawn from the fields of child care, community development, public health, mental health, family planning, social assistance, probation, police, prison officers, volunteer workers, youth officers, clergymen, and nuns engaged in community work, etc.

Health and nutrition (including mental health) are included in the curriculum. A joint seminar with medical students is conducted in which sociomedical problems are discussed and the importance of interdisciplinary collaboration emphasized. Students work with individual low-income families on a "friending" basis in order to get a better understanding of, and empathy with, individuals in these families. Emphasis is placed throughout on cooperation and on an interdisciplinary approach to the problems of the region.

## 2. Service for the Preschool Child in the Commonwealth Caribbean

In 1967, an Interdisciplinary Conference on "The Needs of the Young Child in the Caribbean" was held in Barbados under the joint sponsorship of the Government of Barbados and UNICEF. The University of the West Indies was represented by faculty members from social work, sociology, psychiatry, social and preventive medicine and pediatrics.

Arising from the recommendations of this conference, a regional child development project has been developed jointly by the U.W.I. and UNICEF. Under this project, each territory in the Commonwealth Caribbean is

encouraged and assisted to develop a comprehensive program to meet the needs of the young child (under five years of age). A coordinator has been appointed to the staff of the Extra-Mural Department, U.W.I., to advise and assist the governments in this task.

At the U.W.I., an Inter-Faculty Child Development Committee has been appointed with representatives from the Departments of Paediatrics, Social and Preventive Medicine, Education, Sociology, Extra-Mural (Social Work), the Caribbean Food and Nutrition Institute, and the Canadian Save the Children Fund in the Caribbean. This committee has responsibility for the development of a Child Development and Training Center which is to be erected shortly on the Mona campus of the University. The program of the Center will include:

- (a) an experimental day care center;
- (b) a parent education program - both for parents of children at the Center and other parents in the community;
- (c) research projects related to the development of the young child;
- (d) an experimental toy library (toys will be made by young people in the Youth Training Centers; this will, it is hoped, lead to the establishment of a local toy industry);
- (e) dissemination of information through regional training courses and conferences at the operational and policy-making levels.

Relevant research conducted in the various departments of the University, and elsewhere, will be channeled into the operational programs of the Center and into the region.

The local community will be closely involved in the work of the Center.

### 3. Family Planning

The University of the West Indies, in collaboration with the International Association of Schools of Social Work, is engaged in a project for the training of professional and voluntary social welfare personnel for greater responsibilities in family planning. The project, which is under the aegis of the Department of Extra-Mural Studies, is being developed jointly with the Department of Sociology, the Family Planning/Epidemiology Unit of the Department of Social and Preventive Medicine, the Jamaica Association of Social Workers, and selected social welfare agencies, the National Family Planning Board and the Jamaica Family Planning Association.

This project is an outcome of a two-day conference organized by the U.W.I. Extra-Mural Department in 1970, and sponsored jointly by the U.W.I., the National Family Planning Board, the Jamaica Family Planning Association and the Jamaica Association of Social Workers. At this conference, some 200 representatives of various social welfare agencies, the church, trade unions, political parties, and citizen groups met together to examine the social welfare aspects of family planning, and how family planning could be incorporated into their various programs.

#### 4. Regional Development

In 1967, the Extra-Mural Department of the U.W.I., in collaboration with the Jamaica Agricultural Society, initiated a project of regional development in a small farming area of North Clarendon, based on the development and involvement of the people of the area, rather than on the customary crops and markets. The project was entitled "Operation Self Help," and the motto selected by the people was "With Our Own Hands." Working through the indigenous groups of the Jamaica Agricultural Society, the representatives of the various districts of the area were involved in a comprehensive area survey to define the needs and possibilities. The U.W.I. undertook the tabulating and analyzing of the data. Citizen committees undertook responsibility for various aspects of the program to meet the defined needs, and invited technical officers of government and private agencies to advise and assist them. The program is still in operation in 1973 and the results, in terms of the development of individuals as well as agriculture and other material resources, have been outstanding.

Certain defined health needs, such as clinics, have not yet been fully met, but the Home Economics Section, under the direction of the local Home Economics Committee, and with assistance from the Ministry of Agriculture, U.S. Peace Corps, and others, includes family life and nutrition education.

#### Other Aspects of Training

Securing and sustaining the level of community interest and participation necessary for the achievement of health goals requires a high level of interest and commitment on the part of staff.

Health workers are less likely to facilitate real involvement and participation of the people where they themselves have not participated in the development of program plans and strategies. Responsibility for stimulating staff commitment rests largely on health administrators and on their style of leadership and their group and management skills. Plans are now well on the way for the initiation of a management course sponsored jointly by PAHO/WHO and the University of the West Indies, which is being designed and conducted by the faculties of social science and medicine.

### Health Education and Community Participation

Socioeconomic conditions in developing countries necessitate priority attention to those aspects of health care that reach large numbers and are of a preventive nature. These basic health problems often arise from, or are aggravated by, social causes and they require the utilization of a multidisciplinary and educational approach as an integral part of their solution.

Among the underlying purposes of the educational approach in health are the development of a sense of responsibility for one's own health and the health of the community and the ability to participate responsibly and constructively in programs designed for the well-being of the community. Well organized health education services and programs are necessary if people are to be stimulated and prepared for participation in health programs.

Health workers and workers in allied fields, such as social welfare, education, community development, etc., need to understand the interrelationship of health and social problems and the importance of a coordinated approach to their solution. They all need training in the use of the educational approach in health.

Professional health education services have not been widely available to health agencies throughout the Caribbean. This need for health education services to health agencies in the region was agreed on at the Fifth Meeting, Caribbean Health Ministers Conference in February 1973, and the University was asked to play a role in providing assistance in this area.

A survey of the status of health education in the Caribbean was undertaken in 1972 by the health educators in the area with the assistance of PAHO/WHO and the University of the West Indies. Data obtained from 10 territories, including three large, six medium-sized and one small territory indicated that there are organized health education units in only three of the larger territories headed by an individual who has had professional preparation in health education. Four of the smaller territories have an individual designated as health education staff but only one of these persons has had special preparation in public health education.

Through the assistance of the Canadian International Development Agency, 1969-1972, and with the help of USAID/Jamaica in 1971, the Department of Social and Preventive Medicine has been able to have the services of a full-time health education specialist. This officer is engaged, among other things, in teaching at the undergraduate and postgraduate levels within the University; in developing and conducting special training programs in staff development for family planning and other agencies at national and parish levels; in providing consultation; in research; and in stimulating the development of health education services and qualified personnel throughout the Caribbean.

Clearly, the services of one health education specialist are inadequate to meet the needs for health education within the University itself, let alone the requirements of the various territories within the region.

Conditions Necessary for the Universities and other Extra-University Institutions to Fulfill their Roles in Collaborating with the Health Ministers in the Public Health Program Plans

- A climate of cooperation and understanding between universities and health ministries.
- Clearly identified mechanisms for research findings to be fed into the planning process.
- Opportunities for carrying out direct service programs at the "grass-root" level, utilizing the multidisciplinary approach.
- Specialist health education services available to each country.
- Funding to the universities to enable them to provide training of persons in the particular skills and competencies necessary to carry out the educational tasks.
- Organized health education units strategically placed within the ministry hierarchy to function effectively.
- Clear policy statements regarding health education and school health education to guide action.
- An important underlying principle is that personnel who work with people at the grass-root level (and, indeed, at all levels) who know and understand them and the realities of the situation should be involved in the planning process from the very beginning.

Health education is seen as an important and integral part of long-range community development planning. The University of the West Indies can be extremely helpful in this respect in initiating and guiding the development of educational programs for changing attitudes and imparting necessary and relevant skills to all categories of workers.

The University of the future has no alternative but to continue to accept the challenging responsibility to work with the health ministers and the people of the region, helping them to define their problems and to find and apply solutions.

REPORT ON THE EXPERIENCE OF THE UNIVERSIDAD DEL VALLE, CALI, COLOMBIA,  
IN REGARD TO THE ROLE OF UNIVERSITIES IN THE PROMOTION AND  
ORIENTATION OF COMMUNITY PARTICIPATION IN  
THE DEVELOPMENT OF HEALTH SERVICES

The community is really the physicians's patient. This statement, so simple at first sight, is nevertheless a demagogic slogan used by many medical educators and most of the students who claim to be bringing about "the change."

Looking back over the historical evolution of community medicine or other similar programs in Colombia, it is surprising to see how the trends in such programs have followed a parallel course in different medical schools, not so much in time but in philosophy and development.

Mention should be made of the great importance of the First National Seminar on Medical Education, held in Cali, Colombia, in 1955. Colombian medical educators were meeting for the first time in the Government health sector and among their conclusions was the following: "In the teaching of medical sciences, from the basic to the clinical sciences, knowledge of the concept of preventive medicine should be impressed upon the student."<sup>1</sup>

The corresponding departments were established and with them came courses in preventive and family medicine, a first attempt to put the student in contact with the community. It was at Universidad del Valle in 1955, a year after the establishment of the Department of Preventive Medicine and Public Health, that the first experiment in extramural programs was carried out in Siloé, a marginal district of Cali.

All the available human and technical resources of the educational health sector were brought to bear on Siloé. Was the program adequately planned? Had specific objectives been defined? Was there any evaluation of the program's impact on the community or of the change it was hoped to bring about in the students and, eventually, in medical education?

The only certainty is that it served as a model for the proliferation of similar programs in Colombia and, according to Juan Cesar García,<sup>2</sup> in many Latin American medical schools. This model, described by Santiago Rengifo,<sup>3</sup> also involved the development of a demonstration program (Candelaria)

---

<sup>1</sup>First Medical Education Seminar, Universidad del Valle, Cali, 1957.

<sup>2</sup>Juan César García (1972) La educación médica en América Latina. PAHO Scientific Publication No. 255.

<sup>3</sup>Santiago Rengifo (1959) Enseñanza de medicina preventiva y salud pública en la Facultad de Medicina de la Universidad del Valle, Cali, Colombia. Bol. Ofic. San. Pan. XLVII.

begun in 1957. The purpose was to bring the student into contact with the most common diseases in our communities, both urban and rural, to enable him to study the factors determining regional pathology and to familiarize him with the dynamics of medical attention outside hospitals. This was the origin of the programs instituted in Madrid (National University, 1964), Villamaría (Caldas University, 1965), Santo Domingo (Antioquia University), etc.

#### Santa Matilde Hospital, University Center, Madrid

In 1964 the medical school of the National University, aware of the need to establish contacts between students and urban and rural communities and to make a contribution to the solution of health problems, considered the possibility of setting up a zone where students of the Department of Preventive Medicine, in the twelfth semester of the medical course, could carry out field practice. Because of the need to encourage in students a positive attitude towards multiprofessional work, the gradual participation was envisaged of other health departments, such as nutrition, nursing and dentistry. Subsequently, to achieve integrated development of the selected zone, the value of contributions from faculties such as agronomy, veterinary science and education was recognized.

For the reasons mentioned above, the University selected the Madrid municipal area (Cundinamarca) as a working zone, with the later addition of the Bojacá, Funza, Mosquera and Subachoque municipalities.

The Santa Matilde Hospital, University Center, was a branch of the University and its organization was the responsibility of the Department of Preventive and Social Medicine. The program was based on a tripartite contract between the University, the Santa Matilde Foundation and the office of the Cundinamarca Secretary for Health. Work was begun by the department in January 1964 and completed in May 1970.

#### Objectives

##### I. Educational Objectives

1. To give instruction to medical students in medical care and public health at the rural level.
2. To provide a practice area for students from other faculties and schools for paramedical staff: dentistry, nursing, nutrition.
3. To facilitate the development of specific teaching programs, for application to rural communities by students from other faculties, such as engineering, veterinary science, and education.



4. To develop permanent programs for in-service training of auxiliary staff (nursing auxiliaries, sanitarians, laboratory auxiliaries), with the aim of obtaining qualified personnel at the rural level and ensuring the competence of the health team.

## II. Service Objectives

To provide an effective level of medical and health care to the Madrid community and, at a later stage, to the populations of Funza, Mosquera, Bojacá and Subachoque, with particular attention to activities related to maternal and child health, school health, adult care and environmental sanitation.

## III. Research Objectives

1. To serve as a "population laboratory" for the planning and development of studies at the rural level on demographic, economic and social characteristics of the community, and the physical environment and its impact on health problems, from the standpoints of both prevention and care.

2. To facilitate the study and evaluation of general and specific programs for medical and paramedical care at the rural level, permitting the future establishment of standards and working procedures suitable for application by the official health authorities.

## Student Activities

During their rotational period in the Department of Preventive Medicine, students in the twelfth semester of the medical course carried out their field practice in the University Center. The following are some of the activities undertaken:

- (a) Working in each of the services of the Center in turn
- (b) Carrying out immunizations
- (c) Planning, executing and evaluating programs undertaken with the community
- (d) Holding meetings with community action groups
- (e) Attending some sessions of the Municipal Council
- (f) Visiting families to study epidemiological cases
- (g) Making home visits

- (h) Holding meetings with Center staff
- (i) Preparing seminars
- (j) Forming reading societies
- (k) Carrying out stool, urine and other analyses
- (l) Participating in activities connected with the family planning program
- (m) Taking part in environmental health activities
- (n) Planning, implementing and evaluating educational activities, such as talks to mothers and other organized groups in the community.

#### Community Development Program

At first the medical students took full responsibility for the organization of health services and medical care in the community. It became clear from studies carried out, however, that there was a need to gradually incorporate students from other faculties, such as nursing, nutrition and dentistry and, later, from further faculties such as agronomy, veterinary science and education. The activities carried out by the multiprofessional teams can be summed up as follows:

- (a) Organization of the market garden area as a demonstration center, with a view to extending this activity to the level of families
- (b) Organization of a literacy center
- (c) Construction of a sports field with the help of the community
- (d) Construction and equipment of a children's park in the university center
- (e) Organization of a theatrical group.

Once these activities had been carried out in Madrid, the programs were extended to other municipalities, beginning with Subachoque, more specifically the "El Rosal" rural area. These programs were later phased out until 1970 when the University withdrew all teaching and administrative staff.

What happened to these programs? Since their peak in the sixties they have disappeared. Unfortunately, they have come to an end without any a priori or a posteriori evaluation. The three major purposes of this type of teaching can be summed up as follows:

- (a) To put the health sciences student in contact with the community, as early as possible and in circumstances similar to those that will prevail when he begins to practice his profession.
- (b) To enliven the teaching of traditionally arid basic subjects (biostatistics, epidemiology, administration, social sciences).
- (c) To improve the quality of medical care in the communities selected, as an end in itself and as a means of demonstrating the effectiveness of a system.

If we try to make a very subjective evaluation of the objectives mentioned above, it could be said that the basic, positive result has been to make the graduate think about his social responsibility vis-à-vis the community, which had previously never been mentioned as part of the physician's role. Physicians were simply not interested in health, considering it as an abstract term. They were interested in disease and the large majority sought the immediate gratification produced by curative medicine. Physicians enjoy the hospital environment because all activities, attitudes and thinking are focussed on disease.

When the physician or student is exposed to community problems, gratification is delayed; it is not easy to demonstrate a positive impact and this leads to a sense of frustration.

Demonstration programs create a series of artificial circumstances which are difficult to apply in normal conditions in our countries. It is assumed that such sophistication should at least produce an improvement in the quality of medical care, reflected by a change in the community's health indicators. There is no evidence that this happened and the very short duration of some programs leads one to believe that it was not so. Paradoxically, the first of these programs, Candelaria, was also the last to be discontinued (December 1972). How did it develop?

It is notable that it was also in Cali that the second stage of diversification of extramural centers began. In 1966, coinciding with the development of planning and regionalization of medical care in Colombia, towns or communities of Valle del Cauca began to be used for training purposes. Later, in collaboration with the health services, the rotation of students in a community medicine course was included during internship and, more important, specific objectives were worked out.

The extramural program of the Department of Preventive and Social Medicine of Caldas University serves as an example of the current model.<sup>4</sup>

---

<sup>4</sup>Hernando Henao Rojas (1972). Programa extramural - Curso Sexto. Universidad de Caldas, Facultad de Medicina, Departamento de Medicina Preventiva y Social, Manizales.

### Definition

The extramural program in social and preventive medicine is the last part of the course in this discipline in the Caldas University Medical School curriculum.

Under the program, sixth year students spend periods in rotation in some municipalities of the Department of Caldas, immediately before entering rotational internship. The Department of Caldas now forms part of the central area of the national health services regionalization project with its levels of medical care.

While working in the municipal hospitals the students learn about the history of the hospitals, their organization, administration and operation, and the services provided.

### Organization

The rotation period is eight weeks. The first week is taken up with general group briefing before the students go out into the field.

In each hospital, attendance is compulsory from early on Monday until midday Saturday. The students take turns at emergency duty during the week, and Saturday and Sunday night duty is optional.

A teacher from the Department of Preventive and Social Medicine pays at least one visit a week to the hospital where each student is working to interview the doctors, enquire as to how things are going and listen to suggestions. Later he meets the students and listens to presentations of the subjects set during his previous visit. The topics planned for that date are analyzed and discussed. The activities of the previous week are reviewed and those of the following week discussed.

The hospital directors, in their capacity as the students' immediate supervisors, take an effective part in guiding their activities, indicating the areas in which assistance is most badly needed.

Helped by employees and the community, they prepare and give talks with the sanitarians.

The students record their daily activities in a book provided for the purpose and have to submit written reports when requested.

### Evaluation

Simultaneously with the program, at the beginning of the rotation period, an anonymous survey is held on the students' knowledge of the localities

where they will be working and of the activities of a physician at the level of a local health unit. This is repeated at the end of the period; in addition, a general, critical meeting is held to discuss the quality of the program.

The common characteristics of programs now under way can be summed up as follows:

- (a) Rotation of students in their final year, generally to local hospitals in the area.
- (b) Major emphasis given to activities relating to assistance, with little activity carried out directly with the community.
- (c) These activities are usually limited to a descriptive study of some community problem, as shown by the work done by a group of students from Antioquia University during their rotation to the Department of Preventive Medicine and Public Health.<sup>5</sup>
- (d) Absence of formal agreements with government institutions.

Will this be the answer to the problem of teaching community medicine to our students? If not, what is?

We believe, like Hernán San Martín, that no health program is really useful unless it gains acceptance by the population and the population takes an active part in it.<sup>6</sup>

The two models used by departments of preventive medicine can be analyzed as follows:

- (a) Selection of a zone for experimentation
- (b) Use of local health services

The following measures can be taken:

Under the first system, the students take on the responsibility of working with communities without having sufficient ability to motivate them, identify their health problems and obtain popular participation in their solution. Moreover, the students are unaware of the importance of identifying

---

<sup>5</sup>"Aspectos médicos y socioeconómicos de un sector turgural" Antioquia Médica, Vol. 22, Nos. 9-10, 1972.

<sup>6</sup>Hernán San Martín, "Salud y Enfermedad" Prensa Médica Mexicana, 2a edición, México, 1968.

community leaders as early as possible and using them as key resources for health activities. Although their work is preventive in nature, the students do not have the requisite skill for implementation, execution and evaluation of educational programs with community participation. They are unaware of the importance of teamwork in community development.

Under the second system, the students' work centers on giving assistance in rotation to provincial hospitals, complemented by specific studies of community health problems. The results obtained by the latter method indicate that, in spite of their restricted field of activity, the students' lack of preparation in behavioral sciences prevents achievement of the objectives set.

This demonstrates the need for including adequate instruction in behavioral sciences in the teaching programs of medical schools, to produce in the students the constructive attitude needed for satisfactory performance in field practice and professional training.

What are the prospects for the future? If we believe that research is absolutely necessary to define problems and obtain solutions, then special, objective and dynamic studies should give us the answer. Examples are the research projects now under way in Universidad del Valle, one on simplified medicine and the other on a multidisciplinary program seeking to produce an integrated model for overall community development. According to the latter, the health sector is merely a part of this development. It lays down the following conditions:

- (a) The program and its strategies must be reproduced or capable of being duplicated in other regions or communities with similar characteristics.
- (b) Maximum use must be made of the physical and human resources of the area.
- (c) The techniques used must be of low cost and high efficiency.
- (d) The needs and aspirations of the community must be taken into account so that the program originates from and by the communities.
- (e) The program must favor the decentralization of activities.
- (f) It must provide sufficient high-quality information to serve as a basis for establishing teaching programs.
- (g) It must tend towards integration of the bodies working in the areas.

What are the prospects? A review of the situation described above reveals that this latter program is no more than the original idea of the extramural projects. The great difference is in that the scientific method is now applied and the community taken into account in the making of decisions. We believe that, if this is done in collaboration with other faculties to extend and add new dimensions to the experiment, the right way can be found. Only time will give us the final answer.