

## COMMUNITY, DISEASE AND PARTICIPATORY APPROACHES

### TO HEALTH CARE

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*This is a revised version of a paper presented by K. Tudor Silva Ph.D, of the Department of Sociology, University of Peradeniya in a workshop on 'Community Participation in Health Care' held recently in the Peradeniya Teaching Hospital. The workshop was held in connection with the launching of a multi-disciplinary research project, which evaluates, over a period of five years, the effects of community participation in health care, introduced on an experimental basis in two selected regions in Sri Lanka. One of the areas chosen for this study consists of new settlements created under the Accelerated Mahaweli Programme. The research team, of which the author is a member, is headed by Professor H. A. Aponso of the Medical Faculty, University of Peradeniya.*

Modern health care services in Sri Lanka have always existed within a bureaucratic framework with its inherent problems and limitations. A centrally controlled network of health services, operating under considerable financial constraints, is likely to be less effective in the more remote areas of the country. The wide social and cultural gap that separates the health care planners and the medical practitioners, on the one hand, and the

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rural masses, on the other, implies that the decision-making process associated with health services is necessarily controlled from above. A main weakness of the 'top down' approach to health care is that it fails to activate the people to solve their health problems through their own effort. Although the appointment of District Development Councils, and the allocation of funds through a decentralized budget are important steps in the direction of de-bureaucratization and popular participation, corresponding developments are yet to occur in the national health care system in Sri Lanka. In this context experimentation with community participation in health care marks an important departure from the conventional approach to health problems in Sri Lanka.

The concept of community participation in health care represents a unification of certain concepts and approaches developed independently of one another. The importance of socio-cultural and environmental factors influencing the health status of individuals has always been emphasized in Community Medicine, Community, however, was largely seen as a passive object with no ability to improve itself through its own positive action.

The view that the communities may progress through their own effort stems

from the Community Development Programmes introduced in many parts of the world following the Second World War. Community participation was gradually perceived as a necessary condition for initiating desirable social change at the grass roots level. As a logical extension of this approach it came to be recognised that solutions, to many of our health problems are found within our own communities. Since 1978 the United Nations

agencies such as WHO and UNICEF have played a leading role in evolving a health care policy that seeks active participation of the target populations concerned. (1)

#### Basic Concepts: Primary Health Care and the Community

The concept of Primary Health Care (PHC) delineates the necessary ingredients in an economically viable and socially acceptable health care system adapted to the grassroot level. PHC is defined as a "Practical approach to making essential health care universally accessible to individuals and families in the community in an acceptable and affordable way and with their full participation". (2) It points to the need to strengthen and intensify the base of the medical system, namely the health outpost or the clinic more easily accessible to the rural population, in order

to expand the health coverage in rural areas. As the last link of a health care network, the village level clinic will be equipped with basic facilities, making it necessary to refer illnesses of a serious nature to higher level and specialized health services. PHC defines a package of health practices including environmental sanitation, nutrition and immunization, which may best be instituted, popularized and co-ordinated with the active participation of the rural community.

The recent emphasis on widening the base of the health care system, with a corresponding stress on community participation, must be seen as a response to four sets of constraints commonly found in the Third World countries. (3) First, scarcity of funds and qualified personnel relative to the magnitude of health problems in these countries. Second, the available resources are largely concentrated in urban centres, depriving large masses of rural people who have more pressing health needs compared to the urbanites. Third, the existing health services are curative rather than preventive in their orientation, with a corresponding neglect of long term health objectives. Finally, there are many shortfalls and gaps in the popular acceptance and understanding of modern health practices. While admitting that there are no easy solutions to these problems, an approach that seeks to sensitize and activate the community to utilize its own resources is now accepted as a useful strategy for correcting the present imbalances in the health care system.

As the community is at the centre of the proposed health care policy, we must address ourselves to the following questions, What do we mean by a community? Are we likely to see communities emerge in the newly opened areas under the Mahaweli Scheme? Is community a natural outcome of certain given conditions or can it be created through planned change? According to the conventional anthropological definition, a community is a relatively small, homogenous, stable and harmonious social entity which has some

1. The Alma-Ata declaration of 1978, signed by delegates from various countries and representative of UN agencies, provides a charter for the re-organization of health care programmes throughout the world so as to expand their effective coverage both vertically and horizontally.
2. World Health Organisation, Primary Health Care (Geneva WHO, 1978) P. 38
3. For general discussions on the health care problems in Third World countries see Maurice King, ed., *Medical Care in Developing Countries. A Primer on the Medicine Poverty* (Nairobi; Oxford University Press, 1966) John Bryant, *Health and the Developing World*, (Ithaca: Cornell University *Effectiveness of Public Sector Health Systems in Developing Countries* (Ann Arbor; University of Michigan, Center for Research on Economic Development, 1975)

degree of autonomy from the larger society. (4) Such a conception is clearly inappropriate for our immediate purpose for two reasons. First, communities in the above sense will never be evolved in the administratively created Mahaweli settlements. Second, in a project aiming to improve the health conditions of the people we must necessarily adopt a more dynamic definition of the community. In an effort to find a suitable definition of the community, we may turn to the experts on community development.

The latter see common residence in a clearly demarcated locality and the resulting articulation of certain common interests among the local residents as the defining features of a community. (5) We can expect that the formation of neighbourhood ties and the articulation of common interests will slowly, but gradually take place in the Mahaweli settlements. Viewed in this light, one of our principal tasks in this research project will be to facilitate the articulation of a community awareness concerning local health issues.

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How do we foster community participation in health projects in socially meaningful and acceptable ways? A review of the available literature suggests three ways in which a community can be actively involved in an integrated national health programme. (6) First, local participation in the planning, organization and the delivery of institutionalized health care services. Second, the recognition and the use of para-professionals as auxiliary health workers. Third, establishment and popularization of voluntary associations interested in solving local health problems. Let me describe each of these approaches in detail.

### Community Participation in Institutional Health Care

A necessary sequel to the expansion of PHC coverage is to involve the community leaders in the organization and running of local clinics and medical outputs. This will help the health authorities to reduce their administrative burdens and costs which are likely to increase with the expanding PHC network. On the other hand, "such medical facilities have the potential to be more effective than conventional clinics, provided they are seen as people's own and as responsive to their needs and ideas" (Uphoff, Cohen

and Goldsmith, 1979: 241) Where community participation has been effective, the local medical service will be best equipped to handle those health problems that most worry the local people.

The community involvement in PHC decision-making, however, is not without problems. What sort of community leaders are to be chosen for this purpose and how do we make sure that they have a genuine interest in serving in the community? Given the present political structure in rural Sri Lanka, it is unlikely that any organization controlled by community leaders can remain politically neutral. What implications will this have on the efficient functioning of the rural health care services in Sri Lanka? What strategies will help build up a dynamic and responsible leadership in rural communities? These are some of the issues that we must consider carefully in evolving a strategy for enhancing the community's control over PHC institutions.

Another area of uncertainty is the sharing of responsibility and balance of

power between the health administrators, on the one hand, and the community leaders, on the other. If we make the administrators and the health staff chiefly responsible to the local community, we may have some problems in implementing a national health plan in rural areas. On the other hand, if the administrators and the clinical staff make all the decisions and the community representatives only legitimize such decisions, community participation in health administration will only be a nominal one. Ob-

viously we must strike a middle path that guarantees both community and higher level interests, but just how is this to be accomplished and maintained needs careful thinking.

### Voluntary Health Workers and Traditional Practitioners

The institutionalized medical facilities, no matter how widespread their coverage can be, will have limitations in serving the rural people. The qualified medical personnel are not only scarce and expensive, but also tend to be socially superior to those whom they are meant to serve by virtue of their training, social background and life style. It has been found that a fairly large proportion of ailments among the rural people can be cured with some basic skills in diagnosis and treatment. The burden of the health educator will be very much eased, if he operates through a local man who may activate and utilize the informal communication networks operating within the community in order to disseminate health knowledge and practices. In some, a voluntary health worker drawn from the local community can be used as an effective link between the organized health care system and the community. This intermediary role often combines curative and preventive functions, technical skills and social responsibilities, the task of a specialist and that of an ordinary villager. (7)

There are many important considerations about voluntary health workers. By what name are they to be known (options: Health Volunteers, Health Wardens, Community Health Workers or any suitable indigenous name?) How are they to be selected (e.g. election, nomination or a combination of both?) What is the nature, quality and duration of their training? Is it desirable to make it a long term career or a position held for a period by a

4. Robert Redfield, *The Little Community* (Chicago: University of Chicago Press, 1955) P.4
5. T. R. Batten, *Communities and their Development* (London: Oxford University Press, 1957) pp.4-5; Allan D. Edwards and Dorothy G. Jones, *Community and Community Development* (Hague; Mouton, 1976) pp.12-14
6. See H. Notkin and M. S. Notkin, "Community Participation in Health Services; A Review Article", *Medical Care*, 27 (1970): 1178-1201; and Normal I. Uphoff John M. Cohen and Arthur A. Goldsmith, 'Participation in Rural Health Care Programmes' in Normal I. Uphoff et al (eds), *Feasibility and Application of Rural Development Participation* (Ithaca: Cornell University, Rural Development Committee, 1979) pp.235-256.
7. For a detailed treatment of the subject see Peter Berman, *Village Health Workers: Background and Issues for Analysis* (Ithaca: Cornell University, Rural Development Committee, 1978)
8. See, for instance, M. M. Rosenthal and J. R. Greiner, 'The Barefoot Doctors of China: From Political Creation to Professionalization' *Human Organisation*, 41 (1982)

rotating set of people? Cjina's experience with barefoot doctors can be instructive in all these matters, but we must remember that the Chinese solutions may not be appropriate where the political will and the ideological conviction are lacking. On the other hand, the recent literature (8) suggests that certain social objectives of the barefoot doctor programme such as equity and community participation, may not have been achieved.

A crucial consideration in relation to community participation in health care in Sri Lanka is the role of the Ayurvedic practitioner, exorcists and other types of traditional practitioners. We must necessarily see them as a health resource available within the communities. The community participation strategy involves a strengthening of their role in PHC work. It is important to note that from the angle of the rural people different forms of treatments are complementary rather than contradictory. (9) Recent anthropological research in Sri Lanka points to the therapeutic value of certain traditional rituals especially in mental illness. (10) Although integration of different medical systems may not be a viable proposition, attempts may be made to enhance the mutual understanding between different types of practitioners, so that they may not be aiming at cross purposes

### Voluntary Associations

There is no guarantee that the health care personnel, whether they are professional, will effectively serve the community, as long as the latter remains apathetic regarding local health needs. A democratically organized national health care programme must necessarily recognize and

accommodate local or sectional interests represented by voluntary associations. More importantly, organised collective action is a pre-requisite for overcoming chronic diseases and other health problems associated with lasting behaviour patterns and cultural values prevailing in a community. New practices such as family planning or vaccinations are unlikely to penetrate into rural areas, unless they are consciously and systematically promoted by local organizations. Finally, the voluntary associations can set their own health targets and mobilize the local people in self-help efforts designed to achieve those targets.

The results of the past attempts to build up community associations in Sri

for mobilizing Shramadana work in sanitation and health projects are some of the possibilities in Sri Lanka. These organizations may be evolved as independent bodies or as organs of any existing community organizations. To be fully effective, such organizations must be practical, related to the felt needs of a community, and above all, culturally appealing to the people concerned.

The success of voluntary associations depends on a variety of factors including leadership, popular support and participation and the ability to overcome initial barriers. There is always a danger that a voluntary association will be controlled by a small minority of local elite, unsympathetic to the idea of wider community

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Lanka are not very encouraging. (11) For instance, the Rural Development Societies, first established more than three decades ago with the general objective of raising living standards in the villages, have shown a poor hand, organizations with more limited objectives, such as the Funeral Aid Societies, have had a measure of success in some areas. Maternity and Child Care Organizations, Community Funds for Helping Sick People, Blood Donation Campaigns, Health Education Groups, First-Aid Squads and organizations

participation. Factional conflict within a community can make it difficult, if not altogether impossible, to build up successful community organizations. After an initial period of euphoria a community organization can slowly go into oblivion, in a by now familiar process in Sri Lanka. All this means that building grass - root level institutions to supplement and back up the health care delivery system is a necessary, but difficult task.

In conclusion, let me reiterate that the arguments for giving the community a greater share of responsibility in the fight against disease and debilitating conditions are quite convincing. However, it will be too optimistic to assume that community participation can be brought about easily. We must also remember that there are complex factors associated with health conditions in a given community. The following comments by a writer on the hookworm campaign conducted in Ceylon in the 1920's will sum up the complexities involved.

"The problem of parasites, nutrition, sanitation, social conditions, and economics are interlocked. An improvement in any one of these areas of human problems will effect one or more of the others. But at the same time a lack of improvement in one of the areas may hold back progress in all the others. An invaluable by-product of the Rockefeller hookworm work was the demonstration that no permanent gain can be made in combating disease without a general rise in the social and economic level." (12)

9. See, Gananath Obeyesekere, 'The Ritual Drama of the Sanni Demons: Collective Representations of Disease in Ceylon', *Comparative Studies in Society and History* 11 (1969): 174-211; and Gananath Obeyesekere, 'The Impact of Ayurvedic Ideas on the Culture and Individual in Sri Lanka', in C. Leslie (ed) *Asian Medical Systems: A Comparative Study* (Berkeley: University of California Press, 1976) pp. 201-226

10. Bruce Kapferer, 'Entertaining Demons: Comedy Interaction and Meaning in Sinhalese Healing Rituals', *Modern Ceylon Studies*. (1975): 16-63; Nancy E. Waxler, 'Social Change and Psychiatric Illness in Ceylon: an Investigation of Traditional and Modern Conceptions of Disease and Treatment', in W. Lebra (ed) *Culture-Bond Syndromes: Ethnopsychiatry and Alternate Therapies* (Honolulu: University of Hawaii Press, 1976), pp. Nancy E. Waler, 'Is Mental Illness Cured in Traditional Societies? A Theoretical Analysis', *Culture, Medicine and Psychiatry* 1 (1977) 233-253; and Gananath Obeyesekere, 'Ayurveda and Mental Illness', *Comparative Studies in Society and History* 12 (1970) 292-296.

11. For a review of the role of rural institutions in the agricultural development in village Sri Lanka see 'Introduction' in Barrie M. Morrison et al (ed), *The Disintegrating Village: Social Change in Rural Sri Lanka* (Colombo: Lake House, 1979), pp.31-38.

12. Jane Phillips, 'The Hookworm Campaign in Ceylon', in H. M. Teaf and P. G. Franck (ed), *Hands Across Frontiers: Case Studies in Technical Co-operation* (Leiden: Sijthoff, 1965), p.302