A programme of community health development is reported from two villages in Haiti. It involves close cooperation between a district hospital, a local dispensary, and, most importantly, the inhabitants themselves. The programme is simple, financially realistic, adapted to local conditions, and linked to activities designed to meet basic requirements, such as those of food production and water supply.

The Albert Schweitzer Hospital in the Artibonite Valley of central Haiti was founded by William Larimer Mellon in 1956 to serve approximately 175 000 people suffering great deprivations. It treats patients with various infectious diseases, among them tuberculosis, venereal diseases, malaria and typhoid fever, and also cares for children affected by diarrhoea and malnutrition. Mellon, concerned with the causes of the diseases he encountered, worked on the development of potable water systems and the building of latrines in the villages throughout the hospital’s catchment area.

Early in 1977 the governors of the hospital, which by this time had some 100 beds, decided to extend its services by creating a community health department. Curative, preventive and promotive health programmes were delivered through a network of seven dispensaries, and a mobile immunization team was established.

In 1987 a study group was appointed by the governors to review the activities of the hospital and its outreach programmes. Shortages of medical and auxiliary staff and of facilities outside the hospital, the immensity of the problems, and the limited financial resources, equivalent to about US$ 1.00 per capita annually, meant that it was desirable to consider devising a new way of improving people’s health. It was recognized that it was not enough to take preventive action and care for people who attended for treatment, and that healthy living should be promoted. A community health development programme clearly had to be simple and in accord with the available funds; it also had to be adapted to meet local needs and integrated into a wider scheme, including the improvement of water and food supplies and of shelter. Bearing in mind the need for sustainability, a gradual developmental approach was adopted.

Research and development project

In 1988 two villages with a total population of 1459, in the catchment area of the Plassac
dispensary, were selected for a research and development project. In close collaboration with the communities a comprehensive baseline survey was conducted on major health problems, socioeconomic status, food production, living conditions, environmental problems, and health-related religious and cultural factors.

Among children aged up to five years, 36% were of normal nutritional status, while 41%, 18% and 4% suffered from first-, second- and third-degree malnutrition respectively, according to the Gomez definitions. Of these children, only 31% were completely immunized. Physical examination of a sample of the children showed that 21% had serious health problems such as tuberculosis, malaria and upper respiratory tract infection.

Of the houses surveyed, 93% were made of earth, and 84% had no windows, ventilation or latrines. In 73% of the households, water was obtained from uncapped springs; the others took water from wells and rivers.

The majority of the families lived at subsistence level. Low food production, attributable to seasonal shortages of water and bad weather, caused the high prevalence of malnutrition among children. The period between May and September was the worst in this respect, marked by an increase in the number of children with kwashiorkor in the hospital’s paediatric ward.

The illiteracy rate was around 85%. There being a voodoo priest for every 100 people approximately, almost everyone sought advice on health matters from this source in the first instance.

**Step by step**

The survey indicated that the provision of curative and preventive care through the dispensaries had little impact on people’s health. It was clear that any community development programme would be very difficult to implement. For this reason a cautious step-by-step approach was adopted.

The staff of the community health department and the Plassac dispensary underwent intensive training in preparation for the new task, especially with regard to working as partners with the community.

A village development committee was established, its members elected by the community. Voluntary health workers, elected or selected among mothers, were trained in health promotional activities and each was made responsible for 15–20 families. These workers, in collaboration with the dispensary’s health agents, delivered a minimum health care package, comprising maternal and child care, family planning, immunization, treatment of simple diseases, health and nutrition education, and environmental sanitation. A prepayment scheme financed the package, a contribution equivalent to US$ 0.40 being provided by each family. The committee was also involved in income-generating activities, including food production and the running of cooperatives.

**Progress**

In less than two years the joint effort had a markedly beneficial effect on health status, most significantly in respect of children.
aged under five years and their mothers. There was a strong indication of declining mortality and malnutrition among children aged one to three years. No more cases of third-degree malnutrition were seen in the dispensary, and some 90% of children were fully immunized. Changes were evident in

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the health knowledge, attitudes and practices of the population and fewer serious cases were seen in both the dispensary and the hospital.

The committee and the village health workers demonstrated considerable ability in managing the programme, obtaining contributions in cash and kind, and organizing and teaching mothers in matters of health care. The committee not only managed established programmes but also expanded its activities. For example, grain surpluses were stored in silos after harvest for subsequent distribution as the need arose, and malnutrition among children was thus reduced.

**Difficulties overcome**

The programme encountered no unsurmountable obstacles, although, of course, there were frustrations and setbacks. The most difficult problems were associated with certain attitudes among dispensary staff, community leaders, the committee, mothers, and, indeed, the people in general.

Resistance to change and a reluctance to become involved in the programme were overcome through honest, open discussion and the building of mutual trust between the partners on a basis of equality.

Contributions in cash and kind from the people were made possible by community development activities that generated income, produced food and improved the water supplies. The research and development work led to the issuing of guidelines on the training of dispensary staff and members of the community, and to the creation of strategies for expansion.

It is expected that during 1993 the whole catchment area of the Plassac dispensary, with approximately 20,000 people, will be covered. The increase in activities has required the dispensary to be upgraded to a community health centre with two or three beds for emergency cases.

It is worth noting that foreign input for community health development was limited and that financial resources were used as seed money or revolving funds for income-generating activities, cooperatives and the upgrading of the dispensary.

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Community health development involves interrelated activities aimed at raising health standards and the general quality of life. Rather than a large amount of capital or a highly developed technology, what is essential is persevering, honest, imaginative and intuitive leadership, fully committed and ready to make sacrifices. Community health development depends also on the people's desire and will to emerge from their predicament.
If community health development is managed well and the people are given adequate opportunity and encouragement to play an active role, it is to be expected that the entire cost will eventually be borne by the community itself.

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Shared power

Community participation has considerable potential to contribute to vector-borne disease control, especially to source reduction in urban areas and reduction of human-vector contact by adoption of personal protection measures or acceptance of antiparasitic or antivector measures. This can happen only when centralized programmes are willing to share their authority with the people.

True sustainable participation is possible only when the present trend of “top-down” planning is reversed to “bottom-up” planning and when decision-making power is handed over to the community. The basic requirement of community participation is that the people should be involved in conceiving, planning, implementing, and evaluating all developmental programmes.