Primary Health Care

A village seizes the reins of health care
Abdallah M. Mangoud

The setting-based approach to health promotion and education has been adopted in an Albanian village. The project requires a high degree of self-determination and self-help. External support comes from the International Islamic Relief Organization. Encouraging progress is being made as villagers acquire a wide range of skills, connected not only with the provision of care but also with such matters as fund-raising, health education and relations with public and private bodies.

There has recently been a widespread shift from problem-based to setting-based approaches to health promotion and health education. This change requires community participation, involving self-reliance and self-determination in each setting, together with the integration of health-related activities into everyday life and their linkage to local resources. Support from outside is mainly directed towards raising the competence of communities to deal with their health problems. The new approach falls within the scope of primary care, and the framework of health education is accommodated within the concept of health promotion.

On this basis the International Islamic Relief Organization decided to create a model health promotion project in an Albanian village. A team of experts on community work, supervised by the author, visited several villages and discussed problems and possible solutions with the inhabitants. The mass media were used to promote the project. Emphasis was placed on self-sufficiency and learning processes for people who became involved. No suggestion was made that there would be any financial rewards for the participants, whose only motivation was their desire to improve living conditions. Eventually the village of Bruxhall, 15 kilometres south of Tirana, was selected on the following grounds.

- The villagers and their leaders showed enthusiasm for the project.
- The village was readily accessible and close to Tirana.
- It had a population of approximately 2000 people.

**Mass meeting**

A week after the village had been selected the inhabitants attended a mass meeting at which they gave their views on needs and problems and apprised themselves of the commitments they would have to make in order to improve matters.

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Attention was drawn to the rationale of the project and to the need for self-reliance. The villagers were told that there would be adequate technical support, but no money was offered. The community participated in the process of deciding on objectives and devising a plan of action.

In order to motivate the villagers it was explained that the basic aim was to enable them to improve their living conditions by acquiring a range of skills, including that of soliciting support from their parliamentary representative, the local authorities and non-governmental organizations.

Voluntary village committees and working teams were established. The working teams, helped by experts, gathered information on problems and resources, answered questions, indicated the advantages of proposed courses of action, suggested how tasks should be allocated, and dealt with conflicts and anxieties.

**Initial survey**

The 284 houses in the village were numbered and a list of the families occupying them was obtained from the village chief. Random sampling was used to select 115 households for study, the female heads of which were interviewed by five women who had been trained in survey design, research methodology and community diagnosis. The two previously validated questionnaires employed in this process served to provide information on the social, personal and health characteristics of the respondents’ families and on their competence to cope with health problems. All written materials were in the local Albanian language. A reliability test on 10% of the completed questionnaires indicated 85% observer agreement. For the purposes of analysis, educational levels were categorized as primary, secondary, and college or higher.

It is intended to conduct a further survey on the same sample 12 months after intervention and to compare the results with those of the initial survey.

**Ranking of priorities**

Priorities were determined in accordance with the following criteria:

- probability of excellent results as judged by output analysis;
- effect on large segments of population rather than isolated individuals;
- prevention of future health problems;
- cost-effectiveness;
- fulfilment of perceived needs of the community;
- planning and implementation by the community.

The working teams called a second mass meeting after the survey, at which problems and solutions were discussed and priorities recommended, bearing in mind the resources that were available. The teams were then reorganized to deal with the interests and needs expressed and were charged with developing an operational programme.

**Intervention**

The community leaders and working teams created an intervention programme giving details of aims, indicators, criteria and instruments, and defining the roles of individuals.
and relationships with external agents. No ideas or values were imposed on the community, which, indeed, dismissed some proposed strategies as technically unworkable or culturally unacceptable. The representative of the International Islamic Relief Organization helped to accelerate the intervention process and generate confidence, enthusiasm and commitment, and motivated the villagers to address their health needs.

Workshops were held for community leaders and working teams. The educational levels of the participants varied widely. The community leaders’ workshop dealt with initiating, organizing, managing and evaluating community programmes. The workshops for the working teams focused on mother and child care, vaccination, antenatal care, the management of common diseases of childhood, oral rehydration therapy, common health problems, and personal hygiene.

The workshops were conducted in the primary care centre by the author and health personnel from the International Islamic Relief Organization. There were four subgroups, each guided by a facilitator. In order to stimulate participation, encourage group interaction and increase awareness, the participants were given an introductory computer course. Electronic and other media were used to present common health problems and ways of dealing with them. This led to suggestions from the participants on creating plays about maternal and child health. Opportunities thus arose for discussion to be initiated on causative factors, and for the facilitators to gain more insight into local concepts of health. Endemic goitre, childhood diarrhoea and insanitary refuse disposal were considered the principal health problems facing the community, and a special workshop on these matters was therefore organized.

**Outcome**

Although final evaluation must await the results of the second survey, an assessment can be made of progress so far achieved. The project is being monitored by the community health nurse, the community leaders and a representative from the International Islamic Relief Organization, and the researcher is making assessments four times a year.

The International Islamic Relief Organization provided training in the skills essential for running the programme. This included enabling the participants to:

- understand the links between problems and solutions;
- acquire the skills necessary for mobilizing internal and external support;
- deal with their own health problems and create self-help groups;
- help others with similar problems.

Some of the achievements resulting from this endeavour were as follows.

- Most villagers undertook to subscribe towards improvements in the local school.
- A room for oral rehydration therapy was made available with the community’s help.
- Health committees with responsibility for controlling endemic goitre and solving the refuse problem were established.
Special sites were built where refuse could be burnt.

The International Islamic Relief Organization helped the villagers to resolve conflicts and create alliances. On one occasion the Organization became involved in mediation when the villagers ran into difficulties with a nongovernmental organization which provided a school bus but refused to maintain it.

The Organization also helped the villagers to claim what was due to them from public bodies. This happened, for instance, in respect of drug provision for the local dispensary by the Ministry of Health.

The growth of ability and self-reliance in the working teams was easy to observe. The villagers learned how to supervise, organize and coordinate activities, and how to solicit support from nongovernmental organizations. They succeeded in raising the awareness of the health authorities about endemic goitre to the extent that the Ministry of Health and some nongovernmental organizations began collaborating to supply the community with iodine tablets and iodized salt.

A problem-based approach might have given the villagers some immediate material gains, but the setting-based, participatory approach holds out the prospect of lasting benefit as the community is enabled not only to provide some of its own health care but also to attract resources from external agencies or the government. The absence of a control village makes it difficult to interpret all the findings, but the villagers manifestly developed skills and self-reliance. They became able to supervise, organize and coordinate family health education, fund-raising and other vital work. They also learnt how to approach nongovernmental organizations and government bodies for support.

The community leaders involved in training schemes gained a greatly enhanced self-image and their understanding of health and health care increased enormously. Consequently they became valuable health resources. The villagers became aware of the problems affecting their community and of their own potential for self-help. The eventual success of the project is likely to be attributable in large measure to the active participatory approach and to the preparation of the community for involvement in planning. Promotional and educational programmes designed to encourage self-reliance and self-care within the primary care system were clearly effective. The full participation of villagers and their ability and willingness to assume responsibility for development can be expected to provide a sound basis for continuing improvement even after the departure of external agents.

Acknowledgements
The author is grateful to the International Islamic Relief Organization for financing the project described in the present article, to the Albanian Government for its cooperation, and to the people of Bruxhall for their participation. Professor Leo Baric of Salford University, England, kindly gave technical help and advice, while Professor Z. Sebai, Chairman, Department of Family and Community Medicine, King Faisal University, Saudi Arabia, lent encouragement and support. The author also thanks Mrs H. Ammar and Mrs S. Maryam for their editorial and secretarial assistance.