Community Development

Challenges in health development

Gunawan Nugroho, Rufino L. Macagba, George L. Dorros, & Allan Weinstock

Health development projects in Bolivia and Zimbabwe are described in order to illustrate that, in economically depressed areas, the integration of services within the health sector alone is not sufficient to obtain the desired results. Significant barriers to sustainable progress are inevitable unless there is functional coordination with other sectors.

Even where large amounts of financial and technical aid are provided, people involved in community or health development activities often find that their efforts fail to make an impact on the overall well-being of the communities they serve. If circumstances actually deteriorate, donor agencies and field workers get frustrated and discouraged.

Community development requires activities designed to create conditions that enable people to raise their quality of life. Health status is improved through the provision of adequate food, water and shelter as well as health services. In economically depressed areas the integration of services within the health sector alone is not sufficient to obtain the desired results. Significant barriers to sustainable health development are inevitable unless there is functional coordination with other sectors. In this connection the two case studies outlined below illustrate some of the problems that may be encountered.

Child survival

Food for the Hungry, a nongovernmental organization, undertook relief and development work in 1983 and 1984 during a severe drought on the Bolivian Altiplano. In 1988 this body began a four-year child survival project in the same region, funded by USAID. Its work was carried out at 4000–5000 m above sea level in the provinces of Oruro, Potosí and Potosí, where cold weather prevails for most of the year. The scattered population of some 32 500 Aymara and Quechua Indians was engaged in subsistence farming and the rearing of sheep, llamas and alpacas. Food production was inadequate and only 15% of the people had access to health services. Diarrhoeal and respiratory diseases accounted for more than 50% of infant deaths.

The aim of the project was to improve the quality of life of families in 134 communities, with particular attention to the reduction of infant and child mortality and morbidity. Among the key activities were:
- health and nutrition education;
- treatment of common diseases, including diarrhoea and acute respiratory infections;
- growth monitoring and management of malnutrition in children aged under two years;
- immunization;
- distribution of iodized salt to all families and of food supplements to children aged under six years.

Special attention was given to the encouragement of community participation. Project teams organized mothers' centres, and trained volunteer health promoters from these centres, and community health workers. Each centre had a rotating leadership and the following committees:

- a health committee responsible for follow-up visits to undernourished and sick children;
- a hygiene committee concerned with monitoring cleanliness in people's homes and in the centre itself;
- an education committee involved in teaching and review activities;
- a community gardens committee which gave advice on such matters as vegetable-growing in greenhouses and cereal cultivation.

A baseline survey in December 1988 indicated malnutrition in 19% of children aged under five years and in 22% of those aged under two. In the former category, 14% had experienced diarrhoea within two weeks before the survey and only 35% of those affected had been given oral rehydration therapy. Only 8.6% of children aged under two years had completed the standard immunization series. Among women of childbearing age, only 24% had received two or more doses of tetanus toxoid. Mothers reported that respiratory illness, fever, convulsions, vomiting and diarrhoea were common, and there was conspicuous iodine deficiency.

By the end of the project, 148 mothers' centres had been established, 469 health promoters had been trained, 3,937 mothers had been trained in child survival activities, and 187 community health workers were functioning. The incidence of diarrhoea in children aged under five years had fallen to 4.4%, and 98% of those affected had received oral rehydration therapy. The full immunization series had been given to 87% of children aged under two years. Between two and five doses of tetanus toxoid had been given to 90% of women of childbearing age. Iodized salt was being used by 90% of families, while 82% of children had health cards. Child-feeding practices had improved and a good understanding of health messages was evident.

The community health workers helped to create trust between the communities, the project staff and the local medical officer. Their motivation and their acceptance increased when they were provided with medicine kits containing a small number of essential drugs that could be sold at a profit.

Despite major efforts, however, the nutritional status of children was not raised. The malnutrition rate for children under five years of age declined from 19% to 17%, but that of children aged under two years increased from 22% to 24%. Furthermore, no effort was made to increase the production of staple crops, even though many wells were constructed, springs were utilized, and more than 1,000 greenhouses were built for vegetable cultivation. Better coordination between Food for the Hungry's departments and between the non-governmental organization and local government agencies would undoubtedly have improved matters.

**Community development**

From 1984 until 1991 the Ministry of Health and Child Welfare in Zimbabwe collaborated with WHO and the Danish International Development Agency with a view to strengthening the district health system in the Chipinge
District of Manicaland Province. Unfortunately, this project resulted in improved operations at only the district headquarters and the district hospital.

In 1992 a proposal for the integration of community health systems was adopted in the same district, the overall objective being to raise the economic and health status of the people through intersectoral action in partnership with the community. The Chinyamukwakwa Community of some 7700 people was targeted because of its impoverished status and the absence of other projects. Its health centre serves six villages, the most distant being over 13 km away. Most of the population is engaged in subsistence farming. Malaria and diarrhoeal diseases are endemic. During periods of drought, food aid is provided by the government to prevent severe malnutrition.

A baseline survey identified problems in housing, sanitation, water and food supplies, income generation and health status. The rural district council and the community jointly selected the following priority areas for action:

- malaria;
- income generation;
- basic health services and training in health care;
- improvement of agricultural practices;
- women’s literacy;
- assistance for orphans;
- improvement of water supplies;
- assistance from foreign donors.

Under the guidance of the rural district council, quarterly meetings were held in which village-level workers from different sectors examined progress and redefined priorities where necessary in the interest of improving intersectoral coordination. Simple epidemiological tools used by the district health system enabled the council’s intersectoral team to identify health and community development issues and their causal relationships.

In collaboration with women’s groups, an extension worker of the Ministry of National Affairs mobilized, coordinated and trained people to set up cooperatives rearing poultry and producing soap and other items. Proposals for such enterprises, accompanied by funds to cover a third of the projected outlay, are submitted to the community. On approval, WHO contributes the remaining two-thirds of the cost. So far the largest investment in any one project has been US$ 400. Some enterprises have been started by communities without assistance from donor agencies, although donors and nongovernmental organizations have built schools, sunk boreholes and provided cement for pit latrines. A community bank has been established. There is an understanding that, as far as possible, the project will be sustained jointly by the rural district council and the community when funds from the donor agencies run out.

On the negative side, there has been no training of traditional midwives and village community workers because of the unavailability of drug kits and growth monitoring scales. Adult literacy schemes could not commence because teachers were unwilling to work in the evening without financial reward.

Excessive staff turnover made the health sector relinquish its technical leadership, causing a breakdown in coordination. Trust between the partners in the project was shaken by broken promises relating to borehole maintenance, the provision of cement for toilets, and spraying against mosquitos.

**Sustainability**

The projects in Bolivia and Zimbabwe have not yet answered the main concern of the communities: how to survive when food, water and shelter are inadequate. In underprivileged communities, malnutrition and other major health problems cannot be tackled effectively unless attention is paid to family income, housing, water supply, sanitation, food, and environmental safety. Both projects do nevertheless provide valuable lessons for future acti-
vities. For one thing, they show that a monitoring system is necessary which links the community with its service providers so that progress can be assessed, emerging problems identified, priorities redefined and solutions devised in accordance with changing circumstances.

The health sector reform movement, driven by such principles as equity, decentralization, privatization, and quality of care, is being implemented as a top-down approach to achieving essential change. Community health development projects represent an important complementary bottom-up approach. They can flourish only when leadership is available to organize the community and, by establishing a shared vision, nurture the spirit of participation.

External resources obtained from donor agencies, nongovernmental organizations or governments are complementary to what communities provide. Initially, therefore, communities should be supported so as to enhance their capacities for organizing and managing their own projects. Together with their supporting partners they should identify the technical and other resources needed. Links and coordination between the supporting partners are vitally important from the outset.

The reorientation and training of service providers should be accompanied by changes of structure and operating procedures so as to support intersectoral coordination. Health centre staff should be allowed to plan and organize their work in order to collaborate with other sectors. The health sector should accept the leading role in intersectoral coordination rather than waiting for other sectors or district governments to take action.

In view of frequent staff turnover, declining budgets, and ill-prepared decentralization, district health systems may need to be strengthened by community development activities. It is important to try to retain the services of volunteer community health workers and low-paid government health personnel. Volunteers often gain social status from their activities, but it may also be helpful to provide other incentives if this can be done without disrupting the process of development. Community workers, for example, might be offered free medical care for themselves and their families, a uniform, or drugs that they can sell at a small profit. In the case of government staff the prospect of a career structure would be an inducement for them to remain in place.

Donor agencies and nongovernmental organizations should adjust their policies and procedures to match the processes of development in which they are involved. When development is continuous and a considerable amount of time is required before results become evident, these bodies have a moral obligation to maintain support at least until projects have become firmly established.

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