Primary Health Care

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How do health workers see community participation?

A survey of health workers in Rwanda suggested that they were somewhat reluctant to accept the involvement of lay people in the promotion and implementation of primary care programmes. Various obstacles to community participation were identified by the health workers, who, however, suggested general rather than specific remedies for the situation as they saw it.

The concept of community participation is widely used in primary health care programmes. In trying to define it one is faced with a range of interpretations that depend on the resultant or desired activities: ready responses to programmes and other measures intended to encourage initiatives; decision-making in programme implementation and evaluation; inspection of resources and rules (1). Obviously, the more a community participates the more its health workers have to share decision-making and responsibility with it. The community becomes an important partner of the health workers at every level. There is often an insufficient awareness of the change in outlook and the relinquishing of power which occur in this circumstance.

If new information fits in with what is already known, the network of conceptual relationships is enriched. If, on the other hand, new information conflicts with established ideas, it has a modifying effect or is modified itself so as to become acceptable. How health workers understand the concept of community participation is therefore important since they are the key intermediaries between the bodies influencing health policy and the target populations. They are the point at which instructions or suggestions are blocked or passed on.

In an attempt to throw light on these matters a questionnaire was distributed to the 30 health centres of the Butare Health Region in southern Rwanda; 29 replies were received, covering 23% of staff at the peripheral level.

Rwanda covers 26 338 km² and had a population of 7 200 000 in 1991, only 5% of

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which was in towns. Whereas most rural populations in Africa live in villages, the Rwandese are scattered in all parts of the territory except the nature reserves. The staff in the various public services rarely belong to the region where they work, and frequently change their duty stations.

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Community

For 40% of the health workers who replied the community was the target population of the health centre; 37% defined it as an organized group; 9% regarded it as the population of the commune; and 6% saw it as a particular cell. The remaining respondents offered a variety of definitions, among them “the population we try to organize so that it can take care of its health” and “people who work together”.

Priorities in community participation

The health workers were asked to categorize various aspects of community participation as very important, useful or useless. The order of priorities that emerged was as follows.

1. Identifying one’s own problems.
2. Paying for drugs.
3. Management by the community of its ambulance.
4. Choosing basic health workers.
5. Suggesting a health programme and helping with the evaluation of results.
6. Work on the environment.
7. Helping with management of the community health centre.
8. Maintenance of the health centre.
9. Suggesting better hours for consultations.

Reservations on community initiatives

In response to the question “Do you think it would be a good thing if the community took the initiative in health promotion activities?”, 83% of the health workers replied in the negative. The reasons given for this were as follows.

- The population did not have the ability to take the initiative in health promotion activities, because of ignorance, lack of qualifications, inadequate resources, and other factors.
- The community needed to be guided, motivated, trained, supported, informed and educated by the political, administrative and health care authorities.
- It was desirable for all health promotion activities to be the result of consultations involving health workers.

Obstacles and solutions

When asked about potential and actual obstacles to community participation, and about ways of dealing with them, almost all the health workers mentioned three general problems.

- Poverty and a lack of financial resources for drugs, treatment and environmental
improvement. It was suggested that people who could not pay for treatment or drugs should be helped through community action or the provision of credit.

- Ignorance about the value of participation and of health care in general, resulting, for example, in some patients giving drugs to members of their families.

- Taboos, customs and traditions producing resistance to change. Continuing education of all strata of the people through discussions and home visits was recommended by almost all respondents.

The following replies were more specific to the location.

- Reluctance to participate seemed to be due as much to mistrust and lack of cooperation within the community as to a disinclination to collaborate with the health centres. Some health workers said that the deteriorating economic situation made matters worse, since the prices of services were rising. Moreover, they varied from one centre to another. Volunteers were in short supply and there was a lack of continuity and coordination. It was proposed that specific examples should be explained so as to make people aware of the importance of collaboration and participation. Several respondents maintained that there was a role in this for basic health workers selected and trained by the health centres. One person considered that health workers should be held responsible for the actions of those to whom they delegated tasks.

- Some respondents felt that people were not at liberty to choose management committee representatives whom they could trust, and that some representatives were unsuitable. Furthermore, there was a lack of tradition and general knowledge about management for the common good. It was suggested that in-service training be provided for health workers and people's representatives.

- The tendency for patients to switch from one centre to another needed to be tackled by having uniform management systems.

- It was necessary to counter the expectation of receiving things free of charge from the state by promoting production units and individual responsibility for health.

A final group of replies focused on poor preparation of health workers and a negative attitude on the part of the authorities, and suggested education and in-service training as the solutions.

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It is not easy to assimilate the concept of community participation and put it into practice; success depends largely on personal perceptions. Community participation does not occur automatically: many obstacles have to be overcome.

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The survey showed that there was confusion about the word "community" and that most health workers were reluctant to consider a health promotion situation in which they would not hold the initiative and authority.
Strategy for acceptance and stimulation of community participation

Discussion, community meeting, committee meeting

Can we do things together to improve our daily life?

Yes

Create or improve conditions conducive to our health

Streams and drinking-water

An efficient health centre

Proper diet

Other

No

Individualism? Lack of trust?

Why?

Bad experience of cooperative action

Feeling of having been betrayed

Lack of motivation, traditions, customs

Have all the ideas expressed to be taken into consideration?

Yes

Are you ready to try again, with better supervision systems?

Yes

In which case the best results will come from involving those who attended the meeting

No

Why not?

No

Behavioural and sociocultural approaches: resistance to change, priorities, self-image, etc.

There was a notable tendency to underestimate people’s potential for action and reaction, and to insist on the need for a hierarchical structure. The actions proposed were all of a general kind, on education, training and promotion; no detailed picture emerged as to what should be done.

Two questions arise:

- How can people be taught to assimilate the concept of participation?
- How can people be led to participate?

In other words, “How can behaviour be changed?” and “How can a group of individuals be led to give their support?” Of course, there are no universal solutions; what is required is action and consideration in given cultural contexts. This implies a view of the promotion of community participation as requiring a specific type of knowledge and skill to be acquired or improved in local situations. Where necessary, encouragement should be given through special training, follow-up and continuing evaluation, along the lines of other public health activities.
The content of such training and the tools to be put at the disposal of health workers still have to be devised. In particular there has to be a search for and experimentation with operational strategies and indicators of participation that would allow the process to be pursued and influenced, as shown in the chart.

Reference


Rehydration therapy

The goal in managing dehydration caused by diarrhoea is to correct existing deficits of fluid and electrolytes rapidly and then to replace further losses as they occur until diarrhoea stops. ... Oral rehydration therapy is based on the principle that intestinal absorption of sodium (and thus of other electrolytes and water) is enhanced by the active absorption of certain food molecules such as glucose (which is derived from the breakdown of sucrose or cooked starches) or L-amino acids (which are derived from the breakdown of proteins and peptides). Fortunately, this process continues to function normally during secretory diarrhoea, whereas other pathways of intestinal absorption of sodium are impaired. ...

When a balanced isotonic solution of glucose and salt is given, glucose-linked sodium absorption occurs and this is accompanied by the absorption of water and other electrolytes. This process can correct existing deficits of water and electrolytes and replace further faecal losses in most patients with secretory diarrhoea, irrespective of the cause of diarrhoea or the age of the patient. ...

These principles have been applied to the development of a balanced mixture of glucose and electrolytes for use in treating and preventing dehydration, potassium depletion, and base deficit due to diarrhoea. To attain the latter two objectives, potassium and citrate (or bicarbonate) salts have been included, in addition to sodium chloride. This mixture of salts and glucose is termed oral rehydration salts (ORS); when ORS is dissolved in water, the mixture is called ORS solution.