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IMPLICATIONS FOR AN EXPANDED PROGRAMME OF IMMUNIZATION

by

Mr David Drucker
WHO Social Scientist
(SEARO)

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Mr David Drucker

COMMUNITY PARTICIPATION

IMPLICATIONS IN AN EXPANDED PROGRAMME OF IMMUNIZATION

The development of immunization has perhaps all the elements of a popular story to illustrate the classical concepts, methods, organisation and techniques of science. From the scientific point of view it is a success story:

- the identification of disease;
- the discovery of its etiology and transmission;
- the concept of biological attack and counter attack by anti-biotics;*
- the search for biological substances to induce the appropriate reactions and establishment of anti-bodies;
- the controlled tests and reduction of unwanted reaction and risk;
- the working out of dosages and schedules;
- the predictable resultant drop in infection;
- the mass production of serums and vaccines;
- the storage, packaging and use of technologies such as cold chains;

... and so on.

The message of such a story is the triumph of a particular mode and line of thought, and just now we are able to point with pride and growing confidence to a spectacular manifestation of this scientific approach in the case of the smallpox programme.

Although smallpox may be a special situation with the prospect of elimination of a disease from planet earth, it has given a boost to the determination to tackle other disease entitles and is perhaps one of the reasons why we are here now discussing an Expanded Programme of Immunization.

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* Linda Stone (US Education Foundation) in an informal presentation of her work on "Treatment of Illness in Rural Nepal" beautifully describes the contrast in verbal forms she found regarding sickness as expressed by the people in the village where she worked and western verbal forms. Thus, the Nepali statement was passive, impersonal: "A cut has happened to the hand" as opposed to "I have cut my hand". She says that Western forms talk in military terms: attacked by illness, invaded by bacteria, and medicine is seen as a counter - attack and implies control and containment of the destructive forces. Nepalis apparently use eating terminology: e.g.; heart attack is colloquially "heart eaten", etc. and connected to this terminology is the concept of imbalances in food between sour and sweet, hot and cold, etc., and also the warding off of evil (devouring?) spirits, or propitiating the good ones by offerings of food. In this way the words (imagery) we use, are connected with our conceptual perception both of problem and action.

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One sobering point to be made is that not all disease processes simply give up in the face of man's scientific intervention. Like man himself living organisms have a vigorous tendency to adapt and reappear, and we are also familiar with the way in which we may have produced new problems and even new diseases in our attempts to come to grips with our environment. An even more sobering discovery is that the great mass of ordinary people on our planet do not immediately understand and welcome our scientific approach and seem to have quite other modes of thought, explanations, ways of doing things, and quite different ideas regarding priorities both in values and behaviour.

Sometimes we dismiss their particular way of experiencing their world as "people don't know what's good for them". We perhaps really mean "people don't know what's good for them in our world".

Human behaviour holds more mysteries than our present scientific models can yet explain. Perhaps to our surprise we are up against the profound implications voiced in the words of SIGARIST* - a medical historian:

> "For a long time we concentrated our efforts on scientific research and assumed that application of results would take care of itself. It did not, and the technology of medicine has outrun its sociology".

It is the search for the effective application of one aspect of our highly sophisticated medical science that we are engaged in at this seminar.

We ourselves in the medical field have become increasingly uncomfortably aware of the fact that interlaced in our science is still an amorphous body of magical thinking and counter-productive, human organization. For example, we have found ourselves organized, however, unwittingly into an international tribal group largely concentrated in distinctive tribal areas which the WHO Director-General has described as "Disease Palaces", mainly urban based where people are seen in "clinics"** as "patients" despite the fact that the majority of those in urgent need of health care are not bedridden and who are becoming explosively impatient with the growing disparities between the resources available (not only of medical care but of all kinds) to an urban minority elite, compared to the rural and periurban majority poor.

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* SIGERIST, H. E.: "Civilization and Disease"
University of Chicago Press, 1962.

** Clinic is from the Latin, a bed, hospitals are often described in terms of so many beds, not in terms of people.

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Having introduced this discordant note regarding the social and political realities which will need much courageous and careful attention, let us acknowledge that an immunization programme does hold promise for an attack on disease and the maintenance of health which can benefit the mass of the people and that the implications of "expanded" suggests a determined reaching out to those not in the orbit of our present health services.

This is an important factor for however successful we might be in launching programmes of a categorical kind (as in smallpox), where on-going maintenance of programme is required (as in immunization generally and poliomyelitis especially) we cannot reasonably plan to set up and continue a long-term and on-going programme unless it is part of a package of general health care service. Where a lively programme of health care presently exists the establishment and maintenance of an immunization programme poses no great problem. The difficulty comes in expanding services to the communities where effective service does not yet exist, and this objective is currently being voiced as a medical, social and political priority. At the moment the movement towards providing a system of caring to the multitudes who are not served, is through the medium of Primary Health Care. A vital element of Primary Health Care which we are beginning to articulate is community participation. Community Participation does not mean mere acceptance of programme by the community - a passive nod of acquiescence. "Utilizing the Community" is often the phrase we use which gives a clue to what we really have in mind - an attitude and stance in which they (the community) help us the professionals to do the work which we know best needs to be done and is an extension of our programme. Not just philosophically but technically we begin to see that this does not work, at least it does not work over a long period and in a way which can be successfully managed. At best communities approached in this way are reactive to our activity, as long as the activity lasts and is energetic enough, but they do not take initiatives and become self-sustaining with an innovative spontaneity, and any slump in our input results in a moribund programme. What is emerging is a different view of community participation. According to this view true participation takes place when the programmes are known to be, seen to be, and are felt to be meeting the communities' own needs and priorities and where they can utilize us for their own purposes.

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Such an approach requires us to develop mechanisms and processes by which at the grass-root communities are stimulated to:

- collect their own information;
- consider their own problems and needs;
- rank their own priorities;
- appropriately call upon expertise in examining their needs and in outlining available technical possibilities and solutions;
- weigh the various ways and resources for meeting their needs;
- detail their own contribution and implementation activity;
- apportion responsibility; and
- manage and monitor <u>their own efforts</u>.

This view envisages those responsible for planning health services as sensitively responding to community expressed needs and our beginning to think of designing public services utilized by the community according to the community's wishes.

It implies too, placing expertise <u>on tap</u> rather than on <u>top</u> and deliberately setting out to encourage the local community in decision-making and activity according to its proper capacity. This capacity is latent but can clearly be unleashed and here perhaps is the focus for a new style health educator.

The health educator will need to turn attention to the how, of community (village?) level planning, and be ready with suggesting practical processes adapted to the present traditions of the community (but with a concommitant adaptation of the community to create new traditions). Once the idea, the need, the determination, and the tools for action are engendered in the community, the more familiar context of present day health education will fall properly into place, and into a context where it can be more readily absorbed and acted upon.

What all this amounts to is the institutionalization of a vigorous element of "bottom-up" planning to add to our usual "top-down" and requires effective mechanisms for community (village) level planning, affording a <u>real</u> and <u>respected</u> voice in decision-making to the community along with a practical responsibility in the control of operation and implementation. Such an approach is profound and fundamental. It has enormous potential as a driving force not just for health, but for the whole range of developmental activity. The sooner we recognize that in practice at the field level <u>all</u> our best laid development programmes run into similar difficulties because of the inadequacy of community participation mechanisms - the sooner

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we will find a common focus for activity leading to truly integrated intersectoral programmes where it is needed most - at the operational level.

You may well be thinking that this is all very fine but isn't it a bit "far-out" from the centre of our attention - Immunization Programmes? The answer is that the matter of starting an immunization programme is relatively easy, to maintain it successfully takes us into the wider considerations presented here.

You may well feel - yes, but we can't wait for such elaborate development - maybe not, but perhaps the health sector could lead the way joining up with those already engaged in the beginnings of community development processes. Unless our immunization is based on really solid foundations there can be a serious collapse of programme and a powerful backlash. We need to ponder the warning:

> "In developing countries mass immunization may jeopardize its long-range impact if it gets too far ahead of other health services.*"

So far we have been discussing structure and mechanisms but underlying all this is a matter of attitudes - a matter of mutual trust - the kind of trust leading to a mutually satisfying working relationship between lay people and the technically and professionally skilled. Because in many developing countries the technical and professional health personnel are government officials it also raises attitudes related to the co-partnership we need, between government and governed.

This is no simple matter, there is a huge documentation and solid pragmatic experience showing that the trust of the common people for officials leaves much to be desired.

The fact is that nearly all our health workers right along the line tend to be hospital/office/authority oriented rather than people/village oriented. The problems of "social distance" in relationships, as intimate as matters of health care, are well known.

Officials dress differently, talk differently, and live differently from villagers and the poor. Health posts I have seen are often securely fenced from the community, and commonly located in government - (used in the possessive) - government compounds embellished with much intimidating paraphernalia of authority, and however politely expressed people have traditionally experienced "government as an institution which will take but not give;

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* Carl E. Taylor: "Gainning Public Acceptance and Maintaining Regular Programmes in the Developing Countries".

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orders but does not discuss". Observers suggest that such social distance is a major factor in why "quacks" flourish. The "quacks" seem to have gained the confidence of people by living with them, sharing with them, visiting them, wearing the same clothes, are their neighbours and kin who operate in the common meeting and market places.

It is well stated that "Medicine involves not just what a man knows but what he is." It is a matter of reputation and subjective confidence in person which is not necessarily directly related to the objective effectiveness of remedies. In this regard we should note:

> "Sometimes immunization programmes ..... are quietly sabotaged by local indigenous practioners ..... (they) ..... make powerful adversaries because they work naturally within the belief system, knowing what will be most damaging to popular cooperation. A logical countermeasure is to try and recruit them into the programme.*"

A famous malariologist is quoted as saying, "If you want to control mosquitoes, you must learn to think like a mosquito." Benjamin D. Paul rephrases it, "If you wish to help a community, improve its health. You must learn to think like the people of that community.**" And, to a great extent, this is what the indigenous healers do and we must become skilled in doing, also.

Ancient medicine is rooted in religion, in magical thinking, in superstition, but also in caring. In practice modern medicine has inherited this mantle notwithstanding its scientific base. Some modern practitioners in the region have embraced the pharmacopoeia of Western medicine along with more ancient remedies and have played down examination and etiology in deference to symptoms and their relief.***

This somewhat matches popular systems of belief, for it is an interesting phenomenon that modern medicines are increasingly appreciated even by those most tradition bound. This does not mean that they understand

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* Carl E. Taylor. Ibid.

** Paul Benjamin D.: "Health Culture and Community", Russel Sage Foundation, New York.

*** Riley, N. E. and Santhat Sermsri: The Variegated Thai Medical System as a Context for Birth Control Services, Mahidol University, Bangkok, 1974.

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or care about the underlying scientific method and and philosophy, but that something of what they observe is readily accommodated in their own world view with their own concepts of cause and effect - a preference is expressed for "strong" medicines.* Strong medicines clearly demonstrate the magical properties at work drawn upon through the personal attributes of the healer which enable him to mediate with the demonic and good powers on behalf of his client.

Lest we are irritated by this confusion of ideas we must note that not merely in our more primitive and remote rural areas but even among sophisticated people in cities it is common for traditional and modern systems of medicine (not to mention "quackery") to be utilized side by side.**

A very popular "magic" resorted to widely by those without any grasp of modern medical theory and practice is injections.*** Despite the widespread embargo upon non-qualified persons giving injections (any extension of qualification to others than fully-trained doctors is usually vigorously fought by the medical profession) the fact is that injections

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* It is a practice of some L.D.'s to give clients large injections of a calcium solution because it gives an immediate sensation of dizziness and hot flushes, thus inspiring confidence in the treatment, and is considered by these practitioners to be harmless... "
Boesch, Ernst E.: Communication between Doctors and Patients in Thailand, University of the Saar, 1972.

** "The trainers who were involved in the training programme are well educated, have years of experience and have all lived in Kathmandu for many years. They have taught Child Care, Nutrition, Public Health and so on. It was of interest to note that as we began to talk of Jhakri, Lama, Dhai, etc., the trainers themselves began to relate their own, and their own families' dealings with such persons here in the capital city. At times during the discussion they laughed a little embarassedly but generally told how ailments (some very serious) had been cured which modern doctors either would not or in some cases had tried and failed to cure. Indeed when the writer's children 'fell' sick, a trainer offered the assistance of an indigenous healer (it is clear that despite the Western veneer, the two 'cultures' of sickness and treatment reside side by side without much conflict in the mind or certainly in behaviour)."
Drucker D.: Mantras and Medicine for Development, Mobile Training Scheme, Nepal, 1975.

*** Riley, N. E. and Santhat Sermsri report: "It is common for a client to introduce himself to a Moo (doctor) by saying, "I think I need an injection."

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are generally popular and administered privately by many paramedicals as well as by non-scientifically oriented persons. Interestingly it has been noted that it is difficult to find examples of substances other than those approved by modern medicine being injected by non-medical persons.* Clearly the effective (magical?) qualities of modern medicine are appreciated by the public at large.

The implications for an expanded programme of immunization are interesting. Innoculations are generally well received, but although this strong medicines might be acceptable when pa tients are sick and under stress, which may have even projected them through the many social barriers to present themselves to the institutions where modern medicine is available** - immunization does not ordinarily meet these conditions. Immunization is distinctly preventive in nature and (except in conditions of fear produced by an obvious epidemic) far removed from a sense of priority, necessity or timeliness, and to promote these will require some kind of understanding of why you do something at a particular time in order to ward off consequences in the future.

Of course, protective rituals are common in society and it certainly must be possible to introduce immunization as part of already accepted ceremonial - such as the feast for the naming of infants or other such occasions where rites of passage are observed. However such an introduction requires a careful dovetailing of technical input into a well-appreciated cultural pattern and the mutual trust of service and community.

There is much to be said on the implications of "thinking like the community" but we need not overstate the position in this paper, the important point is that we must use our understanding and empathy to vigorously induce a process of securing mutual trust between those who count and those who are usually just counted.

We have discussed here broad areas towards a community participation approach, its establishment will mean radical change in our thinking, attitudes, skills, and in our administrative structures, but can we really expect communities to respond and especially in the field of immunization?

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* The opposite is common, i.e. modern substances being used in an ancient manner. It has been privately reported by a colleague that acquipuncture points have been the preferred location for injection of anti-biotics.

** These barriers are considerable and have merely been touched upon earlier in this paper.

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It might interest you to know, that recently in the region, the question put to 119 village leaders to list "the 5 essential health needs in your area" that immunization came top of the list. 116 of the 119 thought their community was "ready to accept an immunization programme". Finally leaving aside the broader framework, just to mention simple aspects of community involvement. In one country in the region we found a situation in which an elaborate system of supervision (and supervision of supervisors) had been devised to control a small army of vaccinators - the vaccinators stencilled the date of their visits on the walls of the villages, so that the supervisor could check that they had been. However, the village people themselves had no way of knowing when or where the vaccinators would come. There is no reason why a village which has been properly consulted and has expressed its accord on the desirability and need for immunization should not do some planning and be able to run its own publicity; arrange for people to present themselves at a determined time and place; and for the village to keep their own set of records so that they can effectively know who is and who is not protected, who to encourage to get protection and which and when villagers are due for boosters or reimmunization according to the appropriate schedule. If our technology is good enough the community may with help even handle the simple skills of administering the immunizations. There are examples in the region where volunteers systematically staff health posts and centres and do just this kind of work. It illustrates in a small way the vitalizing condition in which we are not doing for them but they are seeing to it that they utilize to the full whatever technical service is available to us.

We have only outlined a community approach in this paper, the dimensions of such an approach can be further explored in our discussion groups, but the real work remains to be done, when you return home, with the immunologist, planners and policy makers. We hope at least that this paper will have pointed a way, given us the impetus and the will to start.