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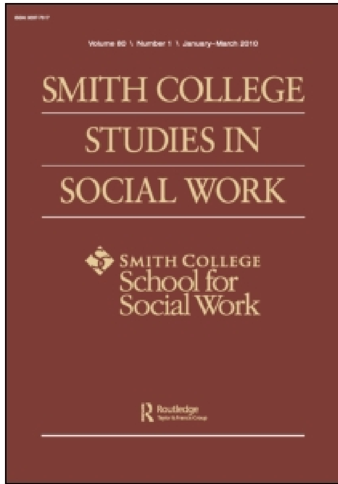

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Ask a Silly Question, Get a Silly Answer: Community Participation, Entry Points and the Demystification of Planning

David Drucker

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ABSTRACT. Careful attention is required to one's entry into community development work. The formation and continued support of genuinely participatory working relationships are essential. These must be given the time and creation of trust to establish and be tested. This requires making sure that the needs of the community (as they see them) are sensitively regarded and integrated within the action plan that they have helped to create, along with the skills and whatever the person(s) bringing development assistance services can realistically contribute. This ought to be obvious, but in practice many things frequently seem to be missed and can go wrong, especially when people cross cultures from the West and enter a Third World situation to "help." This article identifies and gives illustrations (some of which engage children) of some important fine points of the participatory process, providing some flesh to the bones of our social work development values and theory. doi:10.1300/J497v77n04_04 *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2007 by The Haworth Press. All rights reserved.]*

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PROLOGUE

When I was a very small boy I lived in a slum area of London. A charitable organisation provided poor children with a two-week respite in the fresh air away from the squalid streets of the city, and away I went to the seashore. The flat open green country was rimmed with sand dunes and we ran through the salt-damp defiles and sweet-smelling grasses to the long isolated beach. Barefoot in the loose sand I trod upon a half-hidden broken bottle. The towel hastily wrapped around my damaged foot was soon soggy with blood.

My small companions went for help and returned with a distinguished-looking gentleman whom, I discovered later, they had found at the famous golf course nearby. He hauled me upon his shoulders and set off along a path towards the town, the red towel flapping like a danger signal. He asked me my name and whether I knew the names of the wild flowers in the hedgerows, which I did not, and then proceeded to tell me; "ragwort" still sticks in my mind. He then asked: "What kind of car would you like to take you to the doctor?"

My experience of cars was very limited. There had been a taxicab driven by my cousin, and a commercial traveller uncle had also given me rides as a special treat in his 1930 Morris. However, despite my not really caring about cars, especially at that moment, with my crimson swathed foot painfully throbbing, having been asked, I had no hesitation in replying to my benefactor: "I would like a Rolls Royce." The odd part of this story is that my demand was precisely matched by the actual arrival of a Rolls Royce and chauffeur, and for some days after I had been stitched and bandaged the Rolls would call for me and I was driven in splendour on a daily tour of the countryside with my leg propped up on a cushion.

Some time later newspaper men came, took my picture, and there was a long story printed of how the Chancellor of the Exchequer (no less), despite wrestling with tough budgetary matters in times of depression, had had time to perform an act of kindness for a ragged child in need. The journalists were particularly interested in why a Rolls Royce? I did not say so then, but one of the morals of this story is: Ask a silly question, get a silly answer.

Now, almost fifty years later, I find myself wandering back to that early notoriety as I sit at international meetings and listen to what is being said about "community participation" and "entry points" and "primary health care," and hear sceptics reiterate the wisdom that if you ask village people what they want, they will answer: "A ten-story fully

equipped hospital." It is their version of my Rolls Royce, and is supposed to illustrate how expectation of realistic participation by the community in planning projects is unrealisable.

Participation Is Partnership

The fact is that "participation" is fundamentally an act of mutually respecting *partnership.* Partnerships take time and effort to establish and can only succeed and continue to flourish where there is mutual *trust*. Trust is not too easy to come by; it has to be solicited, worked for, have exaggerated demands made upon it at first–so testing its reality and solidarity–and it must be gradually earned and given life. Ever since nomadic man discovered the connection between sowing and reaping, and the advantages of fixed settlements, he has had to defend himself from predators. There is little experience among those engaged in agriculture of anyone coming from outside other than to further *their own* interests, to exploit and often to plunder. Rural people know this in their very bones, and the assurances of those of us who speak the words of development and control, or represent the organisations of modern nation-states, have rarely been followed by sustained action to convince rural communities that anything has yet, or will, change in this respect.

Suspicion, caution, apathy, obsequious acquiescence are very common responses, and are the hostile mechanisms of defence which meet officials and status-bearing visitors to the villages. Naturally, curiosity sometimes overtakes anxiety, especially among the children, and hospitality is often used to contain, disarm, and control real penetration from outside. This is often, of course, experienced pleasurably by short-stay visitors, but as the saying goes: "The back of the head of the departing guest is beautiful."

In any event, real partnership has to be proffered, accepted and focussed upon jointly advantageous activities and goals. It is a matter of relationships, and, to be successful, relationships must be felt through and must develop their own particular pace and rhythm with an ebb and flow which lead the growth. Who the partners *are*, how they are introduced, how they perceive each other, and the nature of the process of agreeing on tasks to be undertaken and goals to be achieved are all-important.

Of course "my" Chancellor of the Exchequer was not acting in any official capacity; he was a kindly, helpful adult, and was perceived as such at that moment. Although used to esteem and authority, now relaxing at his club away from his cares of office, he was responding to the

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human urgency of the children's voices seeking help. He saw the task in hand clearly, as did I, the injured child. He conveyed his sense of what needed to be done; his calm, his smell which was good and clean, and the strength felt in the contact with his body were reassuring to his partner in this circumscribed drama. His question about the flowers opened up some distance between us; flowers for slum-dwellers were of little consequence (culturally, lilies for funerals, carnations in buttonholes for weddings) but one condescendingly forgave him–he was doing his best to be friendly and to distract attention from the bloody towel. His back was carrying me loftily in the right direction for both our purposes; a barrow from the local market would have been perfectly acceptable if it was far to go and he grew tired.

The question of the kind of car was unexpected, strange, and even exotic. It was beyond expectation or need, in fact, *silly*. However, he having raised the possibility of unreality, why not the best that unreality could provide? Extravagance seemed called for in such an expansive redefining of purpose. He wanted to be generous and grand; why not help him, and put him to the test–the test of credibility. But an important new element had been introduced by the question. We were no longer focussed on the joint task in hand (getting to the doctor) which had been the action basis for our relationship. He had sounded an unreal note and to me his motives were now somewhat suspect. Of course the sequel confused me, but unconsciously I was the product of my background. That background was expressed significantly later by my neighbours back home, who commented darkly that "with elections coming up, the publicity had probably been worth a few votes."

It seems to me in a similar way that we who aim to promote development, although with the best intentions, sometimes fail to make real contact with those to be developed and thereby create donor-dependency relationships. True *partnership* is what is required, and this demands new directions, new skills, new activities, and new roles if the age-old fixed expectations and patterns of interlocking behaviour are not to frustrate the new aspirations of development.

This is not just rhetoric. Let me give a simple example of what is involved in practical terms.

Experts and Experts

The Jeep carrying the local medical officer bumps into a fairly isolated village, and while I am talking to the village midwife, three or four hundred children, some carrying smaller ones, come to stare at me, the

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foreigner. I notice the doctor goes among the children looking at their arms. I ask him what he is doing and he tells me that he is taking this opportunity to check the smallpox immunisation status of the children by looking for scars on their arms. "How long will it take you?" I ask. "Perhaps 45 minutes," he says, "but it is worth taking the time since we are here."

I persuade him to ask the children themselves, each to look at the child next to them, and if there is no scar to hold up the arm. Two false starts, while explanation is clarified and by now 450 children perhaps, with a buzz of curiosity and excitement inspect each other. I say to the doctor: "From the beginning to end this activity took 4 minutes, and now we have the 40 minutes saved to tell why we are looking, why it is important, and anything else you think needs to be done." I add: "None of these children have had any special education or spent seven years at medical school. Yet they are the experts–experts at standing next to other children and inspecting their arms." This is the right kind of *partnership*–each bringing his own expertise. In this case the lay child and the medical man focussed on a simple activity and purpose, but of real significance. What has happened is that the doctor has redefined his role and theirs. He has acted differently from what is familiar and expected in the doctor/patient relationship, and the children *have reciprocally* acted differently also. He has launched a short but important step towards community participation. This is a very simple example, but it is not quite as easy as one might think to disconnect people from time-honoured expectations and behaviour and to alter roles and maintain new ones.

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More Child Expertise–Surveillance

Perhaps you are familiar with the easily made three coloured tapes for measuring the mid-arm circumference of one-to-five year old children. The gradations give a quick guide to the nutritional status of children (malnutrition not just from lack of food, but more commonly from endemic parasites and poor feeding habits). A child with a large mid-arm measurement (green) is fine, one with a middle measurement (yellow) is at risk, and one with a small measurement (red) is in very poor condition. I carry around a bundle of these tapes in my pocket when I visit a village. In the teahouse children come to stare at the stranger. I take out a tape and play with it for a while. As the children become curious with my "toy," I beckon to the boldest, measure his arm and show him how to do it. I suggest a small prize for any under

five-year old "yellow" children he can bring me, and something a little more special for a "red." Other children are eager to join in the game, and scatter through the village. One humorist wants to measure me and needs two tapes together. We all laugh as I pat my belly and emphasise how big and fat I am, but we agree that as I am older than five years, perhaps my arm measure doesn't really count.

The fact is that in rural areas, especially where the village is scattered, the *experts* in knowing where all the under-fives are to be found are the *children*. They could be important in ensuring coverage for the care of infants, and also for example in locating the mothers who might be most promising for family planning, etc. With a little organisation, preferably as a game, children (and usually there are many of them) can be mobilised to undertake all kinds of development tasks, including these types of surveillance. What is more, they can do it at a fraction of the time and expense that any health personnel could manage.

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Control Is Not Partnership

Fascinatingly enough, I have found that health workers find it extremely difficult to initiate such approaches and clearly seem to be threatened by giving up their control over such procedures. Over and over again I see trained personnel taking away the tapes from the children and insisting upon doing the measuring themselves ("properly!") The same holds true for weighing, height-taking and so on, which with a little guidance (health education?) mothers could organise and do for themselves, rather than (as is commonly the case) reluctant, sometimes screaming babies and infants being pried from their mothers so that the nurse can take charge of the situation. The nurse then enters the result on what to the mother and the village must seem like a secret and mysterious document (the Health Chart) which emphasises the nurse's power.

It is fundamentally embedded in the medical ethic that this dependency and passive role be assigned to the community, which is required to be *patient* in the face of health expertise, which somehow meets the health worker's need to control and be the active partner. It is of utmost importance in understanding how to "enter" and establish "participation," to recognise that this controlling/patient relationship is very much counter to the principles of community development and to the need for community self-determination, where active initiatives and perhaps impatience are more appropriate.

Experts In Walking

Another example is that of the immunisation workers who, I discovered, carry a 48-hour supply of vaccines in vacuum flasks and spend a very large proportion of their time walking to and from remote villages to a central cold-chain pick-up point in the area. The community could easily be organised so that it is responsible for assigning a reliable person to do the walking to the market town where the cold chain is situated. Shopping and the collection of the vaccine flask could be combined and would only need to be done perhaps once in three months. The trained health worker would then merely need to travel straight from village to village instead of walking repeatedly to the town, and would be assured of a fresh vaccine supply relayed to each village along his or her way. It might also happen that the community having understood (health education!) the need for taking such responsibility, they would make sure that their members were assembled for vaccination, as one of their own people had travelled a long way on their behalf. At present the health worker's programme time-table is poorly adhered to and many workers arrive when convenient mainly to themselves; if the communities are eager for vaccination or other help, the implication is that *they* had better quickly pass the word around that the worker has come and that they must hustle before he/she takes off again. There seems to be a real resistance by health workers to solicit more effective partnerships with the community. This appears to have roots in the health worker's reluctance to place control (and possibly justifiable grounds for recrimination) in the hands of the community, which the community might exercise if the worker did not fulfil his/her part of the bargain by actually turning up as agreed.

Once we begin to look for these invidious types of behaviour, which will certainly undermine all attempts to promote participation, we will find them everywhere. Controlling behaviour by professionals is almost a basic element in our present social structure. Although the health field provides telling examples, the problem is widespread.

Entry Points as Abstract Strategy

The notion of "entry points" is sometimes evoked as a round-about way for health programmes to quietly penetrate communities when they are looking another way, so to speak. The entry point idea is often approached in terms of generalisations such as School Teachers, or Monks and Priests, or Agricultural Extension Workers, or Postmasters, and so

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on, ". . . they have easy access to communities and are respected by them. They are familiar with the local ways and can exercise the leadership required."

There is an attractiveness about identifying such groups, which lend themselves to neat bureaucratic classification and conjure up an image of homogenous simple administrative entities which can be "trained" to perform various tasks and functions.

Unfortunately, although within each of these groups there are *individuals* who have the interest, personality and capacity for development work, the inherent effectiveness of the group as a whole for any such activity is not borne out from experience. Indeed, we often find that many do not carry out their own official and specific tasks satisfactorily. Adding more and quite different responsibilities will provide little to resolve our "entry points" problems. Worse, because of their professional or officious manner and "distance," they already have "entry" problems of their own. Their acceptance by communities often proves illusory, especially if they are expected to bring about change.

There is much to be said in this respect about the whole idea of communities as entities which can be "entered." On the inside of communities things look very different from our comfortable idea of them from outside. They too, like us developers, are made up of sub-groups. They may unite for some things but are divisive on much else. Even when there are not the usual conditions of chronic not-enough-to-go-round, there is frequently profound exploitation within communities as well. The changes intended by development programmers can often be nullified by the internal conflicts, and the "rewards" of development "captured" and so intensify the gap between the grass root "haves" and "have-nots." It is not unusual for those released from exploitation to become exploiters in their turn.

Entry Points as Human Relationships

All these difficulties have to be faced and dealt with and require careful, patient, dedicated, skilled on-going work applied over a long period of time. I know a particular group of outstanding religious workers who for over *twenty-five years* painstakingly earned the trust and partnership of a community by championing the toddy palm climbers when their livelihood was threatened, organised girls into gainfully employed net makers, improved fishing boats, released generation-to-generation debtors into self-sufficient co-operatives, protected and organised labour for public irrigation work, dealt with land reform issues and much

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else before organising for health care could become an agenda item and, after much work, a reality. Even so, as the original workers grow old, real partnership and community self-determination are still far from unequivocally secured. The struggle to control re-surfaces in different guises and requires vigilance and continuity.

What is being argued here is that "entry points" cannot be conceived in static terms of uniformity and administrative neatness, but that we must concentrate upon the importance of persons, personal attributes and the capacity to learn to use self in positive and effective ways in working *with* communities.

This takes us back to the issue of relationships and partnership. An insensitive worker, whatever the source of his contact with the community, can destroy in a mere gesture all that a benign government may have intended in its legislation, plans, programming, and allocation of resources. It becomes necessary to translate all our aspirations for change, social justice, health for all, drinking water, adequate sanitation and much else into the very way in which front-line face-to-face staff *behave* consciously and unconsciously in their daily transactions with communities.

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Professionals Locked Into Their "Culture"

One of the problem areas (as has been illustrated) is related to the way in which our present trained worker has come to perceive his/her superior education and status in relation to the community. Unfortunately most of our training programmes and certainly our higher level educational institutions have grown up unwittingly in urban elitist traditions. For example, in some attempts to provide rural-based training for medical students, the fact is that neither the doctors under training nor the centres in which the training takes place in any way seem to have accommodated their knowledge or their "style" (bedside- or city clinic-manner) to the conditions of village life. The whole atmosphere is usually strikingly doctor-centred rather than patient-centred, let alone community-centred. In a very compelling sense the "institutional" ambience and the relationships set up in the rural centres are indistinguishable from those in the crowded clinics in the towns. The villagers can either take it or leave it. Many studies tell us that a large proportion leave it and the main reason is the "uncordial behaviour of the staff."

In the context of Primary Health Care, with its accent on health rather than disease, on the unreached rural masses rather than the urban elites, and on active community participation rather than passive patient ac-

ceptance, the time has come for restructuring our institutions, and the style and relationship they impose upon the medical professional and those whom it serves. Much exploration is called for if this is to be achieved.

We need to explore ways of providing practical examples of community-focused work and behaviour, and of building these into new teaching and training programmes. This practice and the teaching it engenders will have to mutually reinforce the new participatory skills, and must also be reflected in changing the very arrangements, organisations and institutions which encompass such activity.

This must happen in the long run, but in the meantime some progress has been made in these directions. Here is one approach.

Turning Around to Face the Community

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This approach grew from the experiences of a medical team in India which unrolled a mat on the steps of a temple in view of the whole community; the doctors and health workers were encouraged to literally turn around from facing a patient to facing the community. Such an unusual event brought about a swift assemblage of village people.

Usually the doctor addressed the patient (or a separate organ or part of a patient) on a one-to-one basis. His behaviour was mysterious to the one being questioned, examined, treated, and directed. Often such a procedure ended with a symbolic piece of paper which might produce (at a price and if it was conveniently available) an unknown substance endowed with potent properties.

Now, instead of the doctor being hidden from the crowd which is held back to give the doctor his own hallowed and sheltered space in which to do his secretive work, the doctor gives a public performance; the crowd becomes the prime target for the health team. The doctor acts as a group leader, encouraging the "audience" to become participatory members in a joint activity.

In this participatory approach, patients (especially those suffering from common ailments such as scabies, wounds, diarrhoea, etc.) are drawn from the audience and the professional examines the patient in full view, explaining to the audience as he does so, in very simple and appropriate language, what is being done and what are the signs and symptoms. The questions to the patient and his replies, along with the whole procedure, are conducted in the nature of a public case-conference discussion, in terminology that the villagers are helped to understand.

A simple explanation of the problem is given, followed by appropriate information regarding how such conditions come about and what action can be taken to prevent or minimise them. The treatment and management of the condition is carefully explained. The *preventive* aspects are emphasised. The audience is then asked if there are others among them who have similar complaints to come forward. The professional briefly examines them and where there is some doubt, separates them for more extensive examination. He puts in a group all the patients who he confirms have correctly identified themselves as having problems similar to those of the demonstrated case.

Emergence and Training of Community Health Workers

As small groups are formed in this way, another assigned member of the team can reinforce the health messages and instructions. Treatment can then be communally provided and regimes and management reviewed in detail, with demonstrations as appropriate. For example, cleansing of wounds, the boiling of water, preparation of dressings, etc. can be followed and practised by those accompanying the patient or by one patient assisting another. Questions will be invited and answered. Volunteers can be called upon from each group to act as permanent focal points in the community for specific symptoms and conditions.

To begin with, simple single tasks should be undertaken by those wishing to volunteer. There is an advantage to having the volunteers and training in pairs. Alright, it is agreed that you become the Scabies Ladies. We will train you. Here is the lotion your village will need. Let's review and write down all the things you have to do. (The writing down will constitute a "How to Deal with Scabies" guide). Everyone must hear that you can help when this problem happens. We will teach you to look out for conditions which can be mistaken for scabies and for which different help should be sought, etc.

The same can be done for diarrhoea and the serious threat dehydration poses. So you will be the diarrhoea worker? Everyone must know that you can help when this trouble occurs. We will train you. This is what you must look for . . . what you must do . . . here are your "tools" and medicines . . . Let's review and write down ("How to Deal with Diarrhoea Guide").

In this way the villagers see exactly how their own village-based worker becomes an obvious asset, and they can see the nature and content of the training, so that they too understand it, can support the volun-

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teer and minimise the mystery and superiority arising from it (good health education!).

Of course not all patients need or should be dealt with in this way, although this should be the major "visible" style of practice. It appeals to the curiosity and even to the entertainment qualities of village life and plays down the mystification and "confidentiality" of Western middle-class medical ethics. Even so, in accordance with village values, one is careful to avoid public display of matters which may affect social life chances, such as acceptability in marriage and so on. A village-oriented health worker should soon become sensitive to what these special matters are.

Too many programmes introduce Primary Health Care as an organisational activity and neglect the element of village people being actively introduced to an understanding of the whys and wherefores of Primary Health Care and the value of village health workers. Selection of workers is commonly precipitous and somewhat arbitrary, and is influenced by who is well-connected rather than he who connects well. In one project, I know that a period of nine months passed with profit before the need and value of a Primary Health Care worker was understood and a worker was satisfactorily selected. The pressure to fill training places at a time determined by remote administrative convenience, rather than determined by a community's readiness, is to be avoided. Training of such workers should be on an item-by-item basis which meets a need clearly recognised by the community, and in which the worker can demonstrate his utility and skill before responsibilities are increasingly piled upon him. Often community health workers are trained extensively in a bit of everything at once. Then the training investment becomes a heavy loss if they drop out. The training and responsibilities should be cumulative.

Of course properly oriented and experienced practitioners will have to pioneer the way of performing this group approach, but standards can soon be set for trainees to emulate and meet. These standards can be achieved by having a trainee assigned to conduct a session or part of a session of this kind. He/she is easily observed by peers, and an analysis and discussion of the trainee's performance and presentation can take place after every session. This way he/she will be helped to learn and practice the skills of a village-side manner rather than the usual bedside manner. Experience shows us we can go far in this "do-it-yourself" caring. I suspect we can go much further.

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From a Disease Orientation to Prevention and Participation

The style of the approach previously described introduces a new kind of professional behaviour and a new set of outsider/community relationships. Such a partnership, in this case between a health team and the villagers, is only the beginning. Scabies and diarrhoea have become the entry point. Let us continue.

The doctor or health worker in the situation described can choose his moment and proceed along the following lines. Addressing his audience of sufferers with diarrhoea, scabies or whatever, he says, "Look, there are 70 of you here this morning, 22 from the same village . . . You came to me for medicines . . . Every day there is a large number with the same problem; last week so and so came too late for us to help, and all the time people–children especially–are dying of diarrhoea. Are you just going to wait for a doctor to turn up once in a blue moon or keep running to your health worker, or do you want to do something about it? How long are you going to put up with these conditions? Come! Let us have a quick look around the village and see what we can see."

The doctor sets out followed by the crowd which is fascinated with this unusual behaviour, and the doctor harangues them at every sanitary risk he can point out. He tells briefly what needs to be done and why: "Now if you are really interested in dealing with these diseases, get your headman/teacher/health committee to call a meeting. I'll get a worker to join you, and have a good look at what might be done. Who will take responsibility for fixing up this meeting?"

At such a meeting, the specific extent of the medical problems should be addressed: "In this village there have been at least . . . so many cases, and so many deaths in the last . . . months. One of the main reasons for this situation is . . . and it *can* be prevented or at least cut down by . . . (preventive actions to be spelled out). One of the ways to start is to make a full-scale inspection of the village; you can do it yourselves. Here is a 'How to Look for the Threats to Health in your Village' guide. If you wish to try it, we can arrange for a community worker to help you." (The local schoolteacher and the children can be involved here too).

How To Guides

A whole range of "How to Guides" needs to be developed. "How to Guides" should tell of the real experience of other communities, what arrangements worked, what problems were run into, how they were overcome, what to take into account, advantages and disadvantages of

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different solutions, checklists. This "How to . . ." material should be carefully put together, perhaps in comic strip form, but at any event geared to the literacy level and comprehension skills of the community to be assisted. Beginning kits available in a "cafeteria" style (piece by piece, to be added as and when required) could be worked on by the community worker. Trainers and skills in using each piece of materials can be developed. As more and more actual experience is accumulated, the materials should be updated and made more effective for each job in hand. The inspection of the village is a first step in helping to organise 'bottom-up' planning.

I Spy Games [1]–Village Surveys

I found myself, after much experience of "top-down" planning, emphatically insisting on demystification, and heard myself say that "planning is child's play." I remembered how often I had enthused about the expertise of children and how they constitute an untapped development resource. They are not usually recognised as manpower, even though a recent report states that in South Asia alone, by ILO standards, 29 million children are gainfully employed. Another fact is that children *know*. They know an enormous amount, and adults have failed to gather and put to use the very careful research undertaken, quite voluntarily and without guidance, by children, using their inherent sense of curiosity.

It occurred to me that it was possible to involve children in this preliminary inspection work. I thought this could be managed in the form of "I Spy Games." One such game could be, for example, to look for every conceivable water source in the surrounding area. The children could work in pairs or teams, leaving some kind of marker (a stick and a coloured piece of cloth as a flag) or agreed sign at each source discovered, so that the same source is not claimed more than once by any "player," and so that a proper claim is made of each "find" and can be judged to belong to the first finder. Some kind of points system and reward for the most points could be devised.

All the information from this I Spy game would then be brought together and displayed on the largest possible area on which an outline map of the village or community can be marked out: the school playground, a sports field, a market square, the side of a house. The map can be outlined with chalk, stones or bamboo, or scraped on the dry earth. The children can make models with mud, coconut shells, cardboard, anything. Then with sections of the map allocated to pairs of children, they would fill in the map, marking all the water sources.

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A village leader, a health worker, or a youth group might organise the whole game. Better still, an enterprising schoolteacher might use an I Spy Game to teach and link many aspects of the curriculum, preferably as a practical activity illustrating what the school is supposed to be teaching anyway–making, charts, graphs, handicrafts, hygiene, social studies, essay-writing, or as a valuable learning project in its own right.

Children could be asked to write on such subjects as "Twenty-Four Hours of Water Use in My Family," describing where the water comes from, how it is collected and stored, how much is used for what, and something about the seasonal variations. They could be set the task of producing a wall mural (children paired, each pair taking a small section of the wall) illustrating water use in the village. All of this clearly has direct relevance to the school curriculum.

From this basic game, we can move on to an I Spy "Sanitary Inspector" game. Teams are again formed and rewards given, this time to the team that identifies from all the sources the most water-risk danger situations (having been told as part of health education, all about these beforehand–cattle drinking, bathing, clothes washing, open wells, defecation). They must place a sign to mark the danger and to claim the site for their team. The signs could be semi-permanent so as to mark the site until the risk was eradicated. Now the risks would be added (big red spots?) to the sources plotted on the huge map. These water games might be linked appropriately to local water festivals such as Holi, Mahathingyan, and so on.

When the whole layout is satisfactorily completed, the village leaders and the whole village should be invited to attend a ceremonial inspection of the map. The whole thing will be explained (preferably by the children themselves) and a full presentation made on "Our Village Water Conditions and What Might Be Done for a Clean Village Water Supply."

Of course, these games and the whole procedure expect much of the schoolteacher or whoever, and might require a campaign to back them up with an orientation, practice sessions and materials, sponsored by the education, welfare or health authorities.

Variations can be prepared or experimented with in relation to malaria, nutrition (what is in the market week by week and is cheapest), agriculture, irrigation, forestry, husbandry, transportation, marketing, and so on with whatever might be troubling and is a priority identified by the community itself.

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What has been illustrated is a child-contribution approach to planning. However, the principle is the same even where an adult group is to take responsibility, rather than the children.

The information and the community involvement and interest engendered by these "game" activities are the fertile ground upon which specifically local, tailor-made plans can be built. One way in which communities have been assisted in responding to this encouragement to plan (in this case a new water supply was the focus) is as follows.

An Aid to Planning with the Community

At a large village gathering everyone (try to see that the women are appropriately represented) is invited to list all the things that they foresee will need to be done. The emphasis is on *activities*. Bearing in mind the low level of literacy, someone is invited to do a drawing of each *activity* (no great artistic skill is necessary; matchstick men and crude representations will do, although it is surprising how often a village artist is discovered). Each drawing is pinned on the wall until all the actions have been mentioned and everything seems to have been covered. The activities are then considered in order of precedence chronologically, clustering the pictures where activities have to be undertaken simultaneously.

When the sequence has been pinned around the meeting place to everyone's satisfaction, consideration can be given to timing practicalities such as seasons, wet/dry, sowing/harvest, festivals, and so on. Above the pictures agreed dates for the activity can be placed. (Without talking the language of planning the community will have produced their own flow charts and chronological bar chart representations). How many people, what skills, tools and resources, can be represented under each of the drawings and at some point who exactly will be involved in each activity can be worked out and added–a manpower plan!

A useful device can be utilised to deal with costs and bookkeeping[2], which will clarify matters even for those poorly endowed with numeracy. Plastic bags should be placed under each activity and play-money (as in the game of Monopoly) used to count out what each activity is expected to cost. Where there is to be some revenue, from selling water or some other produce, a similar estimating and counting out can be enacted and shown against costs. (Even those who find difficulty in adding up and subtracting have skills in counting out cash). Later, as money is collected or dispersed, it can be shown to be moved from one plastic bag to another.

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There now exists a very visible representation of the community budgeting for the project, and the whole collection of pictures and bags of money remain in the community publicly displayed and can be used for monitoring and further discussion as the project gets under way and proceeds.

Link with "Support-Down"

Once the whole picture of the step-by-step development and the activities which are necessary at the community level have been laid out, it should then *be* possible and somewhat more familiar to work back up the administrative and technical agency structures and to tie into the community timetable and flow of activity, the inputs and support from outside, detail by detail. Where there are activities determined by technical and administrative imperatives which cannot neatly gear into the community pace and way of doing things, these points of discord must be given special consideration and a mutually acceptable arrangement be agreed upon and fully re-planned in the community. The range, content and timing of the activities must eventually all lead to a service that is satisfactory to the community, the authorities and from the technological point of view.

When these plans have been jointly examined and agreed upon, they should then become the basis for some kind of formal contractual agreement. In skilful hands this planning process at the community level can result in enhancing social cohesiveness; health and development education; and the establishment and improvement of community/government operational relationships–all amounting to the essence of practical nation building! [3]

A Summing Up

Underlying all this is the principle that services must be made to measure (measure up to the local community, that is) and not be rigidly uniform.

First, find out; that is, encourage the community to find out (they can share with the planners later) what their specific needs and conditions are, and what might be the choices, given available resources, for specific improvement. Who, when, what with, how much, etc., must be properly spelled out for each village and community fully involving the people in finding out, understanding and thinking about how things can be done (more "How to Guides").

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In community matters the golden rule is that the community will know best, if pains are taken to involve them in their own problem-solving processes. We must be prepared to take time and energy, and develop our skills in assisting them, with gathering and considering information they can best use, and in offering realistic methods for planning and harnessing their full development potential.

Many of the examples we have given here derive from the field of health. The situations which provided an "entry point" here were the sanitary conditions underlying the problems presented, i.e., diarrhoea, scabies and so on. The health team took a "group development" rather than an individual patient approach, involving health education and preventive action. They moved directly from a point at which people had an immediate problem. The health team dramatised the situation and went on to work towards establishing a *realistic village-made plan* of action, including the beginning of a village-based health worker service, which is current thinking in Primary Health Care.

However, health needs are likely to be fairly low on any community's priority list of needs. Water, which is of course related to health, especially in water-scarce areas, can often provide an "entry point" for development, but different communities will experience different problems. We developers will tend to see the problems with which our own sectors are most familiar and keen upon.

Nevertheless, the fact is that development can start from any presented problem, or any "sectors" built-in perspective, but we must learn to use these starting places to reach into opportunities for establishing the foundation for all development activity. As I see it, one rural-based problem is related to all the others and the foundation for change rests with assisting communities to experience positively a partnership which leads to discovering their own ability for organising themselves, planning, getting things done in successful collaboration with others, and with each achievement to find they have an increased capacity for development and "social preparedness." This kind of community cohesiveness, growth of community skills and trust of outside agencies are important resources in their own right and can be considered as development *capital*. Without such capital not much is possible.

As has been indicated, despite the health orientation of this paper, agricultural workers, teachers, youth leaders, political cadres perhaps, and many others may begin to discover development "entry" from any one of a myriad of backgrounds and formal structures. They can be taught and helped to learn and gradually accumulate and improve community focussed skills. There are specific development skills, but these, as we

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have seen, are not simply added to one's usual role and responsibilities. Such skills must permeate what one brings to the situation and begin to transform the way in which one perceives and the way one has been accustomed to operate.

In this sense the development worker's special technical or sectoral background is secondary; his community skills become primary and above all are inspired by a state of mind.

This state of mind involves recognising and responding to a need as it appears in working with people. A readiness and sensibility to being able to see how and what needs to be done can be translated into assisting the community to mobilise the help itself, and to obtain available help from outside as and when it is needed. The good development worker is always finding ways to broaden and build upon a community's own capacities for planning and implementing development activities.

Inherently there must be a realistic understanding that if trust has been built, outsiders can work with communities and the communities will know what to do if the assistance given is realistic and important enough to them. The worker must function through appropriate relationships and institutional forms, which stimulate and reinforce community participation step by step, action by action.

EPILOGUE

We were returning from one of the sitting-on-the-temple-steps joint health care sessions that I described earlier. The young doctor I was accompanying had with phenomenal patience and skill been discussing, with an enormous crowd, extraordinary matters–the rare necessity for neurological examination and perhaps surgery for a villager who had recently begun to behave in a bizarre fashion and had by all accounts suffered a rapid physical deterioration. The villagers had contributed many important observations regarding the patient and his family, but were inherently hostile, even terrified (not without good reason) of the local mental hospital. But now the doctor said to me, "Do you know that those villagers, without the medical terminology, of course, and without too much in the way of any vocabulary for that matter, nevertheless asked most of the same questions and had tried to weigh the same risks as our doctors do every Saturday morning at the hospital when new cases and autopsies are discussed by the Professor of Neurology."

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The villagers eventually decided that hospitalisation was in the patient's best interest, and they began to plan for the care of his family and his smallholding during his absence. We were carrying the patient on an oxcart towards the road where we were to meet our vehicle. The sandy terrain and the strange wild blossoms incongruously conjured up the memory of the Chancellor of the Exchequer and his Rolls Royce far away and long ago. I thought how good it was that this time there had been no silly questions, no silly answers, but a sensible and sensitive exchange between astonishingly different partners. With this kind of trust, however unusual the circumstances, development can start anywhere, everywhere.

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NOTES

1. The original game goes like this: someone says "I spy with my little eye, something beginning with . . . ." A letter is shouted, and the other players have to guess what object in sight, beginning with that letter, has been selected. When one guesses correctly, he has a turn of shouting out the first letter of whatever he has selected as the mysterious object.

2. Poor attention to such matters has been the curse of development efforts and has caused the failure of many a cooperative endeavour.

3. My experience has been that once this very local planning exercise gets underway, the novelty of it leads to serious verbal give and take but with much ribaldry and laughter. Laughter is not too pronounced at other levels of planning that I have experienced. Indeed I wonder if the degree of laughter measured on a "laughometer" might be utilised as a prognostic indicator of whether projects are likely to succeed!