

DRUCKER

Child survival, immunization and community participation

With the child survival revolution getting underway and aimed at reaching more and more of those as yet unreached, it is of importance to consider the community involvement and participation in this dramatic expansion of health care. To take an example, the development of immunization has all the elements of a popular story to illustrate the classical concepts, methods, organization 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
- 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 infections;
- 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 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 represent a special situation with the elimination of a disease from planet earth, it has undoubtedly given boost to the determination to tackle other disease entities. However a 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 in ^{the} ~~this~~ world don't know what's good for them in our world".

Human behaviour holds more mysteries than our present scientific models can explain. Perhaps to our surprise we are up against the fact that our assumptions that the application of our hard-won scientific knowledge would in due course take care of itself were false. The technology of medicine has out-run its sociology.

However successful we might have been in launching programmes of a categorical kind (as in smallpox), where on-going maintenance of programme is required (as in immunization generally and that for 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 which does not mean mere acceptance of programme by the community - a passive nod of acquiescence. ~~Take the~~ Take the example of the immunization workers who, I discovered, carry ~~as~~ 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 pickup point in the area. The community could easily be organized 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, and this seems to have roots in the health worker's reluctance to place control (and possibly justifiable grounds for ^{termination} ~~exercise~~) if the worker did not fulfill his/her part of the bargain by actually turning up as agreed.

"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.

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 their own efforts.

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

It implies too, placing expertise on tap rather than on top 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 concomitant 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 real and respected 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 all our best laid development programmes run into similar difficulties because of the inadequacy of community participation mechanisms - the sooner 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^M and a powerful backlash^A. We need to ponder Carl Taylor's 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 are often securely fenced from the community, and commonly located in 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, orders ^{but} and does not discuss". Observers suggest that such social distance is a

major reason 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; they 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 a person who 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 co-operation. 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 also become skilled in doing.

Ancient medicine is rooted in religion, in magical thinking, in superstition, but also in caring. It is an interesting phenomenon that modern medicines are increasingly appreciated even by those most tradition bound. This does not mean that they understand or care about the underlying scientific method and philosophy, but that something of what they utilize 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" are experienced by patient and healer as having magical properties, but these properties are at work because of the personal attributes of the healer which enable him to mediate with demonic and good powers on behalf of his client.

There are modern medical equivalents; it is reported that it is a practice of some MDs 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. We may well 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.

For example, "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 embarrassedly 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). 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 are generally popular and administered privately by many paramedicals as well as by non-scientifically oriented persons. In Thailand it is reported that "it is common for a client to introduce himself to a Moo (doctor) by saying, "I think I need an injection". 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 medicine might be acceptable when patients are sick and under stress, which may have even

projected them through the many and considerable 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; to promote immunization will require some kind of understanding of why you do something at a particular time in order to ward off consequences in the future.

We have discussed here broad areas pertaining to a community participation approach. Its establishment will mean radical changes in our thinking, attitudes, skills, and in our administrative structures, and Can we really expect communities to respond, especially in the field of immunization? Recently the question was put to 119 village leaders: "List the five essential health needs in your area." Immunization came top of the list; 116 of the 119 thought their community was "ready to accept an immunization programme". Earlier in this article there was an example of the compulsive walking health workers. In another country an elaborate system of supervision (and supervision of supervisors) have 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.

Once one begins to look for these invidious types of behaviour which will certainly undermine all attempts to promote participation one finds them everywhere. Controlling behaviour by professionals is almost a basic element of our present social structure. Although the health field provides telling examples, the problem is more widespread. There is no reason why a village which has been properly consulted and has expressed its accord on the 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 keep its own set of records so that the villagers can effectively know who is and who is not protected, whom to encourage to get protection, and who and when ^{villagers are} ~~is~~ due for boosters or reimmunization according to the appropriate schedule. If our technology is good enough, the community may help even handle the simple skills of administering the immunizations. There are examples 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.