

Less walking, more working

Community participation does not mean mere acceptance of a programme—a passive nod of acquiescence. It means sharing, and contributing what each can do or knows best.

It is a common sight to see immunization workers who carry a 48-hour supply of vaccines in vacuum flasks and spend a large proportion of their time walking to and from remote villages to a central cold chain pickup point in a headquarters town. Yet walking is not a skill exclusive to the professionally trained.

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 located.

The usual shopping journey and the collection of the vaccine flask could be combined and would only need to be done by each village perhaps once in three months. The trained health worker would then merely need to travel straight from village to village instead of trekking repeatedly to the town. He or she would be assured of a fresh vaccine supply relayed to each village along the way.

If a community understood the need for taking such responsibility (which assumes effective health education), it would make sure that its members assembled for vaccinations—since one of its own people had travelled a long way on their behalf.

At present many health workers' timetables are poorly adhered to. They arrive mainly when it is convenient to themselves. The implication is that if a community is eager for vaccination or other assistance, the villagers had better quickly pass the word around that the health worker has arrived and they must move fast before he or she is gone.

Another example comes from Nepal. An elaborate system of supervision (and supervision of supervisors) was 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.

However, the village people themselves had no way of knowing in advance when the vaccinators would come. Having the date recorded post-facto helped the supervision, but not the villagers.

Such high-handed behaviour by professionals (and it seems to be everywhere, once you are on the lookout for it) will certainly undermine all attempts to promote community participation.

Illustrated here is the real resistance

by some health workers to solicit more effective partnerships with the community. Partly it derives from the hierarchical structure and ambiance of medical institutions which dominate their training. The very word 'patient' gives the who's-active who's-passive game away. Health workers are reluctant to give up some of their control, which in the case of vaccination walkers might give the community grounds for recrimination—if the worker does not fulfill his or her part of the bargain by actually showing up as agreed and vaccines go to waste. ■

To think like the people

Underlying the working relationships between ordinary people and those with skills or authority—which we must seek in community participation—is the matter of mutual trust.

In many developing countries the technical and professional health personnel are government officials. This raises the question of attitudes to the required co-partnership between government and governed.

This is no simple matter; it is no secret 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 off from the community, commonly located in government compounds embellished with much intimidating paraphernalia of authority. However politely this authority may be expressed, many people have ex-

perienced government as an institution which takes but does not give, which orders but does not discuss.

The problem of social distance is one of the main reasons local faith healers or quacks continue to flourish. They have the confidence of the villagers because they live with them, share their lives, and wear the same clothes. They are neighbours and kin who can always be found in the market and the common meeting places. It is well stated that medicine involves not just what a man knows but what he is.

When threatened by health interventions from the outside, local healers can sabotage quietly, but effectively. They make powerful adversaries because they operate naturally within the local belief system. They know what will be most damaging to popular co-operation with those outsiders.

A logical counter-measure is to try to recruit the faith healers into our programmes. Working with a community requires learning to think like its people. To a great extent this is what the indigenous healers do and the authority and the professionals would be well advised to do the same. ■

