Rumishael Shoo

Training primary health care workers to foster community participation

A low level of community participation was identified as one of the weaknesses of the health sector in the United Republic of Tanzania. In order to remedy this situation, a systematic process of training trainers and students was established with full involvement of village people. Twenty-five themes were put forward as starting points for discussions between students and villagers. The students were encouraged to learn from the villagers by listening to them and asking them questions. They also participated in community activities and lived with villagers so as to obtain a good understanding of rural living conditions. In this way, problems were identified and solutions were jointly formulated. A workbook was developed during a series of workshops with students, trainers, village communities, and planners. At least two teachers were trained from each health training school; all schools were supplied with workbooks. The approach has been adopted by most health training schools in Tanzania, and the Ministry of Health is now committed to it. Both students and trainers find this to be a valuable learning experience.

In 1978, the United Republic of Tanzania undertook the first major evaluation of its health sector *(1)*. Eighty-six variables were identified and placed in four categories, one of which consisted of processes in society affecting the health care delivery system; among these, the low level of community participation was a significant factor. As a means of overcoming this deficiency, a programme was developed by the Ministry of Health and the Institute of Development Studies of the University of Helsinki to reorganize the community-based training of health workers.

The programme was designed to:

- analyse community participation training in terms of time allocated and processes used;
- develop and field-test strategies for improving training in community participation;
- enlist the participation of communities in the training and evaluation of health workers.

Following the achievement of independence by Tanzania in 1961, the government

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decided to encourage self-reliance based on labour-intensive development. Unfortunately, this was at a time when state resources were heavily committed to building health facilities and training large numbers of people. As far as the planners were concerned, community participation meant telling people what was in store for them.

The use of questionnaires in an essentially oral culture gives an impression of artificiality and may inhibit discussion.

A programme of settling people in villages to encourage cooperative development and easy provision of social services met enormous resistance. A lack of genuine involvement and a failure to listen to people's advice led to serious mistakes, e.g., the selection of sites which were uninhabitable. As a consequence of this paternalistic approach there was a decline in agricultural production. For politicians, community participation meant responding to what people said and promising to provide what they requested. The demand for curative services soon overwhelmed the system. The economic recession that started in the mid-1970s resurrected the fashion of community contribution, which became the sole element in community participation. There was little involvement of villagers in planning and major decision-making. When village leaders were involved, they often reflected the views of the political party, the literate, males, and the "better-off" section of society rather than those of the majority of villagers *(2)*. People were often consulted about priorities but the design of programmes was still a prerogative of the party *(3)*.

Training tended to concentrate on technical issues and to give less attention to organization, public relations and problem-solving. An interruption of supplies of drugs or equipment often demoralized health workers. In 1981, the curricula in 11 training schools were reviewed with the aim of finding out how courses helped to impart the skills necessary for enlisting community participation. Information was gathered from people in eight villages. All cadres were required to spend some time in the community as part of their training. However, on average only about 3% of course time was dedicated to working directly with communities. Under the prevailing system, community participation was advocated but hardly practised.

Training programmes

The evaluation of community-based training for medical assistants revealed differences between schools. Students found this to be among the least beneficial learning experiences; in some schools it was omitted altogether. The instructions given to the students varied widely. At one extreme, they were sent to remote places to help villagers in their normal activities and were asked collectively to write a report on the local health situation. At the opposite extreme, they designed questionnaires and their main concern was to collect information, analyse it, and write reports based on the data. Many trainers admitted that it was often difficult to design good instruments; even when this was achieved, the analysis of data was inadequate. The students were asked to secure community participation but received little advice on how this might be brought about.

The processes and methods used put students in the position of being experts, actors and initiators, while the villagers

Table 1. Types of schools from which workshop participants were drawn

	No. covered	Total
Medical assistant schools	3	8
Rural medical aide schools	8	13
Registered nurse schools	2	3
Trained nurse schools	3	16
Maternal and child health schools	1	16
Public health officer schools	2	2
Public health nursing school	1	1
Centre for Educational Development in Health	1	1

assumed the role of subordinate passive recipients. In this situation it was impossible for mutual learning to occur.

Activities undertaken

Four one-day familiarization workshops were followed by three one-week workshops. It was decided that the participants should include principals, vice-principals, teachers involved in community medicine training, students, officials from the Ministry of Health, representatives of the university department of community medicine, and at least four villagers. The organizers were asked to ensure full involvement of all participants. All participants were to be treated equally in all aspects of organization, regardless of status. The workshops were to be held in locations from which it would be possible to make visits to villages. The three one-week workshops were attended by 41, 42 and 43 participants respectively. The kinds of school covered are shown in Table 1.

On the basis of issues identified during the preliminary survey, objectives were jointly formulated by resource persons and participants in the workshops. The following questions were considered in discussions between villagers and participants.

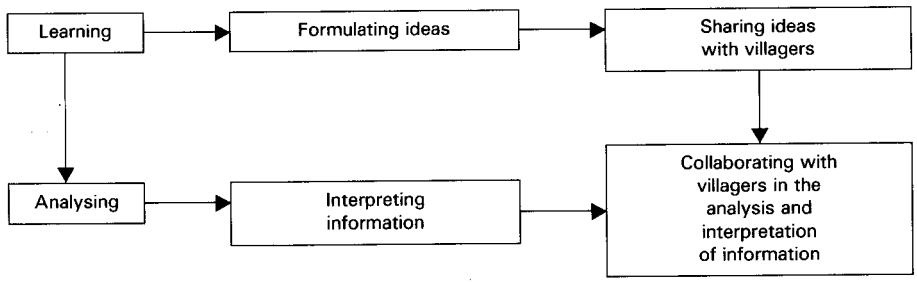
- How should field projects be organized so as to benefit villagers?
- How could villagers participate in the training of students?
- How could students be supervised by village leaders?
- Where should students live while in the villages?
- How could the continuity of projects be achieved?
- What should students do in the villages and what would villagers contribute?
- How should records of student activities be kept in the villages?

For studies in the villages, 25 themes were suggested for discussion between students and villagers. They related to: health workers, the community approach, constraints, resources, nutrition, social conflict, traditional health care, services,

The purpose of the training process is to enable participants to develop analytical skills, experience the complex nature of rural development problems, and understand health issues as viewed by different groups and individuals.

charges, people's participation in their own health care, treatments, medicines, adverse effects of treatments, health education, cleanliness, childbirth, child care, family planning, concepts of abnormality, taboos, circumcision, concepts of health, concepts of illness, concepts of the body, and concepts of death. The participants were given the option of selecting their areas of study and

Process of interaction with villagers in students' field studies



worked in pairs on the field visits. For each theme, codes were listed which indicated the issues for discussion with villagers. It was intended that the students would eventually devise their own themes and subthemes, the latter being smaller topics that could be used to trigger discussion. The process is summarized in the figure.

Evaluation

In October 1988 the programme was evaluated by the Ministry of Health. The ideas had been introduced to all 104 paramedical and allied health training schools in Tanzania. The schools had been supplied with workbooks containing instructions and the themes. At least two teachers in each school had been shown how to use the themes. The continuing education unit in the Ministry of Health had been responsible for coordinating activities until 1983, when this function was handed over to the Centre for Educational Development in Health.

Six schools in southern Tanzania, where the programme had been running for a relatively short time, were selected for follow-up. All had allocated time for work in the community; the actual amount of time varied with the curriculum, teachers' interests and the location. Five schools were using the themes. The sixth carried out a community analysis and then conducted role plays in the villages on the problems identified. This was used as a method of generating discussion and interest among villagers with a view to identifying problems and jointly working out solutions. The school then made monthly visits to the village to review implementation. The involvement of villagers in role plays made discussion even more lively than it would otherwise have been, and helped to break the barrier of status. The perceptions held in communities about health services and health workers were thus ventilated.

Activities

The student activities in the communities involved:

- community analysis;
- creating awareness of identified problems;
- visiting homes to discuss health issues and to agree on strategies for tackling them;
- outreach activities, e.g. immunization;
- participating in village tasks, including weeding and harvesting;
- participating in village meetings to evaluate previous work.

Resources

Three of the schools used four-wheel-drive vehicles. The mean distance from school to village for field work was 14.5 km, the range being 2 to 40 km. Although many schools were in rural areas, few used the nearby villages for field work. It appeared that relations between the schools and local communities were not good and that students were not welcome in the villages. Two schools paid a field allowance to enable students to use public transport and buy food in the villages. The students from one school walked to their village and lived with the villagers. Tutors usually visited the communities to make arrangements before their students arrived and subsequently returned with the students to introduce them. The teachers from one school remained with their students throughout.

Contribution by villagers

The villagers had been involved in all planning meetings, and they provided accommodation for the students. In each village the headman took charge of the students and, in collaboration with the head of the nearest health unit, guided their work. In a number of situations the villagers were very cooperative in answering students' questions.

Students' views on community participation

Most of the 111 students interviewed thought that communities were willing to participate in the health projects and that this was because:

- people were better informed than previously;
- villagers were being visited more frequently by health workers than before;
- people were concerned about their problems.

The communities should be the principal training resource.

However, 6.7% of the students thought community participation was poor because the villagers:

- did not understand their problems;
- were uncooperative;
- were not involved in problem-solving;
- were not motivated to participate.

The negative statements mostly related to poor rural people or the elderly. The most important constraints on training in community participation mentioned by students were:

- poor supervision by teachers;
- bad village leadership;
- unmotivated villagers;
- lack of transport;
- inadequate field allowances.

Village activities and structures

All the villages had at least a school and a health institution. Some also had a market, a party office, a well and a cooperative shop. Of the 169 households studied, 80% were headed by men and 85% had participated in some communal activity in the preceding 12 months.

Table 2. Distribution of communal activities in the households studied

Areas of activity	%
Agricultural and nutrition	42
Political party	26
Health sector	12
Education	8
Water supply	3
Others	9

Types of communal activity

In the 169 households, 288 instances of communal activity were identified as shown in Table 2.

Health workers had visited 52% of the households during the preceding year. On these occasions, the discussions had centred on sanitation and hygiene (55.4%), agriculture and nutrition (13.2%), diseases (8.5%), water supply (6.1%) and other matters (16.8%).

Health workers seemed to give greater emphasis to health issues than did the community. This could lead to a conflict of priorities, and dialogue is therefore necessary to ensure harmony.

Commitment to action

Only 6.5% of the households visited took action as agreed with health workers. This tends to indicate that the credibility of health staff is low. On the other hand, solutions proposed by health staff may be unrealistic. Health workers have little understanding of appropriate village technologies and ways of coping with extreme conditions of poverty. Methods suggested for the construction of latrines or for improving nutrition were often beyond what rural people can afford. Furthermore, advice may not be accepted in some African communities if those giving it are young professionals.

Words versus deeds

When health workers asked villagers what could be done to improve health, 6.5% said they did not know. The rest made suggestions related to sanitation and hygiene (45%), agriculture and nutrition (28.4%), water supply (11.2%), education (1.6%) and other matters (13.8%).

However, the communal work actually performed was predominantly concerned with agriculture and party-building. The political party is a very important local structure in Tanzania.

Continuity

In many villages that are used by training institutions the people become irritated by students asking the same questions every year. It was therefore decided to build up small village libraries containing copies of all reports of work done locally by various sectors. This facility would be used by village leaders to orientate visiting students. The most important document would be the village survey report, which would be updated as required. It was therefore agreed that students would not do latrine counts or population surveys every year but would only review new events. This would allow both students and villagers to devote more time to such matters as devising solutions to problems and implementing them. The survey indicated that this was the least developed area.

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It was very difficult to get policy-makers and trainers to participate as learners. A lot of counselling was required to convince health workers that it was possible to induce villagers to contribute to the workshops. Some participants regarded the codes as questions to be asked. Many health workers did not feel secure without a questionnaire. In using questionnaires, the students evidently felt a degree of power over the villagers. Villagers were sometimes unable to answer questions, and this was interpreted as ignorance. The use of questionnaires in an essentially oral culture gives an impression of artificiality and may inhibit discussion. Among the Chagga tribe in Tanzania, it was often necessary to engage in discursive interviews before coming to the themes; tactfully dealing with hospitality was another challenge. The designing of good questionnaires and the analysis of data require skills that are not imparted in most health training schools.

The use of games and other more innovative and participatory methods of teaching are promising methods for the training of community and health workers. The green revolution game, for example, is a powerful instrument for helping students to comprehend the plight of the rural poor *(4, 5)*. However, the use of such devices in health remains limited, sometimes by cost but often by a lack of skilled trainers. This is unfortunate, because they make learning comparatively realistic and meaningful. In order to develop community-based training, patience and leadership are required on the part of government, and top management and planners have to participate in the process.

In the present case, the programme was planned and implemented in a participatory manner. However, the first part of the evaluation, aimed at informing the Ministry of Health and donors as to what had been achieved, cannot be considered truly participatory. The second, more detailed part, will involve working with communities to review and revise the programme.

The increasing emphasis on community and preventive medicine in Tanzania was reflected during the 1970s in both policy changes and the reallocation of resources. In 1971 resources were increased for rural development, and the decentralization of government machinery followed. By 1974, 40% of government expenditure was going to the regions for water, health and education projects. It was decided to encourage people to participate in the planning, implementation and evaluation of their own programmes. The training of health personnel in community participation became vital.

The reviewing and rewriting of curricula is relatively simple; practical implementation is more difficult. It was therefore decided to train trainers and introduce the innovation at the outset. This approach is crucial if trainers are to contribute to curricular review. Their contribution and experience will form the basis of change. The purpose of the training process is to enable participants to develop analytical skills, experience the complex nature of rural development problems, and understand health issues as viewed by different groups and individuals. Participants and trainers often expect concrete models offering prescriptions for the organization of community participation. This became a more complex issue to trainers when they contemplated the matter of student assessment.

Most government plans have concentrated on the numbers of health workers to be trained, whereas the aim should be to train health workers in such a way that they can mobilize their communities to improve their own health.

Most health workers are expected to serve rural communities. It is important to take this into consideration as from the onset of training. In other words the communities should be the principal training resource. □

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International comparisons will help prevent accidents

The content of all training or education programmes, in both developed and developing countries, should draw on past experience and research results wherever available. This requires close international cooperation between specialists in safety research and in fieldwork, in order to collect, compare and assess existing information on the causation of accidents and the design of countermeasures; to identify the results that can be universally applied and the conditions necessary for transfer of technology; and to design appropriate educational tools to convey this information to the various people concerned. Care should be taken to avoid generalizing results that may have been heavily influenced by the social or economic conditions in the countries where they were observed. Practices that are successful in specific conditions may prove inadequate in different surroundings. Therefore international comparisons of the effects of particular courses of action are invaluable.

— *New approaches to improve road safety.* Report of a WHO Study Group. Geneva, World Health Organization, 1989 (Technical Report Series, No. 781), p. 22.