Malonga Village: A community-centred experience

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Curriculum Vitae

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Summary

As part of the training programme for Primary Health Care (PHC) nurses, they are expected to change their world view, to shift their paradigms especially from an authoritative paternalistic approach to a paradigm of partnership, from 'knowing it all' to 'finding out'. A listening survey was done at Malonga Village and the group then felt they had to become involved in this community to put into practice their skills of empowering a village to constructively work on its needs. This experience is described and analysed here. Three basic issues emerged and are discussed:

1. *leadership style – who takes initiative and how much?*
2. *the choice of a specific community with which to build a relationship – a possible bias of villages which are not known, or a 'hidden agenda' like a 'special patient';*
3. *the parallel between community-centred care and patient-centred care as in family medicine – so often the health worker or developer subtly still remains the controller of outcomes instead of mutual participation with everybody's agenda clearly in the open.*

1. Introduction

Having worked in a rural hospital for 12 years, I have come very strongly under the impression of the futility of a solely curative approach to health[1]. I have been involved in the training of Primary Health Care (PHC) nurses for eight years and have observed that, theoretically, the primary health care principles are taught and held up as icons of health care in nurses' training. These include a holistic approach to

health with attention to physical, mental, social and spiritual needs and community involvement as well as all the other Alma Alta proposals eg intersectoral co-operation, accessibility, affordability, presenting a preventive, promotive, curative and rehabilitative service etc, etc[2]. In theory, this approach focuses on a much more satisfying and comprehensive approach to health than the curative one only. However, getting the theory and practice together is the great challenge!

In the training, I found certain PHC principles easy to teach, knowing that they were well understood and would be implemented in practice. Others were extremely difficult. One of the very important principles, community involvement in health matters, seemed to require such a major paradigm shift in the world view of a health worker that I didn't know initially how to include it in a meaningful way in the training. The importance of this facet of PHC was emphasised at a PHC day conference that we had organised in 1992 where Dr Nicholas Crisp presented a very good discussion based on a WHO booklet entitled 'Community Involvement in Health Development: Challenging Health Services'[3]. Many health initiatives across the world have supposedly failed due to the approach from the health sector. "Over the past 10 years or so, a rethinking of development strategies has led to the emergence of participation as a central concept suggesting a new direction... It is argued that development should be people-centred and that emphasis should be placed on involving people in development processes as partners and not as passive bystanders."[4] This concept makes sense to me and it struck me what a parallel there is between a patient-centred approach[5] and a community-centred approach.

McWhinney speaks of a 'transformed clinical method' or a 'patient-centred' method in which "physicians try to enter the patient's world and ... see the illness through the patient's eyes. ...The physician using the patient-centred method invites and encourages openness by the patient"[6]. This method was introduced because of the ineffective responses often to the traditional clinical method. It is therefore also a possibility to be considered in a more effective community approach.

Her basic world view determines the health worker's approach.

2. The practice

In the training of PHC nurses an orientation time serves as introduction to the Diploma. The concepts used in this period are an attempt to help nursing students to shift their paradigms, specifically from an authoritative, paternalistic approach towards patients, to a paradigm of partnership.

There is a movement from 'knowing it all' to 'finding out'. This applies also to communities. Based on the Paulo Freire method[7], we do a 'listening survey' at a village chosen by the students. "We listen for the issues about which people have the strongest feelings. Emotion is linked to motivation. Only on issues about which they feel strongly will people be prepared to act... The team searches carefully for the Generative Themes – that is the issues which are so important to the community that they will generate enough energy to break through apathy and stimulate initiative in the members."[8]

Many health initiatives across the world have failed...

Following this, interwoven into the year curriculum are ± monthly visits to the village to put into practice the skills of empowering a village to constructively work on its needs.

MALONGA VILLAGE is situated about 40km away from the hospital and about 30km of the road is a fairly good gravel road. It lies in the southern part of Venda and is notoriously very dry and hot. We spent a scorching day moving from house to house and listening to people's complaints and situations and then compiled a list of the people of Malonga's perceived needs

Listening to the agenda of the other person.

and our perceptions of Malonga. See Addendum.

In discussion after the survey, the students felt very strongly that we could not just 'use' the community by doing a survey and that we should return to help them realise some of these needs. In view of this, we returned to Malonga on the GOBI FFF team's visit date. We joined the community nurses and before they began with their immunisations etc, they emphasised the need for the community's involvement and asked the mothers present what they thought. There were about 150 mothers with their children and they confirmed what we had found on our survey and suggested that the caregroup (group of village women involved in health projects) should be 'resurrected'. We discovered that we had actually opened a can of worms as there had been a very destructive episode a few months previously where the very active caregroup had been destroyed by an NGO getting involved and taking over the local community garden project.

As the mothers were waiting to be helped, we made a return date and left them.

On the return date, we sat under an enormous fig tree (the health point), next door to the traditional healer's house, and waited for two hours! One of the students suggested we approach another village as 'these people are not serious'. After the long wait, seven women slowly arrived.

We discussed, for the third time the needs of the village and then asked the women to prioritise their needs. We had noticed that only one in 10 houses had toilets and also that there was quite severe debushing around the area.

On suggesting building a toilet and starting a woodlot, the women laughed and said that the bush was big enough and only lazy people struggled to get wood. In spite of this, as partners, we added a VIP (Ventilated Improved Pit) toilet to the list of things we would attempt.

The small group of actively involved women grew to about 14-18 over the following number of meetings. Negotiations were made with the headman to assist with the digging of a deep latrine hole and also to assist with the fencing. A letter was written by the Malonga committee to the church council to use their church for a crèche and members helped a Pretoria youth group to fix and paint the church. Through donations, we bought fencing from a neighbouring caregroup fence project and managed to get bricks and cement through local businessmen. We invited a teacher to help the crèche teacher (an unemployed matric girl) with a programme and practical tips. We also invited an agriculturalist to help with advice about planting fruit trees and managed to buy naartjie and mango trees for the fenced garden (the Malonga women paid half the price of the trees and the PHC Unit paid half). We also worked with the community at digging holes, off-loading bricks and making the slab of the toilet.

The futility of a solely curative approach in health.

Development should be people-centred.

A local NGO assisted us with the actual building of the toilet and showed the women how to continue once the slab was in place. IDT became involved at this point and assisted with a borehole and pump.

As the year drew to an end we mentioned at a few of our meetings that we would be leaving shortly as the training was a year long, but that the local care group motivators from the hospital would continue assisting with unfinished projects. At our last meeting, we were thanked for our involvement and also bitterly criticised for 'deserting' the community in the midst of its great need! At this point, one (of two) allocated stand had been fenced, the crèche was functioning very well, 30 fruit trees had been planted and the VIP toilet was at waist level.

Involving people in development processes as partners and not as passive bystanders.

At the time of writing, both stands have been fenced, the toilet completed (and during the rainy season when the water level rose too high, another little one built for the crèche children), the borehole has been sunk and is not functioning well, the crèche has 45 children and the teacher is doing a pre-school diploma, daily soup, porridge and sometimes meat is being provided by Operation Hunger (organised by the community with no input from us as health workers) and plans are afoot for the building of a clinic (all forms completed and sent to IDT by the community on their own) and a crèche and football field.

Unfortunately all the fruit trees were eaten by goats during the drought and another plan is to start a large fruit orchard at a later stage.

Contact with this village remains through the health workers eg care-group motivators and community nurses who go six weekly for the GOBI service and also for mobile team visits.

3. Discussion

3.1 There's the circular argument concerning how much initiative should be experienced from whom before one can really speak of community involvement. Some say that initiative from 'outside' already negates the concept because ideally the need should spring from the hearts and minds of the people in a village or group. Robert Chamber discusses this dilemma very well:

"In trying to see what to do, non-rural outsiders are trapped by core-periphery perception and thinking. Looking outwards and downwards towards the remote and powerless, their vision is blurred... However much the rhethoric changes to 'participation', 'participatory research', 'community involvement' and the like, at the end of the day there is still an outsider seeking to change things... A stronger person wants to change things for a person who is weaker.

From this paternal trap there is no complete escape. A decision not to act is itself an action. A person who withdraws or who abstains from intervening, is by that withdrawal or abstention still intervening by default. The weaker person is affected by what does not happen but which might have happened. There is, however, a partial remedy. Respect for the poor and what they want offsets paternalism. The reversal this implies is that outsiders should start not with their own priorities but with those of the poor..."[9]

A paradigm of partnerships.

Relating this to our situation, we do not qualify as outsiders in the way meant by Chambers. The core-peripheral thinking remains a danger because of our 'professionalism" but we are in fact part of the community to which we are reaching out. What is a danger is that though 'insiders', we use a paternalistic or 'traditional clinical method' and diagnose the problem without listening to the community. The parallel of a paternalistic patient-healthworker relationship versus patient autonomy is similar in community work. Whereas a totally paternalistic attitude does not work within a one-to-one health relationship or a community-health worker relationship, neither does a totally autonomous relationship work for either of these categories.

To decide not to act, is itself an action.

There is therefore a tremendous scope for understanding and developing the correct leadership under these ethical circumstances. I think the issue here for me is not so much who takes initiative but centres rather on leadership style. Hope and Timmel present very well the different concepts of leadership in their books 'Training for Transformation':

"One of the key elements enabling people to come to realise their own potential and to have self-respect, is their relationship to the leader of their group. If a group demands that a leader do the work for them, the group is not taking responsibility for its own destiny, nor is the group able to stand on its own. This is often a fault of our own concept of leadership." Three types of leadership are described: authoritarian, consultative and enabling.[10] The aim of the PHC training is to help nursing students to learn *enabling* skills. In practice, we find this extremely difficult. In the Malonga project we had a very talented student who managed to facilitate the most difficult meetings but the pace of development was often so slow that most of the students had periods of withdrawal from the whole situation.

3.2 Another related difficulty is in the choosing of a community with which to build a relationship (as opposed to a patient choosing a doctor) – this is also important for involvement: "Plans, projects and programmes are often nowadays intended to benefit 'the rural poor', 'the vulnerable groups', the 'backward classes' ...The first and most common type (of programme) can be described as 'spread-and-take-up'. The imagery is of a service being pushed out from the centre and being taken up by people further and further into the periphery ...Those who take up and make use of the services are at first those who are better placed geographically, socially and economically. But the aim is that by pushing hard, and reaching down and out, all will at last be reached.

A second and less common approach has been to start from the other end, with programmes designed for the last first. ...Both ...are vulnerable to interception by the elite".[11]

Our approved choice as health workers, was the 'most deprived' and was based on the knowledge of the students who were all community nurses, with experience in large geographical areas. There is obviously the possible bias here of villages which are not known to any of us, as well as that of the 'hidden agenda' (a 'special' patient, family members etc).

Respect for the poor.

3.3 The parallel between community-centred care and patient-centred care. A great deal of the bias which relates to my problem of who should take initiative, is a basic family medicine issue. The models discussed by Szasz and Hollender[12] regarding patient communications have indeed a great deal to do with health worker: community communication. The 'activity-passivity' model is the way in which a great deal of community development failed because of the dominant role played by 'outsiders' in defining the problem, bringing in the expertise and taking control in a totally paternalistic way. The argument may be used that one is sometimes faced with a comatose community which needs this type of intervention, but I think this approach is one left for times of disaster – and even then, a great deal of co-operation and planning can be done together. The 'guidance-co-operation' model is very much what is still effectively happening. The health worker or 'developer' often pays lip service to community involvement but subtly still remains the controller of outcomes. In family medicine, one of the distinguishing features "is its insistence upon the need to enlarge the conceptual field within which a physician attempts to understand the pathology of the presenting individual patient...

A totally autonomous relationship does not work.

While such a view is not novel in the literature, of course, problems of both acceptance and implementa-

Who should take the initiative?

tion of that view in the practice of family medicine are formidable..."[13] We need to move towards the 'mutual participation' model with the agendas of developers or health workers as well as the agendas of the community clearly in the open (as far as this is possible!). As difficult as it is to move from a disease-orientated medical practice towards a person-orientated practice, just as difficult it is to move from a controlling to a participative community-relationship. The parallel has helped me a great deal in understanding basic communication.

4. Conclusion

The basic worldview of a health worker is essential in determining his/her approach. Where there already is a readiness to listen to patients' agendas, there should be a like-minded sensitivity towards listening to the agenda of a community or to one's child's agenda or to one's friend's agenda etc. This world view is something to be promoted in PHC training, in undergraduate training and in education in general.

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Addendum

Malonga

Community's Problems/Needs	PHC Problems (observed by Health Workers)
1. Clinic	1. Sanitation
2. Crèche	2. Clinic
3. Water	3. Wood for cooking
4. Vegetables	4. Water
5. School too far for small children	5. Rubbish pits at houses
6. Care group (having collapsed)	6. Poverty

Positive points: Many mackovy ducks and chickens
Shop
Secondary school
Strong leader

± (private enterprise: women weekly rotating the local shebeen!!)