THE COMMUNITY BASED APPROACH TO DEVELOPMENT :

A DESCRIPTION AND ANALYSIS OF THREE RURAL COMMUNITY HEALTH PROJECTS

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A DESCRIPTION AND ANALYSIS OF

THREE RURAL COMMUNITY HEALTH PROJECTS

by

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ABSTRACT

This study investigates the work of three rural community projects implementing primary health care through the use of auxiliary workers: the Manguzi Community Health Project in KwaZulu, the Manzimahle Village Health Workers Project in Transkei, and the Elim Care Group Project in Gazankulu. Their work was viewed from the perspective of the community-based approach to development, which itself is an integral part of primary health care.

The study was motivated by a dissatisfaction with available 'models' of community development, based on a review of community development and primary health care literature, and on personal experience as a community worker. The conventional community development approach assumes a consensus of values and interests between local communities and the local or national authorities, which is inadequate in the Southern African context. Critical social theory, which is analytically more helpful, and can usefully inform urban community work, has thus far had little to offer to the practice of rural development work.

While it is accepted that changes in the dominant economic and political structures are necessary for a significant impact on the underdeveloped state of rural areas, the research proceeded from the assumption that the work of innovative projects can, and should, usefully inform the development of indigenous social theory.

The study was thus an attempt to bridge theory and practice in local rural community development, by starting with the concrete experiences of projects in three different settings. The purpose was to gain an understanding of the ways in which such initiatives were shaped and formed, and thereby to draw lessons for other projects in health and related development sectors.

Individual interviews, group discussions, site visits and a four-day workshop were used to investigate key factors which would illuminate central principles and stages of the community development process. These factors were the recruitment, training and payment of the auxiliary health workers; organisational structures established by the projects; the projects' interaction with the formal health system and with tribal authority structures; and forms of evaluation undertaken by the schemes.

The projects had brought material benefits to their areas, inter alia, improvements in some aspects of health care, and limited income for the auxiliary health workers. They had developed indigenous training materials, and had attempted to introduce an alternative training pedagogy. They provided a platform for women's inclusion in development initiatives, and formed an embryonic basis for community organisation.

The study identifies shortcomings in project planning, training and organisation which led to an over-dependence on project staff, and to the concomitant under-development of the organisational structures necessary to ensure that projects can be self-sustaining.

The projects, like most innovative development organisations, were marginally placed in their environments, in terms of resources available to them, and in ideological terms. They were thus vulnerable, and regardless of whether they were governmental or non-governmental organisations, the structures and procedures of the formal health system and the tribal authority system mitigated against their ability to implement essential processes of the community-based approach.

The context of rural development projects will become more polarised in a time of rapid social change; community issues, already politicised in the urban domain, will become an increasingly contested terrain in rural areas. This reinforces the responsibility which falls on development agencies to build a firm organisational base, with the introduction of democratic processes and procedures. It is hoped that recommendations derived from the experiences of the projects can contribute to an understanding of how this might be done.

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Acknowledgements would not be complete without an accompanying apology to the study projects and their staff who so willingly spent their time with me. I accept the irony involved in submitting a written study more than two years after field work was completed, when that same study exhorts social researchers to deliver findings punctually to the participants in their research.

Finally, I hope that I have described and represented the work of the projects, and the views of those within them, accurately. It has been difficult and unnerving moving from the position of friend and colleague to the position of assessor. I hope the assessment is fair and constructive - that is the spirit in which it has been undertaken.

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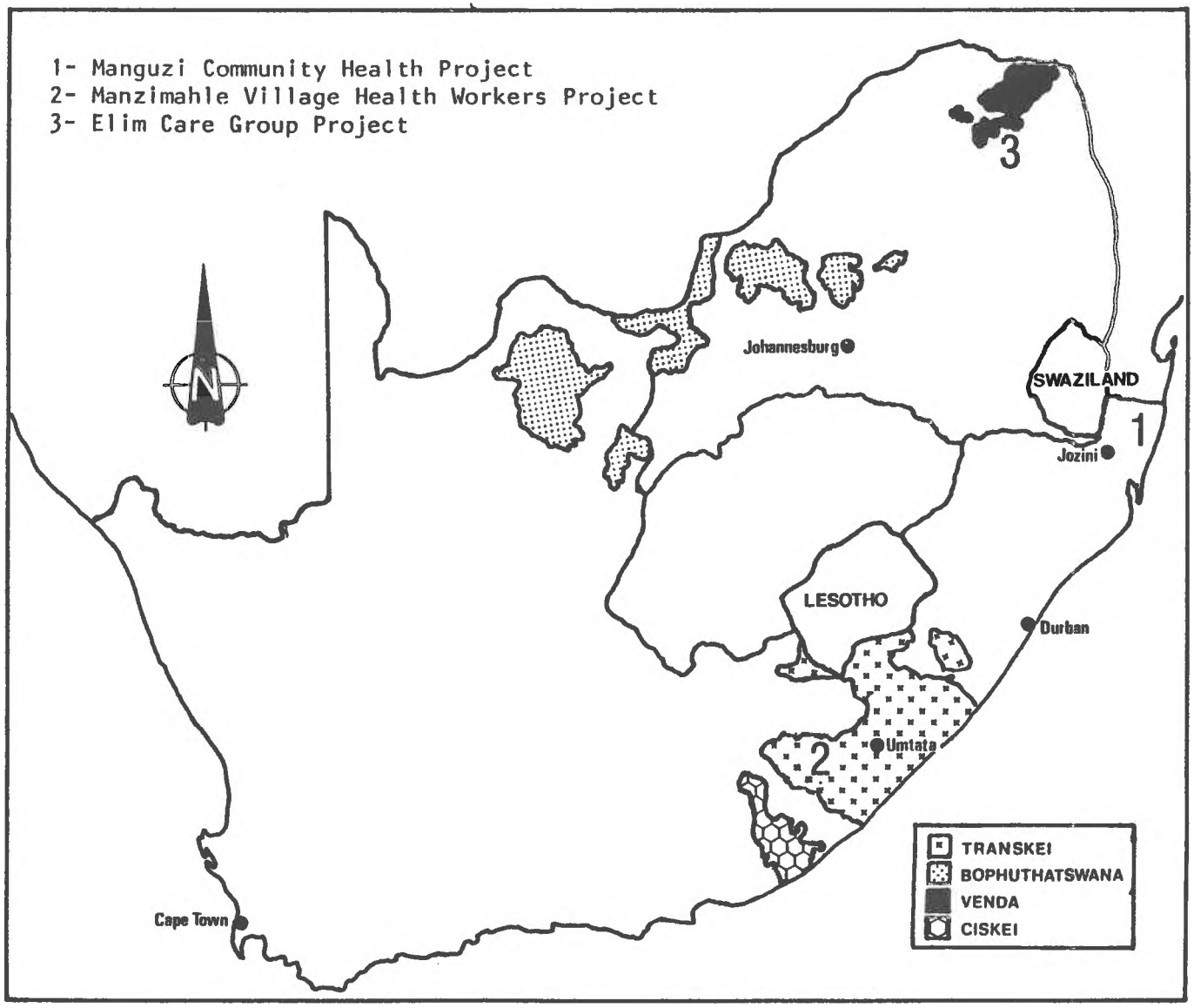

THE LOCATION OF THE COMMUNITY HEALTH PROJECTS

A NOTE ON THE USE OF TERMS

1. NAMES OF PROJECTS

The official titles of the three projects selected for study are: Manguzi Community Health Project, the Manzimahle Village Health Workers Project, and the Elim Care Group Project.

All three schemes are widely known, in their project areas and at conferences, by variations on these names, and I have adopted this popular nomenclature in the text, except where the schemes are introduced for the first time. The first is called simply Manguzi, the name of the hospital in which the project is situated. The second is referred to as the Health Care Trust, which is the name of the organisation that runs the health project. Where the work of the Health Care Trust in other areas than Manzimahle is discussed, the distinction is made clear. The last is called the Care Groups, or the Care Group project.

2. TITLES OF PROJECT PERSONNEL

The titles given to personnel in the study projects in this text are in some cases different to the titles used by the projects themselves. For convenience sake, terms are used in the following way:

Community health worker: There is a great deal of international and local variation in the terms used to describe the category of worker which is the focus of this study: the person, usually selected by the community, who is trained in certain aspects of the provision of health care.

Vaughan (1980: 4), who has international experience of community health programmes, suggests that the term Village Health Worker be applied where the worker operates as an extension of the formal health system, and that Community Health Worker should be used where the person is more directly responsible to his or her community, and fulfils other developmental and sometimes political functions as well.

There is no consistency in South African practice. In the projects under consideration here, the Health Care Trust grassroots workers were titled Village Health Workers. At Manguzi Community Health Project, they were termed (by project staff) Community Health Workers, as people do not live in villages but in scattered homesteads. They were popularly known as 'onnesi bomphakathi' (community nurses). At Elim Hospital, site of the Care Group project, the category of people called Community Health Workers were not the focus of this study, for reasons explained in the text. The focus was on the Care Group members.

In this text, the term community health worker, or health worker, is used to refer to the grassroots level of worker in all schemes, except where in specific instances a distinction needs to be made between the Care Group members and the community health workers in the other two schemes.

Project director: This title is used to refer to the leader of a project. At Health Care Trust, the official title of this person was Project Coordinator.

Trainer: This title is used to refer to the category of worker situated between the project director and the community health workers. At Manguzi the actual title used was Health Educator, and at Health Care Trust, Trainer. At the Care Group projects, the trainers were called Motivators. Where appropriate, the Motivators are specified separately.

SECTION ONE

PERSPECTIVES ON COMMUNITY DEVELOPMENT

INTRODUCTION

The concern of this study is the practice and potential of community health programmes as a platform for community development in rural areas in Southern Africa. It is based on an investigation of the work of three community health schemes: the Manguzi Community Health Project in KwaZulu, the Manzimahle Village Health Workers Project in Transkei, and the Elim Care Group Project in Gazankulu.

A great deal of work is being done in the broad field of community development in this region in both rural and urban areas. A range of organisations and agencies are busy 'developing people and their communities', from welfare agencies and independent self-help projects, through to large bodies such as the Urban Foundation, the Foundation for Rural Development, and the Development Bank of Southern Africa. More recently this has included state programmes such as the government's National Community Development Strategy and Population Development Programme.

The work is called by a variety of names - community development, community organisation, community action, community social work, integrated rural development. Yet key words and phrases are shared - self help, community participation in decision-making, improving the quality of life, enhancing communities' problem-solving abilities.

Such an array of people are busy with so many different kinds of activities, that one may ask: "What is community development?" There is no one answer, except for: "It depends". It depends on who is doing what, how, and with what objectives.

Community development does not take place in a vacuum - it is always situated in a concrete social, economic and political context. Neither is it an abstract, value-free body of knowledge or principles:

'All community work is shot through with assumptions that some forms of social life and change are better than others.' (Younghusband, 1968: 77)

At the very least, community development is about deliberate, purposive intervention in social change. As such, community development programmes have social theories which lead to a set of methods and strategies, mediated by their social policy objectives.

In order to understand and assess any particular community development activities, then, it is necessary to understand the theoretical influences which have informed the different approaches to community development. In this section, an overview will be given of the emergence of community development as an international movement, and the theoretical basis that underpinned its central principles. The critique of this 'conventional wisdom' of community development will then be presented, and it will be shown how this arose as a result of the failure of community development programmes, and was influenced by the shift in dominant theories of social change and development.

One central principle of community development, community participation, will then be used to exemplify the way in which it is not a body of knowledge 'out there' : it always has a theoretical basis which is translated to work in a concrete situation.

Following that, an account will be given of major thrusts in community development in Southern Africa, both in terms of the literature and with reference to concrete programmes. I will argue that there is little in the available models that is useful to, or appropriate for, community work in Southern African rural areas, and thereby will explain the premises and objectives of this particular study.

1.1 THE INTERNATIONAL COMMUNITY DEVELOPMENT MOVEMENT

Great Britain was an important influence on the early establishment of community development in less developed countries. It was formulated as response to the end of colonial rule, with a number of countries gaining independence. It was seen, by both the colonial power and by a number of the new governments themselves, as a partial answer to major problems that they faced.

Four factors are commonly cited as central concerns which gave impetus to the birth and rapid extension of community development (Batten, 1957, 1960, du Sautoy, 1958: United Nations, 1963). First, there was a need for mass adult education and literacy initiatives, where formal education had been available for only a privileged few in the indigenous populations. Then, the previously untapped labour of rural populations was seen to be a valuable national resource, if people could be mobilised to develop the physical infrastructure such as roads, dams, and public buildings in rural areas.

Thirdly, it was acknowledged that the administrative structures which were part of the colonial legacy were inappropriate. Local and regional institutions were needed to mediate new government policy to the people, and communities' needs to the government. Local and regional community development committees (often attached to the party political machinery) were seen as potential channels for

establishing new, more appropriate structures. Finally, many countries faced the need to forge national unity in societies which were deeply divided on tribal or ethnic lines. Collective work at community level could be done in the name of 'building the nation'.

A significant event in the establishment of community development as a development activity in its own right was the Ashridge Conference, held under the auspices of the British Colonial Office in 1954. The simple definition that emerged from this conference was:

'Community development is a movement designed to promote better living for the whole community with the active participation and on the initiative of the community.' (quoted in du Sautoy, 1958 : 2)

Ministries of Community Development proliferated, with their plans running parallel to national economic plans. The community development movement was consolidated when the United Nations adopted and promoted it as part of its policy in the Third World. The United Nations' definition became internationally accepted, and is quoted in full here:

'The term community development has come into international usage to connote the processes by which the efforts of the people themselves are united with those of governmental authorities to improve the economic, social and cultural conditions of communities, to integrate these communities into the life of the nation, and to enable them to contribute fully to national progress. This complex of processes is then made up of two essential elements: the participation by the people themselves in efforts to improve their level of living, with as much reliance as possible on their own initiative; and the provision of technical and other services in ways which encourage initiative, self-help and mutual help and make these more effective.' (United Nations, 1963)

In some countries, such as Kenya, community development was firmly tied to mass education; in others, more attention was paid to the building of physical facilities and to communal agricultural activities, and India is a good example of this.

What were the prevailing social theories that informed the philosophy and principles of the community development movement at that time? Much can be gleaned from a critical analysis of the United Nations' definition itself.

First, there is an assumption of a harmony of interests between communities and the nation state, who will work together for 'national progress'. Then communities are viewed as homogeneous entities - 'the people themselves' depicted as of one mind in terms of what constitutes progress or upliftment.

If these are initial signs that theoretical paternity is to be found in structural-functionalism, one can then look further to the writings of the 'founding fathers' of community development, the two chief exponents of which, in the British post-colonial context, were Batten and du Sautoy. MacPherson (1982: 164-167) has shown how their works are based on a conception of social order and social change which have a firm

basis in consensus theory. Both authors locate 'the problem of development' firmly within the developing societies, and see a central role for community development in changing people's so-called resistant, traditional attitudes.

A connection can be seen here with Rostow's theory of modernisation as well (Rostow, 1962). His work was extremely influential on prevailing ideas about development, in particular his central theme that in order to 'take off' into industrial growth (which was what development was crucially seen to be about), societies had to go through certain inevitable stages of development, the model for which was provided by the growth of Western industrial nations. Modern institutions had to be established, and a change in the worldview of people was needed, from the 'traditional conservative worldview' of the peasant, to 'rational, economic man'.

Development was defined primarily in economic terms, such as in measurable growth in the Gross Domestic Product. National Economic Plans charted out strategies for the hard business of economic growth; community development could mobilise the rural unemployed and contribute to the necessary attitude change. Where populations were reluctant to participate in community programmes, then community development should, according to the Ashridge Conference, develop:

'... techniques for arousing and stimulating (community initiative) in order to secure the active and enthusiastic response to the movement.' (quoted in du Sautoy, 1958 : 2)

Before the Development Decade of the 1970's, announced by the United Nations, had started, there were profound changes in the entire field of development theory and practice, which had implications for the theory and practice of community development as well. Sufficient time had passed for the practical failures of development initiatives internationally to be seen and documented. At the same time, at the theoretical level the dependency school, informed by a Marxian analysis of social change, provided compelling arguments that changed the understanding of the causes of problems in less developed countries. These practical failures, and the theoretical shifts, will be dealt with in turn.

1.2. THE FAILURE OF CONVENTIONAL COMMUNITY DEVELOPMENT

The 1970's saw a growing acknowledgement that development programmes based on pure economic growth were not only working, they were also destructive of resources and social institutions in the societies they were meant to develop. Chambers (1983: 31), in a review of the assessments which were made internationally, summarises as follows:

'The outcomes are well known. Many settlement schemes in Africa were found to be expensive, to create privileged settler groups with dependent attitudes, to disappoint in agricultural production, to be staff-intensive, and to represent a misallocation of resources. For their part, cooperatives were found to be

inefficient, to be captured by local elites to the exclusion or exploitation of smaller farmers, to fail to pay their members, and to have a high turnover of both staff and funds which tended to disappear simultaneously. The green revolution in India as less negatively reported, but it was found that increases in production mostly benefitted the rich, the landlords, the merchants, and the owners of tractors and tubewells, while the poor and landless gained less, or did not gain, or lost.' (UNRISD, 1974; ILO, 1977)

In the narrower field of community development, the 'Community Development Decade' was adjudged a failure. Programmes were typified by the following problems, which highlighted contradictions between the philosophy of community development, and what happened in practice.

Community development programmes were designed at central, national level, and then imposed at local level. This ran counter to a central premise, which was that community development should be flexible, and responsive to local conditions, taking people's felt needs and priorities for collective action into account. 'Participation' meant, in many instances, enforced physical labour on projects identified far from local level, without participation of citizens in the design, implementation and control of community programmes.

Further, whereas community development was held to be a broadly democratising process, whereby increasing numbers of people should be brought into decision-making, programmes were typically administered via existing institutions of authority, which entrenched the power of local elites.

Community development ministries were usually low in status, lacking the authority of, say, economic planning or finance ministries. Thus at national level, ministries competed for a greater share of the limited budget and other resources, with the community development sector not being in a strong bargaining position. At local level, community development officers did not have the authority to promote cooperation and coordination with extension agents from related departments. This mitigated against the holistic, integrated efforts required for programmes to be successful.

These failures, and failures in the broader development field, led to a move away from the narrow focus on economic growth, to a greater concern with issues of equity and distribution (Nattrass, 1983), a concern to 'put the people back into development', and the creation of programmes which would be more responsive and appropriate to local conditions.

The basic needs approach has been one response to the overthrow of the economistic view of development (Seers, 1972; Streeten, 1977; Streeten and Burki, 1978). It has been widely adopted by dominant international funding institutions such as the World Bank and the United States Agency for International Development. It places emphasis on how resources and benefits of development initiatives are allocated and distributed, and it reflects a concern with equity and equality as well as economic growth.

It acknowledges that 'top down programmes' imposed on target groups are not necessarily developmental. Appropriate technology has its place, as manifestation of the need to graft external innovations on to what is already in place and locally acceptable.

The basic needs approach does not signal a change in theory, however, so much as a re-ordering of priorities for development programmes. Structural-functional theory remains intact as its base, and it can be seen as a more liberal version of the old paradigm. The basic needs approach describes and lists new priorities such as housing, food, clothing, and the creation of labour-intensive employment, and emphasises community participation. But it gives little guidance as to how to effect the attainment of these priorities, because it does not address squarely the powers and interests that mitigate against their attainment.

1.3. THE MARXIAN ANALYSIS AND 'THE DEVELOPMENT OF UNDERDEVELOPMENT'.

At the same time as these failures of development programmes, based on consensus and modernisation theory, were being acknowledged, there was a significant shift in the dominant paradigms of social change and development. Where consensus theory had emphasised social order, value consensus, and evolutionary progress, the Marxian analysis presented an alternative theory of change. It focussed on the ubiquity of conflict in capitalist societies, caused by the differential location of social classes in terms of their relationship to the means of production, and the alliance between the state and capital.

In terms of community development within industrial nations, the new analysis gave birth to what is often termed 'community action', or 'social action' (see, for example, Rothman, 1977; Warren, 1969). The problems of inner city slums were linked to the poverty and oppression of working class people in general. As such, neighbourhood 'self-help' or 'community improvement' programmes were seen to be entirely inadequate. The contribution of community work was to facilitate organisation against the authorities and institutions which combined to keep the poor poor and helpless.

In terms of the Third World, Marxist theorists such as Baran (1957) and Frank (1969), through their analysis of the historical spread of capitalism and colonialism, redefined and relocated the causes of the problems of lack of development. Rather than attributing the 'backwardness' of less developed countries to ignorance, resistance to change, lack of technology or lack of modern institutions, the emphasis shifted to the characteristics of a system of international economic and political relationships which led to the underdevelopment of the colonised to the benefit of the industrialised colonisers. Frank's work was seminal in demonstrating the effects of these relationships on local and national development efforts in underdeveloped regions. The importation of foreign technology, the strings attached to foreign aid, capital- rather than labour-intensive policies all undermined the ability of the underdeveloped countries to become self-reliant, and to set their own development goals.

There is an extensive literature on these theoretical changes and their implications for the understanding of development. Here, attention will be drawn to the way in which they have had a bearing on previously taken-for-granted notions in community development. Contributions have come from a variety of disciplines, notably sociology, social geography, economics and anthropology.

Schwartz (1981), an anthropologist, has noted how the conflict perspective has influenced the notion of 'community'. Rather than this being seen as a homogeneous entity, attention is paid to the patterns of social, economic and political stratification, both in a limited geographical area, and to the interconnection between local patterns and those in the surrounding society.

Communities cannot be seen as viable entities, isolated from the broader society. Ideas of community autonomy and self-sufficiency do not take account of the forces at work which structure patterns of, for example, land distribution and employment opportunities - patterns which are determined outside local communities, and which determine local life chances.

Then too, a profound shift is signified by the materialist basis of the Marxian analysis. As has been mentioned, a key role for conventional community development was in the realm of attitude change. A feature of 'non-modern man' was taken to be his conservative value system which led him to be resistant to take up opportunities for, for example, entrepreneurial activities. This gets overturned, and rather than attitudes and values determining behaviour, material conditions are seen to determine behaviour, which becomes normative. Tradition and values then become what Schwartz (1981 : 316) has called 'labile, dependent variables'.

The precise relationship between values, attitudes and behaviour will continue to be a central arena of theoretical debate and research. The Marxian analysis can tend to be too prescriptive and deterministic, not accounting for the role of alternative determining factors in particular circumstances (such as religion or charismatic leadership). What it has done is to break the tendency to 'blame the victim', whereby:

'... the peasant with the "incorrect" cognitive orientations has tended to become the scapegoat for all of the burdens of underdevelopment which he himself suffers.' (Hutton and Cohen, 1975 : 127)

An important implication for community development is that programmes should be designed which both ensure material improvements, and which are sensitive to the fact that involvement in programmes entails a risk for people. The emphasis changes from focussing on people's 'apathy' and 'lack of motivation', to a concern with the practicability and rationality of the programme in the terms of the local people themselves - their material circumstances, their history and strategies for survival, and their previous experiences of planned social intervention.

1.4. A CRITIQUE OF 'COMMUNITY PARTICIPATION'

As Kasparson (1977 : 189) eloquently notes:

'Beneath every participation programme lurks a particular social theory, paradigm, or at least a set of assumptions concerning the need for intervention and the connection of participation to the operation of the political system and the creation of social change.'

At this point, a critical analysis of 'community participation' will be undertaken in order to exemplify the way in which the community development process is manipulated for particular objectives. The same critical analysis could be done for other essential elements of community development, and indeed will be done in relation to the work of the development projects which are the focus of this study.

Thornley (1979) constructs a framework for interpreting how an understanding of community participation derives from particular theoretical positions. He uses Almond, Verba and Parsons as representative of what he calls conservative theorists, whose position is that representative democracy works because of value consensus in a society. Social sub-systems, which need to adjust to one another, need information and feedback, and citizen's participation can be a means of providing this. However, most people have little interest in active civic participation, besides exercising their right to vote in elections.

Thornley takes Dahrendorf's later writings to be representative of the liberal position. He acknowledges the existence of conflict in society; where it breaks out, it has to be managed and contained. Community participation in neighbourhood councils over local issues, for example, is a forum where interested citizens can meet and bargain with policy makers, and where information can be given to the under-represented.

The radical view of participation, according to Thornley, would have as its point of departure the need for fundamental structural change. Participation within, for example, government programmes is doomed to fail for the poor, as they have no powerful bargaining position. Participation must entail full participation of the working class in all aspects of the class struggle. The residential community is one terrain of struggle, where local issues are understood in terms of a wider perspective.

Probably the best known and most thoroughly documented example of the ambiguity of community participation was the War on Poverty in the United States (see, for example, Marris and Rein, 1972; Moynihan, 1969). The Office of Economic Opportunity under the Johnson Administration was concerned with inner city poverty. It diagnosed the problem as not only to do with lack of material resources, but also with the alienation of the poor from the decision-making institutions that affected their lives. People needed to be able to exert more local level over the kinds of anti-poverty programmes they wanted.

Thus, along with the provision of millions of federal dollars was promoted the idea of the 'maximum feasible participation' of poor communities in implementation of, and control over, the anti-poverty programmes. Moynihan described how this turned into what he called 'maximum feasible misunderstanding', culminating in the collapse of all significant parts of the War on Poverty.

The federal government saw participation as an end in itself; the urban poor, led by militant community activists, wanted an overthrow of those very government institutions they felt were oppressive. The urban poor wanted citizen control; the government saw participation as a vehicle for containment and placation.

Merely to advocate community participation, as do exponents of community development, thus begs a number of questions. Sewell and Coppock (1977) raise critical questions to do with participation in the town planning process, which are applicable to community development programmes as well. Important among these are, who is likely to participate? How much participation is possible and desirable, according to whose definition of the situation? Who gets selected into community programmes, and who not? What weight should get given to the views of organised interest groups as opposed to the less articulate, unorganised majority?

The above discussion of community participation has been within the context of Western industrial democracies. What was remarkable about the American War on Poverty was that the government was rich and confident enough to pour millions of dollars into poor areas to equip them to participate in a struggle against its own authority.

In poorer countries, such leeway does not exist, and community participation in community development has most often meant contribution of labour towards the development of rural infrastructure. However, the dynamics of the analysis of participation hold in these areas as well.

Community participation in rural areas can be used to shore up existing patterns of power and authority, and, as Bratton (1978 : 33) says for pre-Independence Zimbabwe:

'The entire community development approach can be seen as an attempt to relocate costs for social services away from the settler state.'

Conversely, community participation can mean involvement in programmes that really alter the life chances of the poor, at a material, social and political level.

1.5. COMMUNITY DEVELOPMENT IN SOUTH AFRICA

A variety of organisations and institutions are using the language of community development in the work that they do, while having a wide range of social and political objectives, and using different methods and strategies. It is not the intention here to provide an inclusive list of these organisations and their activities. My purpose is briefly to outline the broad groupings who are involved, and, at the risk of oversimplification, to show how they are situated in terms of the positions discussed in earlier sections. The goal is to place rural community programmes on the broad canvas of community development in this region.

1.5.1. Government programmes

Until recently, South Africa has not had a ministry of community development in the accepted sense. The now defunct Department of Community Development was an instrument for administration of the Group Areas Act, with the removal of people from settled residential areas to racially separate Group Areas (Schlemmer et al, 1978: 1).

In 1983, a National Community Development Strategy was announced, emanating from within the Department of Constitutional Development and Planning. It is being implemented by the Department of National Health and Population Development, and is firmly linked to the Population Development Programme:

'Community development is not a project with an aim of its own - it is a modus operandi for attaining the objectives of a population programme... Community development is a decentralisation mechanism for the implementation of a population programme.' (Republic of South Africa, 1983: 221)

A detailed description and preliminary assessment of this policy has been made elsewhere (Lund, 1985b). It is sufficient to note here that it is the first time that state-employed community development officers are operating at grassroots level, that the theory underlying the strategy is that of conventional communty development, and that little attention is paid to distributional issues.

Furthermore, since that preliminary assessment was made, the prediction that it would be used as a vehicle for surveillance of the security situation in urban townships has been proved to be correct: Community Liaison Officers have been required to report on township unrest to local Joint Management Committees, comprised inter alia of representatives of the defence force and police.

1.5.2. Private sector organisations and foundations

Bodies such as the Urban Foundation, the Foundation for Rural Development, and Anglo American and de Beers Chairman's Fund, also subscribe to the principles of community development. There has been a

dramatic growth in the 'corporate social responsibility' budget. The manifest intention of this involvement of the private sector in sponsoring housing, education and community facilities is to create a 'stable black middle class'. There is a concern, though, to consult communities in the decision-making about projects, to include elements of self-help, and to build and develop leadership and management skills at community level. This sector is influential in that they fund a good many independent community projects.

1.5.3. Social welfare organisations

Social welfare organisations have traditionally rendered primarily case work services. From the 1970's there has been a growing acceptance of the need to undertake community work as well. Lund and van Harte (1980: 17 - 21) have described the varying forms this has taken, and the conflicts between community social workers and their supervisors and management committees. In these government-subsidised social welfare agencies, community workers are exhorted to 'stay out of politics'. They are trained in, and expected to work according to, an incremental reform approach at neighbourhood level, while the communities in which they work are increasingly defining welfare and community issues as the local focus of a broader struggle for political change.

1.5.4. Independent community programmes

There has been a proliferation of independent community organisations and projects in the last ten or fifteen years, who describe what they do as community work or community development. They represent a wide range of ideological positions, some with an emphasis on neighbourhood self-help activities, others with a more overt political analysis and agenda.

Religious organisations have played a prominent role, perhaps particularly in the training of community workers as an alternative to university social work schools. Also, organisations have been established which provide a resource service for organisations in the field, collecting and developing audio-visual and written materials.

1.5.5. Civic organisations

While there is some overlap between organisations in the last two categories and urban civic associations, the rise of the latter has been such a significant event that it needs to be mentioned separately. Since the end of the 1960's a community-based civic movement emerged in African, Indian and Coloured urban residential areas which has directly affected urban community development work. Civic associations have organised around the provision of local services, often in direct confrontation with local authorities. The language has been that of assertive community action, and demonstrations, sit-ins and boycotts have been the tactics. The influence of the American urban community activist, Saul Alinsky, is evident, as is the

radical community-based urban politics model from the United Kingdom.

There is a significant difference between this and the previous local models of urban community development. Local residential issues such as housing, transport and welfare have become mobilising points in the broader political struggle. Many such groups have affiliated to regional civic structures, which in turn have affiliated to the United Democratic Front.

1.5.6. South African community development literature

There is a dearth of indigenous published literature relating to community development in Southern Africa, and much of what has been written has uncritically adopted models developed in other situations. Because of the contribution of so many disciplines, it is difficult to keep track of all publications; in addition, much that is valuable is in the form of organisations' annual reports, conference papers which never reach the stage of publication, and informal, unpublished papers issued by community organisations.

Thus an attempt to review the literature is on the one hand made easy because there is on the face of it little to review; on the other it is difficult because one is aware that sources are partial and incomplete.

Bearing the above qualifications in mind, the following overview of some indigenous literature merely serves to indicate the scope, and limits, of what is available.

in terms of formal textbooks, the literature is scarce and only minimally helpful. One approaches Ferrinho's 'Towards a Theory of Community Development' (1980) hopeful because of its title, and the fact that it was written in this region. An elaborate interdisciplinary framework is constructed, based on a cybernetic systems approach. He recognises that community development is basically a democratic process:

'To prevent the inequity of a social order in which the self-actualisation of individuals and groups in general is impeded by the interests of elites in power, the institutionalised methodology of action in community development must be democratic, in spirit, organization and operation. This means opportunitity for all to express ideas and concerns and to participate in decisions regarding all collective issues.' (Ferrinho, 1980: 53)

However, he does not recognise the ironic contradiction, in the South African context, between this democratic process and the following statement:

'... the necessary support for action from the government must be assured. The latter can, and must, assume certain responsibilities in supporting community development planning, of which one of the most important is **to provide local people with true and valid information** concerning the interests of the community'. (Ferrinho, 1980: 68 - emphasis his)

This is followed by:

'... community development is possible only when the political situation permits the existence of local institutionalized ruling bodies with adequate autonomy over the internal interests of the community and with voice in national affairs.' (Ferrinho, 1980: 69)

This is simply not helpful as a theory for community development in this region. Jeppe (1985) likewise gives an approach to rural community development which hides the fact that community development is always used to further some social policy objective, and is not an abstract body of knowledge devoid of a concrete context (although he situates the work in Bophuthatswana). He provides a useful overview of contemporary trends in community development, but then adduces some rather odd conclusions.

He agrees with Ferrinho that community development should be concerned with equity and not equality, for:

'Equality is the process of reducing the more eminent to the level of those who are at the bottom of the scale or vica (sic) versa.' (Jeppe: 1985: 30)

He says firmly that community development always takes place in a political context, but that:

'... CD in its conventional and normal application does not have an explicit political or ideological aim, nor does it promote political ideals, but retains neutrality with local and national political ideals and actions.' (Jeppe, 1985: 43)

Further reading shows that 'neutrality with local and national political ideals and actions' means that it is perfectly appropriate when community development is used to bolster local tribal authorities, but:

'Different and unusual or non-typical use of CD methods for political, ideological or revolutionary purposes may be applied in a variety of ways and have been typified by different names viz "social action", the "idealist" or "political activist approach", "agit-prop" and even the "negative" use of CD.' (Jeppe, 1985: 43)

There is not much that is 'neutral' about his theoretical location.

Fitzgerald (1980) gives a useful explication of the so-called non-directive approach to community development, using as case study her own work in Kliptown. She relies heavily on the work of the Biddles (1965). Swil (1982) who presents social work students' field work placements to elaborate on the nature of community social work, derives her theory largely from Dunham's framework of community organisation (Dunham, 1970). These local authors thus both draw on theories generated by an urban American framework, and neither attempts to answer the difficult questions relating to the specific task of indigenous community development in an apartheid society.

Lund and van Harte (1980), in their discussions with South African community workers, describe the then contemporary reality for community workers in an apartheid society, but do not develop this into an indigenous theory. Taylor (1977) similarly attempts to sketch the parameters within which such a local theory will have to be attempted, but goes no further than that.

A number of writers have attempted to analyse critically aspects of the conventional wisdom of community development at a conceptual level. Ferron (1975), for example, pays attention to the distorted meaning of 'community' in South Africa, if 'community' implies a common geographical area. The Group Areas Act and Physical Planning Act have legislated a spatial ecology, removing and resettling millions of people, destroying established community networks in the process.

Helm (1974) in discussing the concept of community participation in the South African context, shows how tactics associated with the community action model, which are an accepted part of urban community work in the United Kingdom and the United States of America, are proscribed by law locally; she discusses the problem of 'working with local leadership' when accepted leaders are detained and formal leadership lacks legitimacy; she describes also the problems for efficient and representative management of community development activities when welfare regulations forbid racially mixed management committees.

A rare example of a thorough empirical community study which was undertaken in order to plan the feasibility and form of a community development project, is that done by Schlemmer and his colleagues (Schlemmer et al, 1978). Perspectives on community development are presented in terms of their appropriateness to South Africa. Among the objectives of the study was:

'... to uncover social processes and patterns of interaction in the community which will either assist in developing a community programme or which may impede community action.' (Schlemmer et al, 1978: 7)

Thus the research was done in order that the proposed project could be grounded in and on the needs of the community, with realistic limits. The authors, clearly mindful of the negative effects of failed projects, say:

'We have seen many community projects fail because of naive assumptions that community participation would be forthcoming simply because of the merits of a project. Community participation requires planning and organisation of a highly sophisticated kind, and it requires offering many attractions for many different kinds of people. We will not be enthusiastic about any half-baked attempts to launch something with a minimum of planning and with only hope and faith to steer the project. A certain amount of optimism is necessary, but we plead for an adequate context for such optimism and for thorough planning and preparation.' (Schlemmer et al, 1978: 140)

A different kind of community study, though similarly useful, is Silk's account of the destruction of Modderdam squatter township (Silk, 1981). He depicts the forces at work which shaped and divided the community in the face of demolition; shows the utter disrespect of the authorities for human life, while they

mouthed the jargon of community development; and he graphically describes the conflicts and tensions between the community and welfare organisations and university research institute who were involved in Modderdam. This book, written by a practising journalist, teaches much about the reality of grassroots crisis intervention work - and the need to understand more about that is something that will certainly increase in this region. It is an example of the kind of indigenous literature that is required to understand the potential and limitations of local community development efforts.

A critical analysis of conventional community development appeared in a 1980 issue of Work in Progress. The (unnamed) authors correctly describe the hollowness of the principles of community development when disembodied from a concrete socio-political context. They conclude that community development programmes are:

'... the last desperate attempts of a ruling class to preserve the dying social structure over which it presides.' (Work in Progress, 1980: 42)

The language may be exaggerated, but the general analysis of the article is in line with MacPherson's judgement (1982: 164) of the international community development movement:

'... this was a concept elaborated in order to maximise the extension and growth of colonial penetration and control.'

The Work in Progress authors advocate a new form of community organisation directly related to working class struggles. Their themes have been continued by a group of theorists from beyond the usual disciplines of sociology and social work. McCarthy (1985) and Smit (1983), using Castells' theory of urban social movements, have made contributions which deal with the contemporary dynamics of community movements in urban areas. Their contributions come from the disciplines of social geography and town planning respectively.

On the rural front, even more than the urban, much of the valuable work that has been done by local projects, and the lessons learned by them, goes unrecorded. This contributes to the lack of a grounded theory which can guide and inform future efforts.

Derman and Poultney's ongoing series of papers about the Mboza Village Development Project describe the patterns and processes at work in one local area which shape the development programme (those of most relevance here include Derman and Poultney, 1984, 1985a, 1985b, 1986). They work and write from an anthropological dependency perspective, and reflect well the dialectical interaction between theory and practical work which is needed to achieve the balance between heady optimism and faith, and the despair that comes when yet another ill-conceived, under-planned, over-ambitious development project fails.

Claasens (1978) gives a detailed study of producer cooperatives in Transkei. After a careful analysis of the financial workings of her sample of groups, she concludes:

'The aspect of class differentiation becomes significant (in Southern African rural areas) because this thesis implies that there is only room for a few people to be rich, and these not from expanding production, but basically acting as middlemen between external capital and the mass of poor people in the reserves'. (Claasens, 1978:81)

The results of her research lead her to say:

'I think 'developers' should consider whether, in advocating projects which cannot change the basic conditions in people's lives, they are avoiding the root problems and perhaps diverting attention from them.' (Claasens, 1978:80)

Quite so, and then what is needed is more published studies of this kind, which take one inside the lives of projects, and show what it really is, on the ground, that development initiatives are, or are not, able to achieve, and the constraints that they face.

1.6. THE POINT OF DEPARTURE AND OBJECTIVES OF THIS STUDY

The point of departure of this study derives from the foregoing account of perspectives on community development. In the context of South Africa, the theoretical basis of conventional community development is inadequate. This is a society of structured inequality, riven with racial and class conflict. As mentioned, any assumption that a residential area is a 'community' is problematic, when the Group Areas and Physical Planning Acts have determined where people may live. Areas are heterogeneous in terms of socio-economic status and political alliances. A community worker who assumes a harmony of interests within areas, or between local areas and the local or national authorities, does not deal with contemporary reality. And the idea of 'self-help' is problematic in a context of years of neglect in providing black residential areas, rural or urban, with essential civic services and facilities.

The conventional style of community development is thus not helpful in terms of its ability to throw up viable strategies of local social intervention. Yet despite the empirically researched and documented failures, in societies more homogeneous and integrated than this, of programmes fashioned by this conventional wisdom, it continues to be used as the basis for university training programmes, informs the practice of many welfare organisations' community work, is actively promoted by the South African government, and is viewed by some 'homeland' governments as a partial solution to their development problems.

So the one set of voices this study argues with are those who say uncritically 'we must help the people to help themselves'. It sets itself against the textbooks and articles prefaced by the tired and over-used aphorism: Give a man a fish and he will eat for a day; teach him to fish and he will eat for the rest of his life.

This exhortation has truth in it, in so far as it is arguably always beneficial when individuals or groups are enabled to be self-reliant and independent. It hides, however, central questions which are **not** addressed by too many advocates of this kind of development: are there any fish in the river? Are certain sectors of the community precluded from eating fish? Who determines the market value of fish? And who controls the fishing licenses?

The conflict perspective is analytically more helpful in understanding the dynamics of societies characterised by inequality, focussing as it does inter alia on the economic and political forces that combine to keep the poor poor. It gives due weight to the historical basis of poverty and underdevelopment. It leads away from pedantic notions of 'irrational man', and reveals the set of relationships that have led to the failure of so many development efforts, at considerable risk to the poor.

A problem arises, however, when a community development agency attempts to derive a method and strategies from this theoretical position. Purist academics would assert that it is only when the dominant economic and political formations in capitalist societies change, and land and other resources are redistributed, that there can be an authentic and non-exploitative meaning to key notions in community development such as self-reliance and popular participation. Anything short of revolutionary work aimed at transforming or overthrowing oppressive structures is seen as 'reformist' or 'entrenching false consciousness' or 'working against the true interests of the working class/peasantry'.

Yet a community worker in Southern African rural areas who openly promoted these objectives would not remain in employment for long (and this is a different issue to the principle in community development of 'working yourself out of a job'!) Development workers in rural areas have far less room to move than their urban counterparts. They are much more visible than workers in the relatively anonymous urban situation. They put people at risk through the work that they do, as a close eye is kept on projects and workers. Rural workers are also under greater pressure to 'deliver the goods' in material terms, in the face of more evident poverty and deprivation.

As Schwartz (1981: 319) says, for those informed by the Marxian approach:

'One way to avoid the dilemma is to drop completely out of applied work, but this is hardly an interesting solution.'

The initial, and simple, premise of this study is that there is something worth doing in rural areas in the realm of community development. People will continue to live there, and for the foreseeable future, they will have to see to themselves in terms of many aspects of their lives.

Under the present government, and its alignment with the private sector, rural areas will continue to be neglected and underdeveloped. In a post-apartheid society, whether run as a capitalist, socialist or mixed economy, it is probable that any national programmes of reconstruction will reach the grassroots level of rural areas last. Administrative bureaucracies will remain in place, the problem of reaching the poorest of the poor will remain intractable, and there will be a shortage of skilled people to manage rural development.

With this in mind, and acknowledging that this is a time of rapid change, it seemed worthwhile to enter the lives of selected rural community programmes and ask: what is it that they are doing? How are they doing it? What seems to make some strategies for planned intervention work, and others not, under what conditions? What problems are they facing in involving communities in their work?

It was not the intention to 'test out' any particular social theory, except in so far as the study was undertaken at a time of an increasing awareness of the need to 'put the people back into development', or as Chambers (1983) calls it, the need for 'putting the last first'. This caused me to be particularly concerned to investigate organisational aspects of primary health care programmes, to view them in terms of Korten's 'learning process approach' (1980) to community development. Are organisations structured in such a way that they can be responsive to community needs, establish the basis for authentic community participation and control, and work towards being self-sustaining and effective? If so, what do the structures look like and how did they get that way? If not, what has constrained the development of such structures?

The projects were not selected because they explicitly articulated particular social theories of change. All saw primary health care as the basis for an integrated approach to development - 'health as a wedge', as MacDonald (1983: 164) has called it. (The connections between the principles of community development and cornerstones of the primary health care approach will be discussed in section 3.4.) All had a commitment to the achievement of broader social objectives than more accessible and effective health care.

They were selected because they were similar in some respects, and different in others (the basis for selection is described in section 2.1.) - similar and different regarding key variables which it was hoped would illuminate the processes and conditions which give shape and weight to development initiatives, and thereby provide a useful comparative perspective.

Given that there is a paucity of documentation of projects, and that these operate in relative isolation from one another, the modest objectives of this study were as follows:

1. Through a literature review, and on the basis of personal experience in community development, identify key issues germane to community development which would be faced by schemes doing rural community health work.

2. Through a series of focussed interviews and group discussions with project personnel in, and through personal observation of the work of, three selected schemes, describe and analyse their work in terms of these issues.

3. Establish, through this analysis, what aspects of their work have been successful and why, and what constraints exist to the successful implementation of community development principles when applied to health and related development projects in rural areas.

4. While avoiding 'blueprints' or rigid guidelines, present suggestions and recommendations for the work of these and similar schemes, based on concrete project experience.

SECTION TWO

THE RESEARCH METHOD

INTRODUCTION

In South Africa, a divided and rapidly polarising society marked by economic and political inequalities, the problems facing the social researcher are acute. The dethroning of positivism as the dominant social scientific paradigm has opened wide-ranging debates as to the most appropriate, effective and useful ways of undertaking social research. An awareness of some of these problems influenced the choice of research design and method.

This section is organised as follows:

2.1. Choice of schemes for a case study approach
2.2. Choice and design of focussed interview
2.3. Sources of information
2.4. Analysis of information
2.5. Some questions arising from, and limitations of, the study.

2.1. CHOICE OF SCHEMES FOR A CASE STUDY APPROACH

It was decided to focus in some depth on the work of three different schemes. The objectives of the study, to explore in detail the process by which projects try and translate into action aspects of the community-based approach to development, could not have been fulfilled by including more projects as case studies, given limitations of time and cost.

Development projects (unfortunately) come and go at such a rate that it was difficult to determine the universe of projects from which a selection could be made. Robbins (no date) had done a survey on seven rural health programmes, and this provided some useful background material. My own involvement in the field of community development gave me a national overview of who was active at that time.

The basic criteria for selection, if the study objectives were to be met, were that schemes should be situated in a rural setting, should be training local people with low levels of formal education, and should be committed to implementing the primary health care approach. I wanted at least the following variations to be present in the choice of schemes.

2.1.1. A mix of governmental and non-governmental projects

The literature points to advantages and disadvantages to be gained from the location of rural development projects either inside formal government systems (in this case, the health departments), or run and sponsored independently. Hyden (1983: 119-122) says that, although in Africa the potential of non-governmental development organisations has yet to be fulfilled, they have the advantages of being closer to poorer sections of the community than are government officials; the staff are usually highly motivated; they operate economically, because of a greater cost-consciousness; they are more flexible than government agencies; and their independence gives them the opportunity to place demands on government for public resources. Government programmes, on the other hand, have better access to policy-making machinery, and to the resources required to make an impact on, for example, health indicators in rural areas.

I thus considered it would be useful to have a mix of both governmental and non-governmental projects. The Manguzi scheme emerged from, and was firmly lodged within, the KwaZulu Department of Health and Welfare, although it received some small private funding. The Health Care Trust project was independently funded, and operated separately from, though in cooperation with, the Transkei Department of Health. The Care Group scheme emerged from within, and operated out of, a hospital run by the Gazankulu Department of Health, but had somewhat more private funding, and thereby independence, than did Manguzi.

2.1.2. A mix of regions

I was interested in whether the presence or absence of regionally specific organisations (such as Zenzele, Inkatha, and various women's church groups) at community level made a difference to the work of grassroots health workers. Thus I decided to draw schemes from a variety of regions, rather than restrict the scope to projects operating only in the Natal/KwaZulu area, close to my research base.

2.1.3. A mix of settlement patterns

Manuals written on community health schemes in rural areas come up with blueprints or prescriptive guidelines as to how many workers should be trained in what way to cover how many families. They assume a homogeneity of social organisation and spatial patterning which is simply not present in the Southern African region. The nature of project work must to some extent be affected by settlement patterns, and the three schemes were chosen with this, inter alia, in mind.

The Care Group area is densely settled, relative to Manguzi, and has been seriously affected by resettlement (population removals). In the health ward served by Manguzi, homesteads are widely

dispersed and do not form villages as is the case in Transkei (also affected by resettlement). The aim was not to use settlement patterns as a controlled variable. I hoped the variety would help illuminate the different kinds of choices faced by schemes in the design and implementation of their work, and the limits which project environments placed on the nature of the work.

2.1.4. A mix of roles for grassroots health workers

When the research was being designed, a topical issue of debate was whether it was better to train fewer people to perform a greater range of functions, or vice versa. I hoped to shed some light on this debate by choosing schemes which differed in this respect.

The Manguzi and Health Care Trust workers are more similar to each other in role and function than are the Care Group members. The former two schemes have trained a limited number of people in a broader range of skills; the Care Groups have involved thousands of women, setting up a 'health buzz', as it were, but without the same accountability to the project, or depth of training.

2.2. CHOICE AND DESIGN OF THE FOCUSSED INTERVIEW

A focussed in-depth interview was chosen as a key information-gathering tool. According to Moser and Kalton (1971: 298):

'Such interviewing gets away from the inflexibility of formal methods, yet gives the interview a set form and ensures that all the relevant topics are discussed. The respondents are all asked for certain information, yet they have plenty of opportunity to develop their views at length. Interviewers, on their side, are free to choose when and how to put their questions and how much to explore and probe, all the time keeping within the frameworks imposed by the topics to be covered.'

I had used this interviewing technique successfully in a previous research project, and in this study it allowed for the combination of systematisation and flexibility that was necessary. While a core group of topics was covered in all interviews, which enabled comparisons between schemes to be made, the focussed interview allowed the unique aspects of each project to come to the fore.

How were the topics for discussion chosen? And how much weight should be given to each? These were determined broadly by the objectives of the study, with the following factors being influential.

Extensive reading of both local and international literature played its part in isolating key issues and variables in the developmental process of rural health care projects. Particularly influential were Feuerstein (1976), Robbins (no date), Vaughan (1980), Vaughan and Walt (1983) and Werner (1981).

At a practical level, I had extensive involvement in a number of development projects. In the specific field of primary health care, I had been an evaluator of a rural project in the Ciskei, a management committee member of a 'model' primary health care centre in an urban informal settlement, and a committee member of a regional Health Policy Committee initiated by a state health department.

While formulating the research project, I also had a number of conversations with people involved in community health, and asked for their ideas as to key issues facing projects of this nature.

Finally, all interviewees were asked during the interviews whether there was anything of importance they thought I had left out - in other words, what had they been expecting me to ask which I had not.

The major subject areas dealt with are given below. They were not covered in any particular order, and, as expected, some people had much more to say about particular topics than others. The subjects were noted down as an 'aide memoire' - a simple guide to ensure that no topic was omitted.

1. Formation of the scheme: when started, who by, why, with what sponsorship, relationship to formal health system.
2. Recruitment and selection of community health workers: process, criteria, community involvement.
3. Training of community health workers: who by, where, what methods and resources.
4. Payment of community health workers: are they paid, who by, how, changes over time, problems. Other forms of incentives.
5. Role and functions of community health workers, any changes over time.
6. Structure of the organisation: personnel, committee structures, accountability, relationship to the formal health system, project - community structures.
7. Relationship between health workers and health professionals in the area as well as other extension agents.
8. Relationship of scheme to tribal authority structures.
9. Forms of evaluation done by schemes.
10. Achievements to date; major future plans.

2.3. SOURCES OF INFORMATION

Field trips were undertaken to each scheme following letters or phone calls to project directors explaining the nature of the research, and asking permission to visit. The field trips took place over the period November 1982 to October 1984.

The Manguzi project and Health Care Trust project were visited twice each, with eleven days being spent in all at each project for the purposes of the study.

The Care Group project was considerably more distant from the research base, and was visited once for five days. This scheme is much better documented than the other two, thus interviewing could concentrate on processes and problems, with background historical material taken care of in the documentation.

2.3.1. Interviews with project directors

Focussed interviews were conducted with each project director. These lasted between three and five hours each. The tapes were transcribed and sent back to interviewees for verification, and to allow them to specify any sections which they wished to be 'off the record' for publication purposes - these were specific names and actions of individuals and organisations.

2.3.2. Interviews with trainers of community health workers

A focussed, tape-recorded interview was likewise conducted with a trainer from each scheme, which lasted between two and four hours each. In addition, a two hour tape-recorded group discussion was held with seven Care Group motivators (one of whom had been interviewed separately). The transcription was sent to them for verification and to check for confidentiality.

Project leaders were asked not to attend the individual interviews with trainers, as it was felt this might have inhibited trainers from communicating freely on all subjects covered (for example, project leadership). The motivators' group discussion was attended by the project director.

2.3.3. Group discussions with community health workers

At Manguzi, a group discussion was held with the community health workers on each visit (i.e. five months apart). Each lasted about two hours, and the trainer attended both. They were not tape-recorded: I made notes as the interpreter proceeded during the first discussion, and added to them after the meeting. During the second discussion, the workers were divided into three small groups; group leaders made notes, and following the discussions, the group leaders and I had a tape-recorded session, adding details to their notes.

Two group discussions were held with the Health Care Trust community health workers, one on each visit. The first was attended by the director and trainer, the second by the trainer. They lasted two-and-a-half and one-and-a-half hours respectively. They were not tape-recorded. In the first discussion, the director took full

notes (which, by mutual agreement, effectively precluded her participation in the meeting); in the second, a visitor to the project, who was a trained researcher, took detailed notes.

These group discussions took place in Xhosa or Zulu, with the help of an interpreter. I can understand enough of both languages to know when I or respondents are being misinterpreted or misunderstood. Also, in all cases, at least one health worker was fluent enough in English that he or she acted as a check on the interpreter.

Group discussions were not held with Care Group members. Care Groups typically number forty women, and there was no way of choosing one or even a few 'typical' Care Groups from the four thousand-strong membership, that would have been able to be accomplished within the limits of this study. Instead, Care Groups were observed in action and in training.

I had feared that the presence of directors and/or trainers in the group discussion might hinder the health workers' ability or willingness to express their problems openly, but did not feel able to insist on their absenting themselves. To their credit, and to the credit of the health workers themselves, real disagreements arose during discussions, and were hotly debated. Furthermore, at the national workshop for health workers (attended by some of these same workers, and mentioned below), which was organised specifically to exclude directors and trainers, the same priority themes and issues emerged spontaneously.

2.3.4. Visits of observation

Apart from these formal, structured interactions through interviews and group discussions, I had the opportunity to observe the health workers in action.

I attended two Care Group meetings, and observed one group's health education play. At Health Care Trust, I spent some hours with a group of workers while they did spring protection work with community people. In the Manguzi area I attended clinic sessions where the community health worker was part of the health team.

Most helpful of all was spending a day accompanying a Manguzi community health worker on her weekly round of home visits. We went most of the way by foot, from sun up to sun down, covering five homesteads in these twelve hours. It gave me new insight into the value of these frontline workers in terms of reaching inaccessible areas, and also into the tremendous physical hardships the workers face in such an area.

In all schemes, I was driven around the area at the beginning of the visit. This proved invaluable in preparing for interviews and discussions. It gave an overview of settlement patterns, levels of living and development infrastructure, and enabled me to pose questions in concrete, local terms.

2.3.5. Project records

All schemes generously made available any written materials which they had. These ranged from initial project proposals and motivations for funds, to annual reports, formal and informal evaluation studies, conference papers, etc.

2.3.6. National workshop for community health workers

During the course of the field work, I became aware of the isolation of the schemes from each other, and of how much the health workers could learn were they to have the opportunity of meeting. I obtained funding for, and organised, a four-day residential workshop for health workers from seven different schemes (including the three in this study). The workers determined the programme themselves, proceedings were held entirely in Zulu and Xhosa, with Zulu-speaking friends and colleagues acting as group facilitators, and health professionals from the schemes were deliberately excluded. This was a very successful event, which provided me with a deeper insight into the nature of grassroots community health work, the problems faced by health workers, and the position of women in rural areas.

2.4. ANALYSIS OF INTERVIEWS

A content analysis of the transcribed interviews was done, in terms of the themes generated by the objectives of the study. Many passages were cross-referenced twice or thrice. After six weeks, during which no reference was made to the interviews, the content analysis was repeated, and the two sets of classifications were then compared. There was an extremely high coincidence of categories.

Any passages which had been unclassified in one or both exercises were then extracted and analysed. This material fell into three subject areas. First, it concerned project staff's own feelings about their leadership of the programmes. This was a major omission, and a clear example of the trap of only finding what you are looking for. This material was consequently included in the analysis and interpretation.

The other two subject areas of omission were justifiable and trivial. First, I had not classified interviewees' requests to me for help with specific training materials and resources. Second, I had not classified the informal digressions about the weather, what to do about tick bite fever, whether to take malaria pills, etc.

On the one hand, then, I am confident that there was no deliberate exclusion of sections of interviews from analysis, and that there was a consistency in allocating categories to portions of interviews. But two problems, which can be stated as questions, remain. How do I know that people were telling me what they

really meant, what **really** had happened in the project's life? And, how do I know that I am not selecting from the totality of what they said only what fits my idea of what I would like them to have said?

The first is partially an epistemological question. My response is that the interviews are noteworthy for the candidness and self-critical reflection of the interviewees. Yes, their interpretation of history and events and processes, is but one interpretation. I bring my own judgement to bear as well, and point out in the text where I think there are alternative interpretations, or where different staff members have different interpretations of the same issue. This issue is dealt with in more detail in the next section.

As for the second question, researchers cannot escape the problem of bias in either quantitative or qualitative work. More is **overtly** at risk in this kind of qualitative study. One can only declare one's own theoretical position, and personal bias. I did not do the study to 'prove' that one scheme would be better than another, or that any would be all good, or all any good at all. I understood that all projects are moulded by personalities, who will, as will the researcher, have their own 'ways of seeing'. I understood that all rural work is difficult; that projects are constrained by their own resources and environments; that the quality of life in rural areas is largely dependent on structural economic and political changes at the macro level, rather than on small-scale development project work; but that innovative model-building is necessary and can be useful to point ways to the future, to show the possibilities and limits of building organisations in underdeveloped areas.

2.5. SOME QUESTIONS ARISING FROM, AND LIMITATIONS OF, THE STUDY

I will now discuss some of the troubling questions faced by social researchers and development workers in a rural, Southern African setting, and draw attention to some limitations of the study which arise from these.

2.5.1. What's in it for project personnel?

A research visit by an outsider imposes on the time and energy of those 'being researched' - and these two commodities are always in short supply in rural areas. The researcher may want to spend longer in the project area than staff can afford. He or she is usually dependent on project people to be introduced to the area and to significant actors - these may be community groups, grassroots workers, tribal authorities. The researcher's need for accuracy, detail and standardisation of information may be antithetical to the project's need to get on with its work.

I experienced the most remarkable generosity from people in all schemes. There was an overt willingness to talk, and to discuss successes and problems, even though some interviews took place at the end of a long and busy day. People said that, working in isolation as they were, the interviews were welcomed as an

opportunity to sit back, take stock, and consolidate their thinking. This was one advantage of a focussed interview method, as opposed to a tightly constructed questionnaire.

Thus certain benefits of the research could be seen immediately by project people. On the other hand, being the projects' guest, there were limits on what I could do. In particular, I wished to spend more time in group discussion with community health workers at Manguzi. However, the workers come together only one day a month for training, and this time was precious to them - I felt I could not impose further.

2.5.2. (non)Use of a survey schedule for community health workers

An issue I wished to pursue was the socio-economic status of the health workers. A rationale for training community people to be health workers is that they are 'typical' of the people they serve. It seemed important to establish whether they were in fact 'typical', or whether, as with other schemes internationally, they tended to be drawn from the somewhat better-off sectors in the community. I also wanted to establish their ages, family status, and formal educational levels.

This would have involved administering individual survey schedules to the health workers at Manguzi and Manzimahle, and, ideally, doing a sample survey of Care Group members. In addition, it would have meant doing a control sample for non-health workers, as there is little demographic or socio-economic data available which pertains to these areas.

In two project areas, I was advised that asking community health workers for individual household information would be unwise. This was argued both in terms of the time it would take, but more important, that people in these areas were suspicious of filling in forms and giving personal information. At the national workshop which grew out of this study, I was again advised against asking for personal details.

Now, although I am aware of the insensitivity and personal invasiveness of some social survey research in rural (and urban) areas, I do not at all think that it can never be done reliably (though income and expenditure data seem exceptionally difficult to ascertain with any degree of accuracy), nor that it is always necessarily discourteous to the interviewee. Much depends on the researcher's approach and sensitivity - but building rapport and trust takes time, as does working through interpreters, which would have been necessary in this case. Again, being the guest of the projects, it was important to be guided by them.

In this study there is thus no statistical description of 'who the community health workers are' in terms of demographic variables. There are my own observations; there are the impressions of project personnel; and there is some detail from discussions with the health workers themselves. It is a weakness in the study, but in my view it could not be avoided.

There is similarly no investigation of community attitudes towards the projects. This had not been part of the research's original intention, but during research visits I came to see what a valuable addition this could make. Once again, limitations of time and cost made it impossible, and the decision can be justified in those terms.

It does mean, however, that this is one more study that has failed to reach, in substantial ways, the same people who are continually unreached by much social research, because of 'limitations of time and money'. In project terms, these are the workers in the lower echelons, the grassroots workers themselves, so that interpretations of the project come largely from the more articulate, better paid development workers. In broader terms, the opinions of people in the communities whom these projects are intended to serve have yet again not been heard.

2.5.3. The problem of prepared answers

The schemes were chosen because they were interesting and unusual: pioneers of a kind. As such, they had been visited by other researchers, people who would have been asking at least some of the same questions as I was. The danger arises of people delivering a 'learned' set of answers - a package of responses thought to be appropriate to the situation.

This problem did not exist with project directors. As mentioned, the interviews show a rare candour and critical reflection.

As far as the trainers were concerned, there was a fairly consistent dynamic in the interviews where matters of a sensitive nature were in focus. For example, when discussing tribal authorities, two of the trainers first glossed over problems. Further probing, with the help of examples from other schemes, elicited a more candid response.

The problem was initially more severe in group discussions with community health workers. It was at first difficult to get beyond glib, text-book answers - the development gospel, as it were. For example, when I asked, "What made you become health workers?" the prompt answer was invariably, "We want to help the community". It proved difficult to uncover supplementary or alternative motivations. The national workshop for health workers overcame this problem to a large extent.

2.5.4. Language and interpretation

A linked problem is that of language and the use of interpreters. I mean language in two ways: language in the conventional sense of Xhosa, Zulu, Tsonga, English, and the 'language of development'.

As regards the former, group discussions were held in Zulu and Xhosa with the help of interpreters. This is a poor substitute, however, for a researcher being fluent in the language being used. It is impossible to pick up on nuances of expression. One kills a discussion if, on observing a small group of people talking to each other, looking discontented with the flow of the discussion, one has to ask the interpreter to draw attention to them and ask what the dissension is about, because that is what one **really** is interested in. It is also very frustrating to have asked a question, the question is interpreted, two or three people give lengthy replies, and the interpreter says, "they say 'yes'". I was fortunate in the quality of interpreters, my own ability to understand enough Xhosa and Zulu to detect underinterpretation or misinterpretation, and the presence always of at least one health worker whose good English was a check against interpreter bias.

Still, the best interpreters do not quieten one's anxiety about research in a multi-linguistic or multi-cultural setting. With other English speakers there is confusion enough about meanings and connotations of 'community', 'participation', 'development', 'progress', to name only a few of the over-used words in the development vocabulary. Research experience in other settings had shown me how difficult it is to render some concepts intelligible in another language.

Quite a large section of the interview with a Care Group motivator revolved around how the words 'motivator' or 'to motivate a community' translate into Tsonga. Briefly, they don't translate at all, and the substitute words used all have the connotation of teaching or instruction, which is precisely what the scheme was attempting to get away from in using the word 'motivator'.

2.5.5. Race, gender and class: on being a white, female, middle class researcher

The researcher in a conventional social research setting normally starts out in a dominant position. Usually an 'outsider' to the research area, he or she may , for all the training in research method, start off wearing a pair of spectacles which bear the perspectives and prejudices created by background, by education, and by academic discipline.

A white South African researcher in black rural areas has many barriers to cross, apart from that of language. Being a member of the dominant political group, he or she will have assumptions and stereotypes, and simple lack of knowledge, about the society to be investigated. The people, in turn, will categorise the researcher both as a white person and in terms of their own past experience, if any, of researchers.

As a community worker and researcher in black Cape Town areas in the early 1970's, I found very differing reactions to myself as a grassroots worker when entering a new community. The older people initially categorised me as coming from 'the welfare'. This meant: we'll smile benignly at you (even when we think your suggestions are daft); we'll thank you profusely for your presence in the area (even though we're not

at all sure what all this community work language is about); and we'll wait and see what material benefits you will bring us (and you seem to be taking a long time 'getting to know the area', and saying you are here to help us help ourselves - **you've** got the car and the clout, why don't you do more **for** us people?).

The more politicised younger people who ascribed to black consciousness were quick to reject a white community worker. By definition you represented 'the oppressor', and were seen to be 'reformist'. If you managed to achieve something with a community group, you were judged to be contributing to the group and community's 'false consciousness' about the nature of the political struggle.

What are the likely perceptions of whites by people in rural areas? Residents are much less likely than in urban areas to have been in any equal relationship with white people. Familiar categories would be missionaries, development workers and government representatives (e.g. health and agricultural personnel, court personnel and the armed forces).

My own approach in this situation, based on experience as an urban community worker, and given that people would have every reason to be mistrustful or fearful or in a patronage position, was actively to draw attention to my race and class position as a likely barrier to people's inclination to talk freely, and to my own ability to understand their experience. This proved a helpful technique. The risk is a personal one - the vulnerability that comes with stepping out of the role of 'expert', and sharing experiences mutually. The gain comes in the rich possibilities for mutual learning about yourself and the lives of others.

I used a similar approach with the issue of gender. On the one hand, with women's groups it was valuable to discuss common experiences as women in order to drive discussions deeper, to soften or reduce the class and race barrier (without ever pretending that the latter two were bridgeable). On the other, in addressing meetings of predominantly rural men, I have drawn attention to the unusualness of the situation in their terms. This has been on the lines of: "I am white, I am younger than most of you, and I am a woman, yet I am addressing you. These things could make you wary of me. This is how I come to be here, and what I need to learn from you, and why I need to learn it. I know you won't tell me all that you know - that's okay".

I would rephrase the proverb like this, with reference to the role of the researcher who is in racial and class terms in a structurally different position to the community being researched: When in Rome, on no account attempt to do as the Romans do, because they know you're not one of them. Acknowledge publicly that you aren't a Roman, and work with it creatively.

I do not mean that there should be a lack of respect for local ways of doing things - far from it. It has been important, though personally problematic, to adhere to rural norms about 'a woman's place'. I do mean that to the extent that I was able to get beyond the polite smiles and the rhetorical development answers,

and enter into other people's experiences even to a limited extent, it was partly by saying, "this is how different we are, and how problematic I might be to you". This, rather than assuming there would be an automatic openness and honesty and generosity towards outside researchers simply because we all belong to the human race.

SECTION THREE

SOUTH AFRICA'S HEALTH AND HEALTH SERVICES, AND THE EMERGENCE OF THE PRIMARY HEALTH CARE APPROACH

INTRODUCTION

It has been widely acknowledged, as will be shown below, that health services as presently structured and delivered in Southern Africa are failing to improve the health of the majority of the population, and it is in the light of this awareness that primary health care is being promoted as a more appropriate response to health needs.

The purpose of this section is to present a brief overview of the context in which this changed orientation is taking place. The intention is not to give a detailed analysis of health patterns. It is rather to indicate the background in which primary health care development projects are located, and from which they have emerged. The section is organised as follows:

3.1. Patterns of health and health service delivery.
3.2. The origins of the present patterns of health status and health care provision.
3.3. Changing orientations to health care.
3.4. The primary health care approach as a platform for community development.

3.1. PATTERNS OF HEALTH AND HEALTH SERVICE DELIVERY

Great care needs to be taken in interpreting health statistics in this region. First, different researchers and research agencies may include or exclude the 'homelands' or 'independent states' in their data analysis. As health in these areas is relatively poorer than in the Republic, health status in the latter may appear to be more positive when the TVBC areas, for example, are excluded.

Then, there are poor base-line data for Southern Africa's rural areas. There is no routine registration of such basic information as births and deaths, and major diseases are not notifiable. Epidemiological studies are tied to specific localities, and data are collected in such a way that makes comparative analysis and monitoring of long term trends difficult, if not impossible.

Furthermore, statistics are normally collected and classified according to race. This obscures important differences which are tied to socio-economic status. Bearing the above problems in mind, the following

health indicators nevertheless illuminate the patterns that exist in both health status and health service provision.

3.1.1. Health status indicators

It is internationally accepted that the most reliable indicator of a nation's health (and indeed of its overall state of development) is the Infant Mortality Rate (IMR). This refers to the number of babies per 1000 live births who die before one year of age.

TABLE 1: INFANT MORTALITY RATES IN SOUTH AFRICA

urban black	90
coloured	62
asian	20
white	13

Source: Republic of South Africa, 1983: 39

Table 1 shows the South African IMR in 1980 (Republic of South Africa, 1983: 39). The rate for whites compares favourably with that for countries such as the United Kingdom and West Germany. The black IMR in the table is derived from an urban black population. Knutzen and Bourne (1977: 392) have demonstrated the great differences in IMRs which are dependent on, inter alia, urban/rural residential status, with a low figure of 82 for settled black Cape Town residents, and a rate of 282 for a traditional rural Ciskeian population with no access to migrant earnings.

In a study done in 1980, Loening (1985: 5) found a variation in the black IMR ranging from 145 in a rural area of KwaZulu, to 54 in an urban township. He demonstrates too the lack of reliable infant mortality statistics, estimating that approximately half of infant deaths are not reported.

The life expectancy rate (the number of years a person may expect to live calculated at the time of birth) is another reliable indicator of health status. Table 2 shows the striking difference in rates according to racial classification.

TABLE 2 : LIFE EXPECTANCY RATES IN SOUTH AFRICA

	female	male
black	60	55
coloured	61	56
asian	67	62
white	74	67

Source: Republic of South Africa, 1983: 34

Once again, the rate for white people is similar to that for industrialised populations. The rate for South African black people, while among the higher of the African countries' rates, is similar to the rates for the less developed countries.

3.1.2. Health service indicators

Health services are rendered by both the private and the public sectors. Within the public sector, expenditures are incurred by at least twelve different state health departments, as well as by provincial and local authorities (the provincial authorities have recently been dissolved, and it is impossible to ascertain to which other authorities their services have been delegated in the interim). It is therefore difficult to establish accurately patterns of health service provision and expenditure, but figures can be given which indicate the distributional patterns.

The hospital bed to population ratio has been cited by Pillay (1984: 17) to be 1:92 for urban whites, 1:154 for Bophuthatswana, and 1:527 for Kangwane. He also shows (1984: 3,5) that while South Africa's mean doctor to population ratio, 1:1842 in 1980, compares well with middle-income countries such as Brazil, and Peru, the ratio in the 'homelands' and 'independent states' is of the order of 1:20000. And as Ross (1984: 5) notes:

'... one should remember that the homelands populations have a disproportionate number of the old and young who require a disproportionate amount of medical care.'

Ross furthermore points out that 3,5% of South Africa's Gross National Product is spent on health, which is a lower percentage than that for the nineteen low and middle income countries for which figures are given in the World Bank's 1981 development report. Of this 3,5%, it is estimated that less than 3% is spent on preventive services.

The above indicators show that the black population bears the greatest burden of health problems. There is an urban bias in the provision of services, where cities are relatively better catered for, wheareas rural populations, with severe health problems, have limited access. There is an emphasis on expensive curative services, with a fraction of the low health budget being channelled to the prevention of ill-health and disease.

3.2. THE ORIGINS OF THE PRESENT PATTERNS OF HEALTH STATUS AND HEALTH CARE PROVISION

The disparities and inequalities in health, educational and socio-economic status of the population in Southern Africa is often explained in terms of the parallel existence of 'two worlds', the so-called first and third worlds. This is not an explanation so much as a tautology: it does not address the nature of historical development that leads some sectors to have better health status, nor does it explain why health services developed in the way that they did.

Doyal and Pennell (1981) and Navarro (1976) have provided penetrating analyses of the political economy of health, for the United Kingdom and Latin America respectively, showing how patterns of ill-health reflect patterns of social and economic organisation. As Gish (1979: 210) says:

'... in the Third World improved health is not primarily a matter of medical systems, but rather a broader question requiring better understanding of the nature of underdevelopment itself. As a consequence, all activities concerned with health must begin with the specifics of underdevelopment in particular circumstances.'

South Africa's health history has been documented by a number of scholars who have been concerned to elucidate the process by which health services for black people, and particularly those in rural areas, have been undeveloped and underdeveloped. De Beer (1984) and the World Health Organisation (1983), inter alia, show how patterns of disease and the provision of health services have been inextricably linked to patterns of social, economic and political development and control.

It is not appropriate to repeat these analyses in detail here. It is sufficient to note that they demonstrate convincingly the impact of the migrant labour system on the spread of disease to rural areas; the neglect

by urban employers of their employees' health; and the introduction of public health measures by successive governments only when the health of the white population in urban areas was threatened.

Zwi (1984) pays particular attention to the ideological and political roles that 'homelands' health services play in enforcing dependency on Pretoria while encouraging ethnicity and providing some degree of legitimacy for the 'homelands' governments.

It is also appropriate to mention here that by the 1940's there was sufficient national concern about health problems that the government appointed a National Health Commission to investigate South Africa's health and health services, and to come up with guidelines for planning future services. The Gluckman Commission presented far-sighted recommendations for a national health service, having shown the serious inadequacy of services existing at that time. Few of the key recommendations were implemented, and the 1948 Nationalist Government then started institutionalising an already unequal and segregated service into further formally separated departments.

Since that time, South Africa has on the one hand gained an international reputation for medical excellence in terms of research and technological sophistication. On the other, the health needs of the majority of the population continue to be neglected, and what services there are, are unaffordable by and inaccessible to the majority. Little has been done to find low-cost solutions to the prevention of disease and ill-health.

At the same time, administrative structures have proliferated with the creation of 'independent states' and 'homelands', and more recently with the introduction of the tri-cameral parliament. Loening (1985: 10) has described the present health structures as follows:

'If the devil himself had been set the task of evolving a health structure so complex in nature that it would confound the mind of the most skilled health administrator, he would not have come up with anything quite so bizarre as we have managed to create in this country.'

3.3. CHANGING ORIENTATIONS TO HEALTH CARE

Recently there have been changing orientations to the provision of health care. There has been an international move toward the adoption of the primary health care approach (Djukanovic and Mach, 1978; Hardiman and Midgley, 1982; Morley et al, 1983) and South Africa has been influenced by this (de Beer, 1984; Loening, 1985; Lund, 1985a; Ross, 1984; Spencer, 1980).

A key factor in the international acceptance of this new approach was the success of the 'barefoot doctor' movement in the People's Republic of China (Sidel and Sidel, 1982). By concentrating on prevention and

education, and sending people with limited but focussed training to rural areas, dramatic reductions were made to the infant mortality rate, life expectancy rates improved, and widespread problems such as bubonic plague, measles and venereal disease were virtually eliminated.

Then the Alma-Ata Conference, held in 1978 under the joint auspices of the World Health Organisation and UNICEF, consolidated the ideas, experiences and policies of a number of developing countries into a united movement. Many countries accepted the definition and principles of primary health care which were articulated at this conference (World Health Organisation, 1978).

The ideas underlying primary health care are in fact not 'new' to South Africa. The Kark's work three and four decades ago at Pholela, in Natal, where they established a rural health centre, embodied many of the elements of primary health care, and drew international attention. One of the Gluckman Commission's central recommendations was the development of a national network of such centres, based on the Pholela model.

The Institute for Child and Family Medicine, at the University of Natal's Medical School, was likewise informed by primary health care principles. The Valley Trust Socio-Medical Project, established in 1952, is another well-known forerunner in the field of projects which understood that the causes of ill-health are rooted in socio-economic factors, and require integrated, holistic interventions rather than Western medical 'cures'.

Thus primary health care ideas have been introduced over the last forty years, with pilot schemes being established principally by independent organisations and missions hospitals. University medical schools have gradually integrated the approach into their teaching and research, and many have established community health units or schools.

The state authorities and the professional health bodies previously resisted the implementation of primary health care as the basis of national health policy. A change came when it was built into the Health Act of 1977, and it forms the foundation of the National Health Service Facilities Plan of 1980. It has thus been accepted offically as an appropriate form of health service for South Africa's health needs.

It must be noted here, though the issue is discussed in greater detail further on, that while the official acceptance of the primary health care approach is to be welcomed, serious obstacles lie in the way of the policy being translated into practice. There are no signs as yet that budgetary allocations are reflecting the change in policy. The approach is being promoted at the same time as the Pretoria government is vociferously advocating privatisation as the economic solution to a range of services, including health. In addition, broad calls for the rationalisation and consolidation of public health services in a single health department have not been heeded.

3.4. PRIMARY HEALTH CARE AS A PLATFORM FOR COMMUNITY DEVELOPMENT

How does this new orientation to health and the provision of health care differ from the Western model which it has replaced? While some of the activities of primary health care are similar to those which have been provided by public health services in industrialised countries, what is new about primary health care is that it explicitly sets out to address the health problems of the majority of people, and subscribes to the need to find appropriate ways of doing so: ways which make health services affordable and accessible to those in need of them.

Though there are varying descriptions of the detail of what primary health care actually is, there is agreement that the following constitute the cornerstones of the approach.

- Regular monitoring of children's growth, for the early detection of ill-health.
- The promotion of oral rehydration for gastro-enteritis - one of the chief killers of children in less developed situations.
- Immunisation programmes to eradicate preventible diseases.
- The promotion of breast-feeding.

These four aspects fall within the domain of health departments, and the objectives are largely realised through education and improving the accessibility of services. Primary health care advocates that a greater responsibility for health should be assumed by people themselves, with the assistance of health personnel.

- The provision of clean water.
- Improved sanitation, regarding both human waste and refuse disposal.
- Improvement in nutritional standards.

For these objectives to be reached, inter-departmental cooperation is required from related sectors, for example, agriculture, education, and public works. To this extent, primary health care recognises that the causes of ill-health are multiple, and require integrated, coordinated solutions.

- The use of local people with limited training to do both preventive and curative work, replacing some of the role of highly trained, highly paid professionals.
- An emphasis on participation of consumers in the design, implementation and control of health services. The definition that emerged from the Alma-Ata Conference states that primary health care:

> '...requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate.' (World Health Organisation, 1978: 4)

These last two aspects of the new approach to health care place it firmly in the domain of community development. The community-based approach to development has participation and self-reliance as key principles. It subscribes to respect for indigenous institutions and practices, attempting to graft new ideas and practices onto existing ones, rather than substituting or replacing them. It recognises the value of local people with focussed training being important educators, rather than 'outside experts' who may have a different language, culture and class position.

MacPherson (1985: 3) holds that the primary health care approach, as an articulated and internationally accepted body of knowledge, holds the most positive and advanced thinking about development strategies. He argues that this is because primary health care is:

> 'First, a conception of health which begins with, and builds on, the needs of the vast majority; ... Second, primary health care embodies a far-reaching, socially defined and powerful concept of health itself. The attainment of health must, in this approach, be measured by the condition of the people, by the quality of lives that are lived and not by expenditure patterns, technology or buildings... Third, the primary health care drive has put enormous emphasis on the building of systems of health "from the bottom-up", giving much less power to professional experts and much more to accessible health workers and to the people themselves.'

In this study, the work of selected organisations who had as an essential part of their work the training of non-professionals, or auxiliary workers, is analysed in terms of the implementation of primary health care as a platform for the community-based approach to development.

SECTION FOUR

A BRIEF DESCRIPTION OF THE PROJECTS AND THEIR ENVIRONMENTS

INTRODUCTION

A brief description will be given here of each project in turn: its setting; its formation and objectives; its organisational structure, staffing and funding; the role of the health workers and their major activities; links with other development organisations; and major planned changes at the time of the study. The aim is to give a synoptic 'photograph', as it were - an overview of the projects and their contexts - before proceeding to the more detailed description and analysis of aspects of their work.

Before pointing out the unique and particular aspects of each scheme, it should be noted that they are all located in rural areas, and the populations served have characteristics which are typical of rural, underdeveloped societies: low socio-economic and educational levels; the absence of the majority of able-bodied men who have left the area to seek work, so that the remaining population comprises largely children, women and the aged; widespread unemployment and underemployment; poorly developed infrastructures in terms of roads, educational institutions, communications and formal financial institutions; poorly developed water supply and scarcity of fuel.

As far as health status is concerned, all areas suffer from typical rural patterns of ill-health: malnutrition, high infant mortality rates, high rates of infectious diseases such as measles and tuberculosis. It will be seen, though, that each area has features unique to it, and the nature of the projects has been to some extent determined by their response to particular health problems.

4.1. MANGUZI COMMUNITY HEALTH PROJECT

4.1.1. The setting

The Manguzi project is based at Manguzi Hospital, which is situated at KwaNgwanase in the Ingwavuma magisterial district of KwaZulu. This is in the far north eastern corner of KwaZulu, not far from the Mocambique border. KwaZulu is a 'self-governing homeland', and it took over the running of this previously Methodist mission hospital in 1982.

There are about 30 000 people living in the health ward served by the hospital. They live, not in villages, but in widely scattered clusters of homesteads. They are mostly a mix of Tembe-Thonga and Zulu-speaking

origin. Until recently, migrancy rates appeared to be somewhat lower than for other rural areas; however, more and more men are now leaving the area to find employment.

Water is not usually as great a problem as it is in other Southern African rural areas; however, in the last few years a prolonged drought was followed by the devastating cyclone Demoina.

At the time of the study, health professionals thought there was a lower incidence of malnutrition here than is generally the case in rural areas. This was attributed, inter alia, to considerable reliance on traditional foodstuffs, a usually reasonable rainfall, and relatively plentiful,easily grown fruit and vegetables. Malaria and cholera are endemic.

The major settlement in the project area is KwaNgwanase itself, which has, apart from the hospital, a few stores, markets, a petrol pump, a Post office, magistrate's office and police station. There is a military base on the outskirts of the town. Apart from primary and junior secondary schools, and a senior secondary school, which fall under KwaZulu, there is a also private Catholic senior secondary school.

The KwaZulu Tribal Authority buildings lie near to the town. The area is under the control of a chief, who appoints headmen and sub-headmen for local zones.

Roads in the health ward are generally extremely poor, and even main roads become impassable in the rainy season. A major new development has been the building of a tarred road to link up with Jozini, which is the site of a large military base. This will make the area more accessible, and the KwaZulu government is planning a development at Kosi Bay to attract more tourists. Thus an area which has been inaccessible and remote has recently opened up to the outside world.

4.1.2. Formation and objectives of the project

The training of community health workers was started in 1977 by the then medical superintendent of Manguzi Hospital. The 230-bed hospital has mobile clinics, which were started in order to take the health services closer to more people. The superintendent, matron and another doctor at the hospital were aware that the predominantly curative services offered by the hospital were doing little to promote health, or to prevent the pattern of cured patients returning again and again to the hospital for further treatment.

The community health workers were intended to be based in the communities they lived in, offering preventive and promotive health education, informing people about clinic services, and in some cases doing simple First Aid procedures. They were to be the front-line workers for the hospital service, directly and continuously in contact with people at a grassroots level.

4.1.3. Project structure, staffing and funding

The director and the two trainers (one a staff nurse, the other a trained health assistant, whose project title is Health Educator) wereemployees of the then KwaZulu Department of Health and Welfare (this department has subsequently separated into two). They are based at the hospital.

There is no project committee as such, such as one usually finds in a development organisation. The one trainer is head of the hospital's liaison team for community health work, but this has no jurisdiction over the work of the community health workers.

The project draws on other hospital personnel for help with training in specific modules; in turn, all pupil nurses and sisters doing courses in primary health care get exposed to the work of both the community health team and the health workers.

Community health committees have been initiated in almost all communities from which workers have been sent for training. These comprise local people, always with at least one representative of the tribal authority (usually the headman). In addition, at the time of the study visit a health steering committee had just been formed. This body comprises representatives from the local community health committees, and its function is to represent the work of the community health workers to the tribal authorities. A project trainer is a member of this committee.

4.1.4. Grassroots workers and project activities

Having started with the training of community health workers from one headman's area, the project has expanded into nearly all of the sub-health areas in the health ward. Approximately sixty-five people had been trained at the time of interviews, with about thirty-five to forty active in the project at any one time. The health workers are paid, through a combination of money from an international development agency, and a system of community payment. The sum has varied, but has been not less than R10,00 a month since payment was introduced.

There are two categories of community health worker: Educators-and-Motivators, who live close to the hospital and receive a three week, hospital-based training; and Clinical Community Health Workers, or First Aiders, who come from remoter areas, and get a longer (about three months) hospital-based training in some curative as well as preventive and promotive skills. They attend a refresher course at the hospital one day a month after their training is completed.

They are expected to attend clinics when the mobile team comes to their area, and to conduct home visits. They encourage people to build pit latrines and to start compost heaps and vegetable gardens. They work about one day a week.

4.1.5. Linkages with other development projects

There were no independent development projects in the immediate area at the time of the study. The hospital itself had a fairly extensive community development section, some of it funded by external sources. Activities included a nutrition rehabilitation unit, tree nursery, fish and duck pond, chicken farm, literacy training, and a handcraft production and marketing centre. Of these, the handcraft centre and tree nursery seemed to be the only fully functioning activities.

The trainers had been to Valley Trust for a training course, and the project director and sometimes the trainers attended development workshops and conferences away from the area. The community health workers themselves had not had formal contact with other similar schemes.

There was no alternative accommodation to the hospital for visiting researchers and development workers, so it served as something of a base for a variety of people. Thus project staff did have some opportunities to share their ideas and understanding about development work, specifically in the field of health.

4.1.6. Future plans

No major changes were envisaged for the scheme by staff at the time of the study visits. There was a concern to strengthen community control of the project through consolidating the health committees, thereby reducing what was seen as over-dependence on the hospital.

The wish was expressed that the health workers should be trained further in promoting appropriate technologies such as mud stoves and 'wonder boxes'; consideration was being given to embarking on a food bulk-buying scheme - a sort of consumer co-operative.

The need for more staff had been realised. By the time of my second research visit, the project director had left, and the trainer was largely carrying the project on his own.

4.2. MANZIMAHLE VILLAGE HEALTH WORKERS PROJECT

4.2.1. The setting

The Manzimahle project is situated in the Cala district of Transkei, which is an 'independent state'. It is about two hours by car from Umtata, and a little less from Queenstown. Manzimahle is a settlement covering about 5km^2, divided into a number of sub-villages. Approximately 3 000 people live here,

predominantly Xhosa-speaking. There are three headmen (one of whom also acts as the chief of the area), and a number of sub-headmen.

The nearest town of any size is Cala, 18 kilometres away. A public transport service operates daily, but a large part of the settlement is far from the road network, and long distances must be walked to reach the roads. Manzimahle itself has a junior secondary school, but no shops or other commercial services. The migrancy rate is estimated at about 75%, and there are virtually no local employment opportunities. Unemployment has risen in recent years with the decision of the South African government to 'repatriate' a number of Transkeian workers.

This is an extremely arid district, hot in summer and bitterly cold in the winter months. People grow crops and vegetables for subsistence purposes, but few meet their own needs this way. Water is scarce, and is a pressing basic need.

Cala has a 75-bed hospital, with a network of eight clinics. One of these is in Manzimahle, and was built with the labour and funds of the local community. A nurse or sister stays overnight at the clinic in order to deal with emergency cases, and there is a residential midwifery unit.

4.2.2. Formation and objectives of the project

The Manzimahle Village Health Project was established by the Health Care Trust in 1979. Health Care Trust is a private, non-profit organisation, based in Cape Town, which was formed by the South African Medical Scholarships Trust. This Trust had previously been giving scholarships to medical students who would have been otherwise unable to afford a medical education. At its 1979 conference, it decided to get engaged on a more practical and direct level with health in rural areas, and formed the Health Care Trust to this end.

In broad terms, Health Care Trust's policy is to 'promote the improvement of health care in the widest sense in Southern Africa'. A more specific statement of policy comes from a Health Care Trust document (Johnstone, 1982: 20):

'The health of people is by and large determined by the social, economic and political environment in which they live. The limitation of the HCT in changing these factors is recognised but we wish to establish the principles of an alternative health care system in a practical way. The following is therefore established as the basis for HCT programmes:

1. To put the interests of those who are the recipients of our health care first.
2. To set a new direction in medical care by introducing new concepts and democratic ideas about health to both the recipients and those responsible for delivering health care...
3. Together with people in communities, to study the problems related to health and collectively find a way to deal with these problems.
4. To make it possible for people to acquire skills and techniques necessary to deal with the problems they have defined.
5. Wherever possible, to work out a democratic programme whereby people can exercise these skills collectively.'

A Health Care Trust employee investigated a number of rural areas, looking for a location for the pilot project. Manzimahle was finally chosen, for a combination of reasons: it had a clinic, it was not too far from a town with a hospital, and a local doctor was very supportive of, and enthusiastic about, the idea.

4.2.3. Project structure, staffing and funding

Health Care Trust is governed by a board of trustees, situated in Cape Town, where the organisation runs an office with full-time workers. It is funded by independent aid organisations. The Manzimahle project is but one of their activities. When this scheme was started, staff were sent to visit and supervise the local trainer from time to time. This was found to be unsatisfactory, and at the time of my visits, a project co-ordinator was in the area for more extended periods of time - an oscillating migrant, as it were, between Cape Town and the Transkei. She was a qualified nursing sister who identified closely with the objectives and policy of the organisation.

Between my first and second study visits, the co-ordinator left the project, and a local person with no formal health training, but with an intimate knowledge of the project and its goals, was appointed in her place.

The trainer is a qualified nurse. The other full-time staff member was initially employed as a driver. He became increasingly engaged in different kinds of project work. They both resided in Cala and drove 18 km to the project area daily.

The Manzimahle project established a Health Care Trust Co-ordinating Committee as soon as the first community health workers were elected. This committee comprised hospital and clinic representatives as well as the project trainer. Later on, a local businessman with a keen interest in the work joined the committee.

At village level, there is a Health Care Trust Community Committee, as well as a number of sub-committees with village representation. All have representation from the tribal authorities as well. The clinic sister is a member of this Community Committee.

4.2.4. Grassroots workers and project activities

When the project started, fourteen people were elected and trained to be community health workers. At the time of the study numbers varied between seventeen and twenty, all but two of whom were women. They appeared to be unevenly distributed between the three zones which had been created to coincide with headmen's areas.

Their chief tasks were to recognise common illnesses; refer to clinics people they were unable to treat; detect and follow up on people with tuberculosis; and educate the community in oral rehydration. They learned first aid skills, and could do simple bandaging and splinting, treat scabies and ringworm, and attend to superficial burns.

Training took place for two hours a week in the community, usually in a school room. They were then supposed to disseminate their knowledge to the community through home visits and at community meetings. The health workers had differing perceptions as to how many hours a week they were supposed to work: from "we do health work all the time, in the course of our daily lives", to "one morning a week apart from the training session".

The community health workers are paid R15,00 per month (R10,00 when the scheme started) - this money comes from the annual budget of the organisation, and there is no community contribution.

In addition to this strictly health-related work, Health Care Trust has attempted to get involved in a broader integrated approach to health. The health workers were encouraged to establish their own vegetable gardens and to promote these in the community. While they did this with some success, the urgent need for water with which to irrigate the gardens (apart from for household use) was soon expressed, and they engaged in a programme of spring protection.

A rotating fencing loan scheme was initiated in 1982. The organisation provided capital for the initial fund, and villagers who paid a small deposit could then receive a loan with which to buy fencing, and later gardening implements. This was followed by a seed distribution scheme - the project bought seeds in bulk at low cost, which were then divided into appropriate size packages and could be bought cheaply by village people.

A milk scheme was started in 1984. Milk is fetched regularly from a farmer about 40 kms away, and delivered to distribution points in the village where it is sold at lower than the commercial price. Five cents from every litre sold goes back into the organisation, and goes a small way to paying transport costs.

Attempts were being made to start a communal demonstration garden but the organisation had been obstructed by bureaucratic ineptitude and delays. The health workers had been trained in candle-making, and some of them, along with some villagers, had started making candles for their own use, and to sell.

4.2.5. Linkages with other development projects

There were no other independent development projects in the area. The trainer and some community health workers had attended training courses at Valley Trust, and there was some contact with a development project run (then) by the Environmental Development Agency at Herschel. However, it appears that there was generally less contact and communication with and within the 'development community' in the Transkei than in other areas. The project co-ordinator, of course, had access to other organisations when she was in Cape Town.

4.2.6. Future plans

Every effort was being made to complete the spring protection work, and then to pursue the idea of the communal garden. The staff envisaged the garden having a community centre attached, which could be used as a resource and training centre, as well as a storage depot for, for example, fencing and seeds.

The scheme was considering expansion to a neighbouring village. However, the Transkei health services, although they knew that the organisation was considering moving to this particular area, had just started a pilot project for government-employed community health workers there.

Shortly after my last visit to the project, the new co-ordinator was brutally murdered. This came at a time when the project was showing every sign of becoming self-sustaining, with an entirely local full-time staff, and with the health workers and villagers more confident about their work because of the strides that had been made in spring protection. At the time of writing, Health Care Trust is deliberating on their future involvement in the area.

4.3. THE ELIM CARE GROUPS

4.3.1. The setting

The Care Group scheme originated at Elim Hospital, which is situated in the 'self-governing homeland', Gazankulu. Gazankulu is divided into a number of health areas, each of which has a hospital and peripheral clinics.

The Elim Health Area has a population of about 150 000 people, who are are from a number of language groups, but are predominantly Tsonga-speaking. They live in settlements of between 1 000 and 20 000. The district has been a focus of resettlement of people from other places, and is very densely populated when compared with Manguzi.

It is a semi-arid region, and lack of water is a serious problem. It has a relatively good public transport system, but many minor roads are impassable in the rainy season.

Gazankulu as a whole provides few employment opportunities. Moody and Golino (1984: 7) estimate that in 1980 there were jobs in Gazankulu for only about 10% of the economically active population. Migrancy and unemployment rates are thus high. Recent years have seen an influx of refugees from Mocambique, many of whom get absorbed into local households.

As with the other two project areas, a tribal authority system exists, and the region is divided into chiefdoms, each chief having headmen controlling sub-zones.

4.3.2. Formation and objectives of the project

The Care Group scheme was initiated in 1976 by an ophthalmogist who had worked at Elim Hospital for a number of years. It was formed in direct response to the problem of trachoma. This eye disease was holo-endemic and was, according to Sutter and Ballard (1983: 3), 'a classic example of the inter-relationship between poverty and disease which may occur in developing areas'.

Trachoma is readily treatable, with the application of antibiotics, and preventible, by relatively simple behavioural changes such as the use of individual face cloths. Epidemiological surveys had shown that pre-school children were the most vital group to be reached. The ophthalmologist and a team of field workers, consisting at first of a social worker and nursing assistant, embarked on a scheme of setting up groups of voluntary workers based in communities who would visit homes, apply ointment to those infected with trachoma, and promote the use of individual face cloths and other improvements in household hygiene.

Three pilot communities were initially chosen in the Elim Health Area, with fifteen volunteers in each - the first Care Groups. At the time of this study, the scheme had spread throughout Gazankulu, and groups had formed in neighbouring Venda as well. It was estimated that at the end of 1983 there were some 102 Care Groups, with approximately 4500 members.

4.3.3. Project structure, staffing and funding

After the formation of the first few Care Groups, an Elim Care Group Project Committee was established. It comprises the project director, other hospital personnel, a health inspector, a representative from a regional welfare organisation for blind people, and two or three community representatives. The project is registered as a subsidiary organisation of the welfare society for the blind, chiefly to facilitate fund-raising.

The Care Groups elect a chairperson and secretary, but there is no extended committee structure. Local Health Advisory Committees exist in most communities, on which Care Group members may sit. There is no umbrella, co-ordinating structure with Care Group representation either within settlements where there is more than one Care Group, or for the project as a whole.

The need for a cadre of trainers to go out into communities and train the Care Groups was identified early. To this end, the job category of motivator was created. Motivators have mostly been women, and have been through nursing assistant training at the hospital. Some are employed by the Gazankulu health department; others are funded by independent sources. As nursing assistants, they are accountable to the hospital matron as well as to the scheme.

The project receives some funding from a variety of independent sources, but most of the staff are employees of the hospital, and as such are accountable to the formal health service.

It should be noted that there are Community Health Workers at Elim Hospital, who may appear to be more equivalent to the grassroots health workers who are the focus of attention at Manguzi and Manzimahle. However, they are trained nursing assistants, and they are more clearly restricted to the clinics than are those in the other schemes. It was decided to concentrate on the Care Groups rather than the Community Health Workers at Elim precisely for their comparative value: they are voluntary workers, there are many, many more of them than at the other two schemes, and they are grassroots workers as are the community health workers in the other areas.

4.3.4. Grassroots workers and project activities

The Care Group members are voluntary workers, who work in groups rather than individually. They are supposed to meet every two weeks, in their communities, for training sessions with the motivators or on their own. They then do house visits where they disseminate the information they have learned.

In the first few years, the project focussed on the control of trachoma as its chief objective. Over time, the emphasis diversified into broader health educational concerns. Nutrition education, particularly about weaning foods, was included in training, and there was a new focus on the construction of gardens, compost heaps and pit latrines. Also, a revolving loan scheme for fencing, gardening equipment and seeds was started.

4.3.5. Linkages with other development projects

Of the three schemes in this study, the Care Group project is in closest proximity to other organisations doing development work. There is a textile co-operative project nearby, a handcraft production centre for blind people, and a general development agency. A major primary health care project, run by the School of Community Medicine, University of the Witwatersrand, is situated at Tintswalo Hospital, in the neighbouring health ward. In addition, Elim Hospital is used as a training centre for community medicine students.

The Care Group scheme has called on the services of people from a variety of development and educational organisations to help with training and the development of materials. Some of the motivators had been to Valley Trust for training courses.

My impression was that the Care Group scheme was more in touch with, and part of, a 'development community' with whom problems could be discussed and ideas shared, than were the other two projects.

4.3.6. Future plans

The major change imminent at the time of interviews was that the project director was due to retire. A new director was being sought, and the project was looking at ways of strengthening the ability of Care Groups to act more independently.

With trachoma largely under control, some Care Groups were asking for training in income-generating activities. All project staff were aware of the need to introduce new ideas and activities, to prevent a decrease in membership, and to attend to people's needs beyond the strictly health concerns.

4.4. SUMMARY

The three schemes have many features in common. All operate in relatively isolated rural areas, and are either based within, or work alongside, formal health institutions. They have all identified the causes of ill-health as being linked to poverty and underdevelopment, and have decided to implement a primary health care approach to complement, or supplement, the primarily curative services offered by the hospitals and clinics. All have committed themselves to training local, community-based people, primarily women, who are then expected to spread their learning through the communities they live in. All these health workers are trained largely in promotive and preventive skills, though there is some training in curative work as well. All schemes were initiated relatively recently, by people who had little training themselves in a community-based approach to health work.

But there are significant differences between the schemes. The Manguzi Community Health Project is lodged firmly within the local formal health system, although it receives limited external funding. The Care Group project is somewhat more independent of the health services than is Manguzi, but is still accountable to it in important ways. The Manzimahle Village Health Workers Project, on the other hand, is entirely independently funded and made a conscious policy decision to attempt to create an alternative health care system.

Then, the latter project and Manguzi have given more intensive training to fewer workers; the Care Group scheme, on the other hand, has given a more superficial and narrow training, but to over four thousand people. The community health workers at Manguzi and Health Care Trust operate at community level singly or in pairs; the Care Group members work collectively in groups. They differ in the extent to which they are able to provide curative services. Some are paid, whereas the Care Group members work in a voluntary capacity.

These, and other differences between the schemes, may be expected to produce different challenges to each project, determine the limits of the projects, and provide lessons or guidelines about what seems to work best, where, and why.

SECTION FIVE

THE RECRUITMENT OF COMMUNITY HEALTH WORKERS AND CRITERIA FOR THEIR SELECTION

INTRODUCTION

The manner in which village health workers are selected, and the criteria used for their selection, are issues to be faced by all schemes in their initial stages. The conventional wisdom of primary health care is that all workers get selected by their own communities at a public meeting where the idea of local health workers has been put to the people. The rationale is that people will be more likely to co-operate with workers they have chosen themselves; that the workers will have more credibility in the eyes of the community; and that local people will have a more informed idea of suitable potential health workers than will hospital staff or health officials coming in from outside the area.

This section is organised in the following way:

5.1. The process of recruitment.
5.2. Criteria for the selection of community health workers.
5.3. Discussion.
5.4. Summary.

5.1. THE PROCESS OF RECRUITMENT

5.1.1. Manguzi

At Manguzi, the recruitment process went through four distinct stages. When the scheme was initiated in 1977, the staff approached a particular headman known to them. He himself chose five women from his area, who went for training.

When the hospital decided to continue and expand the scheme, the idea of community choice was incorporated. Hospital staff went to an area and asked the headman to call a community meeting about general health problems. At the meeting, the community was asked what was needed in the line of health, and people would ask for a doctor, nurse or clinic. It would be pointed out that there were not enough professional staff for every community, and the idea of training a local person would be introduced. This was followed by an explanation of the kind of qualities suitable for the post. The meeting would then choose their representatives.

Once the idea of community health workers spread through the area, it was no longer necessary to initiate such recruiting meetings. Women arrrived at the hospital from areas as yet not involved in the scheme, and asked to be trained. The trainer then went to the headman and called for a community meeting, at which the women would be vetted by those assembled. The trainer reported that "the people normally seem to respect the fact that they volunteered".

By the time of the interviews, the trainer said that there was no longer any need for hospital staff to call for community meetings in new areas. All people know about the health workers, and a person simply presents herself at the hospital with a letter from the headman. This may or may not have followed, or be followed by, approval at a community meeting.

5.1.2. Health Care Trust

A similar process occurred at the Health Care Trust. When the programme started, community meetings were held at the headman's place, where candidates were either nominated or elected. As the scheme became known, if a health worker left and had to be replaced, the trainer brought the need for a new health worker to the attention of the headman or chief. He would organise a community meeting where a new person would be chosen.

5.1.3. Care Groups

The Care Group members are voluntary workers. Because they are unpaid, and because there are many more of them, there is less accountability of the mass of members to the project than is the case with the other two schemes, and the recruitment procedure is different.

The director initially started promoting the Care Group idea through a local women's homebuilders association. This lasted for a few months only, as the women restricted their visiting to their own, relatively well-off friends. In 1976, three pilot communities were chosen in which to start afresh. The chiefs in these areas were approached, and trachoma and its control explained to them. They were asked to call community meetings, where people were asked what could be done to control trachoma.

As happened in Manguzi, the response was that a doctor or nurse was needed:

> "And I said (said the director) okay, there is one hospital, and there are two hundred and fifty villages, so I suggest you take a big knife and cut the doctor into little pieces."

Persuading people of the merits of self-help in health may be diffficult when people have learned to believe that it is doctors and nurses who make people healthy. A motivator overcame this resistance in one area in the following way:

> "I once had a problem at a village. The chief was there. We went for the first time... They did not quite understand what a Care Group is... We explained to them about trachoma, that it is an infectious disease and so on, and asked them if they are having such a problem. We knew that they had that problem. They said 'Yes, we have that problem'. 'What are you going to do?' 'Well, we will just come to the hospital because we have no other ways, there is no clinic here.' 'But do you have any transport?' 'No.'
>
> "So we kept on discussing it until it came where the women said, 'If you can give us the ointment we will put the ointment to our own children.' And I said, 'What about the neighbours? We told you that this is an infectious disease, and if you give the ointment to your child, your child is going to play again with the children with trachoma and without ointment... Children like each other. When playing, they touch each other, and the flies are there also, they go to the eyes and they get infected again. What are you going to do? May you please keep your child at home after putting [ointment] in, so they must never play with other children.' They said, 'Oh! That is impossible... You had better give us enough ointment so that we will give to the other families.'
>
> "'So' (said the trainer) 'to who shall we give the ointment? How are we going to know if the ointment is enough? Or if this week, some people are coming to get ointment, the following week, different people?' They said, 'Oh, we can then always come and get this ointment.' In that way, the Care Group was formed."

The idea of people learning to get involved themselves in the prevention of trachoma having been introduced, volunteers were asked for. These became Care Group members, who visited the homes of children who had been identified at school as having the disease.

The three pilot communities were chosen because project staff considered they would be likely to succeed there. When they started in new villages, one of the motivators introduced a successful strategy: she went informally to the community, and made friends with some of the women, telling them of the Care Group idea at the same time. When volunteers were called for at the community meeting, these women would break the ice by volunteering first, and others would follow.

After a few months, word of the scheme had spread, and other villages had witnessed the 'graduation ceremonies'. The demand for more Care Groups grew, and more motivators were employed to go out to new villages. In time the need for active recruiting dropped off entirely, and in some instances, Care Groups were formed independently without the help of project staff.

Recruitment also happened via adult education classes in one area. The adult educator decided to combine reading classes with a Care Group meeting in an attempt to integrate the teaching of literacy with health education.

5.2. CRITERIA FOR THE SELECTION OF COMMUNITY HEALTH WORKERS

It can be surmised from the recruiting procedures that none of the schemes had laid down rigid qualifying criteria for community health workers. In the case of the Care Groups, the issue did not arise as volunteers present themselves for membership. The other two schemes have faced the question of whether basic criteria regarding gender, age, marital and child-bearing status and level of formal education should be used to screen prospective health workers.

It is usually held that community health workers should ideally be mature women with children. The rationale is that many of the problems they deal with relate to mother and child health. An older mother will have the respect of the community, credibility, and personal knowledge and experience to share with others. The logic of this is sound, but interviewees pointed to some interesting alternative considerations.

The age range of the health workers was large, with both Health Care Trust and Manguzi reporting that newer recruits tended to be somewhat younger than the original group. One person speculated that, with social change taking place in even the remotest rural areas, the traditional respect accorded to older people for their widsom is being overtaken by a new respect and status that goes with formal education. It is the younger people who have had access to schooling, and they may thus gain in status even though young and without children.

As far as gender preference was concerned, nearly all the community health workers and Care Group members were women. There were no exclusion rules for men from the side of the projects, and all felt there was a place for men. The disadvantages men may have in discussing, say, gynaecological problems with women could be offset by their contribution to the perceived 'masculine' tasks of fencing, pit latrine construction, and so on.

Manguzi started off requiring basic literacy and numeracy, and also had a preference for married women with children. As time passed, however, the staff realised that the most important criterion was the **attitude** of the person, both to the work and to the community. They also specified that the worker should be chosen by an **informed** community, by which is meant that the community should have a clear idea of the kind of role to be played by the community health worker. Basic literacy and numeracy were seen as helpful in terms of keeping records of house visits, helping people fill in forms, reading labels on medicine bottles, etc., but were not considered to be imperative.

5.3. DISCUSSION

The process of recruitment came in the early phases of the activities of the schemes. Straight away, difficult and important questions were raised for the practical application of the philosophy and principles of community development.

5.3.1. Community participation in decision-making

It is evident that there was a degree of public participation in the selection of the community health workers. Interviewees from both Manguzi and Health Care Trust pointed out that this 'community decision-making' is not necessarily a very democratic process.

Firstly, there is no assurance that the whole community will be present at the community meeting. At Manguzi, the director said that an attendance of sixty or a hundred people out of several hundred under a headman's domain was considered good. In the Transkei area of this study, on the other hand, it seems that attendance at weekly public meetings is enforced on the whole community, so attendance is high.

This then raises the question of the method of decision-making at public meetings, and the influence of the tribal authorities. One interviewee said:

> "If someone from the community put their hand up to nominate someone and a sub-headman nominated someone else, the chief would just tell the person in the community to sit down, and the one that the subheadman nominated would be taken as the community health worker."

On the other hand, another interviewee reported that in his area, the headman did not have the final word if the community felt strongly about a person whom he did not nominate.

It is noteworthy that Care Groups, even though voluntary, had to be introduced via the tribal authority. The trainer referred to an incident where the chief, teacher and sangoma in one village went against the usual pattern of calling for volunteers, and themselves nominated women to form the Care Group. A survey in the area later uncovered substantial distrust and dislike of the Care Group scheme at this place - members were seen as the elite's favourites, and not as representative of the community.

It is clear that areas differed in the extent to which the tribal authorities influenced the selection of health workers, but their presence was pervasive overall. This has been the case in all rural health schemes I have visited, whether governmental or run by independent organisations.

The concern about the influence of tribal authorities on who gets chosen emanates from the likelihood that they will nominate or promote direct members of their own families, or members of the local elite. If this is the case, the health workers are not truly representative of the communities which they serve, and will be in a position of authority over them. More attention is given to this in the section which deals with tribal authorities (section 10).

The strategy used by the Manguzi health team in the early phases of the project would seem a helpful antidote to this, where schemes cannot avoid, or choose not to avoid, the tribal authority presence. The Manguzi team stressed that health workers should be chosen by an informed community . In other words, they outlined to the community what would be required of a health worker, paying special attention to personal qualitites, rather than for example formal educational levels or elevated social status.

This is in principle a constructive approach. It is based on the idea of providing people with information, and then leaving them free to make an informed choice. However, it was found impossible to fulfil the essential requirement for this strategy to work: that someone needs to be present to do the informing.

It was clear that all three schemes underwent a similar process in this regard: the recruitment of the initial health workers was done with substantial involvement by project staff. Because the idea of community health work took root relatively fast, requests came in from other areas to join the scheme, and project staff had both to do more training and follow up on expanding project activities.

Thus the more the schemes spread, the more people joined, the more the selection process became routinised - the less could project staff monitor the selection process. They experienced the tension which has been articulated by Korten (1980) of how to weigh the need to respond to expressed needs by expanding, against the need to establish, maintain and develop organisational processes and structures which ensure community participation and democratic decision-making.

Another issue pertinent to community participation is that the idea of community health workers as a central part of the primary health care approach was in fact the decision of project staff, at both Manguzi and Health Care Trust. They went into communities with the 'hidden agenda' of grassroots health workers, and discussions were directed to the point where this idea was put to the public meeting. This is not a particular criticism - the most non-directive community workers are always also manipulators of decision-making. It is interesting to speculate, though, on the possibility of a health campaign being mounted, in which the shortage of nurses and doctors would be pointed out. Communities would then be asked what

they thought the solutions could be. They just may have creative ideas and solutions which could improve on the present axiomatic acceptance of community health workers.

5.3.2. Screening of community health workers

It does not necessarily take the presence of a tribal authority to impede communities choosing health workers who are not appropriate to the task of implementing the community-based approach. Implicit in the notion of democratic decision-making is that the 'popular choice', in the sense of the choice of the common people, will coincide with the choice of someone who will represent common people's interests in a democratic, non-authoritarian way.

However, people are known sometimes to 'freely choose' their own oppressors, and this may particularly be the case in a socio-political context as oppressive, heirarchical and stratified as the one in which development projects in Southern Africa operate.

All schemes found that some of the health workers who came for training were entirely unsuitable in terms of their relationship to their communities and their level of motivation.

Given that schemes lost control over the recruitment process, they were all concerned to introduce some kind of screening process after training. The Care Group project had attempted to do this by stipulating certain things a Care Group member had to have done in order to 'graduate' and receive the badge which identified them as full Care Group members. However the work expanded so rapidly that little control could be kept over this.

It is an idea, though, that could be adapted by other projects whether in the health field or not, when 'community decision-making' cannot be monitored, and produces people who are transparently going to be a liability to both project and community.

All trainees could receive some kind of certificate which says that they have attended the particular course (this avoids the negative reinforcement of school-like judgement of 'passed' or 'failed'). Only some, however, would be selected to continue as practising project health workers.

5.3.3. Working with existing organisations

The conventional wisdom has it that it is usually better for projects to work through, and build on to, organisations which are already established in the project area. Gow and Vansant (1983: 434) explain the rationale for this - that it is efficient, in that the organisational groundwork has already been done; and it is potentially effective, in that existing organisations have a proven capacity for survival. However, they also

say that there are dangers in this approach, and a careful analysis needs to be made of the patterns of power and interest reflected in existing organisations.

The Care Group's experience with the homebuilders association highlights the importance of making this analysis. Initially, the attempt was made to build the first Care Group through this association. It proved itself to be an elite group, concerned only with what the community project could bring to them and their small group of friends.

The Health Care Trust decided not to work through the Zenzele Women's Association for the reason that it, too, was a relatively elite group, and there was local concern that it had on a number of occasions collected funds which had not been put into local community development, as had been promised.

At the time of the fieldwork, the Inkatha organisation was not particularly active in the Manguzi project area, though it has since become so. Neither during interviews nor during group discussions and the workshop with health workers was mention made of the desirability, or not, of working in conjunction with this organisation.

As the South African political crisis extends deeper and more explicitly into rural areas, development organisations will have to make increasingly difficult political choices about the costs of associating, with whatever degree of formality or informality, with existing organisations. I would concur with Gow and Vansant's guideline (1983: 434) that:

'...the most important criterion for selection of an existing organisation is its ability to reorient its activities to those other than those for which it was formed.'

The 'ability to reorient' needs to be assessed in social, economic and political terms.

5.3.4. Criteria for selection of community health workers

The projects showed commendable flexibility in their stance towards criteria according to which health workers should be selected. There was a willingness to adjust criteria as they themselves learned more about how to meet the requirements of a community health programme.

Three issues arise which these schemes did not at the time have to deal with, but which are pertinent to other health projects, and work involving extension workers in related sectors.

As mentioned, none of the schemes set out to exclude men from being grassroots workers, but in fact the vast majority were women. It would seem unlikely that there will be a rapid shift in this position. Were this to happen - if, for instance, rising unemployment leads to many more men in rural areas, and the (limited) pay of community health workers leads to a greater competition for these positions - care would have to be taken to ensure that these projects do not become one more platform for the further dominance of men in community life.

Secondly, if and when community health workers are integrated into formal health systems to the extent that they are state-salaried workers (which has now happened in Transkei, Ciskei and KwaZulu) some minimum level of formal education is required to qualify for the job. The experience of the schemes in this study suggests that this would exclude some of the most effective workers: those who, while barely literate and numerate, had enthusiasm, commitment, and a particular ability to relate well to their communities.

Thirdly, and on the other hand, the health workers themselves, during group discussions and at the workshop,said they were often called on to provide a broader range of functions than they were equipped for. They referred particularly to curative services and to general advice-giving. As regards the latter, they were frequently asked to assist people with applications for state pensions and grants, where to apply for educational bursaries, and a range of other resources. Those who were illiterate or minimimally literate were aware of this as an impediment to their ability to deal with this advice-giving and referral role.

This broader function could be an invaluable spin-off of community health schemes, given the almost complete lack of formal advisory services in rural areas. The local social work profession is as yet far from promoting the idea of welfare auxiliaries in any way that would be helpful and appropriate to rural areas. Organisations such as Durban's Legal Resources Centre and Career Information Centre have started to extend their services beyond cities, but their contribution has been limited to date.

The community health workers are a rare category of people who are there, based in rural communities, with potential access to basic information and resources. They were hard-pressed to fulfil even the limited range of functions they had been trained to do, and consideration was being given to creating a more specialised role for them. What is suggested here is that, should health projects be in a position to expand their training, an expressed need of communities is for community-based advice-givers, particularly in the welfare and educational fields. If projects respond to this need, those trained to do this work would need a level of education such that official forms and resource materials could be read and understood.

5.4. SUMMARY

All three schemes subscribed to the principle of community involvement and participation in the

recruitment and selection of community health workers as opposed, for example, to health personnel unilaterally nominating people for the work, or to leaving it to the decision of a chief or headman.

Commendable flexibility was shown regarding the criteria for the selection of community health workers. The project staff felt that personal qualities of enthusiasm and commitment, and people's ability to relate to the community, were more important than rigid stipulations regarding level of education, age and marital or child-bearing status, though basic literacy and numeracy were seen as helpful attributes.

There were three major problem areas, which are germane to development organisations in other sectors as well. Firstly, tribal authorities controlled the entry of schemes into areas, as also the selection procedures, particularly at Manguzi and Health Care Trust. This raises questions for the notion of 'decision-making by the community'.

Secondly, the Manguzi and Care Group projects grew so rapidly that their ability to monitor the recruitment process diminished. This significantly affected their ability to meet their objective that communities should select people, or volunteers present themselves, with a full and clear understanding of what the work entailed, such that judicious choices could continue to be made.

Thirdly, all schemes experienced problems with screening procedures following training (at Manguzi and Health Care Trust this applied to the community health workers, at Care Groups to the motivators). Where 'community decision-making' produces people who are clearly unsuited or ill-equipped to undertake project work, schemes need to give closer attention to instituting mechanisms for screening.

SECTION SIX

TRAINING IN COMMUNITY HEALTH PROJECTS

INTRODUCTION

Three categories of people in community health schemes are the focus of training:

- the community health workers, or, in Elim's case, Care Group members;
- the trainers: the (usually) local people, with some formal health background, who teach the community health workers;
- the project leaders, who train the trainers, and who sometimes get involved directly in training of the community health workers, or supervise the trainers' sessions with them.

There is also of course the need to train health committees, and to educate members of the formal health system, which is dealt with elsewhere.

There are two aspects to the training: the clinical education and what might be called social training. On the clinical side, the workers are taught various subjects to do with primary health care, with an emphasis on how to detect symptoms of common illnesses, and when to refer to health services.

In addition, all schemes included, explicitly or implicitly, social learning as well. Ideally, this is taken to mean experience-based, participatory learning, starting with where the learners are, and building on to what they already know. The rationale is that they are from the community, and account must be taken of local understanding of the aetiology of illness and disease. Again ideally, there is an emphasis on respect between trainer and learner, and thereby between learner and the community. This method purports to encourage people to become responsible for their own learning - to become active learners rather than passive recipients of information. The aim is to work towards self-reliance in learners, so that project staff may eventually 'work themselves out of a job'.

This section is organised as follows:

6.1. DESCRIPTION OF TRAINING AND RESOURCES

6.1.1. Manguzi

Two categories of workers are trained in this scheme. The Educators-and-Motivators are given a three week block training, and the Clinical Community Health Workers receive a three month block training. Both groups are trained at the hospital.

The Educators-and-Motivators come from areas relatively close to the hospital. Their main tasks are preventive and educational, the rationale being that their communities have access to curative services. The Clinical workers come from areas further removed from the hospital, and they are trained in certain limited aspects of curative care as well.

The basic training resource is a manual devised by the project leader and trainer. It covers largely clinical training. Once the block training is complete, the trainer is supposed to spend up to one week in the home area of each community health worker, for follow-up and supervision. In practice this sometimes does not happen, as the trainer has further training to do at the hospital, and sometimes gets involved in other duties (for example, he had been drawn into the cholera campaign just prior to the field trip).

The community health workers gather at the hospital one day every month after their training, for revision and refresher courses.

There were two principal trainers: one, a staff nurse, was involved in other hospital community projects as well. The trainer who was interviewed, and who worked full-time for the project, was a health assistant who had received no additional training in community health. He and the director, a medical doctor, who likewise had no specific community health training, learned together as the scheme progressed.

Other members of the hospital staff were called on to make a contribution to the training from time to time.

6.1.2. Health Care Trust

This organisation differs from Manguzi in that the community health workers did not receive initial block training for an extended period. Weekly training sessions are held in the village, usually in a church or school building. At the beginning, training appears to have been narrowly clinical in content. Since the arrival of a more permanent project leader, there was a shift in emphasis towards attitude change and

social learning. The sessions are conducted either by the trainer alone, or by trainer and project leader together.

The trainer was a qualified nurse who had no specialised knowledge of primary health care when she joined the project, at which point she received little advice and guidance from project headquarters. She 'inherited' a set of lessons from the initiator of the project, and after a while asked the health workers what **they** would like to learn. On the basis of this she started devising lessons of her own.

The project leader, also a professional nurse with no primary health care training, was at the time of the interviews working out with the trainer a detailed training course for future use.

6.1.3 Care Groups

In the nature of the Care Group scheme, training of Care Group members is less intensive than in the other two projects. They are not training a small cadre of health workers at grassroots level: rather, they have attempted to promote a broad community awareness around specific health issues, starting with trachoma. Limited and specific goals and practices were targetted, for example the use of individual face cloths, and the application of medicine for trachoma.

Care Groups are in principle visited once a month by one or two motivators. These give lecture or demonstrations on specific themes or practices, and encourage members to build health-related facilities such as pit latrines, compost heaps, and vegetable gardens.

The motivators, who were nursing assistants, had weekly training sessions with the project leader, and there was an ongoing series of refresher courses.

6.1.4. Resources used for training

The training of para-professionals offers challenges to the trainers and learners, in terms of finding, adapting, and devising materials and techniques that will be appropriate to the learners' needs. There were many examples in the projects where ingenuity and creativity had been shown in meeting these challenges.

The trainers relied heavily on David Werner's book, 'Where there is no doctor' (1980), and on Werner and Bower's 'Helping health workers learn' (1982). The other text which was extensively used was the Environmental Development Agency's 'People's Workbook' (1981). These texts were the basic source of

many of the training techniques, though it is not suggested that all schemes got their initial ideas from them.

All projects had an extensive repertoire of **health songs** which they had composed around health-related topics. The Care Groups had made a specific attempt to teach these songs to school children in their areas. The community health workers sing these songs at public events such as health days and community meetings. Apart from their educational potential, they seemed also to serve the purpose of promoting solidarity and confidence amongst the health workers themselves, and were a feature of training sessions.

Of the three schemes, the Care Groups had made most use of **community theatre** around a particular health issue. As with the songs, they are educational in purpose, and attempt to convey health knowledge in an interesting and stimulating way, tapping the dramatic skills of the health workers and sometimes of a broader group of participants as well.

All the schemes used the **role play** technique in training sessions. Trainers and project directors remarked how readily health workers took to the idea of role playing, and its usefulness in getting people to reflect on their own behaviour and attitudes in doing their health work.

Examples of **educational aids** used by projects were: specially made dolls with which to demonstrate the effects of dehydration; a modification of the Shakir strip to make the measurement of malnutrition more comprehensible to the community; posters with health messages; and games, such as Broken Squares, to demonstrate the virtue of co-operation in work. Stories about health and poverty in other parts of the world were found useful by Health Care Trust in generating discussions about local problems.

6.2. ISSUES IN TRAINING IN COMMUNITY HEALTH PROJECTS

While the issues discussed below derived from the experience of development projects working in the field of health, it should be noted that they all apply to training of extension or grassroots workers in other development sectors, such as agriculture and adult education, as well.

6.2.1. Centre-based or community-based?

Strong arguments have been put forward that community development training should ideally take place in the prospective worker's community. Van Rensburg (1974), for example,shows how agricultural extension workers in Botswana found it difficult to transfer skills learned at the training base, Swaneng Hill, to their

home areas. Small differences in climate, soil and topography made it difficult for the newly trained workers to apply their knowledge and skills effectively.

The Valley Trust in Natal has frequently considered taking their extension teams to the home areas of their (many) visitors, for the same reason. They have had to decide against it on grounds of expense and limited manpower.

A common complaint of Coady Institute diplomates returning from Canada is that they cannot apply their new knowledge and skills. Local Southern African institutional and social arrangements which affect the development of co-operatives are fundamentally at variance with, or obstacles to, the blueprint designs they learned in Canada. This is despite the fact that Coady personnel travel extensively to the countries of their trainees.

The project leader at Manguzi pointed to the necessity for, and advantages of, centre-based training in that particular region. The most salient point was that that the trainees come from widely scattered areas, and it would simply be beyond the resources of the scheme to train in each area. In addition, the hospital has centralised resources for training: personnel, accommodation, photocopying facilities, a nutrition rehabilitation unit, and, of course, patients. He felt the important thing was:

> "...whether you've got a conception of what the life is like where they are. I think we do lose a bit by not having more practical work in the community when they are being trained. But what we do have is regular follow-up visits once a year...staying with them for a couple of days...and going with them when they do their rounds... In that way, mistakes in the training can be made right. I really don't think it makes much difference whether you train in the community or in a big centre as long as you are relevant... I mean you can go out there and have a highly technical training which is going to be no good to them. And then you can come to the hospital and have a training which will be relevant, practical, because you know what the situation is like because you've been in it."

This is an entirely practical approach, based on the staff's confidence in their knowledge of the area - a confidence which was justified, according to the health workers I spoke to. A disadvantage is that the need for trainees to leave home for a relatively long period at the hospital must surely be a constraint on the ability of some people (and particularly women) to join the scheme.

The Health Care Trust is in a different position. Their training took place in the village, where all the community health workers live and work, and project headquarters is some distance away.

An advantage in their village-based sessions is that the health workers are seen by the general public seen to be actively learning. A disadvantage, however, has been the lack of a suitable venue - this has sometimes been one end of a classroom with a school class in session at the other end of the room.

From this study it appears that there are no axiomatic answers to the question of whether training is better done (which can mean should ideally be done, or can practicably be done) at a project centre, or in the heart of the communities where community health workers will work.

6.2.2. Who determines the training curriculum?

If the principle of participation in primary health care is to be fulfilled, this should apply also to participation in determining what it is that the community health workers should be working at, and thereby what the content of their training should be.

There are at least four different parties involved who may be expected to have their own perceptions about the training curriculum, and it is possible, indeed probable, that these will conflict with each other. These are: the communities in which the health workers will be active, the health workers themselves, the project staff and leadership, and the formal health system in the area.

Within each of these parties, there may well be conflicting opinions. For instance the tribal authority may have ideas not shared by the community at large; the project staff may have different factions with different opinions; the formal health system will most certainly be divided into those supporting the community approach including a curative role for the health workers, and those who do not fully understand the potential role that the workers can play.

The Manguzi project leader said that an attempt was made in early community meetings to get some idea of what people thought their chief health problems were, and to include these in the syllabus. He said though that this had fallen away over time - less consultation was done once the scheme got underway (and presumably also once the manual had been written and formed the basic resource for training).

When the Health Care Trust started its work in the Transkei, it appears there was no consultation with the village people or the health workers as to what the content of the training should be. The initiator decided on key issues and started teaching them. It seems that the "highly technical training which is going to be no good to them", quoted above, applied here. When the present trainer was employed, the health workers complained that their training had been too theoretical. They asked to be taught practical skills which would be of immediate use to them and to the community.

According to the project leader, the community health workers were increasingly making their own views known as to what they would like to concentrate on. They were asking for training in sewing and other income-generating activities which went beyond the strict confines of health. Although she had

reservations about the economic viability of, say, sewing co-operatives, she had nevertheless agreed to pursue the idea with the workers.

The Care Groups were formed specifically to tackle the problem of trachoma, so the issue of community participation in a training curriculum did not initially arise. As time went on, and activities dealing with the prevention of trachoma had been effectively routinised, there were discussions with Care Group members as to what activities should follow.

If a project attempts to work in accordance with locally felt needs and build these into training, this might well conflict with the development organisation's or health professionals' sense of urgency in dealing with their assessment of priority needs, and with their ability to meet community needs.

For example, in many Southern African rural areas, communities experience water to be the major basic need. But the provision of water is nearly always beyond the ability of the grassroots extension workers themselves. Health Care Trust took a long time to respond to the need that was being expressed, by both health workers and the villagers, for water. They delayed because it was so difficult to respond. When the organisation was finally able to get the services of a semi-governmental development organisation to protect springs, the community health workers reported that their credibility and status was immediately enhanced.

Malnutrition is another problematic area. The health professionals who were interviewed all identified malnutrition as a major health problem. However it is not at all clear that people with little formal education make the connection between malnutrition and disease. When the community health workers at the national workshop were asked to identify and discuss health problems, which they did at length, malnutrition was not specified once.

A project in another area faced this problem, and stuck to community development principles. The health trainer started her work by entering into extensive dialogue with the female, middle-aged health group. They identified high blood pressure as a priority health problem, though there was no clinical evidence that it was. Although high blood pressure is not to be found on the usual primary health care priority list, the trainer believed that she had to hold to the principle of working on felt needs, in order to build the commitment of the women to the group, and to show that she took the idea of community decision-making seriously.

6.2.3. Curative or preventive?

Another arena of conflict in the content of training is to do with the curative or preventive role of the health

workers. The health workers themselves want some curative role - they need it to 'buy' credibility in the community, to show that they are indeed useful health personnel, and should therefore be listened to when they do their promotive and preventive work. The health professionals, on the other hand, generally limit their curative scope.

It must be noted that all health professionals in these particular projects were in favour of introducing a greater curative role for the health workers, but were constrained from doing so by bodies such as professional nursing councils. This is dealt with in detail when discussing the influence of health policy-makers over projects, but needs to be noted here as an impediment to community consultation and participation in the training.

Of course, there is also the fact that trainers can only train in what they themselves are adept at doing, and are always also limited by the resources at the disposal of the project. Where the trainer and project director are formally health trained, they are obviously likely to have a bias towards, or be more confident about, clinical health issues. They can, of course, and in these schemes did, broaden their knowledge and skills in response to needs presented to them by communities or by the community health workers themselves.

6.2.4. The training of the trainers

Though the community health workers are the focal point of training in community health schemes such as these, the trainers - the mediators between project leaders and front-line field workers - are another key group. This cadre has become a focus of attention in recent literature, and concern about their training was evident in interviews.

Project leaders are typically 'expatriate' and will eventually leave. The trainers are usually from the local area, and will remain to continue the work, sometimes in leadership positions, after the initiators of the scheme have gone. In this study, however, it would be spurious to separate the training of the local trainers from the training of project leaders. The latter had no specific training in community development or primary health care when they started the schemes. They drew on what resources or contacts they could, and in an eclectic fashion educated themselves at the same time as training the trainers.

All schemes found it difficult to find the time for training of project personnel, in the face of urgent demands of clinical work (in the case of project leaders who were also hospital doctors) and demands arising from setting up the teams of community health workers. Once community expectations had been raised and activities had begun, it was difficult to take time out systematically and routinely to broaden their own

knowledge and skills - especially as they were the people whom the community and the health workers themselves saw as senior and more knowledgeable.

Some despair was expressed by project directors as to the effectiveness of their training of the local trainers in non-clinical fields - as one said, in "training the trainers to have the broad vision". The feeling was that trainers were not taking responsibility for their own learning; were not transferring learning and skills from one context to another; were sometimes using techniques inappropriately and ineffectively; and were not sufficiently reflective and evaluative about their own work and programme.

This problem is common in development projects in all sectors - teacher upgrading, agricultural extension, literacy training, to name but a few. It surely stems partially from the educational background of the local trainers. Most of them have been through 'Bantu education', followed often by a term of employment in the health services. This is a background of hierarchically organised, didactic education. There are few rewards for the enquiring, critical mind; indeed, often there are negative sanctions. Spoon-feeding is how one is educated, so spoon-feeding is how one in turn educates, or expects to be educated further. Presumably the position of women in rural areas contributes to the reluctance to grasp learning opportunities critically and actively.

However, the educational background of 'expatriate' senior staff members is also hierarchically organised and didactic, particularly those who have undergone professional health education. The project directors discussed frankly that nothing in their training equipped them to deal with, let alone teach to others, the process of becoming an active learner, resisting the temptation to instruct rather than guide, to lecture rather than nurture group discussions, and to handle the conflicts that can arise when the conventional pedagogical method is overturned.

The project leaders at both Health Care Trust and Care Groups said that, if they were to start the project over again, they would introduce a much more systematic and thorough course for trainers **before** recruiting community health workers or Care Group members. This is obviously and understandably wisdom following experience - they were innovators, who did not have available models to rely on and learn from. They emhasised the need for block training as opposed to disparate, weekly sessions. Both related this to the need to 'untrain' or 'retrain' what were seen as negative, authoritarian attitudes learned in professional training.

The Health Services Development Unit at Tintswalo, Gazankulu, recognised this as a key problem to be tackled. They took the then unique decision, when embarking on a primary health care programme, to focus on a year-long course of training the trainers. They saw that the Primary Health Care Nurse in rural areas would be a key member of the health team. She would most likely be working in isolation and under

stress in clinics, where the temptation would be to revert to autocratic behaviour. The curriculum places a great deal of emphasis on attitude change, and on social interaction between the health worker and the patient and community.

At the time of the interviews, the Health Care Trust director had visited the above unit, and was drawing extensively on their training materials to guide the development of her and the trainer's course.

6.2.5. Problems with the use of training materials and techniques

The projects had learned useful lessons through experimenting with innovative training methods.

The Care Group project director reported that, while she and the motivators had thoroughly enjoyed the making of 'dehydration dolls', they were not popular at community level. Either the idea was not locally acceptable, or the way in which the health workers had tried to demonstrate using the dolls was not acceptable.

A project director described how the Cape Town branch of Health Care Trust had devised a health-related puppet show. Puppet shows are promoted in much of the literature dealing with appropriate community education methods. However, in this case, children in the audience were at first terrified to the point of tears. The idea of puppets seemed to be totally foreign to them, and the 'experiment' was at first counter-productive to its aim of getting an interested and involved audience.

Interviewees also discussed the danger of different training techniques becoming mechanically used, rather than used where appropriate and relevant. A motivator, for example, started a role play just at the moment when the Care Group members had started discussing a problem openly for the first time. The director felt the motivator had wanted to 'prove' to her, the supervisor, that he had learned and could implement this new technique, and this took precedence for him over a sensitive analysis of appropriate behaviour at that moment in the life of the meeting.

In the same line, what may start out as inventive and educational may in time become routinised and gimmicky. In one visit during my field trips, a health group put on a play regarding the treatment of tuberculosis. It was performed enthusiastically (though a hidden message regarding problems with traditional healers was in my view destructive). But the play had come to be performed largely for project visitors like myself, rather than being promoted around the local area as a teaching medium, as it had been at first.

There is a danger here of such pieces becoming showcase events, as it were. Research done on community theatre in Botswana, where pioneering work in this technique has been done, confirms the potential danger of routinisation of popular theatre. Over time, community participation in the play, in terms of active discussion of its themes, with the objective of mobilising a collective solution to a particular problem, can fall off.

The difficulty of obtaining local and international health education materials was pointed out by all schemes. There was also difficulty with accessibility of the material in terms of its comprehensibility to trainers, community health workers and the local residents to whom the health workers in turn disseminate information.

The first and most obvious constraint is language. English material has to be translated into a local language, which is an enormous task for small schemes with limited resources. Even when translated, some material remains at a level which is either too advanced or in other ways inappropriate for the target audience.

It appears, for example, that though sections of the 'People's Workbook' (Environmental Development Agency, 1981) have been translated into Xhosa and Zulu, they are not readily understood by people with even a matric education - and the workbook was written specifically for people with limited formal education.

Examples abound of health messages being received or interpreted mistakenly, or being hopelessly inappropriate. This would appear to be the case particularly with health materials put out by state health departments. Many would be amusing if they were not also potentially dangerous. The (then) Department of Health and Welfare distributed a series of posters four years ago in a campaign to educate the public about venereal disease. Their central symbol was a butterfly, with the message "Don't flit". A colleague was approached by a nursing assistant in a rural clinic. The assistant pointed to the poster, and said in a concerned voice, "Explain this to me please. I didn't know that butterflies cause VD".

In similar vein, the posters distributed by government departments during the cholera epidemic were patronising and unrealistic. A series of orders was given: wash your hands before and after using the toilet or cooking; boil all your water; keep the area surrounding your taps clean. The posters were translated into various vernacular languages. Apart from the fact that the wrong languages were sent to different regions, the instructions took no account of the realities of life for most rural people: certainly no tap-running water, extremely limited water for drinking or washing, and poor or costly fuel supplies with which to boil what water there is.

All groups work against pressures of time in training. The community health workers in Manguzi, for example, come together for one day a month for refresher courses; the Care Groups are visited once or twice a month by motivators. Individuals may arrive late for a session, others may have to depart early - the length of a day is determined by daylight hours, and transport in rural areas is unreliable.

Against this pressure of time, experience-based training, while effective educationally, is more time-consuming than didactic, one-way instruction. The temptation may be to try and cram too much into the few available hours, and this can have unfortunate results:

> "There with the threat of cholera [the motivators] were very busy explaining to the people about chlorination [to purify drinking water]... The Care Groups then explained to the community about chlorination... At the first meeting they explained both rehydration and chlorination. And then people got terribly confused, and purified the water with sugar, and put a tablespoon of Javel for dehydration."

6.3. DISCUSSION

The major problems relating to training have been discussed in the last section. Arising from this, three suggestions can be made which would go some way towards alleviating some of the problems.

6.3.1. Contribution of other disciplines

As mentioned, the trainers themselves had insufficient training in how to implement participatory approaches to learning. While it is possible for them to attend training courses along these lines, such one-off courses are usually of limited use. The participatory approach requires a fundamentally different set of skills to those learned during professional health training. The trainers then have to put themselves, and their trainees, at risk, in trying out new skills and methods.

There is a serious need for people with a background and experience of alternative learning methods to make a contribution to schemes such as these. All projects acknowledged this; none had managed to employ such people on a full-time basis.

A challenge exists here for urban-based, inter-disciplinary courses such as the University of Natal's Community Organisation Project, and the University of Cape Town's Community Adult Education Project (both lodged within the universities' respective Centres for Adult Education), to cooperate with and assist rural projects such as these. They need to take appppropriate training modules, adapt them to a rural context, and implement them in rural areas.

This will be both difficult and expensive in the short term, but at the same time as benefitting rural work, could be a vehicle for their expansion beyond the present confines of a relatively privileged urban sector.

6.3.2. Inter-project communication

In going from scheme to scheme for this study, I was struck both by how isolated from each other the projects were, and by how many experiences and problems they had in common. There was clearly fertile ground for peer group learning among the trainers as well as the community health workers.

In suggesting that, as a general rule for development projects, there should be more inter-project visits as part of the training, I am aware that schemes would like to do this, and that practical constraints impede them. However, such visits, and attendance at workshops and conferences, should not be done only if and when there is money and time available.

They should be consciously and routinely built into project budgets and training schedules. They should not be seen as an added luxury: exposure to the work and experience of others is potentially an effective and efficient way of training. It can also contribute to the broader need to build networks of community organisations in rural areas.

6.3.3. Regional training and resource centres

This study showed clear evidence of the need for a number of regional training and resource centres to be established. Since field work was completed, such a centre has since been set up in KwaZulu. In addition, the Ubuntu Social Development Institute, a project of the Wilgespruit Fellowship Centre, has been initiated in the Transvaal. Such centres potentially have the advantage of a centralised training venue with accommodation, where people at all project levels could gather for courses. Such centres could also serve a number of other training-related purposes.

They could employ staff specifically to translate local and international training materials. These could then be tested out in the field. Very little systematic empirical research has been done in Southern Africa on testing health education materials. Tomaselli and Tomaselli's study (1984) on breast-feeding materials was rare in that it tested existing materials (including a section on breast-feeding from 'People's Workbook'). They then devised new posters on the basis of local conditions, understandings and aspirations, and tested these out in the field before broader distribution through the health services. Though there was not sufficient follow-up of the accuracy of the knowledge gained from these posters, it is an example of the

kind of rigorous communications research that needs to be done in a multi-cultural, multi-linguistic, stratified society such as this.

This requires inter-disciplinary work, and should ideally be located in, or attached to, a training centre which is integrated to practical field work conditions.

6.4. SUMMARY

Training has a central place in any development project, and particularly in those using auxiliary workers. It is in training that the material and social objectives of a project are transferred to a core group of local people; it is in training that people are enabled, or not, to make a project self-sustaining and viable over time.

This study has shown the need for carefully planned and implemented training courses for project staff before the recruitment of auxiliaries takes place. The latter should in turn, as at Manguzi, receive training before intensive community activities are started. It is recognised that this conflicts with the projects' need to demonstrate tangible results to both communities and sponsors. However, there is ample evidence of the damaging effects of projects to themselves and to communities if the importance of 'people development' through training is under-estimated.

From this study it can be postulated that the closer a health project is lodged within a formal health system, the more likely it will be that the health system will determine the content of the curriculum for community health workers. Conversely, the more independent the project, the more potential flexibility it will have to consult with community health workers and the community about content of training, and take their wishes into account.

Further, regardless of whether the project is independent or lodged within the formal health system, the less the access to formal health services, the greater will be the demand from community health workers and communities for a curative content to the training. However, possibilities for responding genuinely and flexibly to communities' felt needs will ultimately be determined, in a partial yet important way, by the stance and regulations of professional associations.

It is accepted that many problems in training would be ameliorated if the nature of formal education, at both school and professional levels, were of a fundamentally different nature. In the absence of this, the training of auxiliary workers such as the community health workers offers challenges to both trainers and learners, in terms of introducing new kinds of relationships, resources and techniques.

An ironic side effect of the backward and repressive state of formal education is that innovative schemes such as these have tested the ingenuity and creativity of the people involved. They have concretely identified the needs and gaps which must be responded to; they have also started the important work, in co-ordination with people from resource organisations such as universities, of developing appropriate, indigenous materials which may form the basis of community health programmes of the future.

SECTION SEVEN

COMMUNITY HEALTH WORK: VOLUNTARY SERVICE OR PAID OCCUPATION?

INTRODUCTION

Should community health workers get paid or not? This question was the focus of much discussion in interviews with project directors and trainers, in group discussions with health workers themselves, and in the health workers workshop.

The central theme in the question of payment is the concept of voluntarism in working for communities. Those **opposed** to payment tend to stress the following points.

First, working 'for the community' is seen to be good in itself. It is argued that there is an intrinsic value to altruism which should be promoted.

Going further, some argue for the preservation of 'community spirit'. Traditional societies are supposed to have had supportive community networks where people 'naturally' helped each other. Modern society is supposed to have torn these networks apart, and attempts should be made to preserve, nurture and protect what shreds are left.

Another argument made against payment is that paying people for community work fosters or encourages dependency on institutions (such as hospitals) or agencies (such as independent projects) outside of the community. This works against the notion of self-reliance which is central to community development.

Those **in favour of** payment of auxiliary workers such as these community health workers typically draw attention to the following factors.

The majority of people in rural areas have a poor economic standard of living. Unemployment is high, and there is little cash income. There is insufficient land for many to derive even a subsistence living from it. People need extra sources of cash income. Consequently, the idea of voluntarism is unrealistic. There is an opportunity cost attached to time spent in voluntary service: time is a valuable resource, and that spent on, for instance, home visits, or attending clinic, is time not spent cultivating fields, collecting wood, or engaging in income-generating activities.

At a different level, fee for service, no matter how small the amount, can create the opportunity for reciprocal accountability between health workers and project staff. The latter can exert some influence over

a health worker who may not be working adequately; the paid worker earns the right to a say in working conditions, content of training, role description and so on. Furthermore, it is argued that payment is an incentive to regular and thorough work, and engenders commitment to the work.

This section is organised as follows:

7.1. Forms of payment and recognition.
7.2. Problems associated with payment and recognition.
7.3. Discussion.
7.4. Summary.

7.1. FORMS OF PAYMENT AND RECOGNITION

7.1.1. Manguzi

When this scheme started, there was no intention of paying the community health workers (who at that stage were Educators-and-Motivators only - the Clinical Community Health Workers were introduced later). At the suggestion of a headman, it was decided to put a ten cent levy on attendance at child welfare clinics, which would be paid to the workers. This worked well at first, as they were bringing many children to clinics to be immunised - children who were being reached by the health services for the first time.

As immunisation coverage improved, the numbers of children to be brought to clinics obviously diminished, and this source of money became less. The workers presented themselves at the hospital as a group, threatening resignation unless they were paid more.

The project director pointed out that at that stage the community health workers saw themselves to be working for the hospital - they had not as yet developed the idea of a community health committee as a support or supervisory structure. Project staff agreed to obtain outside funding. Educators-and-Motivators were then paid R10,00 per month, plus the ten cent levy from child welfare clinics. Clinical workers were paid R10,00 per month, plus a per patient clinic fee from other clinics. It was explained to them that this money should not be seen as a salary. Rather, it was to ensure that they were not out of pocket through their community work.

Thus Manguzi had a combination of private sponsorship (in this case, from a religious organisation) and community payment. The sponsors had declared their intention to phase out financial support, and there was some anxiety about what the next steps would be.

7.1.2. Health Care Trust

As at Manguzi, the community health workers in this area were not paid at first. Then the Ciskei branch of the organisation introduced payment, mainly to compensate for transport fares between villages. Although the health workers at this branch do not have transport costs, as they work in a closer settlement, the idea was introduced here as well. At the time of the study, payment was R15,00 per month.

As at Manguzi, the workers are told that it is not a salary, but is to compensate for expenses they may occur in the course of their health work.

Unlike Manguzi, where the community makes a contribution by way of the clinic levy, the full costs are borne by the organisation.

7.1.3. Care Groups

The situation here is different, owing to the different nature of the scheme. The motivators are full-time employees, funded either by Gazankulu health service or private funds. It was never the intention to pay Care Group members: work was always seen as entirely voluntary. However, it is also held that members should not be out of pocket through the work they are expected to do, and they are given writing materials with which to keep their records.

A system of incentives has been developed, which also provides a means of identification with the scheme. Scarves and skirts were created by a local textile cooperative, which all members may buy. There are different colours for different areas, and are supposed to be worn only when busy with Care Group activities. Once a person has been in a Care Group for a year, and provided she has met the conditions for on-going membership (which will be discussed later), she is awarded a Care Group badge. The project arranges 'graduation ceremonies' where the transition to full membership is recognised.

7.2. PROBLEMS ASSOCIATED WITH PAYMENT AND RECOGNITION

Manguzi was, at the time of the study, in a transitionary period. The sponsors were going to withdraw their contribution, and the KwaZulu government had disallowed the patient levy for community health workers at clinics. Money could be collected from the community, but not via the health services.

The trainers's interpretation of this was that it was to encourage communities to help themselves, and not to be reliant on the government. It is more likely that it arose from financial regulations of the bureaucracy, to prevent unauthorised 'loading' of clinic fees, and to protect clinic nurses from accusations of misappropriation of funds.

This change in regulations posed problems for the project. Collecting money from the community presumes the presence of a community-based agency to supervise and administer the process, and to whom the community health worker would be accountable. A system of health committeees had been set up in most areas. Their efficiency was very variable, however, particularly since the trainer had been able to spend less and less time with them. In some areas, no committees existed at all.

The project was considering administering payment through the tribal authorities. Staff were aware that this body already controls the collection of money for many different services and events; it is certainly not necessarily the case that any officials would have the knowledge and experience of community health to be able to check on accountability and act in a supervisory capacity.

A further problem with delegating control to a health committee or tribal authority is that the community health worker may get caught between two sets of authorities: these community structures and the hospital. More detailed attention is given to these last two points in section 10.4.5.

Another problem is to determine on what basis money should be levied. Some would argue for a flat rate to be paid by each homestead in the area on a monthly or annual basis, regardless of whether the homestead actually has contact with the health worker. Two difficulties arise in this regard. First, the health workers can provide only limited curative services, and it is difficult to 'see' or 'measure' the effects of the educational and preventive aspects of their work.

Were their curative role to be expanded, the second problem emerges. Communities who are already asked many times a year to pay for schools, community buildings, public ceremonies etc., may question the need for universal payment of a community health worker when the homestead may not need curative services.

The Manguzi trainer felt that flat rate payment could work where community health committees were operating well:

> "I don't think they will say they won't pay just because they are healthy. Even if they are healthy, their kids should be immunised. And again, what about when a woman delivers, and she comes across problems. To be healthy can't mean a thing in that case. We have got snakes - that you are healthy doesn't mean that the snake doesn't do harm to you."

The project director, while recognising the need for payment, felt strongly that it needs to be a community responsibility, and that this requires a sound committee structure in order to organise it. The scheme's

mistake, he felt, had been to introduce payment by an outside sponsor without explaining from the start that it was a temporary arrangement, and that the eventual goal would have to be community responsibility for payment:

> "...very often we made mistakes like this, like starting to pay them... It remains to be seen whether it is going to be possible for them to take over. **That** the communities have all accepted now, the responsibility, at least openly at the meeting: people have said we do accept we must find some way now, and ideas were raised. So I do sometimes wonder whether there isn't a place for an outside input, but with the proviso that people know it's temporary...**that** it's going to stop, and **when** it is going to stop."

> (Interviewer: "There are some who would argue that in a situation like this that is so deprived, you can't expect a spirit of voluntarism to be operating - that women are taking time outside of the household, even the young unmarried women.")

> "And that's economically useful time? Sure, that's right. I think there is probably something in that. I don't know enough about that, but I think it would be wrong to be hard and fast and say it's **always** wrong to have an outside input to pay for them. I think it's **always** wrong if that's going to be continued. I think it's **always** wrong if it isn't done with the express aim of eventually mobilising the community around the issue, so that it could eventually take off and do it by itself."

A very different implication arising from payment came to light at Health Care Trust, one which had not come to my attention anywhere in the literature or during visits to other schemes.

As mentioned, this organisation itself pays the health workers, to whom it was carefully explained that the R15,00 was not a salary as such. Thus, when workers at the end of the year asked for a 'bonus', the refusal was explained in terms of their not being salaried people. At the time of the visit, workers were not asking for a 'raise' as their colleagues at the East London branch had done. But staff had begun to pinpoint a different problem.

All villagers are encouraged to attend the health workers' training sessions, but attendance has been chronically poor. Staff were beginning to suspect that this could be explained in two ways.

> "I have been hammering all the time that the health workers must try and invite the villagers to their gatherings. Maybe these villagers don't want to attend, seeing that they are wasting their time because they are not going to get money, since the health workers are doing their work by going there... It is discouraging the villagers to come together."

And another staff member thought it was possible that the health workers were not actually encouraging more popular attendance as they might be feeling:

> "'No, we don't actually want villagers because then we aren't seen as people who have got extra knowledge.'"

There are limited funds, thus only a few people can be paid, though 'lessons' are open to all. Paying the few might thus have the effect of **limiting** broader participation in the program - it is seen by both village people and the workers as 'for the community health workers,' not 'for the community'.

A further problem with payment encountered by Health Care Trust was that of accountability. No worker is penalised for non-attendance at training sessions, or for not working diligently. In the group discussions it was clear that there were very different understandings among the health workers themselves as to how many hours a week they were expected to work.

Presumably, peer group pressure in this relatively small, densely populated area can be effective in sanctioning an unenthusiastic worker. However, a staff member said that it had happened that some workers appeared only at training sessions which coincided with pay-day, and there was little the project could do to overcome this. Though here, as in the other projects, they are expected to keep a record book of their weekly activities, there is still little control that can be exerted.

The issue of payment was high on the agenda of all participants at the national workshop for community health workers. Along with problems with tribal authorities, it was the theme that evoked the most discussion. Workers expressed extreme dissatisfaction with the amounts they were paid.

They said they realised that their work was not 'a job', and that they truly wished to help their communities. They were not asking for a 'proper' salary: indeed, the name given to the payment in various areas indicates their understanding of it as compensation. In one project it is called 'soap money' i.e. people promoting hygiene and cleanliness must themselves set an example to the community. Another scheme calls it 'shoe money' i.e. compensation for wear and tear on footwear during their long walks to homesteads.

However, they were at the same time most articulate about the difficulties they faced. First, they were under pressure from their families about the amount of time spent away from their homes. With increasing unemployment, some women were being pressured to take up informal forms of employment which could generate more income than the amount paid them as health workers.

Then, they argued that the R10,00 or R15,00 (which was then the standard amount paid by most schemes) was not in fact enough to cover their expenses. How could they, they asked, as concerned human beings **not** buy food for a family without any? How could they **not** pay for transport to clinic or hospital for a seriously ill child (fares which the hospital services did not repay) when no family member could afford it? **Much** money for soap and shoes is needed, they said, considering the conditions they work under, and the distances they must walk.

They felt that their requests for increased money had not been taken seriously, and commented knowingly about the salaries of the professionals who turn them down while exhorting them to further community service ideals.

The Care Group project experienced problems with its system of incentives. The lengthy passage from the interview with the project director that follows is justified as it depicts vividly and realistically the practical problems of applying and monitoring an apparently simple system.

> "I was enthusiastic [about the scarves and badges] at the beginning, because it lent them status and people knew, 'That's a Care Group member', and they felt like joining. Now I am not so sure. Specially as there was quite a racket with the badges...
>
> When we got money to do something to recognise them, we discussed with the groups what they think Care Group members should be, or have to do, to receive the badges... There was remarkable unanimity, that the members should have done everything she is supposed to be telling people. So they decided themselves she must have a garden, she must have a rubbish pit, she must have individual face cloths, the house clean, her children at the under-five clinic, the Road-to-Health chart. They decided she must be at least one year a member... and they made these rules themselves.
>
> For graduation, we left it to the groups themselves to decide who deserves a badge, because with a thousand members it is very difficult to check on every person. But then you could go to households where everybody had a badge, but nobody had a face cloth, and we discovered then that they just took one year of membership as a criterion. The rest fell away.
>
> Then at the next graduation [a motivator] went to see everyone, and then there were only a few who got a badge, and people were cross, and it took a long time to explain.
>
> Then last year we discussed again how shall we do it. They suggested... that the neighbouring Care Group should check on them... (But) again lots of them got badges which I am absolutely sure they do not deserve...

> And then we discussed it with each other. 'You see, when we get this badge this means that everybody in the community knows this person has a badge, and [they can go and see] what it looks like when we do all that we tell them. And then they will be very disappointed to see that it doesn't look like that.' They understood that... and they said, 'Okay, we will have the graduation in February, but then we will be very strict that only those who have really got everything... will get the badges.' But it is difficult [for a group] to say to a group member, 'No, you are not getting a badge.' That would need a lot of education, cooperative education."

7.3. DISCUSSION

In order to understand why the payment, or non-payment, of this level of extension workers is so contentious, it is necessary to place it in its economic, social and political context.

Before doing this, I must reiterate the extent of concern about the issue voiced by all project directors and trainers. They were working in difficult circumstances, with limited resources, at a time when funding for rural projects was difficult to come by. They were breaking new ground, without the benefit of others' experiences on which to base their ideas and decisions. What follows is necessarily my own interpretation of the issue, based largely on the opportunity this study afforded of viewing different ways of dealing with payment in these and other projects.

As mentioned in the introduction to this section, the context of rural development projects is bleak. Extreme poverty combines with low educational standards. There is limited local employment, and restricted opportunities for finding work elsewhere, particularly for women. The chief sources of cash income are migrant remittances and state pensions, yet people are in a cash economy, with relatively few being able to meet subsistence needs from the land.

It comes as no surprise, then, that the issue of payment for community health workers is a vexed one. On the one hand, community development promotes self-help and an ideal of voluntary service for the betterment of the whole community; on the other, there is the need to create employment opportunities. The tension between these two conflicting forces can be helpfully addressed through the concept of **accountability**.

A rural community health worker accepts her election or nomination at a public meeting or volunteers herself. She knows there is limited money, and is told about the commitment required of her. The choice is hers. Her motivation may be a perceived status attached to being a health worker; she may be attracted by the social activities attendant on training and working; she may think that her real goal, which is to become a nursing assistant, will be more easily achieved by using the community health work as a first step; she may, for religious or humanistic reasons, genuinely want to 'help the community'. Her chief motivation may be for the cash income itself.

Once she accepts her role as health worker, she enters a complex web of expectations and obligations. The moment she is **expected** to do a certain number of visits a week and attend regular refresher courses; the moment the role includes the right of a clinic sister or project staff member to sanction her for activities done or not done, she is accountable to the project, as is the project to her.

I would argue that at that point she is employed, and that in most community health projects, she is the junior partner in a relationship of unequal accountability. The expectations on the worker, and the functions she is meant to fulfil routinely, are worth more than the (typically) R15,00 a month that is paid, not as salary, but as a kind of honorarium to cover out-of-pocket expenses. She is undermined in the eyes of the community ("they think we are pretending at being nurses", was the comment of a health worker). She is also undermined in the eyes of the nursing professionals in her environment.

At least three objections can be raised to this position. First: the health workers (and thereby their communities) may be argued to have benefitted from the 'free' training and education provided by the projects, thus some reciprocation can be expected. The question is then, at what point have they 'paid their dues'?

Secondly, some may argue that there is no money available in the project, and that in rural areas even a limited amount of cash is better than nothing. This misses the point - it avoids the principle behind the issue, which is the latent or actual exploitation of people in the name of community service. It detracts attention from the need to restructure organisational budgets such that auxiliary workers are paid more fairly.

This leads to the third point. If individual projects were in fact to improve payment for their workers, they would be solving the problem only for their particular areas. It may be argued that the state is, in fact, the proper institution to be implementing the primary health care approach on a broad scale, and that the independent projects allow the state to renege on its responsibility. Should these projects not be providing a model for the integration of community health workers into the formal health system?

My answer is both yes and no. In principle, health is a universal human right, and the provision of health services should be primarily the role of the state, though individuals and communities have their part to play. It is not acceptable that certain communities are being expected to 'help themselves' in the field of health services which are provided free to, or are more easily afforded by, other communities.

However, there are serious risks attached to the integration of community health workers into the formal health system. Independent or quasi-governmental organisations provide a valuable service by their freedom to be innovative, and their potential for creating authentically community-based organisations.

Much would be lost if, because organisations are unable to pay decent salaries, all community health programmes were to come under state control.

For as long as such programmes operate independently or semi-independently, and health workers continue to be paid a minimal amount, they will reach only the better-off members of the community who are able to afford the unequal relationship they are in. This is not to suggest that there are not other benefits to the workers, and to the communities in which they work, of their involvement in programmes. But it is felt that, whatever else it is that development schemes are doing, they should not be contributing to the material exploitation of people in rural areas.

7.4. SUMMARY

The schemes in this study had different approaches to, and forms of, payment and incentives. The Care Group project expected voluntary participation on the part of its some four thousand members, and had developed a system of incentives and forms of identification with the scheme. Health Care Trust paid community health workers from its own budget, whereas Manguzi had a combination of community payment and private sponsorship. In both these schemes there was clarity that this was not a salary as such, but a way of covering out of pocket expenses of the community health workers.

The study showed that where development projects subscribe to community payment, problems arise with using existing, or creating new, structures for the administration of community money. This reinforces the importance, particularly in rural areas, of developing a solid local organisation to support the work of the auxiliaries.

An interesting finding was that the experience of Health Care Trust suggests that payment of indigenous auxiliary workers may have had the effect of limiting broader community participation in project activities.

The notion of accountability between project and auxiliary workers is helpful in understanding the tension between the need for payment and the value of voluntary work. Where workers are expected routinely and systematically to perform given functions, and where they are accountable to a supervisor who can sanction them, I argue that a reasonable fee for service is necessary. Otherwise projects are in danger of using the principle of self help to further exploit and underdevelop rural people.

SECTION EIGHT

INTERACTION BETWEEN PROJECTS AND THE FORMAL HEALTH SYSTEM

INTRODUCTION

The theme of this section is the interaction between the formal health system and the projects, and this will be dealt with at three levels: the attitude of health professionals in the environment of the community health schemes; the characteristics of bureaucracies which affected the ability of schemes to meet their objectives; and the control of professional health bodies and health policy makers over the role and functions of the community health workers, and over the implementation of the primary health care approach generally.

Two things must be noted before taking up these themes. First, the projects were differentially placed in terms of the formal health system. The Manguzi and Care Group projects were part of a hospital setting, while the Health Care Trust was structurally independent of it. The former two projects were, however, carriers of norms and values about the delivery of health care which were in some respects fundamentally different from those of the health system in which they were lodged, and they had some independent funding. To this extent they may be seen as a partially independent sub-system, at odds with the dominant system.

Secondly, it has been difficult to separate material relating to the attitudes of health professionals from the material relating to training, which was covered in the last section. They were often part of the same conversation in interviews, as the problems surrounding attitudes are to an extent rooted, and then find their solution, in training. There will thus be some duplication in the first sub-section that follows, but an attempt has been made to focus here on health professionals in the daily environment of the community health workers, once the community health workers have been trained, and the effects of training on the health workers in the community.

The section is organised as follows:

8.1. The attitudes of health professionals towards community health workers.

8.2. Interaction with bureaucracies.

8.3. The control of professional health bodies and health policy makers over the role of the community health workers, and over the implementation of the primary health care approach.

8.4. Summary.

8.1. THE ATTITUDES OF HEALTH PROFESSIONALS TOWARDS COMMUNITY HEALTH WORKERS

Primary health care is an approach, not merely a set of medical cures or techniques. It emphasises the quality of the relationship between the health team and the community, and within the health team itself. It advocates a non-authoritarian style of both teaching and learning, including experience-based learning and the development of problem-solving skills. It stresses respect for the individual and the inculcation of self-reliant and independent attitudes. These elements are all shared in common with the community-based approach to development.

A problem can be expected to arise when an approach such as this exists alongside, or within, institutions which are predicated on a different form of relationship between people. The formal health system is one such institution. A concern expressed by Werner (1981) among others, is that primary health care may become a vehicle for extending the rigid hierarchical relationships of the health system even further out into communities. Werner, in making the distinction between 'community supportive' and 'community oppressive' community health worker schemes, refers to the possibility that exists that community health workers, with professional nurses or doctors as their role models in training, will become yet another cadre of 'officials' in the community, working against the goal of generating trust and co-operation in activities for the benefit of communities.

The problem was very evident in the schemes under consideration here. The health workers learn part of their role modelling from doctors and nurses in the course of their training, and also interact with them in the course of their daily work. This interaction can be undermining to the health workers if, as was often the case, the health professionals 'pulled rank' and treated the grassroots workers as inferior:

> "... there are some nurses who are aware of the dignity of their profession to a pathological degree."

> "... many of the sisters don't support the health workers at all. On the contrary, they think it is an intrusion into the realm of their closed profession of sisters."

The reality for clinic staff must be taken into account. They often feel that being sent to rural clinics is a form of punishment (which it has on occasion been proven to be). They work in isolated conditions, with little in the way of professional or social support networks. In addition, the clinic nurse contends with several different specialist branches of the health services - such as school nursing, family planning, communicable

diseases, the local doctor - and she must try and meet their different needs. The professional clinic staff may not fully understand the potential role of the community health worker as an ally - in the short term, she is seen as creating more work.

The experiences of the health workers, on the other hand, are real for them. They complained bitterly in group discussions about the lack of support from health professionals, and were particularly offended when sisters were rude and hostile to them in front of the patients they brought to the clinics. Their legitimacy, always fragile, was weakened by such attitudes and actions.

There was substantial evidence in interviews, group discussions, and from my own observations, that community health workers acted in authoritarian ways towards their communities.

Staff at Health Care Trust said that, despite their training efforts, "most community health workers consider themselves instructors or teachers of health and they perpetuate the system". It was felt that the early training might have contributed to this:

> "I think they were trained very much in the way that nurses were trained, which is a way of telling people what to do. You have the advice, and people must take your advice, rather than getting involved with people, and getting people to work together."

As another put it, "That word 'teach' is still very much in their minds".

The consequence was that community health workers themselves said that they came to be seen as 'village police', particularly when they used the threat of calling in the tribal authority system to back them up.

The trainer at Manguzi discussed a practical consequence of health workers coming to be seen as authoritarian. He was referring to Werner's point that the task of the community health worker is to point, rather than to push:

> "If you push people and make them feel scared, they will make a toilet just for you - you forced them. They can **build** it, that's possible. But to **use** it, that's another thing. You can ask, 'Are you using it?' 'No.' 'Why?' 'You said we must have a toilet and there it is. To use it? You didn't say we must use it. You say we must use it now? Okay, we'll go."

It is not suggested that, to the extent that some community health workers act in authoritarian, unsympathetic ways, this is always the fault of the professionals who train them. Different forces influence

the health workers: some may coerce people because they want to prove their effectiveness to project personnel, and some pointed out that, especially at first, people **expect** to be instructed - this is a legacy of educational norms in the surrounding society. Some undoubtedly have a personal need to act out the status and prestige that they perceive to come with their new role as health worker.

One interviewee spoke of the benefit of community health workers working in their home areas, as a possible antidote to the tendency of health workers to 'act like professionals' because of their own need for status and prestige:

> "It's not easy to show that you are dignified to your own people. They could do it if they changed their areas. Let's say the community health worker comes from one place and works at another place. They can show that they are more high or more superior. But if they work in their own areas it will not be easy for them. The community know that this is your father, and this is your grandfather."

All schemes realised that the solution lay partly in training and education, both of the health workers, and of themselves as health professionals. At Manguzi, commendable steps were taken to include the idea of community health work throughout the training of enrolled nurses. The project director was also medical superintendent, and as such was well-placed to influence and promote this integration:

> "It's part of the underlying thought behind the lectures (for community health workers) that you of the community are at the hospital, that we haven't kept our knowledge to ourselves because we believe everybody should have it. And so they should have the same attitude towards the people among whom they will work, sharing everything that they know. So that eventually - and we say this to them specifically - we say that their aim should be that everybody should know as much as they do. Other than that I cannot see how else you can do it, but by the attitude of the people involved with them."

Nurses were exposed to the various community projects of the hospital, so that "this is normal for them. They don't find the health workers funny".

At Elim, staff felt that the Care Group idea was not sufficiently integrated in to the nurses training, even though the project was strongly linked to the hospital. Clinic sisters were thought not to have sufficient idea of the benefits which could derive from the Care Groups. This was despite the efforts of the project director to influence the training syllabus: even though the beneficial impact of the Care Groups had been scientifically proven, she felt that the community health approach was tacked on to training, rather than given the priority it merited.

The motivators felt that other hospital staff undervalued them; they said that hospital-based staff thought their (the motivators) job was easy and comfortable, away from the hospital wards, whereas they themselves found the work physically and emotionally demanding. They said that it made a tremendous difference to the functioning of a Care Group if an individual clinic sister was actively supportive of their work.

Thus the two projects which were lodged within the health system demonstrated the importance of the exposure of professional health personnel to the community approach as an integral part of training, but also the difficuly of doing this effectively.

The Health Care Trust was, as has been pointed out, in a structurally different position vis a vis the formal health system, as it was an independent project. By choosing to operate in an area with a clinic, it needed to interact with the hospital and clinic. The Coordinating Committee was established to ensure a harmonious relationship between the project and the health system, but this committee gradually became ineffective.

The perception of a staff member was:

> "These hospital people, they don't even go out to see the project at grassroots level. They are sitting there waiting for me to go and give them a report every time... you will hear them claiming I am too scarce. Why is it necessary for me to go to hospital when there is no need? You will never see them coming to our offices, asking for minutes, asking for anything."

The answer to her rhetorical question lies in an assessment of the balance of power between project and hospital: who needs whom most? Once an independent project has made the decision to cooperate with the health services, and where it is reliant on these services for referral and back-up, it will be the small project itself which will be the more threatened of the two parties by indifferent or strained relationships.

The project staff found that, while the hospital gave assurances that nurses were told about the community health workers and their work, this was not in fact done. New clinic sisters arrived in the community with no idea as to their existence. Because of the deteriorating relationships with the hospital, the project tried to solve the problem at community level with individual sisters. They held regular meetings at the clinic, and sisters attended village meetings where project matters were discussed.

This is a far less efficient way, of course, of dealing with the problem, and leaves the health system relatively uninfluenced and unaffected by the potential of an alternative approach to health care and health service provision.

Project leaders were all critical of their own efforts at ensuring that trainers, hospital staff, officials such as health inspectors, and the community health workers themselves were exposed sufficiently to the 'new' approach. All were faced with shortage of time, a busy work schedule, and the fact that in rural areas unexpected situations constantly arise which interrupt training and public relations work. Where the project leader also has a curative role to fulfil, the needs of an emergency case always had to take precedence over the community work.

Part of the problem is shortage of manpower: whether independent or not, projects did not have sufficient staff to do all the patient, persuasive work that is required when innovations are being introduced into, or alongside of, existing ways of working. Increased manpower to promote particular projects might improve their own effectiveness, but would not have the necessary broad-based, substantial impact on the overall existing approaches to the provision of health care, and attitudes of professionals providing these services.

The long term, effective solution would be a substantial change in orientation in all professional health training - at medical, nursing and social work schools. A medically trained interviewee spoke of the need for:

> "... drastic changes in the curriculum of the doctors' training. They are being trained to serve in sophisticated western hospitals. There is a tacit assumption that they will function where those hospitals exist... The people who train them must become different. The people who train them, train them to become like themselves. But I don't think it is only the doctors. I think it is the nurses, everybody. All the professionals have to have a change of heart. In their training it must be possible for them to end up as a product which is interested in, and will find fulfilment in, this kind of practice... in a rural set-up or a development set-up."

The constraints in the way of such a radical reorientation of health training will be discussed in the section dealing with the making of health policy.

8.2. INTERACTION WITH BUREAUCRACIES

Authors such as Chambers (1974), Hyden (1983) and Lele (1975) have concentrated on management aspects of development work in rural areas. They have pointed out that, no matter how enlightened or indigenously appropriate social policies are, they will not be translated into social action unless there are adequate and appropriate structures for implementation.

The reality for most rural projects is that they depend on state resources to some extent. Even non-governmental projects, if they are working with an integrated, holistic approach to development, will recognise that the state is the institution with the kinds of resources, influence and authority necessary to tackle, for instance, water provision, irrigation, immunisations, or changes in educational syllabus.

There are characteristics of bureaucracies which mitigate against the requirements of innovative developmental projects. These appear to exist independently of the context of socio-economic and political arrangements in which they function. An independent rural health project in rural Tanzania, for example, will face many of the same problems in dealing with the health department as will a rural health project in neighbouring Kenya, although the political economy of both countries is significantly different.

This point does not hold only for state bureaucracies. Korten (1980) points out that the problem is to some extent one of scale: independent organisations, if they grow to a certain size, will usually succumb to an organisational imperative to take on characteristics of bureaucracies. At this point, organisations become unresponsive and inflexible in terms of meeting the needs of people they are designed to serve, and maintaining the essential elements of consultation, participation, and democratic decision-making.

The problem is exacerbated in Southern Africa because of the multiplicity of state departments which have been created in the 'homelands' and 'independent states'. There are in a sense two layers of bureaucracies, so that once Ulundi, for example, has taken a policy decision which would require a change in legislation in the health field, this must still be ratified by Pretoria's health hierarchy.

What follows are points raised by interviewees with reference to the rules, regulations and organisational climate within the formal health systems which affected their work. Some of the issues may appear to be trivial, but they had a very real effect on the ability of project personnel at all levels to achieve their objectives.

8.2.1. Transfer of staff

Health Care Trust and the Care Group projects both complained of the adverse effect of recurrent transfers of hospital staff, particularly those based in clinics at community level. It often happened that, just as a community health worker or other project member had formed a good working relationship with a clinic sister, and they had started coordinating their work to the benefit of patients and community, that sister would be transferred back to the hospital or to a clinic in another area. This worked against the cumulative growth and impact of the projects, though of course transferred sisters may well have promoted their new ideas in the environments to which they were sent.

This problem affects projects in related sectors as well. A common complaint of educational upgrading projects is that teachers who have been for special training, whether in science, guidance, or English, in project schools, are then transferred away from the area, or to different subjects in the same school.

This seems to happen regardless of the quality of relationship between state department and independent scheme: in other words, it is not suggested that there is a conspiracy to disorganise development initiatives. Rather, the regulations and ways of proceeding are too rigid and cumbersome to take the special needs of relatively small projects into account. Furthermore, with the reluctance of professional people to work in rural areas, rotating duties may well be the only way in which rural facilities can be staffed.

8.2.2. The need for flexible working hours

Community workers need to be in the community when people are there, and have the time to work with the community worker. In an urban residential setting this means the flexibility to work in the evenings and over weekends; in rural areas without electricity, weekends may be when people have spare time; the timing of interventions may also be seasonally determined.

Where project personnel are employed by the health service, or where an independent project works together with employees of the formal health system, the 'shift duty' working hours do not mesh with the needs of community activities. This was a problem for the Health Care Trust and the Care Groups. At the latter it was a source of tension between the motivators and the hospital-based nursing assistants employed at the same level in the health hierarchy.

8.2.3. Commitment

Characteristic of most innovative projects is that leaders assume and expect from all involved in their work a dedication and commitment which surpasses that expected in a 'normal' job. There is a missionary aspect to the work, with the 'missionaries', whether inspired by religious or socio-political commitment, frequently being the more highly educated, often white, leaders from outside the project area.

There is an expectation that all staff connected with the project will work overtime, not retire when the bell rings, carry discussion of project work over into social gatherings. The enthusiasm of the leaders is often not matched by the field workers. The latter may well think the project is a worthwhile venture, but know there is no reward coming from the extra commitment. They may also have a different perception of what it is possible to achieve in the situation within a given time. In addition, they are usually on a very different salary scale to the leader, and have different demands on out-of-work time. The Care Group motivators, for example, articulated clearly that they were aware of the different employment position they were in, compared to the director.

This was a problem for all schemes in this study. The directors of the three projects had experienced frustration in this regard, but at the time of interviews were trying to overcome it through continuing education and persuasion.

This raises questions for the principle in community development of working 'at the pace of the community', where auxiliary project workers are part of the community. It means that there will be an abiding tension between those directing programmes and those implementing them at the grasroots level.

Where senior members of staff have little experience of grassroots community work, they may not fully appreciate the difficulties and slowness involved in 'reaching the poorest of the poor'. In a sector such as health, the urgent need to get on with the job, literally in terms of introducing life-saving education and technology, is evident.

In schemes where leaders are both health professionals and less insightful and compassionate than was the case here, it is to be expected that serious divisions in the health team may arise.

8.2.4. Transport

At a more mundane level, transport was a problem felt keenly by the two projects operating within the health services, the Care Groups and Manguzi. New forms of health care delivery require new forms of implementation. This can put different or additional demands (probably both) on bureaucratic rules governing the allocation of transport.

The problems of transport provision in developing situations are well-known. First, it is an expensive service, and there is usually a shortage of (working) vehicles. In the health sector, the demands on available transport to serve curative or emergency needs always takes priority over preventive or promotive work. Then, community-based work may need to be done in the evenings or over weekends, whereas government departments may require vehicles to be based overnight at the hospital depot, or may not provide transport past a certain hour. This inhibited the two projects from extending their community outreach.

8.2.5. Provision of other resources

Whereas transport is a major resource required by projects that is controlled by the health and related departments, there were other examples of the inability of bureaucratic structures and rules to respond flexibly to the projects' resource needs.

One area of difficulty was with replenishing medical supplies for the First Aid kits of the health workers. This particularly affected the Care Groups, when at one stage the health service stopped supplying them with the antibiotic ointment necessary for trachoma control. This was sorely felt by Care Group members, as their ability to provide and apply the medicine was their first way of gaining support in their communities.

A project director spoke of the role that health departments need to play in facilitating the work of community sisters, regarding the need to get educational material from a London-based organisation, Teaching Aids at Low Cost:

> "If you want to write to TALC overseas (to order health posters) you must first get a money order in pounds. It's all very well for me personally, because I have got money. But to get the government to pay for something from TALC is totally impossible... It's alright for myself, but for a sister, say at a clinic... she's interested in this, she's got a very busy job: from where can she get hold of relevant posters? It's impossible! The odds are stacked against her. She may be very interested and very enthused but then she's going to become depressed and disillusioned because she can't get any of the community work started. She sees she must, she would like to, but she has no resources at all. And that is what the government must tackle... It's easy to make long laws, for bureaucrats to sit down and make all kinds of rules that community programmes must be like this and that, then they feel they have done a good thing. But what they really have to do is to make it possible for people who are in the community to be more effectively involved, practically."

It should be noted that, while officials in the bureaucracy have this responsibility to facilitate the work of the schemes, it is also important that project personnel make it their business to find out how the bureaucracy works, so that they can get access to whatever is available.

8.2.6. Specialised government departments

Bureaucracies typically have specialised departments, which because of scarce fiscal resources are in a a competitive relationship with one another. Departments of health, education, agriculture and public works, for example, have to bargain for their share of the always limited budget. Within departments, sub-sections are likewise competitively oriented in respect of gaining the best possible share of resources.

The experiments with mass-based health education in Tanzania showed the effects of this very clearly. Each of the participating departments (health, education, communications) wanted the campaign to be run primarily under its own banner, in order to claim the credit for itself and thereby hopefully a better share of the following year's budget. The result was a very expensive, very unsuccessful campaign.

There are serious implications for the work of primary health care and related developmental activities, both in and outside of state bureaucracies.

In the first place, primary health care, while specialising in health, requires an integrated approach to the solution of problems, and to their prevention. It accepts that multi-faceted, holistic interventions must be made, which means working closely on an inter-departmental basis. Obvious examples would be the provision of clean water, which could involve health, public works and agriculture; or school gardening projects in schools, which could involve health, education and agriculture.

Specialised departments are characterised by the lack of communication or co-ordination with each other, and decision-making within each hierarchy is slow. The problem for the grassroots worker who has motivated for something requiring a bureaucratic decision, is that he or she sits with raised expectations in the community. Enthusiastic volunteers become slowly demoralised while the request goes from section to section up and between hierarchies. In addition, the people responsible for the motivation have no control over the decision-making: they are not present at meetings to explain fully, or put forward possible compromises, if objections are raised.

One project decided to fall back on its own resources, even though it would be more costly:

> "With the communal garden, someone asked me, 'Why don't you get the Agriculture Department to fence it, so you would get the material free?' And I said that would be more of a problem because then we are relying on when they are going to fence it. If we do it ourselves, we can do it in the time that actually suits the project better. If we wait for the Agriculture Department, we **might** get it end of next year."

Furthermore the community health worker at grassroots level will seldom encounter the agricultural extension worker or school nurse because, for example, they are allocated transport on different days. They certainly do not have the influence over other departments such that co-operative work can be done, or to see that people's primary felt needs are attended to. An interviewee said:

> "I think in rural areas people have got so apathetic because of the problem of people coming along - like the Agriculture Department will come along and speak to them about growing orchards. The community health workers say, 'What is the use of planting orchards when there is no water organised? Why not do the water first? Why not come to us and ask **us** what they must do first?'"

Where, for instance, a health worker and an agricultural extension officer agree jointly with a community on a plan of action and feed a request into the lowest accessible rung of their respective departments, they have no assurance that there will be joint decision-making at more senior levels.

Hyden (1983: 130) outlined the advantages that a non-governmental organisation may have over within-systems projects in terms of their ability to manipulate linkages with government departments. Being outside any one department, they are better placed to make different departments responsive to their needs. In the case of Health Care Trust, having been let down continually by the Department of Agriculture, they had the freedom to approach another government agency to assist with spring protection.

For those projects working within the formal health system, part of the solution would have to come from joint planning with other departments in the planning stages, before the scheme is launched. The difficulty is that all departments may not have a similar sense of the importance of integrated work, such that they would be willing to make the time and resource commitments required to coordinate with the health workers at grassroots level.

The KwaZulu government has recognised this problem, and has reoriented the role of the Bureau of Community Development to be primarily one of coordinating the development functions of other departments, rather than undertaking actual community development activities itself. This would appear to be an encouraging advance, and in line with the international trend to see community development not as a movement or set of activities on its own, but rather as a community-based approach to the different development sectors.

8.3. THE CONTROL OF PROFESSIONAL HEALTH BODIES AND HEALTH POLICY MAKERS OVER THE ROLE OF COMMUNITY HEALTH WORKERS, AND OVER THE IMPLEMENTATION OF THE PRIMARY HEALTH CARE APPROACH

The project directors at all three schemes believed that the community health workers should have, and could manage, a greater responsibility for curative services. The health workers themselves, at both Manguzi and Health Care Trust, similarly wanted to be able to expand their curative role. As one put it:

> "How shall the mother listen to my words on education and prevention when she has a sick baby in her arms and I cannot help that child? I must first make the child well, then she shall know she can listen to my advices."

This was a recurrent theme at the health workers' workshop, where they pointed out the absurdity of the fact that it was possible for people to buy, from local stores, medicines that they were not allowed to have in their First Aid kits. This, said one worker, led community people to accuse them of "playing at being nurses", with no authority or credibility.

One project director said that if the community health workers were able to use even simple antibiotics, which could do no harm even if wrongly prescribed, they could have a much greater impact on the control of the more common illnesses.

The bodies with jurisdiction over the curative role of the health workers, especially in so far as the use of drugs is concerned, are the professional councils: the South African Medical and Dental Council, and the South African Nursing Council. These statutory bodies make the regulations regarding the parameters within which different categories of health personnel may work.

At the time of the study, there were signs that inroads were being made in terms of allowing trained primary health care nurses to execute some functions that only doctors had previously been allowed to do. The significance of this should not be under-estimated: there are chronic divisions and hostilities between the medical and the nursing professions, and this extension of the role of primary health care nurses indicated that community health needs took priority over professional rivalry.

Some of the training and curative work being done by the schemes was technically illegal, with the South African Nursing Council turning a blind eye, as it were. There were no signs of any changes being made which would actively facilitate and extend the curative role of the grassroots workers.

Doyal and Pennell (1981: 288), in reviewing the response of health professionals internationally to the introduction of grassroots doctors, found that:

'... wherever a western system of medicine predominates, any attempt to train auxiliary personnel to take responsibility for "medical" tasks has met with very considerable resistance from the medical profession. Even where there is a severe shortage of doctors, the training of auxiliaries has been regarded as a threat to the profession.'

It seems that local South African professional attitudes are no different in this regard. The problem is compounded by the establishment and growth of administrative structures in each of the 'homelands' and 'independent states'. As is the case elsewhere, the social groups who control administration get their power from it. They want to influence the allocation and distribution of resources away from those which would benefit the poor majority. In addition, the aspiration is for services to be 'modern' and 'sophisticated', even where this is objectively inappropriate.

Some factors need to be considered which reflect changes in the thinking of professionals, and which might affect the control of the professional councils. One is the recent emergence of an alternative medical

association, the National Medical and Dental Association (NAMDA). It was formed in reaction to what was perceived to be the lack of responsibility of the Medical Association of South Africa to various medically-related political events, in particular the circumstances surrounding the death of Steve Biko.

NAMDA has a limited membership as yet, but already its influence is being felt in medical schools, in lobbying for changes in health legislation, in pushing for the formation of alternative associations in other related professions, and in lobbying for international pressure for political change. It has accepted the relevance and appropriateness of primary health care.

Secondly, there are professionals who oppose the primary health care approach on the grounds that it represents 'third class medicine for third class citizens'. They argue that, in the context of apartheid, primary health care and the promotion of auxiliary workers is being advocated for black rural areas, while a policy of privatisation and the provision of sophisticated services continues in the cities. They argue that primary health care can, and will, only be really viable and valuable once there has been fundamental social transformation.

Finally, it might be thought that the 'independent states' have an opportunity to introduce regulations which would be more appropriate to indigenous needs and conditions. It appears that they are so far replicating the models produced in the Republic, which is not surprising given the influence of Pretoria's advisors over policy-making in the peripheral areas. Furthermore, in order to ensure job mobility for their trained professionals, the 'independent states', as indeed the self-governing 'homelands', are bound to adhere closely to the rules and limits laid down by the councils in the Republic.

Thus while widespread lip-service is being paid to primary health care, and to the need for increased community involvement in health programmes, and a reorientation of health services to meet the needs of the majority, powerful forces are at work which have prevented the translation of this into meaningful budgetary reallocations, and the changes in training and rules for professional practice which are necessary if the potential of primary health care is to be realised.

8.4. SUMMARY

The formal health systems in the environments of the projects had a substantial impact on their, the projects', ability to meet their objectives.

In the case of Manguzi and the Care Group project, which were structurally located to a greater or lesser extent within the state department, salaries and other resources such as transport and medicine certainly enabled the projects to exist. The Health Care Trust as a private organisation depended on the local clinic and hospital for referral.

However, there were marked attitudinal, practical and policy problems emanating from the formal health systems which were obstacles for the projects, and these may be expected to exist for development projects in other sectors as well.

The attitudes of health professionals undermined the community health workers, and the trainers, in their own eyes and in the eyes of their communities. There were characteristics of bureaucracies that ran counter to the needs of the projects and grassroots workers to respond flexibly and innovatively to their own and community expectations. This was so both in terms of regulations regarding the use of existing resources, and in terms of parameters for the role of community health workers laid down by health policy makers.

While primary health care has been accepted in principle by the formal health system as an appropriate response to health needs, powerful interests are in the way of the system's actively facilitating the work of community-based health projects. More attention needs to be given to ongoing education of the policy makers (and rigorous evaluation studies demonstrating the effectiveness of community projects would be helpful here). Alternative professional associations such as NAMDA have a potentially useful role to play in lobbying assertively for the further expansion of primary health care.

SECTION NINE

BUILDING COMMUNITY ORGANISATIONAL CAPACITY: THE ROLE OF COMMITTEES

INTRODUCTION

One of the objectives of this study was to explore the potential of primary health care activities for building organisations in rural areas. That is, what institution-building effects might such programmes have, apart from their potential impact on health status and health services?

David Korten, in his assessment of five rural community development programmes in Asia, found that a vital factor contributing to the effectiveness and sustainability of successful schemes was that they had:

'... worked out a program model responsive to the beneficiary needs at a particular time and place, and each had built a strong organization capable of making the program work.' (Korten, 1980: 496)

In his formulation of what he calls the 'learning process approach', he shows how the emphasis on building community problem-solving capacity, and the creation of appropriate structures to achieve this, is time-consuming, and conflicts with the needs of organisations and their sponsors to 'get on with the job'. But he argues forcefully that rural development projects will continue to fail if the building of such structures is not dealt with.

One place to look for the development of problem-solving capacity is in the structures of decision-making and control in and surrounding a project, most typically in committees which are set up because of the existence of the project (Gow and Vansant, 1983: 437).

The investigation of committees in this study ties in closely with the linkage between projects and tribal authorities, which is the concern of the next section. The two topics have been separated here but need to be considered in association with each other.

This section is organised in the following way:

9.1. Project committee structures.
9.2. The benefits of committees.
9.3. Problems with committees.
9.4. Discussion: some strategies for building more effective institutions.
9.5. Summary.

9.1. PROJECT COMMITTEE STRUCTURES

9.1.1. Manguzi

The idea of forming local health committees in areas sending people for training as community health workers was raised early on in community meetings by hospital representatives. Where health committees were formed, they were elected or nominated at community meetings. No criteria for membership were laid down: committees are mixed in terms of gender and formal educational levels. The local headman is often, but not necessarily, on the committee. The secretary is the person who, according to the trainer, usually has a higher education so that he or she can take minutes.

The project director placed great weight on the importance of community committees in encouraging community participation: "No committee has meant no concrete community involvement at all".

The role of the committee is to supervise the work of the health workers - it was not more specifically defined than that. They are also meant to see to it that the clinics function well.

According to the trainer, the committees meet as often as they decide to. They call in the trainer only when they have a problem they feel unable to tackle themselves. These community health committees had been formed in about twenty of the twenty-five areas in which the health workers were active. The trainer reported that the obstacle in areas without committees had been resistance or indifference from local headmen (see section 10.2).

A health steering committee, comprising representatives of nine health committees, was formed in 1981. Its chief purpose was, in the words of the project leader, to "represent health work to the tribal authority". The trainer was vice-chairperson and was the only project staff member on the committee. It was supposed to meet once every two months, but for various reasons was doing so less often.

9.1.2. Health Care Trust

At the inception of the project, Health Care Trust realised the need to establish a sound relationship with the hospital and clinic services. To this end, a Health Care Trust Co-ordinating Committeewas formed. It comprised senior hospital personnel (including the hospital superintendent who had been a key actor in the formation of the organisation) the project trainer, and a local businessman who was interested in the project.

Over time this committee became less active, until at the time of the interviews, it had met only once in the previous year, and the project staff were not expecting further meetings to take place. Some issues in its demise were that the hospital superintendent, who had been an enthusiastic project supporter and carried most authority at the hospital, had left the area. The remaining hospital committee members requested that meetings be held in the hospital, away from the village, for their own convenience. They also stopped visiting the village.

Project staff felt this to be unreasonable, as hospital staff were more mobile than project people - they took it to be an indication of hostility to the project. When the hospital committee members turned down the project staff's request to have the health workers themselves represented on the committee, the staff stopped going out of their way to initiate contact with, and support from, the hospital members.

Health Care Trust formed a village level Health Care Trust Community Committee soon after their work started. This comprised the headman, sub-headmen, and some villagers who were 'elected' (in fact, nominated by the headman). The membership largely overlaps with the local Clinic Committee, which was set up by the hospital to be a link between the clinic and the community.

As the number of community health workers increased, the project divided the area into three zones which coincided with the sub-headmen's areas. Each zone has a Health Sub-committee, which were initially formed to administer seed distribution and to co-ordinate spring protection.

The project staff tried to introduce the idea that these sub-committees should not necessarily have representatives of the tribal authorities on them. However, the headmen insisted on the presence of sub-headmen. Thus of the approximately ten members of each sub-committee, one or two are sub-headmen, one or two are health workers, and the rest are villagers.

9.1.3. Care Groups

The organisational structure of the Care Group project is substantially different from Manguzi and Health Care Trust, because of the different nature of the scheme.

The Elim Care Group Project Committee included the project director, some hospital personnel, a health inspector, two or three community representatives, and a representative from a regional welfare society for the blind.

There are Health Advisory Committees in each area: these were not initiated by the project, but by the Gazankulu health service. Care Group members may sit on these committees.

At village level, each Care Group elects a committee from within its membership. It appears that the chairperson (invariably a woman) is the key official - at no time during interviews did people mention other official positions, though chairladies were discussed often.

There was no co-ordinating or umbrella committee of Care Groups, either at village level (where there may be more than one Care Group in larger settlements) or regional level, or at overall project level.

9.2. THE BENEFITS OF COMMITTEES

The creation of committee structures can be important for the following reasons.

First, committees can develop the community's responsibility for, and ownership of, the project. If local people are involved in, and learn to run a project themselves, this will ensure that it will be self-sustaining after project initiators have left the area.

Secondly, it can ensure responsiveness to local needs. Community representation on committees can mitigate against policy and programme decisions being imported or imposed from above or from outside the community.

Thirdly, committees can be a vehicle for skills training in, for example, book-keeping, accounting, and minute-taking. They are also a platform where qualities of leadership and public-speaking can be developed.

Then, in areas where public decision-making is primarily in the domain of tribal authorities, project committees may represent the beginnings of alternative decision-making structures. Democratic procedures may be introduced, with principles of mandating and popular accountability.

Finally, community committees may be a potential vehicle for promoting women in rural areas into formal decision-making positions.

Interviewees at Manquzi were very positive about the development of the health committees. They felt that real advances had been made in transferring ownership of, and responsibility for, the community project to local communities:

> "People are aware now that this is not for the hospital. What they are doing is for them, not for the hospital... they are aware that all they are doing is for their own."

> "There is now a group of people who have undertaken to do something for the common good, without being paid, and that group wasn't there before. I think they are a really important group of people... And I think that is why these committees have been important, because now at least there are a few people... who feel that this is something that should continue and that should become part of the life of the people."

These committees, with their awareness of, and responsibility for health, are a direct result of the existence of the project.

It would be extremely difficult to determine the effect of project committees on the learning of specific skills such as leadership, public-speaking, book-keeping, etc. However, the following statement exemplifies the kind of potential committees can have for the development of self-esteem and confidence, especially for women:

> "At the end of year function, one of the chairladies was chairing the meeting. The chief - who is good in talking but not in working or doing - in his speech he said, 'Doctor, do you see this lady in the chair? Two years ago she would not have opened her mouth. Now she is chairing a meeting, thanks to your Care Groups'."

A criticism which is often levelled at rural development committees is that they merely mirror existing formal leadership patterns, entrenching educated or powerful elites even further, and seldom open up channels for broader involvement. While the Manguzi and Health Care Trust committees had representatives of local elites on them, it is noteworthy that all three projects had people on their committees who had not been involved in local formal decision-making before, and this was particularly true for women.

The Health Care Trust Health Sub-committees actually had a majority of ordinary villagers (though decisions are not made by majority vote); and the Manguzi trainer stressed that health committees had less educated as well as more educated membership.

9.3. PROBLEMS WITH COMMITTEES

All projects, but most particularly Health Care Trust, were concerned about the election procedure for local committees. As with the procedure for the recruitment of community health workers, they were aware that 'elected by the community' can be far from the democratic process that it sounds.

A chief concern was with the influential role of the tribal authorities in the election process, and this is given attention in the section dealing with these authorities.

Another concern was that, once elected, committees may be simply automatically re-elected year after year. This problem obtained in some of the Care Groups, where a dominating chairperson was not allowing for broad participation and power-sharing, but the Care Group members were too afraid to elect another person in her place because of her senior status in the community.

The following quotation illustrates two further problems at the same time: committees may become self-serving to members rather than community-oriented; community divisions, caused by factors outside of the community's control (in this case resettlement), may prove obstacles to project work and to the efficient functioning of committee structures.

> "Because of resettlement, the village consists of two parts... The people from one area were Christians, more educated, and the core of the Care Group came from these people. Their chairlady got sick and a person from the other section took over. She took over because they wanted to start a community garden, and she wanted this garden to be started on the plot of her son, and she would then have all the benefit of this garden. And now there is faction fighting and just nothing happens. We find that in many places the resettlement is so destructive to the community working as a community... People having been resettled are put somewhere they don't want to be. And those who are there, they don't want to have these new people."

The collapse of this particular Care Group is an example of the fact that, contrary to the principles of community development, and the objectives of the projects, projects are often primarily perceived to be vehicles of material gains in areas where there are limited resources. Powerful individuals may turn their involvement in a project to their personal benefit, rather than work towards sharing benefits with the broader community.

Of course, the establishment of organisational structures such as committees are intended to work against this happening. But where local power patterns are such that existing leaders automatically get in to

project decision-making positions, development organisations may do little in the way of equitable sharing and redistribution of any project benefits.

As this example shows, existing social arrangements and power groups may be affected in the process of resettlement, with new groups of people arriving into a previously settled area. The already problematic notion of 'community', conveying as it does a sense of an integrated, solidary unit, becomes spurious in a situation such as this.

There is a debate in community development as to whether a committee structure should be established as a condition of project intervention (i.e. prior to a project bringing resources to an area) or whether this can be a later development. Some organisations take it as axiomatic that a community must first organise a committee (around, for example, the proposed protection of springs) as this lays the basis for organisation, and demonstrates commitment to participation in an activity.

The project director at Manguzi threw interesting light on this debate, based on his experience of rural conditions. He felt that especially when a new idea such as community health workers is being introduced, it may be necessary for the workers to start their activities, and show what their role is, in order for the community to understand the need for a complementary committee structure to be developed.

The Health Care Trust village-level sub-committees were set up specifically to administer and coordinate practical activities to do with fencing, seed distribution and spring protection. The Manguzi health committees, on the other hand, had a more vaguely defined role of 'supervision of community health workers'. Though I did not attend committee meetings, nor observe interactions between health workers and committee members, I would foresee inevitable problems arising from this diffuse committee role. To whom are the community health workers really accountable, and for what?

Health committee members do not necessarily have a knowledge of health matters (which the project staff have); the project staff, needing to coordinate project policy and activities for a wide geographical area, may wish to determine or influence roles and activities for the health workers which health committees think are unnecessary for their particular area.

Project staff in all schemes emphasised the need for continuing support for the various committees. They were not, at the time of the interviews, seen to be self-motivated or self-sustaining bodies. They needed regular visits for advice, training and new ideas, which stretched the resources of projects. It must be noted that all three projects were relatively new, and the hope was that over time the committees would become more independent.

9.4. DISCUSSION: SOME STRATEGIES FOR BUILDING MORE EFFECTIVE INSTITUTIONS

All three schemes had as an ideal democratic election and operating procedures for both community health workers and the health committees. This ideal is built into principles of the community-based approach to development.

The projects under consideration were relatively new, and were learning as they went along. All had paid attention to the development of an organisational base, with attempts to include communities in decision-making, with Health Care Trust having devoted considerable energy to this. However, it is difficult to achieve at the best of times, whether in urban or rural areas, and my assessment is that Manguzi health workers and the Care Groups were, at the time of the field trips, still very dependent on the project staff for their continued work.

Projects which want to survive find themselves having to look for innovative ways of introducing these processes and procedures, often slowly and diplomatically. The following are some strategies which can facilitate the building of an organisational base.

9.4.1. Forming a constitution

Many development projects operate without a formal constitution, and have not thought to introduce constitutions to health committees as a way of institutionalising democratic processes. This is not difficult to do, and need not be a burdensome, legalistic exercise remote from people's perceptions of how things happen.

9.4.2. Rotating chairperson

Either without a constitution, or written into the constitution, the idea of rotating leadership can be introduced. This is a foreign idea for many rural communities. Where the local chief or headman or other official is always automatically made chairperson, organisations can consider creating the token or nominal role of President for such a person, with the managerial power going to a rotating leadership.

9.4.3. Delegating power to sub-committees

If the idea of rotating leadership through the chair and other committee positions is not accepted (which may happen precisely when there is a dominating chairperson whose power is difficult to break), a system of sub-committees can be instituted, to which a measure of real control is delegated. This may be

especially useful where women, or another minority group, are traditionally excluded from formal decision-making positions.

9.4.4. Breaking up family control in committees

A common committee scenario in community groups, in urban or rural areas, is this: husband is chairperson, wife is secretary, husband or wife's brother is vice-chairperson, another family member is treasurer. This situation is more common, and more difficult to deal with, in rural areas, where local power may be in the hands of one or two strong families.

This mitigates against increased sharing of power and control within the project, and it often leads to financial corruption. The practice of having two or three signatories for financial transactions is not effective, because the controlling group is closed. And in rural areas, finances of local committees are often not transacted through banks in any event, as this institution commonly does not exist there.

While there is always a need for the greatest awareness of the negative effects of rupturing existing social networks, it would seem that if an organisation has, or is about to introduce, a constitution, it could build into it rules against husband/wife/family control over executive committee positions.

9.4.5. Enlisting the help of sponsors

Development workers are in contact with community people, including the leaders, on a regular basis. If they have come from outside the area, they are likely to be viewed with suspicion (and quite rightly) for an initial period. Their job is to introduce innovative ideas, or to be working for change. As such, they are vulnerable, and their working and domestic lives are characterised by diplomacy, compromise andaccommodation. Where they are trying to introduce procedural or constitutional changes that threaten existing power relationships, they may feel unable to push sufficiently vigorously for new arrangements.

There is a strategy that is available to independently funded, non-governmental projects. It is perhaps Machiavellian, but it can be effective. The sponsor may be asked to stipulate to the project that money will only be allocated on certain conditions: that there must, for example, be a constitution; that the constitution must have written into it procedures for rotating leadership; and that women or other disadvantaged groups must have effective representation on committees.

In this way, the frontline project staff, in face-to-face interaction with communities, can pass the buck, so to speak, to an organisation (the sponsors) whose resources are needed, but who are far from the area. Some may object that this is not in line with non-directive community development, and that it is

manipulative. However, the committee in question always retains the right to refuse the money, if the sponsors' conditions are so antithetical to local custom.

Two local organisations have used this strategy to good effect. The Built Environment Support Group (BESG), a University of Natal-based association of town planners, architects, quantity surveyors and geographers, offer their professional skills free of charge to community and civic organisations who cannot afford professional fees. BESG's condition for working with organisations is that they must be democratically constituted. They will give advice on how to build democratic procedures into organisations if required.

The University of Natal's Rag Allocations Committee also makes allocation of funds conditional on applicants placing emphasis on developmental aspects of their work. The application forms have been structured in such a way that applicants must involve as many people in the organisation as possible in the decisions regarding the use to which the funds will be put.

9.4.6. The need for training of committees

There is a clear need for training in committee and administrative skills in rural organisations. Though interviewees were aware of this need, and some had started trying to do some training, they explained that they themselves lacked expertise. Even where they felt they could make a start, time and other resources such as transport were obstacles in the way. They pointed out also it is easy to postpone training sessions in the face of more obviously urgent demands on time.

Organisational structures thus remain undeveloped, and this is a key contributing factor to the demise of community projects when the project leaders move on.

Projects do occasionally have the possibility of sending their trainers or committee members to courses organised by resource organisations in urban areas. This costs time and money, and in many cases is beyond the scope of isolated rural projects.

Two alternatives present themselves. One is that if regional primary health care training centres are established, the training of health committees should be a key aspect of their work - if they are to promote seriously the idea of community participation in, and ownership of, primary health care projects.

The other is that urban-based resource and training organisations need to orient themselves more firmly towards taking their services out to rural areas, rather than running centralised courses in towns. This would be more difficult, more inconvenient and more expensive for them, to be sure. However, in relative

terms, they have greater access to outside funding resources to cover expenses. It may also contribute towards making the training courses that they do run properly grounded in the local conditions prevailing in rural projects.

9.5. SUMMARY

The development of organisational structures and procedures to facilitate the achievement of both task and process goals of developmental initiatives has been widely acknowledged to be both centrally important, and frequently neglected. The existence and state of development of project committee structures is one indicator of the process of organisation-building.

In all schemes in this study, auxiliary workers and the community at large had been involved in project decision-making processes. In particular, the existence of the projects had provided a platform for the increased participation of women.

However, with Health Care Trust as a partial exception, the schemes had grown at such a rapid rate that it was beyond their ability to pay sufficient attention to the development of a strong organisational base. On the positive side, this reveals that projects were accurate in their assessment of community health needs, and were responding to needs in ways which were acceptable to the communities (or at least to certain sections of communities).

While the schemes were relatively new, and may have been able to give increasing attention to this aspect of their work once they consolidated (which Manguzi was in the process of doing), this meant a dependence on project staff, a sense that staff still controlled the direction of projects, and a continuing influence of tribal authorities over project decisions.

Some strategies for the development of an organisational base were presented.

SECTION TEN

TRIBAL AUTHORITIES AND COMMUNITY DEVELOPMENT

INTRODUCTION

A central principle of community development is that it should involve, and be a platform for the development of, local community leaders.

Now any community will have both formal and informal leadership roles and networks. In the southern African 'homelands' and 'independent states', formal local leadership resides in the tribal authorities. This is a hierarchically organised administrative and legal system, with the local level functionaries being chiefs with their appointed headmen and sub-headmen, tribal secretaries and tribal police.

The account and analysis of the schemes' relationship to, and experience of, tribal authorities is arranged as follows:

10.1. The stance of the schemes towards the tribal authorities.
10.2. The influence of the tribal authorities on project activities.
10.3. The response of the tribal authorities to the schemes.
10.4. Discussion.
10.5. Summary.

10.1. THE STANCE OF THE SCHEMES TOWARDS THE TRIBAL AUTHORITIES

The position of the projects with regard to tribal authorities was varied, and reflects the projects' different origins, as well as their location with regard to the formal health system.

The Manguzi and Care Group projects grew from within a hospital setting, a setting in which the formal health service is part of the same administrative apparatus as that served by the tribal authorities. They accepted the reality of having to work with tribal authorities from the start. They interacted with as many chiefs and headmen as needed in order to promote their work in new areas.

The Health Care Trust was in a different position. An independent project, it had from the outset explicit objectives of building democratic institutions and promoting socio-political awareness. It had a critical stance towards the tribal authorities, but field workers soon accepted the inevitability of forming some kind of working relationship with them.

Whereas Manguzi and the Care Group project interacted with tribal authorities over a wide geographical area, the Health Care Trust covered a limited area - in fact, one 'location' which was under the jurisdiction of a chief-cum-headman, and a number of sub-headmen. For the former two schemes, if any one tribal authority representative was indifferent or actively obstructive, this affected a relatively small local area, and the work of the project could continue overall. Health Care Trust was in a much more vulnerable position, depending for its continuing survival on the permission of just one headman and his sub-headmen.

10.2. THE INFLUENCE OF THE TRIBAL AUTHORITIES ON PROJECT ACTIVITIES

The extent to which the tribal authorities influenced, and to an extent dominated, the lives of the projects can be seen through an account of concrete, detailed examples given during interviews and observed during field trips. It should be noted that apposite quotations and points have also been made in sections 5.1. and 5.3.1., and 7.2., with reference to recruitment and payment respectively.

In the first place, all schemes had to get permission from the tribal authorities to establish a presence in the area at all. In this respect, there is a concurrence with reports from other development projects and research workers: a condition of entry is that it be via these formal channels, and local people want to know whether the agency, organisation or research team has been 'passed'.

At Health Care Trust and at Manguzi, the recruitment of community health workers took place at community meetings presided over by the chief or headman. Their influence over the proceedings has been noted in section 5.1. It was clear that, though there was a variation in the amount of control they exercised over who got elected, their word was usually final.

They exercised similar influence over the election of health committees, where these existed. The Health Care Trust attempted to exclude the tribal authority representative from the lowest level community committee, but did not succeed. At Manguzi, the headman was automatically part of the committee structure, and the project had not attempted to change this.

The presence of tribal authorities was also felt in official attendance at all public gatherings to do with the projects: end-of-year celebrations, inaugurations of communal gardens, and the like. In addition, they had the power to give or withhold permission for specific project activities such as Health Days and sewing classes.

The Health Care Trust project was active in a limited geographical area, and as such the details of their activities were visible daily to tribal authorities. Permission had to be obtained from them for the community

health workers to leave the area to attend a national workshop, as well as to invite another development organisation (even a para-statal organisation) to help with spring protection.

The above are detailed instances of tribal authority control and intervention. There was also a more covert, less visible role that they played, which was mentioned by all schemes but particularly by the Health Care Trust. They were aware that their activities were being monitored at all times: a surveillance role which did not have to result in formal negative sanctioning of project activities because it effectively tailored what projects decided to get involved with in the first place. Though present in all schemes, the sense of 'Big Brother is watching you' was most keenly felt in the Transkei project.

10.3. THE RESPONSE OF THE TRIBAL AUTHORITIES TO THE SCHEMES

Scholars and practitioners who take a critical stance towards tribal authorities because of their structural position as an extension of the state apparatus tend to conceive of all tribal authority personnel as a uniformly bad and illegitimate lot. A marked feature of interviews in Manguzi and the Care Groups was that the chiefs and headmen were by no means a homogeneous group. They varied a great deal in terms of their credibility and standing in their communities; they also had differing attitudes towards, and thereby effects on, the projects.

What follows is a depiction of the ways in which these varying attitudes made practical differences to the work of the health programmes.

10.3.1. Active supporters

After the first approach to the tribal authorities by the Manguzi health team in some areas, a few headmen actively mobilised their communities to attend meetings to discuss the idea of community health workers. They encouraged the people to get involved in the selection of health workers and health committees.

In one Care Group area, a chief exempted Care Group members from their compulsory weekly village labour duties. He considered that the health work was as important for the community at large as was the construction of, for example, a road.

Project personnel said that this active support made a tremendous difference to their ability to generate community participation and involvement at grassroots level, even though they were mindful that the chiefs and headmen could in future co-opt the project to their own advantage.

10.3.2. Passive sympathisers

The majority of tribal authority officials at both Care Groups and Manguzi appear not to have resisted the projects, but also not to have actively supported beyond the minimum involvement requested by project personnel or the health workers themselves. Following their initial role in holding a public meeting or meetings, they were content simply to be notified of intended activities or expansion of the programme.

10.3.3. Antagonists

Examples were given by all projects where a tribal authority representative blocked their work. In a situation where this authority structure has such control, there is in fact a fine line between indifference and active resistance, as indifference impedes work, and constrains activities, as effectively as more overtly antagonistic tactics.

One project had been unable to intitiate health workers or health committees in at least five areas because of the headmen's refusal to co-operate:

> "I can remember a place like Z. We used to visit this place many times to meet the headman, and he failed to call a meeting with the community. And another place is B. It's far from the hospital and there are no community health workers. And again the problem is really the headman. I'm sorry if this is an insult but I should say it out. Some of the headmen are full-time drinkers. And some are not good leaders... I mean, (they) are not faithful. You talk with the headman and you say 'would you please call a meeting of the community for us'. And we come on that day to the meeting place and we find that there are no people. And people know nothing about the meeting. And it is the headman himself who is nowhere to be seen. So such people are not good leaders, ... and as a result (in those areas) there are no community workers."

A staff member from another project articulated well the point that indifference is just as effective as active resistance in obstructing attempts to elicit community participation:

> "Let's say you want to make a meeting for the whole community, and then you ask the chief to organise it. He may forget or go somewhere, and you find that he is not present, and not even telling people. Not that he does not like it, but he maybe forgot or is not very much interested in it."

The latent authority of tribal officials is evident in the following statement:

> "Usually things won't be opposed so long as they are consulted on the thing. If they (the community health workers) went ahead without going to the headman or sub-headman, you would find that just to renew their power and authority they would say, 'no, things can't go on'."

Only two instances were given of tribal authorities actively refusing to co-operate with projects (as opposed to passive non-cooperation or indifference cited above). One was where a particular headman refused to allow the project into the area at all, as he was opposed to any community activities to do with health. The other was where a headman refused to allow the project to hold a community Health Day, on the grounds that preparation for it would interfere with school attendance (which was not in fact the case).

10.4. DISCUSSION

In order to understand and assess the influence of tribal authorities over projects, and their affect on the process of community development, it is necessary to locate the source of their authority and control.

Traditionally authority in an area was vested in chiefs by virtue of inheritance. There was a reciprocal relationship of accountability between a chief and his subjects: in return for certain material gifts, the people received rights to the land and a measure of safety.

Colonial rule brought with it a change in the position of the traditional system of authority, and in the relationship between a chief and his subjects. Chiefs were co-opted into the new administrative structures, and in some cases (as in parts of Zululand) the colonisers nominated people for the posts of chief who had no inherited right to that position. The dilemma for the chiefs was clear: on the one hand they were meant to represent the interests of their people to the colonial authorities; on the other, they were statutorily obliged to act as policemen over their own people.

Limited research has been done in Southern Africa which addresses the role of tribal authorities specifically in connection with community development in the areas covered in this study. Southall (1982) and Streek and Wickstead (1981) mention tribal authorities in the context of their broader studies of the politics and economics of the Transkei, while Haines et al (1984) give more specific attention to the interaction between Transkei's tribal authorities and local communities in terms of the former's constraints to rural development efforts.

For KwaZulu, Daphne (1982, 1984) and Zulu (1985) set out specifically to assess the tribal authorities in relation to community development, in Daphne's case with regard to a particular development project. No comparable studies have come to my attention for Gazankulu.

While the above studies differ in approach, methodology, and in the details of their findings, it is possible to extract the following common concerns which have a bearing on rural community development.

All point out the extent of control that tribal authorities have over the lives of their constituents. Haines and his colleagues show that while some of this is legally derived, there are also 'a range of other informal and less explicit mechanisms' of control (Haines et al, 1984: 16). All the authors cite the allocation of land and governance over access to state old age pensions as primary mechanisms of control. These provide the means of subsistence for a majority of rural people, and the chiefs and headmen are thus powerfully placed to exert authority and influence.

Zulu emphasises the material cost to the people of their enforced participation in this system of control. Some levies raised, such as for school buildings and clinics, are legal, but considerable cash gets paid to the tribal authorities in order, for example, to get support in obtaining a pension. He argues that these traditional structures 'increase the economic marginality of rural areas' (Zulu, 1985: 242).'

The informal control has led to charges by all authors of nepotism and corruption. With little formal financial accountability or effective book-keeping mechanisms (partly due, no doubt, to the lack of administrative training of the personnel involved) these formal elites can, and do, siphon off community monies for their own use, and bestow patronage and favour on other members of the elite in their areas. It must be added that they are salaried officials.

The researches above have shown that the tribal authorities have little popular credibility and legitimacy, and in many cases are greatly feared. This presents a problem for the principle in community development of 'working with and developing local leaders', who are likely to be working against the interests of the people they are meant to serve.

A reading of the literature enables one to predict, then, that tribal authority structures may be expected to present a problem for development programmes in rural areas.

The schemes in this study showed that tribal authorities were varied in terms of their openness to new ideas, and the degree of their support for the community health workers. Those who were willing to work actively for the improvement of health made a difference to the ability of the projects to reach out to and engage with communities. But, as Daphne (1982:13) says when discussing the contradiction between the operations of the tribal authorities and the development goal of self-reliance:

'A benevolent autocracy, in the form of chiefs and indunas who genuinely have the interests of their people at heart, is still an autocracy and will stifle the development of such feelings of self-reliance. A person who takes all the decisions, even in the interests of others, is depriving people of full participation in what could be viewed as an educational process. For as large a number of people as possible to be part of the growth of organisations, to grapple with constitutions, and to confront differing concepts of democracy is development in its own right.'

In my view, the tribal authority stuctures in the project areas were a hindrance to the achievement of development goals at community level.

They were a constraint to the development of local, representative leadership, and mitigated against the growth of popular participation and democratic decision-making procedures. It has been shown how they preside over most situations, such as community meetings, where development workers want to 'consult the community' or 'elicit the will of the people'. They act as a filter or mediator between people and projects.

The tribal authority system reinforces the oppressed position of women in rural areas, where women form the majority of people. Exclusively male-dominated, the tribal authorities reflect, at a formal administrative and legal level, and in their ways of working, women's exclusion from significant platforms for decision-making. I do think that the notion of 'oppressed rural women' is sometimes stereotyped or reified. Women are not naive dupes; they learn strategies of influencing decisions, whether in the household or concerning public issues. However, having voting power or executive office is clearly a more effective way of having one's interests represented. As tribal authorities are structured at present, men make or control decisions which women have to accept and implement.

Some development agencies attempt to work independently of these structures. There are urban-based organisations who provide resources and training for rural organisations. They stay in the area for relatively short periods, and they may have more freedom to adopt an overtly oppositional stance. But for development personnel who reside in a project area, the risks to their constituency are only too clear.

The reality for most is that some modus vivendi for co-operation must be forged, even though they may perceive the tribal structures to be repressive and anti-developmental. Are there ways of doing this without compromising on essentials of the community-based approach? Is it possible to engage in some form of relationship with them while not reinforcing their power? The remainder of this section deals with a consideration of how this might be done. They have been distilled from lessons learned by these and other development schemes.

10.4.1. Choosing the project area

In most circumstances, development projects make a choice as to which particular area to work in. A number of variables are taken into account. These may include topography and climate, the presence or absence of other organisations in the area, convenient access, etc.

The Health Care Trust staff members who were interviewed did not know whether the local tribal authority was considered as part of the decision to work there rather than in another area. They certainly felt that

there were more sympathetic and progressive chiefs in adjacent areas, who would have facilitated their work to a greater extent.

At Manguzi, the hospital team purposely chose a pilot site on the basis of a headman with whom they had a good working relationship. It is not known whether the three pilot sites for the Initial Care Groups were chosen with this in mind.

One school in community development hold that it is better to choose an area where there is a good chance of the work succeeding. Initial success will then be seen by people in adjacent areas, and the scheme will start replicating its work. Others argue cogently that by doing this, development projects reinforce the problem general to development that this ensures that the poorest of the poor will continue to be unreached: projects affect and help only those communities who have already shown signs of breaking out of the cycle of poverty. They hold, as did Neil Alcock in choosing Msinga as the site of the Church Agricultural Project, that the challenge is to intervene in the very worst areas. Rural areas will become more impoverished, more overpopulated, more internally divided, and if community developers cannot find ways to succeed in the bleakest conditions at present, there is little that can be contributed significantly to rural development.

Wherever one stands in terms of the debate about choosing to work in areas where success is reasonably likely or not, close consideration should be given to the quality and attitudes of tribal authority personnel in determining a site for projects. Rather than this being one additional variable to be taken into account, its importance should be fully realised. This applies to non-governmental, independent projects as much as it does to schemes with more formal links with governmental authorities.

The implications should be fully understood. If a site is chosen because of the presence of a relatively progressive tribal authority, this may well facilitate the initial phases of work. However, if this were to become a determining variable for community development projects in general, this would be at the expense of the possibility of positive intervention in areas with more blatantly repressive or corrupt authority structures, where a development agency might help with building an alternative organisational structure.

10.4.2. Clarity about the field workers' role

Field workers in development projects, in this case the grassroots community health workers, are in and of the community. As such, they bear the risks involved in implementing project policy towards tribal authorities. Important aspects of the daily lives of their families and themselves are under the headman and chief's domain and control. They do not have the opportunities that development agents who come in from outside the area have, of leaving the area or finding alternative employment if the project meets with

disfavour. Thus project policy must be guided, partially but importantly, by the opinions of the field workers themselves.

But within this, there are steps that can be taken to ensure that health workers or other field workers avoid becoming a simple extension of the tribal authorities. An example of how **not** to do this comes from the early period of the Health Care Trust project, when there was little supervision from project headquarters in Cape Town. One of a Transkeian sub-headman's duties is to make people build toilets. Those who do not are summoned to the tribal court and fined R20,00. The community health workers arrived at households before sub-headmen, encouraging them to build toilets, but threatening people with his arrival if they did not co-operate. To the organisation's consternation, the health workers earned an early reputation as 'village police', a reputation which took some time to overcome.

Such a problem could have been prevented by closer contact with the health workers, and by careful attention in training to precise job descriptions, and to the nature of the relationship between health worker and the community. It reinforces the recommendation made in the section on training that an intensive, block-based initial training **before** intervention in the field is necessary if schemes want to avoid being a vehicle for the entrenchment of authoritarian attitudes and behaviour.

10.4.3. Continuing education

The stance of Manguzi and to a certain extent the Care Group project can be characterised as "keep on trying to educate them". Both schemes showed remarkable resilience and persistence in their efforts to 'convert' the authorities to the objectives of the scheme, so that they could reach out to new areas.

One trainer nicely captured her manner of getting co-operation from a chief:

> "You go to the chief. You tell him the problem first, why you want to start that [community health programme]. If there are some people from his community who invited us, we say it in that way. If we saw a problem ourselves, we talk to him, and ask him if he can see that it is a problem. Then if he manages to see that it is a problem, we ask him, 'What can we do with this problem? Are we going to leave it hanging like that, or do you want to call your people? Then we will also come to help you to explain.' It happens like that."

This person showed a political astuteness in her dealings with the chief. She effectively drew attention, in the politest way possible, to the fact that the chief was neglecting his responsibility to his constituency. She was confident about her ability to make him 'manage to see' the health problem.

10.4.4. Support from other leaders

Where chiefs or headmen were resistant, both Manguzi workers and Care Group motivators had called on the support of other senior influential community leaders. They asked sympathetic traditional healers and teachers to try and get the cooperation of the tribal authority.

10.4.5. The use of tribal authorities for collection and allocation of community monies

The debates surrounding the principle of payment of health workers have been discussed elsewhere. Those who advocate some form of contribution by the community have to find or establish administrative structures for collection and disbursement. In Manguzi's case, the plan for the future was to do this via the health committees or the tribal authorities.

My view is that, as a general rule in southern African rural areas at this time, payment of community-based auxiliary workers such as the health workers should not be administered by tribal authorities. There are professional issues such as the ability of these authorities to supervise and judge the work of the health workers. There are practical issues such as the lack of training in administrative procedures which would ensure routine collection and payment. Both of these sets of issues could arguably be overcome by close co-operation or shared responsibility with professional health personnel, and by a concerted effort to train tribal authority officials in administration and management.

But underlying these is the issue of power and control. It has been pointed out that these authorities call on their constituencies frequently for contributions to community services such as road building, classrooms, clinics etc. In addition, people have to pay, legally or illegally, for access to vital commodities such as land and pensions, and may be expected to contribute towards vehicles or additions to the chief or headman's house: payments which are directly to his individual benefit.

A fundamental principle of community development should be to avoid extending the control that the tribal authorities have over people's lives.

10.4.6. Innovating on 'local custom'

An unusual, and to my mind highly innovative, strategy was thought up by a health project in another region. The local headman had blocked plans to mobilise the community, and was repeatedly obstructive to various project activities. He was also much given to alcohol. Whenever a major decision had to made by him regarding their work, the health workers plied him with liquor before the community meeting at which such decisions were made. In the headman's consequent sober but amnesic state, they could assure him that he had, indeed, allowed the activity or event in question to be held, had even nominated

so-and-so (a person sympathetic to the project) as his deputy.

They (dis)ingenuously pointed out that they were merely acting 'according to our custom' - it was customary to give a gift of some sort when favours were being asked. I wonder whether the liquor account fell under 'entertainment allowance', 'running expenses', or 'contingencies'. Is this acceptable community development practice? Given the dominating and often negative but unavoidable influence that tribal authorities have over the lives of projects, I think it is. It works.

10.4.7. Building alternative organisations

Community organisations have task objectives, to do with providing services and materially improving the quality of life. They also have process objectives, which are concerned with the educational aspect of the work, and with mobilising collective action so that task goals can be met with the participation of as many people as possible.

Significant achievements are made by such organisations if and when they can develop democratic ways of working and organising that present themselves as an alternative to prevailing systems of authority, where it is these systems that entrench the powerlessness of the poor. Some ways of doing this suggest themselves from the work of these and other schemes.

It may seem a self-evident point, but in order for new ways of organising to be introduced, the first step may be to enable community members to see that alternatives are possible. Where tribal authorities preside over every public meeting, it may not be possibile to discuss different ways of doing things.

One way to overcome this, though it is costly, is to provide people with opportunities to visit other organisations doing similar work, or attend workshops and conferences, away from the area.

There are two potential advantages. The one is that people may simply feel freer to talk when away from the dominating influences in their local area. The other is that discussing mutual problems with people from other areas can contribute to a changed understanding of the causes of local problems - what C. Wright Mills characterised as understanding the difference between 'private ills and public issues'.

This was a striking feature of the workshop for community health workers. Workers from seven schemes expressed their astonishment at how similar their needs and problems were, and said this of three things in particular. These were the vexed issue of payment, their subjugated position as women, and their relationships with tribal authorities:

> "We thought it was just **our** headman who caused us such a problem. Now we see that it is all the tribal authorities who cause problems."

This development of socio-political awareness, reinforced by seeing that other projects have been able to do some things differently, may be a necessary first step to building alternative organisations. Plans for visiting other areas and attending workshops, need to be built in to annual budgets.

In so far as committee structures are automatically and routinely dominated by tribal authority personnel, the possibilities for developing alternative organisational structures are stultified. Some of the suggestions made in section 9.4. for developing committee structures are appropriate for dealing with tribal authorities as well. They will not be repeated here, but important ones would be the introduction of constitutions which limit the extent of tribal authority representation, and the creation of systems of rotating leadership which provide space for new leadership to emerge.

There are few examples of organisations in rural areas which have managed to maintain relative independence from tribal authorities, build a substantial popular following, and survive, all at the same time. Two which have succeeded have taken a pragmatic approach, recognising that an overtly oppositional stance to tribal authorities presented too great a risk to the target group they wished to reach.

Daphne (1984: 66) described the position of the Mpukunyoni Farmers Union, which had at that stage a membership of a thousand households:

'The MFU does not see itself as being in opposition to the tribal authority, but rather as an alternative outlet for people's aspirations. Its constitution states that it is open to all, regardless of race, religion, sex or political affiliation. Thus, members of the tribal authority are welcome to participate provided they do so as equals; women have the opportunity to vote and express opinions unlike at tribal authority meetings.'

The Mboza Village Development Project, also in KwaZulu, has likewise paid careful attention to building organisational structures which enable more representative and democratic decision-making (Derman and Poultney, 1984, 1985b, 1986). The development committee introduced a constitution which was both locally acceptable and contained within it the potential for altering the local relationships of power and influence. They have demonstrated to people in the area that there are different ways of organising themselves which can be to their benefit.

Poultney has suggested (personal communication) that, where a tribal authority is basically supportive of a project, there might be merit in focussing on an issue that has the prospect of mobilising the community including the tribal authority, on the condition that it contributes towards breaking local systems of dependency. So, for example, the Mboza Village Development Project initiated a Social Learning Centre partially because the desire for a general educational facility was a keenly expressed need. But the construction of the Centre also challenged the state-land status of the area - an issue which was in the interests of the local tribal authority as well.

In the health and welfare fields, analogous issues might concern the provision of water, or improved access to pensions.

It is clear that the methods of forming working relationships with the tribal authorities mentioned above are all what Warren (1969: 210-218) would call consensus or collaborative strategies (as opposed to conflict or campaign strategies). The Health Care Trust personnel did state that, were they to move into a new area, they would attempt to make as a condition of entry popular representation on all committees. They felt that their bargaining position was relatively strong because of repeated requests from this new area for the organisation's presence. Whether they will succeed in this is open to speculation.

What Health Care Trust illustrates here is the recognition that projects enter into **negotiated relationships** with tribal authorities. They enter into a complex network of exchanges. Having established a presence in the area, the task is then to bring material improvements (or the promise of them) and, through effective organising, a change of attitudes in sufficient local people that the projects have something to negotiate and bargain with. In this way the exchanges may benefit the majority of people and not just the tribal authorities themselves.

The ability to manage and manipulate these relationships may be a decided advantage, in the short term, that a development worker from outside the area has. He or she will not be dependent to the same degree as local people on the tribal authority, and will therefore not be so susceptible to the latter's power and control. One implication is that development workers need training in negotiation skills. But it should always be borne in mind that if these skills are not transferred to people in the community, there is the danger in the longer term of creating a different type of dependency - a dependency on 'outside experts'.

It should be noted that the problematic interface between development organisations and tribal authorities is not a uniquely South African phenomenon - it is cited internationally as a key variable affecting development work. The situation here is possibly more complex in that the co-optation of tribal authorities by colonial authorities was followed by their further co-optation, indeed an entrenchment of it, by the South African government that followed. The tribal authorities have become a crucial extension of the state apparatus in maintaining control in both 'homelands' and 'independent states'. They are locally-based representatives of a much broader network of state control. In the same way as pensioners get angry with the local pension clerk, rather than linking this functionary with Ulundi and Pretoria, so it is easy to focus on the visible, present tribal official rather than the national structures of power and authority.

As Zulu (1985: 249) recognises, the tribal authorities are not about to be abolished, and though they lack legitimacy they must be reckoned with by people who believe that there is something useful to be done in rural areas. He rightly says that the challenge for rural community development is the 'creation of counterbalancing forces accountable to the people'.

The point is to demonstrate that there are alternative ways of proceeding, while accepting that changes may be slow to implement, and bearing in mind that it is always risky to meddle with the rules governing the allocation and maintenance of power. Development, if it means anything in the Southern African context, has by definition to represent a threat to those in power.

10.5. SUMMARY

Black local community authorities are in disarray and crisis throughout the region, with government-appointed bodies lacking legitimacy and credibility. Urban community development agencies have a number of choices of strategy in their dealings with them: from ignoring these bodies, to organising actively against them, and as has recently been seen, to cooperating with and help develop alternative civic structures, such as street committees.

Rural development organisations have in their environments tribal authority structures which, while they may lack credibility, have a powerful influence over the lives of their constituents. The mutual interaction between the schemes and the tribal authorities in their areas was detailed, and it was seen that the independent or governmental status of projects made no difference to projects' ability to act independently of them.

The schemes had dealt with these authority structures in different ways, and found that the stance of particular individuals within the structures influenced their ability to meet their objectives.

It was argued that tribal authorities are fundamentally anti-developmental; nevertheless the reality for most schemes is that they must enter into a negotiated relationship with them. Suggestions were given, based on the work of these and other schemes, as to how to negotiate this relationship to the benefit of the majority of community members, while upholding principles of community development. The challenge facing community organisations is to create alternative decision-making organisational structures.

SECTION ELEVEN

EVALUATION IN THE COMMUNITY HEALTH PROJECTS

INTRODUCTION

The evaluation of development programmes has become a major enterprise. One reason for the recent growth in focus is the acknowledged failure of so many large- and small-scale development efforts. One 'development decade' has followed another - the community development decade, the decade of the child, the water decade - but their objectives have not been met. There has been a growing sense of urgency to find out what works, and why, in what situations, and also to establish reasons for failure.

The demand for a greater emphasis on project accountability is justifiable. Meeting the demand in ways which satisfy the needs of different audiences - needs which may conflict - is an extremely difficult undertaking. These audiences may be the projects themselves, their sponsors, the academic and non-academic 'development community', and professional groups.

The description and discussion of the place of evaluation studies in the lives of the projects is organised in the following way:

11.1. Types of evaluation undertaken by the projects.
11.2. Some difficulties with evaluation.
11.3. Discussion: some recommendations for evaluation.
11.4. Summary.

11.1. TYPES OF EVALUATION UNDERTAKEN BY THE PROJECTS

The term 'evaluation' is used in this section to cover a broad range of activities and processes. My concern was to find out how schemes monitored and assessed their own performance, if at all. I extracted from interviews those passages where people were discussing in any way issues to do with evaluation, and schemes were asked for any reports or surveys which were evaluative. Thus included in this section are activities ranging from structured staff discussions about the direction of the organisation, to formal scientific surveys assessing project performance. The aim was, as it has been throughout the study, to find out what practitioners are doing on the ground, to learn what difficulties they have, and to consider ways of overcoming these.

The project directors were acutely aware of the need for regular and objective evaluations of their work. One said:

> "It is absolutely essential that we do evaluation, so (we) know if the work is going well or not. We do it all the time, but it is not scientifically done... There is a lot of uncertainty surrounding things which most people consider to be axiomatic... It's axiomatic to some that if the family starts using bacteriologically clean water that they must get healthier, but that is in fact not true. That kind of research needs to be done... It's no use carrying on, otherwise you work with uncertainty... You don't know if something is really working."

The need for measurement of project impact on health indicators was being referred to here. There was also consensus on the need for some form of assessment of the less tangible objectives, such as development of self-reliance, leadership and morale.

The different types of evaluation undertaken by schemes will now be discussed.

11.1.1. Observation

Starting with the least formal, most impressionistic form of assessment, the projects all mentioned that some aspects of their achievements can simply be **seen** or monitored without structured research:

> "This place didn't have a single toilet at first, and now it is a forest of toilets."

> "It is part of our setup that the trainer or me go once a year and live in the area and see how it is going. We see whether the health committee is meeting regularly, and what it does at its meetings. We see what the relationship is like between the health worker and the health committee. We see, when we go out visiting with the health workers, what changes there have been in households where they have been, and see what their health education is like. And then, from that you are able to make certain suggestions as to improvements. And as far as I am concerned that is the most important sort of evaluation. It is the evaluation on site."

> "Oral rehydration is quite widely practised now and I know instances where people go to the [community health worker] in cases of diarrhoea."

> "If you look at (the project village) and you look at other villages around, there is definitely a difference here as far as material benefits from the project like fencing, gardening, toilets, compared to the rest of the area... Especially when the rains have fallen and everything is growing, then it is amazing. And people from surrounding villages also see the difference, and quite a lot of them have asked, why don't we come and work there."

The above quotations point to observable impacts and benefits which have come from the schemes. There has not been systematic measurement of the difficult set of questions embedded within the provision of these services (such as the complementary behavioural changes) which interviewees themselves referred to.

For example, a salient issue to do with fencing and gardening is that it is sometimes assumed that growing vegetables automatically leads to better nutrition. However, vegetables may be sold for sale and the money used to pay for education, furniture, or unnutritious foodstuffs. Another example mentioned was that acquisition of a toilet does not necessarily lead to proper use of the toilet.

11.1.2. Surveys

Of the three schemes, the Care Group project stood out for its regular use of systematic surveys to monitor its impact. The Health Care Trust had undertaken no measurement of this kind. At Manguzi, a substantial survey had been done but the results had not been analysed.

From the inception of the Care Groups, great emphasis had been placed on careful data collection. Barry (1981), the Elim Research Group (1978), Sutter (1982), and Sutter and Ballard (1983)report on surveys done on the effects on communities of Care Group intervention. Impressive, because rare in rural research, is that control groups have been routinely used. What stands out (partially made possible by the use of control groups) is the authors' concern not to claim as project achievements things which might have happened because of other developments in the area.

In evidence also in these reports is a willingness to 'embrace error' (Korten, 1980): to give proper weight to the limitations, as well as benefits and successes of a relatively small project, and to learn from the mistakes that will inevitably be made when breaking new ground. Barry, for example, found that there was no significant difference between Care Group and non-Care Group households in terms of the level of nutrition of children. This caused the project to re-assess the techniques used in nutrition education.

Results of these evaluative studies have been used to inform the ongoing life of the project. The benefit of such measurement is inestimable to future work: no matter what else the project has or has not done, it has reduced the incidence of trachoma significantly in some areas. The phrase 'no matter what else' holds and hides some important and intractable questions for development work. But a confidence can be derived from accurate measurement of impact, if the results are in the right direction (and arguably even if they are not - then there is at least certainty that something is wrong).

This is different to the position of organisations who have not done such evaluative work. They work with the uncertainty spoken of above, which may be paraphrased: "We are not sure if what we are doing has an effect, and if so, how much and in what direction, but we **believe** what we are doing is worthwhile".

It is commendable, and exceptional, to see such weight being given to ongoing systematic assessment by the Care Group project. This project had the advantage of a close working relationship with the University of the Witwatersrand, whose students contributed to the survey work. Difficulties faced by this and the other schemes in doing formal surveys will be discussed further on.

11.1.3. Organisational assessment

A form of evaluation available to human service organisations such as these is social analysis or organisational assessment. The objective may include a determination of impact in terms of measurement of specific indicators. However, the primary emphasis lies elsewhere: an analysis of the structure of the organisation, its decision-making processses and patterns of control, its relationships to and interaction with institutions and groups in its environment, as well as internal relationships and interactions. Such an evaluation seeks to answer the question: is this organisation and its structures and procedures working in such a way that its objectives can be met effectively and efficiently?

The most common and least formal instance of this type of evaluative process is part of the daily fabric of many development organisations. Staff meetings, in-service training sessions, and committee meetings may focus on these issues, either as a regular part of the formal agenda, or spontaneously as and when issues arise. At Health Care Trust, the director and trainer had built it into their training sessions, and an attempt had been made in the Care Group project to incorporate it into weekly staff meetings and training workshops.

The closest thing to a formal organisational assessment was an evaluation done at Health Care Trust in 1983 (Ntsebeza, 1983). A member of the Co-ordinating Committee was asked by the trustees to undertake an evaluation of the scheme, to help them make decisions about its future in the area. The committee member had the benefit of being a local person, who had access to people in the community and to hospital personnel, and stood further outside the project than the staff members.

A limited form of social analysis is sometimes done by a person acting as consultant to development projects. None of the schemes in this study had the services of such a person, though all relied extensively on discussions with others in the development community to inform their work.

11.2. SOME DIFFICULTIES WITH EVALUATION

11.2.1. Lack of base-line data

Rural areas throughout the developing world lack thorough information-gathering systems that can be of help to research and development efforts (Bulmer and Warwick, 1983; Peil, 1982). South Africa is no exception, and the absence of an adequate data-base was felt by all the schemes in this study.

The Elim Hospital, base of the Care Groups, was a partial exception. It had conducted epidemiological studies on trachoma, which helped the scheme identify the most important target for community action in terms of controlling the spread of infection - the pre-school child.

Hospital and clinic records were used to a greater or lesser extent by all schemes to determine major health problems and to identify vulnerable groups or pockets of poverty. They were also used to monitor the increase in clinic attendance and immunisation rates. They are limited in so far as they are a record only of who has used the health services. It may be assumed that some non-users may be those most in need, with distance, and cash for fee or transport, influencing the accessibility of the health services.

The same applies to the use of school health records as collected by school nurses. They do not account for the children who are not able to attend school, who in turn are likely to be out of school through poverty or ill-health. Mann (1984), for example, has shown the effects of Mseleni Joint Disease (which occurs in the Manguzi area) on school attendance. Children whose parents have the disease are less likely to attend school.

The absence of thorough (if any) base-line data at the inception of a scheme means that they fall back on less rigorous, more impressionistic assessments of their work. The strategy of building in data collection as the first phase of a project might seem to be the sensible solution. There is a clash, though, with other dynamics propelling projects when they start: the need to achieve something practical and tangible to gain credibility and acceptance; and the resistance to research by some communities, to which project staff have to be sensitive.

A compounding factor may be the urgency and obviousness of what needs to be done - possibly more apparent in the health field than related sectors. Staff with health training know what the major health patterns and problems are, inter alia high infant mortality rates, malnutrition, measles, and gastro-enteritis. The determination of exact rates and extent would take valuable time, money and energy.

Base-line data collection in rural areas is beyond the scope of small organisations. In Southern Africa, as in many other countries, the development of information systems for rural areas has been grossly neglected by government institutions, who are the proper agencies for such information gathering and analysis.

11.2.2. Controlling for external variables

Would the observed effects of schemes have happened anyway, regardless of agency intervention? This question complicates the issue of evaluation always, but particularly in situations of extreme poverty - building the necessary control groups into the research design has both ethical problems, in terms of isolating groups who will receive no intervention, as well as implications for the cost of the research.

As mentioned, the Care Group project had guarded against claiming for itself benefits which might have derived from elsewhere. In one survey, for instance, it was found that there was a decrease in the incidence of trachoma and an increase in the acquisition of hygienic facilities in the control village. However, this was a significantly smaller change than in the villages where there had been Care Group intervention (Sutter, 1982). The studies are also careful to point out that in some communities the Care Group members themselves come from a more health conscious sector of the community.

The experience of the Valley Trust Socio-Medical Project is instructive in this regard. When they started in the early 1950's, the rapid and significant lowering of malnutrition and infant mortality rates could safely be assumed to be a result of their intervention. Soon, however, the area started developing rapidly in terms of improvement of transport networks and thereby access to urban employment. The project then became less able to determine which of the improvements in health were due specifically to their intervention, and which were attributable to overall improvements in the area.

11.2.3. The measurement of the elusive: attitudes, awareness, morale, level of community organisation

The discussion of evaluation has so far concentrated largely on assessment of relatively tangible factors such as health indicators and the provision of services. These may be called the **task goals** of schemes. The organisations also had, to a greater or lesser extent, what may be called **process goals**. They wanted for example to develop an awareness about health, promote self-reliance, improve community's problem-solving capacities, strengthen local community organisation, etc. One project director said:

> "I didn't understand this when I started - I just thought of it in terms of results: the number of immunisations, like that kind of result. Now I understand that there is another aspect which is probably more important than results, although the two go together... The sort of development aspect, where people are getting organised."

Now these qualities are difficult to measure at the best of times. 'The best of times' might imply a research team with ample time and money, and similar linguistically and culturally to the community being researched. The community would ideally be homogeneous and isolated from extraneous variables which

would confound the research design, and the community would have tolerance and patience in abundance.

It is of course possible to assess the achievement of these process goals by methods other than individual attitude measurement. A perspicacious observer will have a sharp eye for 'critical incidents' - sudden unexpected events in the project itself, or in its environment, which elicit a response from people. This may show, for example, whether the group retreats in fear and submission, or formulates and articulates new ways of coping with a problem; whether a group takes the initiative when confronted with changed circumstances, or continues with known, though now inappropriate procedures.

The awareness of trachoma and knowledge about the steps necessary for its prevention were measured in at least two of the Care Group surveys. Apart from this, none of the schemes had attempted to ascertain by research how far their process goals had been met.

There were evaluative statements in the interviews such as:

> "I can say there is a change now. Why? Because most of the people now from the community are aware that their kids should all be immunised in their area, and they know the reason why."

However, another interviewee saw the problem with laying claim for this sort of growth of awareness:

> [Interviewer: So you are working on the assumption that clean water and some more vegetables will, must change...]
>
> "Must change something. Whether it does or not is another story. I think also another thing it does change, a little bit, is the morale of the people in the village. But I don't know if that is claiming anything."

The Care Group project read positive signs about process goals in the fact that some groups, with little ongoing support from the team, undertook a number of new activities on their own initiative. Some organised clean-up campaigns, others visited schools to detect further trachoma cases, yet others initiated new Care Groups in adjoining areas. A scheme can justifiably claim that there has been some transfer of skills, and that it is enhancing local problem-solving capacity, when groups act in this independent way.

Conversely:

> "I was very disappointed that neither the motivators nor the Care Groups have seen the need in the polio campaign to actively involve Care Groups in the vaccination campaign."

This was a sign to the project director that the potential of Care Groups was being perceived in narrow terms, and that the project had not managed successfully at that stage to educate sufficiently about the broader potential role of the grassroots workers.

This highlights a pitfall faced by many schemes where there is no precise measurement of the process goals. There is a tendency (not evident in these interviews) to judge or evaluate by exemplification. In moments of optimism, or when in need of bolstering of confidence, it is **always** possible to find an example of one person who was affected positively by a project - someone who rose to the position of leader, or who in the face of a multitude of problems managed to mobilise his or her community to wrest resources out of a government department.

Equally, it is **always** possible for people critical of a project to find a story or incident which exemplifies disaffection towards it - and the hostile stories get more wildly distorted with each recounting.

11.2.4. Evaluation in the context of scarce resources

Evaluation studies, whether conducted by staff or an outside person or persons, inevitably drain project resources. Staff at all levels will normally be involved. Even where a study is funded by an outside agency (the sponsors, for example) few evaluation budgets make an adequate assessment of the contingency costs which will be borne by projects.

Further, human service organisations in Southern Africa do not yet routinely budget for evaluations - this was the case for all schemes in this study. Thus when the need for an evaluation arises, the cost normally competes with existing budgetary allocations, or additional funds have to be specifically sought.

The context of rural development projects is poverty and deprivation, and project resources are in short supply. The cost of evaluation has always to be measured up against alternative uses for resources. A project director said:

> "We tried one evaluation, a huge properly scientific evaluation... and all the information is lying there waiting to be analysed. There hasn't been time to do it... It can't be done by people like ourselves, who are already absolutely swamped with curative work."

11.2.5. Using 'outside' researchers for evaluation

The Care Group project and Manguzi had used the services of visiting research teams (mainly from university medical schools) to do survey work. The advantages of outside evaluators are in principle clear. They have the time to do the research (as opposed to project staff who have competing demands on their

time); they can be objective, bringing a new pair of eyes with new insights; they may have research experience and expertise not possessed by the project team.

There are, however, problems. The fortunate project may be able to find a researcher or research team who speaks the local language, is sympathetic to the organisation while remaining sufficiently open-minded, and is accustomed to working in rural areas, respectful of and sensitive to ways of doing things that will not offend local sensibilities.

One person said:

> "It is very important, scientifically speaking, that people come in from outside, because internal people are biassed... But again, I'm not sure how good it is to have outside evaluators coming in, from a development point of view... People don't like a stranger coming in to their house and asking them all kinds of intimate details about how they use their toilets - it's dehumanising... If you're going to do it on a regular basis, the people are just being guinea pigs."

And another pointed to disadvantages of outside research teams:

> "In certain groups where we did evaluation, we were pretty thorough. But many groups have never been evaluated and the question is, how much do you evaluate? Because these big evaluations with the students were very disruptive. The [health workers] were very upset and said please don't make any surveys any more, because they were so involved with it they couldn't work with their community groups."

The students' report on this particular survey showed their own awareness of the problems inherent in their role as outsiders (Elim Research Group, 1978: 2):

'... the white students present were often seen as officials or doctors and thus the interviewees may have attempted to give the answers they thought we wanted to hear rather than the true answers... The interpreters were not adequately informed of the nature and motivation of the survey and may have been embarrassed with the community's lack of knowledge - a factor which may have led to some inaccuracies.'

The use of university researchers for evaluation work has problems other than these as well. There are expectations and constraints that flow from their employment position. There may be academic pressures to collect and analyse data with a degree of accuracy not necessarily useful to those in the field; the 'language' they may be required to use for publication may be such that they cannot 'speak' to the programme being evaluated. Once the field trip is over and they are back at base, there may be conflicting demands on their time which means the report is delivered long after it could have been useful to those in the field.

11.3. DISCUSSION: SOME RECOMMENDATIONS FOR EVALUATION

An evaluation may be undertaken with one or more specific audiences in mind. It may be primarily for the use of the **project staff** in their attempt to formulate or change policy and objectives. Alternatively, and commonly, an evaluation may be done with **project sponsors** in mind. From the point of view of the project personnel, an evaluation may be a useful tool to raise funds from new sponsors, or to demonstrate to existing donors that a scheme is worth continued support.

Sponsors themselves may press for systematic evaluations. In the late sixties and early seventies, when the private sector was beginning to get involved in the sponsorship of community projects on a large scale, organisations often committed themselves to the idea of evaluation on paper, but there was little pressure from sponsors to do this sytematically or rigorously. As the 'corporate social responsibility' budget has grown (in 1985 it was estimated to be R200 million per annum) sponsors have been putting more pressure on organisations to demonstrate the worth of their investments. There have been increasing demands to prove cost effectiveness, sustainability and replicability.

A further audience for evaluations may be the **'development community'** and **professional groups**. Development projects are by nature innovative and exploratory. They are social engineering efforts which attempt to experiment with new ideas and techniques that extend the limits of, or attempt to overturn, the conventional wisdom about how things are done. This could involve the introduction of appropriate technology, new irrigation methods, different ways of teaching science, organising collective action for the mass immunisation of children. Where these new ways threaten existing ideas, particularly where institutionalised patterns and relationships are made vulnerable by the success of new ideas, substantive evaluation studies can enhance the legitimacy or credibility of the project team in the eyes of other significant parties: academics, professionals or practitioners. Even where 'success' cannot be easily demonstrated early on, an evaluation can serve to buy time.

The needs of these different parties may conflict with each other. Project staff may want to protect the project itself, and the people in its constituency. They may also be more concerned with the relatively intangible aspects of goal achievement, such as increasing awareness, or development of neighbourliness and solidarity at the local level. Sponsors may want to protect their pockets, and be more concerned with the creation of physical structures (clinic, community centre, classroom) which can be 'seen'.

The development community is itself fractured: people have intellectual, emotional and practical commitments which lead them to proselytise the 'correct' way of doing things. People take up positions and hold to them strongly. Evaluations can be used to entrench and safeguard these positions, highlighting them, and thereby contributing to divisiveness within the development community.

Some suggestions for improving the field of evaluation work in development efforts arise from this study. They will be presented in terms of three parties who could take positive action: the projects themselves, their sponsors, and universities.

11.3.1. Action by development projects

As has been shown, a common problem for schemes is the lack of base-line data on which to construct a set of measurements of the impact of development intervention. The collection of such data is arguably beyond the scope of smaller projects, and is properly the task of central and local governments.

Development projects should ensure that everything possible has been done in the way of **searching for whatever information is available** on the project area. University research institutes would be a particularly valuable source of information, with the increasing commitment to development studies.

Projects should **institutionalise regular staff meetings** in which the direction of the work is discussed, and recorded. It is easy to gloss over this vital function because there is so much pressure on time, but in the absence of this, the experience of development initiatives will remain unshared.

A significant improvement would be if projects were to **budget routinely for evaluation studies**. The drain on project resources that evaluations can constitute has been acknowledged; nevertheless, the need for serious assessment of project performance is clear, in the face of so many failures. Evaluation should not be tacked on to a budget - it needs to be built in to it.

Because evaluation is by definition threatening, projects may be tempted to choose an outside person whom they know to be sympathetic to their work and to themselves. The development community in this region is small, and there are few evaluators available. The problem for projects is **careful choice of evaluators**: finding a person or persons who are sympathetic enough that people will be cooperative and trusting and open in their opinions, without 'packing the jury' so that the evaluation exercise (and this applies particularly to organisational assessments) is a ritual, with evaluators not being able to ask questions beyond those routinely set by the project.

If the business of evaluation is to be taken more seriously, project staff should **negotiate an evaluation contract** with evaluators at the outset. This sets limits for the evaluation, and specifies that findings should be useable and timely, as well as indicating who will 'own' the findings, in terms of publication rights etc.

The role of **permanent development consultants** needs to be more fully explored in Southern Africa. I do not mean to over-emphasise the role that 'experts' can play, and am aware of the disruption it can cause to a project if someone unfamiliar with the daily demands makes suggestions which project staff know only

too well are unrealistic. I do think, though, that having twice-yearly or annual reviews with an outside person or persons can both help to bring objectivity, and can also be a way of forcing project staff routinely and regularly to sit back, take stock, and look backwards and forwards at project policy and objectives.

Finally, every effort should be made, where appropriate, to **build community participation into data-gathering and evaluation**. This is difficult, and can be costly in terms of time and money. However, the role of community people in the gathering of base-line data has yet to be seriously explored in this region. Furthermore, the people affected by development intervention are seldom properly consulted about project policy and objectives. Evaluations can be structured in such a way that they become a platform or vehicle for creating democratic and collaborative channels for community influence over programmes.

11.3.2. Action by sponsors

It has been seen that much of the pressure for thorough evaluation of development programmes has come from those who sponsor them. Sponsors can do much to encourage the further development of evaluation studies.

When proposals are submitted to the private sector for funding, prospective sponsors can **insist on due weight being given to project evaluation** as a condition of funding. Calling for evaluation does not of course solve the problems outlined earlier - how to measure and assess the achievement of process goals, which projects may consider more important than the acquisition of concrete structures and equipment. The rigorous cost-benefit analyses which are likely to favoured, because understood, by the private sector, are largely inappropriate in the development field.

It would thus be worthwhile for the private sector to be encouraged to **fund a conference on the evaluation of development projects**. This would be in their interests, and in the interests of those in the field. Much could be gained through mutual exposure to the need for and expectations of, evaluation studies.

11.3.3. The role of universities

In Southern Africa there is not as yet, as far as I know, a private firm undertaking evaluation studies for the development sector, as is the case in, say, the United States of America. The research tends to be undertaken by university staff, usually lodged in departments in the social sciences or adult education. This is often done as an unpaid service.

This is in line with the declared commitment of at least the English-speaking universities to develop their service commitment to the broader community. However there are two pressures running counter to this,

which may affect the flexibility that some departments and institutes have had in responding to community-based requests for research.

With the financial crisis being faced by universities, community service may be seen to be the soft, dispensable side of the university's role. It could be jettisoned in favour of the 'real' business of the university: the 'pursuit of 'excellence', the maintenance of high teaching standards, etc.

Furthermore, the South African government has imposed the SAPSE system on universities, with a limited list of accredited publications in which material must be published in order to qualify for subsidy. This leaves university staff who wish to assist development efforts with conflicting pressures, as much of the work done (especially in evaluations) is either confidential to the organisation being evaluated, or the report for the organisation is written in such a way that is unsuitable for publication purposes.

In the face of these pressures, universities need to **reaffirm their service commitment to the broader community** as well as **continue to pressure for an alteration in the publication subsidy system**.

There is a great need for attention to be given to the **training of evaluators** in this region. As yet, evaluators have largely learned on the job, or by going abroad for specific short courses. Social research institutes and adult education departments in particular have a role to play in advancing training in evaluation.

Within the development of training in evaluation, particular attention needs to be paid to the **training of black social researchers**. This is a need in the social sciences in general, but is particularly acute in the evaluation of development work in rural areas.

Universities, as well as development associations, have a role to play in **organising conferences and workshops** with evaluation studies as a focus. The few people engaged in this field are scattered around the country, and much could be learned by their convening together to pool their knowledge and experiences.

11.4. SUMMARY

The evaluation of projects is an essential part of the community development process. It has frequently been neglected in the face of the immediate need to fulfil project goals; there has, however, been a growing demand for attention to be paid to evaluation, because of the failure of so many projects.

The forms of evaluation which had been undertaken by schemes were presented. The Care Group project had been most active in this area, and their evaluations had fed back into the direction of their activities.

However, even they had been largely unable to assess the impact of their work on such intangible development goals as the development of community problem-solving skills, attitude change, and growth of morale and confidence.

The conflicting expectations of evaluation studies of projects, their sponsors, and the researchers themselves were pointed out. The experience of projects is that while evaluation studies were seen to be critically important, they were costly and disruptive to ongoing work, in the face of scarce resources (of both time and money) and the urgency of work to be done.

Suggestions were offered as to ways in which conflicting needs and interests could be reconciled. In particular, there is a need for greater emphasis on community participation in evaluation studies, and for projects, sponsors and universities to meet so that their needs and expectations can be discussed. It is necessary that a variety of alternative methodologies for evaluation of innovative projects be explored, so that studies may be useful, realistic, and may inform the work of development organisations in all sectors.

SECTION TWELVE

CONCLUSION

INTRODUCTION

In this study, the work of three rural community health schemes was viewed and analysed from the perspective of the community-based approach to development. The intention was **not** to measure the schemes' impact on health indicators; it was to clarify the processes undergone by innovative projects in their attempts to provide an alternative, grassroots approach to the delivery of some aspects of health care.

The research was motivated by a dissatisfaction with available 'models' of community development, in terms of their theoretical bases (with respect to the conventional wisdom of community development), and their ability to inform the practical work of people in the field (with respect to to the Marxian analysis and the work of the dependency theorists).

The conventional wisdom of community development, as found in text-books, and promoted by the South African and 'homelands' governments, some donors, and most university departments of social work (who train community workers), assume that projects work in a stable society, and see the role of community development as adaptive and a vehicle for incremental reform.

Dependency theorists have rightly criticised this form of community development, and particularly in a society such as South Africa. They have pointed out that its principles can be manipulated and distorted, and in the name of 'helping the people to help themselves', community development gets coopted as a device to get the poor to pay for their own poverty, detracting attention from the need for a transformation of economic and political structures that produce and reproduce poverty.

My own position was that, while largely agreeing with and being informed by the dependency school, the debates and prescriptions for strategies of development arising from this perspective take place far from the field. They fall short of helping practitioners with the problem of "what do we do on Monday morning?"

The field of primary health care was chosen because, of all development sectors, it embodies the principles and priorities which represent the directions in which development must go if it is to remedy the abject failures of rural development initiatives to date (in South African urban areas, alternative education or 'people's education' would be the analogous sector). The study attempted to enter the lives of three projects implementing this approach, with a view to answering such questions as: how are projects shaped

and formed? What are the key issues confronting them? What are the processes and dynamics within projects and within their environments which facilitate or constrain the introduction of a new approach? Can lessons be learned from this for other sectors in development?

This concluding section is organised as follows:

12.1. The achievements of the projects.
12.2. Major lessons learned from the study.
12.3. Looking forward.

12.1. THE ACHIEVEMENTS OF THE PROJECTS

What follows is not an exhaustive list of all the benefits that projects created - these will be found in the body of the text. I summarise and group the most significant acheievements.

12.1.1. Material achievements

Although the objective of the study was not to assess the projects' impact on health indicators, the other achievements must be seen in the light of the improvements in aspects of health care. The Care Groups significantly reduced the incidence of trachoma, and had with some success promoted fuel-conserving stoves, pit latrines and vegetable gardens. At Manguzi, the health service reached many households for the first time because of the community health workers, and this was particularly important regarding immunisations and attendance at mother-and-child clinics. The Health Care Trust's work in promoting vegetable gardens, pit latrines, the milk scheme, and particularly in spring protection, were noteworthy. All schemes concentrated on disseminating knowledge about oral rehydration solution: it will never be known how many lives have been saved by this appropriate technology, but a powerful remedy for the most common illness, gastro-enteritis, is now commonly known about and administered in the project areas.

At another basic material level, Manguzi and Health Care Trust provided some local cash income for the community health workers. A material spin-off of the Care Group project was additional work for the local textile cooperative, in orders for the distinctive scarves and skirts worn by Care Group members.

12.1.2. Platform for the inclusion of women

The projects certainly provided a means for women to be brought into community decision-making processes and leadership roles, often for the first time. Though important decisions regarding their work still resided finally with men (especially with the tribal authorities at community meetings), health activities

were accepted as women's domain.

When four thousand women, in the case of the Care Groups, voluntarily participate in an organisation; and when, for little money in return for a considerable investment of time and commitment, at Manguzi and Health Care Trust, auxiliary workers continue their work, it is evident that the schemes were meeting a psychological or social need.

With the growing concern internationally for gender planning in rural community development (i.e. consciously and intentionally creating structures for the meaningful participation of women in development activities), these schemes have demonstrated that health care may be a potential terrain for women's development.

12.1.3. Basis for building organisations

This links with the fact that schemes had all started establishing a basis for rural community organisation.

12.1.4. Development of training and educational resources

All the projects had developed indigenous resources and materials for training and community health education. Some had been adapted from international sources, others were of their own making, generated by, and built on, local needs and local understanding. Through testing these out in the field, and refining them, the projects are making an important contribution to communications in health education, where material produced by state health departments is most often inadequate and inappropriate.

12.1.5. Contribution to development studies

Papers published by projects, as well as their attendance at national and international workshops and conferences, have contributed towards drawing attention to needs in Southern African rural areas, and have added to the understanding of the potential, and problems, of rural development work.

12.2. MAJOR LESSONS LEARNED FROM THE STUDY

The issues raised do not follow the order of sections of the report. Themes and issues overlap. Detailed recommendations, where appropriate, have been included in each section. Here, I consolidate what in my view are the most significant and important lessons learned from the study, and show the implications of these for the process of community development.

12.2.1. The need for careful planning and preparation

The interviews with project staff revealed that the schemes had not been well thought out in advance, and they had learned as they went along. On the one hand, this is to their credit: the need for some form of intervention was clear, and in rural areas feasibility studies and careful pre-planning seem costly and luxurious. So it is perhaps inevitable, and arguably important, that some people are prepared to take a 'leap of faith', make an initiative, and engineer a design for the project as it grows. Also, at the time these projects started, there were few local models to learn from.

At the same time, though, projects staff agreed that the costs of this lack of planning and preparation were evident. They learned the hard way, for example, about the implications of introducing payment for health workers without a precise understanding of future implications (Manguzi); the danger of running a rural project from an urban base in the project's initial stages (Health Care Trust); and the necessity for training of the trainers (Manguzi and Care Groups) and community health workers (Health Care Trust) before embarking on community activities and raising community expectations.

All three projects showed themselves (though they were not necessarily aware of it) to be models at one level of Korten's learning process approach (1980): they were commendably open to adapting and reshaping their procedures in accordance with new experiences facing them. However, the learning process approach is not a substitute for the thorough groundwork that needs to be done if the approach is to be successful. Schlemmer et al (1978: 140), as cited in section 1.5.6., confirm this point.

12.2.2. The creation of employment opportunities

Given rising unemployment and the continuing underdevelopment of rural areas, projects which involve auxiliary workers as an integral part of their work - at the interface between project and community - need to look very carefully indeed at the issue of payment of these workers.

There will always be a place for voluntary work in community development, and the Care Group model - where thousands of women are involved in limited aspects of self-help in health care - seems an appropriate place for such voluntarism. If the consequence is that the Care Group members perceive their groups as 'clubs', rather than strongly motivated groups with the primary aim of helping their communities, this is an entirely rational response on their part, though project staff may not like it.

Where routine tasks and obligations are expected from auxiliary workers such as the Manguzi and Health Care Trust community health workers, then this should not be seen as voluntary-work-with-an-honorarium - it is employment. It should be recognised that one of the responsibilities of development organisations is the creation of employment, and that community payment may be an unrealistic, and unjust, solution.

12.2.3. The need to give due weight to the contexts of development projects

Whereas the conventional wisdom of community development assumes that projects are lodged within the system (whether health, education, agriculture) and attempt to improve it, the reality for most in Southern Africa is that they stand outside of it (Health Care Trust) or are within it in a marginal position, testing new ideas and the responsiveness of the system (Manguzi and Care Groups).

This study has shown how factors in the environments of projects mitigated against their best efforts to pursue principles of community participation and involvement in decision-making, and to close the gap between the formal health system and the community. The lack of basic needs such as water, the position of women in rural society, community authority structures, the structure of bureaucracies, and the limits placed by policy-makers on the role of the health workers - all these constrained the abilities of the enthusiastic and committed project staff and community health workers to attain their objectives.

The lesson? It is as well that 'development experts' and health professionals within bureaucracies should stop trying to find out "how to motivate apathetic communities", and concentrate their attention on the structures and processes that would enable and facilitate community efforts.

This confirms Hutton and Cohen's contention (1975, cited in section 1.3.), made from within a dependency perspective, that community development should move away from 'blaming the victim' - away from the focus on changing the attitudes of rural people so that they take up opportunities present to them by development agencies. The problem with too much attention being paid to the internal workings of projects, and the attitudes of grassroots people, is that attention is deflected away from environmental and structural features that impact on project performance.

However, there can can be a converse tendency towards 'naive panegyrics in favour of the grassroots', and this too is not helpful. Community members, from whomcommunity health workers and their trainers are drawn, are obviously products of their environments. In rural societies, even more markedly so than in urban, the family, the church, the educational system and local authority structures are overlapping heirarchies, authoritarian in nature. It is into this context that development agencies bring their new and alien training and educational methodologies.

12.2.4. The importance of training

Development efforts bring not only new technologies, but also new ideals or models of social relationships. The elements of this have been described: briefly, an emphasis on participatory or experience-based learning, non-heirarchical relationships, the belief that each and every individual has a contribution to

make, and the institutionalisation of democratic procedures. Projects' internal cultures are shaped by these ideals, and, in training, an attempt is made to transmit and disseminate the culture to auxiliary workers and to the community at large.

The philosophical problem with this will be discussed in due course. Here, given that the projects under review subscribed to this alternative pedagogy, the study showed that far more time needs to be spent on training and education.

Manguzi and the Care Groups grew so rapidly that they acknowledged that the training in social development had been neglected. The project leaders were themselves learning, without available role models and resource people to rely on. Health Care Trust, at the time of the field trips, had concentrated most in this area. They felt that they were beginning to see results, in terms of the community health workers' understanding of their role as facilitators, not teachers, as potential agents of change, and in their perceptions of the benefits of cooperative work.

Such learning does not come easily through one-off intensive courses, workshops or 'modules', no matter how sophisticated the skills of the leaders. And it is at odds with the form and content of relationships in the surrounding social, economic and political institutions.

12.2.5. Community development as missionary activity

There is an assumption at the core of this promotion of social arrangements and relationships - whether it is called social learning or the Freirian 'consciousness-raising' - which is in some respects not very different from a core assumption within conventional community development. It assumes that the people in the constiutency of the development worker are of a lower consciousness, or less conscious, than the extension agent - the consciousness-raiser. An arrogance and paternalism lurks within it: as in the community development that the Marxist Freirians would criticise, some person - the outside developer - has an interpretation, a grasp, of the world that is 'the truth' or 'more true than' those to be 'developed'.

Now, if I take myself as that outside developer, there are undoubtedly ways in which my consciousness is different, and things that I know, which might be helpful to people in a less developed setting. My education and class position have exposed me to a great many opportunities to learn different ways of doing practical things: ways of book-keeping, how to sew, for example.

Similarly, my class position and professional background have enabled me to know about the existence of resources which may be useful to poorer communities: donors, where to buy seeds in bulk, where to procure development manuals.

Then too my employment position has given me access to literature about, and practical experience of, how government departments and local authorities function. In sharing this knowledge and these skills, I may practically assist a community organisation to negotiate with or confront these authorities.

But I do not have first-hand experience of living in poverty, nor has my consciousness been determined by belonging to a (racially) oppressed group. I do not know whether a particular suggestion or idea I may put forward is offensive. I do not know whether my suggested strategy will put community people at risk, or in which ways it may do so.

Still as that outside developer, I do think I can make suggestions, present alternatives, for solving problems, if I am quite sure that my relationship to the community is such that people will reject them if they are perceived to be inappropriate. People learn to strategise against outsiders - there is a tendency in non-directive community work to be overly precious about communities, with the emphasis on 'self-determination of the client' and attending to felt needs based on consensus leading to a sort of paralysed paternalism.

Still, there is an unsettling tension about community development work, with respect to the introduction of new social institutions and relationships. Community development, whether from a conventional or radical perspective, is partly applied social science, but it is perhaps better that there is an acceptance that it is also zealous missionary activity, and an attempt at mental colonisation, as the work of religious missionaries is.

12.2.6. Building an organisational base

The importance of establishing a firm organisational base from which to implement development was emphasised throughout the study, and confirms the conclusions of such authors as Chambers (1983), Daphne (1984), Derman and Poultney (1985b), Korten (1980), Schwartz (1981) and Zulu (1985), who all point out that this is fundamentally also a political activity.

My assessment is that was in the area of organisation-building that the projects in the study had furthest to go. As has been mentioned, they were fairly new initiatives, and the judgement is not meant to be harsh. Health Care Trust had tried, and had met with resistance from the tribal authorities and hospital personnel; Manguzi had established health committees, but their role was unclear and the trainer could not, because of competing demands on his time, train the committees. The Care Group project had established a committee for each group, but there were no inter-group linkages.

This had a number of implications for ongoing work, and for the future of the projects. The communities and the community health workers were dependant on project staff, and particularly on the leaders, for the

continuity of the projects and for new ideas. This confirms Werner's finding (1981) that committed, enthusiastic, charismatic leaders have a central place in inititiating community development organisations, but that over time this can work against projects becoming self-sustaining.

The staff in these schemes, and community workers in other fields, know the self-defeating cycle that ensues: there is urgent work to be done; transferring skills and delegating power takes time; you do it yourself (just this once) - whether negotiating with authorities, or securing funding or other resources; the project grows; there is more work to be done; local people have still not learned the skills; you do it yourself (just this once, again).

The solutions are obvious in principle - more time for training, for discussing and instituting shared decision-making structures, community people accompanying project staff on delegations to policy-makers. These take time, money, effective communication networks, and staff, and all rural development workers know how precious and scarce any one of those resources are, let alone the combination of all of them.

However, this organisation-building is not incidental to the community-based approach, it is the essence of it, if the goals of self-reliance, community mobilisation, and empowerment of people are to have any substance at all. It is also one way in which the mission of the development agents can be tempered by authentic community control of projects, while accepting that the context of projects is a politically contested terrain.

12.2.7. The need to restructure organisation budgets

Many recommendations made in the study have cost implications, and projects were financially stretched and insecure regarding sources of future funding. At the time of field work, rural development was receiving little attention from the private sector, and state-sponsored experimental projects battled for a minute share of available resources.

Much has changed now. The primary health care approach has been widely accepted; the private sector has begun (belatedly) to see the connection between rural underdevelopment and urban working conditions; and, ironically at a time of disinvestment in South Africa, there is a great deal of international money looking for agencies in rural areas (though, ironically again, the 'independent states', truly the creations of apartheid, are being excluded).

While it is certain that more money is needed for rural development projects in purely quantitative terms, this study has showed the need to rethink the way that budgets are drawn up, and the ordering of priorities.

Organisations applying for sponsorship should confidently and assertively build the following items into prospective budgets, items which are not normally included, or are given insufficient emphasis:

- payment of auxiliary workers during an extended training period prior to the beginning of activities in the community, so that people attached to the project can, from the beginning, exert some autonomy and take responsibility for their own future learning;

- visits to other projects doing similar work: the national health workers workshop showed that grassroots workers have as much, if not more, to learn from their peers in similar situations than from inputs from health professionals;

- proper payment of auxiliary workers, which will engender commitment to the project, and so that the notion of 'self-help' is not abused;

- a reasonable staff complement, so that those who have to do curative work (which must always take priority) can be supported by people whose primary task is to ensure that a solid organisational base is created;

- evaluation studies, so that regular assessment of project performance, and monitoring of the fit between the organisation and its objectives, becomes a routine part of project life. The dissemination of these studies will hopefully inform the work of other development projects.

Projects such as these are in a stronger bargaining position than before, with internal private sector donors needing to win credibility and legitimacy through their commitment to corporate social responsibility, and international aid organisations having changed their focus from development of buildings and technologies to development of people and organisations.

12.2.8. The need to educate policy-makers and sponsors

This study has confirmed the experience of many others, that rural development work takes time, and 'results' may not be seen for a considerable period; also if projects are to be flexible and responsive to changing community needs, they need flexibility from their sponsors.

These facts both conflict with the budgeting and funding patterns and cycles of both government departments and private donors. The private sector typically funds for a one-year period, spread to three years if projects 'show results'. But development is slow, and in order to secure the commitment of qualified staff, have an impact on the community, and work towards building self-sustaining organisations, projects need the guarantee of longer-term financial security. There is a need to persuade the private sector donors of this reality.

In terms of the flexibility required by projects, both government departments and private sponsors need to give meaning to their rhetoric about community decision-making by allowing greater decentralisation of control to projects and communities. This study has shown that there are no 'blueprints' - each project is unique, though there are of course similar environmental and structural constraints acting on them. Projects cannot determine details of a budget a year in advance, especially in the early stages - this mitigates against their responsibility to respond to community needs, and design activities accordingly.

12.3. LOOKING FORWARD

The community-based approach to health and to other sectors of development is taking place in a context of rapid social change.

Demographically, Southern Africa is experiencing growing urbanisation, and this takes place at the same time as there have been positive moves to deliver health services outward to rural areas. One of the challenges for communty health will lie in tackling problems on the peri-urban fringes.

Community-related issues have been politicised. A dilemma for, and the sad irony of, community development in Southern Africa is that, when finally the international development community has acknowledged the need for 'putting the last first', putting people back into development, and appropriate indigenous technologies are finding their place, 'self-help' itself has become politicised, and is seen as another trick to disadvantage the poor and detract attention from the necessary redistribution of resources.

Two related areas, fertility control and conservation, show the issues in clear and stark terms. In a global context, there is no question of the need to limit population growth, and for women to have more control over their own fertility. In this region, population control has become politicised, catalysed by grotesque exhortations from the South African government. Thus the Population Development Programme is a non-starter, and people in rural areas avoid immunisations, thinking they are the government's devious means of contraception.

With regard to energy conservation, there is a clear need for greater civic consciousness about conserving fuel in rural areas. But against the background of skewed land distribution and resettlement, and large-scale poverty, the need for conservation is in direct competition with people's daily need for sources of energy.

So too with self-help in development. The dominant cultural context has been one of centralised power and authoritarian decision-making, and there is much to be gained from community mobilisation in terms of

people learning to act on, and control, their environments, and this includes confronting those who make the decisions which govern aspects of their lives.

But self-help is tainted with the suspicion that there is an underlying agenda: self-help is right for some, not for others. No one would dream of mobilising the citizens of Pinetown and Kloof for a local clean-up campaign, or to improve their roads. Yet not ten kilometers away, in the Valley of a Thousand Hills, the community has been mobilised to build a road, and to contribute towards a scheme to lay on piped water - water for which the community will pay more than do the middle class citizens at the top of the hill.

The suspicion is thus justified. The community-based approach (in this study the platform was in primary health care) takes place in the midst of the conflict about the nature of social, economic and political change. On the one hand, the government is promoting privatisation as the solution to a number of civic services, in particular health, welfare and transport, while at the same time advocating primary health care for rural areas. On the other hand, the call from progressive political groupings is for a national health and welfare service - for socialised health care.

One of the points of departure of this study (section 1.6.) was that, regardless of the form and duration of the struggle for a democratic society, rural areas will, during the period of transformation and thereafter, have to be relatively self-reliant in terms of the provision and maintenance of some basic needs. Thus rural development organisations have a role to play, not only in terms of present tangible services, but also as models.

They have already illuminated, and can give further insights into, the potential and problems surrounding the introduction of innovations, the creation of organisational structures, and the development of appropriate educational resources.

While the surrounding inequitable structures are in place, these small efforts will battle to be self-sustaining. They can strive to be internally efficient, but may not be effective in terms of a significant impact on the system.

While the tide has turned for rural projects in terms of financial support, they will face an increasingly difficult time at the political level. Manifestations of the struggle for political power have appeared in rural areas, and people living there will, as in Zimbabwe, Mocambique and Namibia, get caught between opposing sides.

In Zimbabwe, for example, the Smith government's community development programme was first used to coopt the loyalties of chiefs and their communities, and was then abandoned when guerilla insurgency escalated (Bratton, 1978). Community health was then used as a platform for the mobilisation of the peasantry, particularly women, in the struggle for independence.

Rural community projects will have increasingly difficult choices to make, as community development principles and slogans get coopted by one side or another.

The community-based approach to primary health care has much that is valuable in it, but is not a substitute for rightful state provision of health services that are affordable, accessible and appropriate. The potential of these projects is to show how to go about the business of developing self-reliance and community organisation now, so that in Gramsci's terms, we more effectively learn how to 'weld the present to the future', in a post-apartheid society.

The question asked by Bratton for pre-independence Zimbabwe can be asked for South Africa in a time of transformation:

'The key question then becomes whether a powerful state will manifest inherited patterns of administrative organization and performance, and constitute thereby a constraint on development, or whether the state apparatus will itself be transofrmed and harnessed to the needs of peasants and workers... What is the proper balance between state control and popular participation that will ensure that the development preferences of the rural majority are heard and met?' (Bratton, 1978: 47)

What is needed is a closer relationship between the practitioners who are in the slow, messy and frustrating business of rural development work, and the theorists formulating their visions of change, and giving prescriptions for practice. In debates about development, perhaps because they address the most urgent issues facing mankind, there is a tendency for people to take up positions in corners, hold to them, and deliver categorical judgements about what practice is 'correct', or 'reformist', or 'collaborative'.

More dialectical interaction between theorists and practitioners could improve indigenous social theory, which in turn could more helpfully inform practice. A potentially constructive and challenging role for applied social researchers is to mediate between the two.

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