CHAPTER 6

Learning and Working with the Community

"In some ways, the village or community health worker has a far greater responsibility than does the average doctor. The doctor feels a responsibility for those sick or injured persons who come to him—those whom he sees as 'patients'. But the community health worker is responsible to the entire village or community where he lives and works. His concern is for the health and well-being of all the people. He does not wait for those in greatest need to come to him. He finds out who they are and goes to them."

How nice all this sounds! But in reality, many community health workers do little more than attend the sick who come to their health posts. They might as well be doctors!

If health workers are to develop a sense of responsibility to the whole community, they need these two things (at least) during their training.

- **Good role models:** Student health workers need the example of instructors who are themselves active members of the community. This does not simply mean instructors who make 'house calls'. It means instructors who are doing something to improve health in their village and who relate to the poor as their equals and friends.
- **Practice doing community work:** Health workers-in-training also need practice working with people in a village or neighborhood similar to their own. It is not enough to study in the classroom about 'community participation'. Theory is often far different from reality. If health workers are to work effectively with groups of villagers, mothers, and children, their training needs to provide first-hand community experience.

Community practice means more than discussions, flannel-boards, posters, and role plays (although all these can be useful if used imaginatively). It means finding ways for health workers-in-training to actually visit communities and carry out specific health-related activities with the people.

For many health programs, this will involve re-examining the course content, revising plans, and perhaps choosing different instructors.

Learning in and from the community is essential preparation for community work.

MAKING COMMUNITY EXPERIENCE A PART OF TRAINING

Some people-centered programs have found ways to make interaction with the community a key part of health worker training. These ways include:

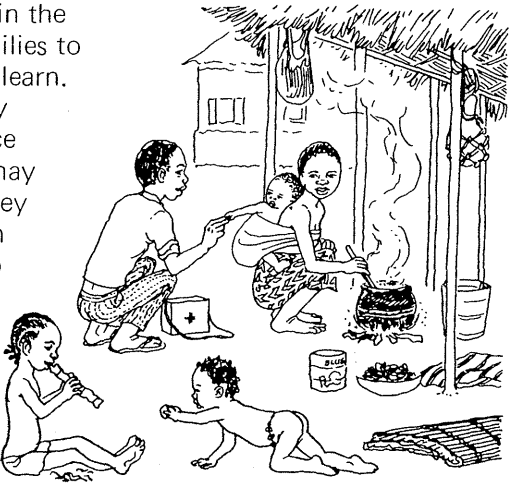
1. **Locating the training center in a village or community similar to those where the health workers will be working.** This needs to be done in cooperation with members of the community.

Example: Project Piaxtla, in Mexico, has its training and referral center in a village of 950 people. The old, mud-brick building used for classes is actually the farm workers' meeting hall. The village permits its use when it is not needed for meetings. The fact that all the instructors are from that village, or nearby villages, also helps bring the community and the training program closer together.

2. **Arranging for health workers to live, eat, and sleep in local homes during training.** This has many advantages:

- It brings local families close to the training program. The people take responsibility for the health workers' well-being, not just the other way around.
- It spreads students out and mixes them in the community. This prevents them from becoming a group apart, as often happens when students live together.
- It gives the students a chance to exchange ideas every day with mothers, fathers, and children. They can observe the customs, attitudes, joys, and difficulties of the families. They experience the families' problems and their ways of solving them. At the same time, the families learn from and with the health workers, as they bring home new ideas from the training course.

When the course begins, it helps if instructors **hold a meeting with the host families.** Explain the purpose of the training and ask the families to take part in helping the health workers learn. That way, the local people may actually encourage the health workers to practice teaching them and their children, and may even offer suggestions and criticism. They will take pride in helping prepare health workers to serve other communities. So learning goes two ways.



3. **Home visits.** Some programs make regular visits to homes (once or twice a week) an important part of health worker training.

Example: One program, located in a huge 'lost city' near the capital of Mexico, starts training by sending each student to visit 15 families in the poorest *colonias* (neighborhoods). The students try to help the families solve their health problems as best they can—through self-care when possible, or through public clinics and services. In this way, the students get to know the people and their hardships. They also discover the strengths and failings of the city's health and social services. **The content of the training course is planned by the students and instructors together, according to the needs and problems that they see during these home visits.**

Another example: Project Piaxtla also makes home visits a key part of health worker training. Each Saturday, the students plan what they hope to accomplish, then spend half the day visiting families. Each student always visits the same 8 or 10 homes. The main purpose of the visits is to listen to what people have to say. The students ask the families' opinions about community activities, and encourage their ideas and participation. They sometimes give suggestions about preventing or managing health problems. But they take care not to tell people what they ought to do. Perhaps for this reason, and because they rarely use formal questionnaires, in most homes the students are well received.

4. **Having student health workers carry out activities in local communities during their training.** In some training programs, students take part in some or all of the following:

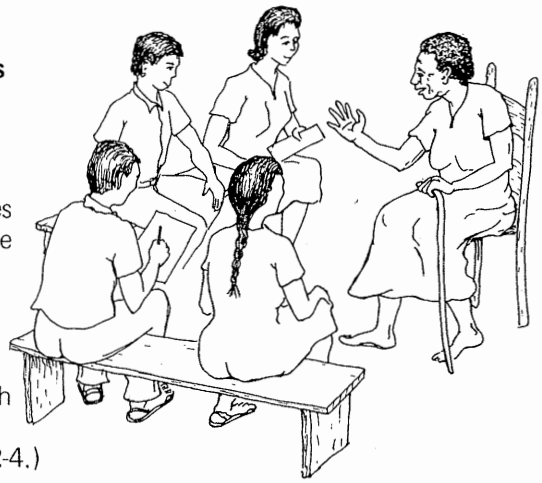
- Under-fives and nutrition projects. Students visit nearby villages, hold meetings to plan activities, demonstrate ways of preparing food, conduct feeding programs for children, train mothers as nutrition volunteers, etc. (see p. **22**-12 and **25**-6,7,9, and 36).
- Cooperation with villagers in building latrines, garbage disposal areas, water systems, or rat-proof bins for grain storage.
- Vaccination campaigns in neighboring villages (with educational programs for parents and children).
- CHILD-to-child activities. Health workers meet with children in the local schools, or with groups of non-school children (see Ch. 24).
- Village clean-up campaigns with children and adults.
- Working with village people in family and community vegetable gardens.
- Helping to run a local cooperative or corn bank.
- Health festivals and circuses (see p. **27**-12).
- Theater and puppet shows with mothers and children (see Ch. 27).

5. **Welcoming community participation in the training course.** People from the village or neighborhood can be involved not only in planned activities, but in a casual way, even in the classroom.

Here are some possibilities:

- **Open door policy.** Some community-based programs make a point of leaving classroom doors and windows open at all times to everyone. Mothers, fathers, farm workers, children, and especially teenagers often wander in or sit in windows to watch what is going on. The use of colorful, active teaching aids, role plays, and simple language to explore new ideas sparks the people's interest. Sometimes their opinions are asked, or they are invited to take part in role plays, games, or demonstrating teaching aids.

The 'open door' approach to classes for health workers can sometimes cause confusion, but it has many rewards. (For an explanation of the teaching aids shown here, see pages **11**-30 and **26**-6.)

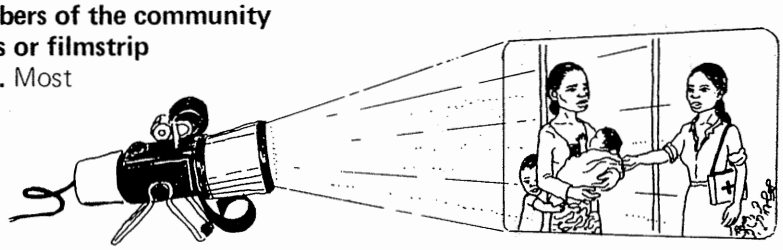


- **Inviting traditional healers, herb doctors, midwives, and other persons from the community to take part** in classes that deal with their special skills.

  One of the most memorable classes we have seen took place when a village midwife was invited to meet with a group of health workers-in-training. Together, they made lists of the specific information and skills that local midwives could share with health workers, and that health workers could share with midwives. (See p. **22**-4.)

- **Inviting mothers and children from the community to help with role plays and other activities.** Health workers need practice in dealing with the health needs of mothers and children. Role playing can help. But having health workers play the roles of babies is not very convincing. It is more realistic if village mothers can be persuaded to bring their small children to class, pretending they have certain health problems. (Real problems may be found as well.) This makes learning much more alive and exciting for everyone. See Chapter 14 for more ideas.

- **Inviting members of the community to slide shows or filmstrip presentations.** Most people love to see slides and films. When these are shown to health workers as part of their training, invite members of the community, too, and include them in the follow-up discussions. If health workers live with families, be sure they invite them.



- **Use of clear, simple language, teaching aids, and methods that everyone can understand.** It is important for instructors to keep their language simple and clear, so that anyone can understand. This way, health workers will not have to 'translate' what they have learned in order to share it with villagers. If community people are present at some classes, encourage them to interrupt and ask for an explanation each time they do not understand a word. This helps both instructors and students to keep their language clear and simple. (See p. **2**-16.)

LEARNING FROM, WITH, AND ABOUT THE COMMUNITY

The main job of a health worker in a community-based program is not to deliver services. And it is not simply to act as a link between the community and the outside health system. It is to **help people learn how to meet their own and each other's health needs more effectively.**

In order to do this, the health worker needs a deep understanding of the community's strengths, problems, and special characteristics. Together with the people, the health worker will want to consider . . .

NEEDS

- local health problems and their causes
- other problems that affect people's well-being
- what people feel to be their biggest problems and needs

SOCIAL FACTORS

- beliefs, customs, and habits that affect health
- family and social structures
- traditional forms of healing and of problem solving
- ways people in the community relate to each other
- ways people learn (traditionally and in schools)
- who controls whom and what (distribution of land, power, and resources)

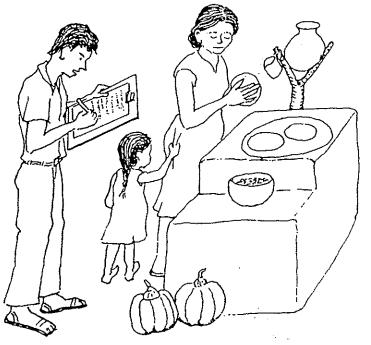
RESOURCES

- people with special skills: leaders, healers, story tellers, artists, craftsmen, teachers
- land, crops, food sources, fuel sources (firewood, etc.), water
- building and clothing supplies
- markets, transportation, communication, tools
- availability of work; earnings in relation to cost of living

This looks like a lot of information. And it is! But fortunately, **a health worker who is from the community already knows most of the important facts.** He does not need to run around collecting a lot of data. All he needs to do is sit down with a group of people and look carefully at what they already know.

For local health workers and their communities,

the need is not to gather information . . .



but to gather everyone together and look at what they already know.

People in a village or community already know most of the essential facts from their own experience. (Not exact numbers, perhaps, but these are usually not needed.) What they need to do is ask themselves:

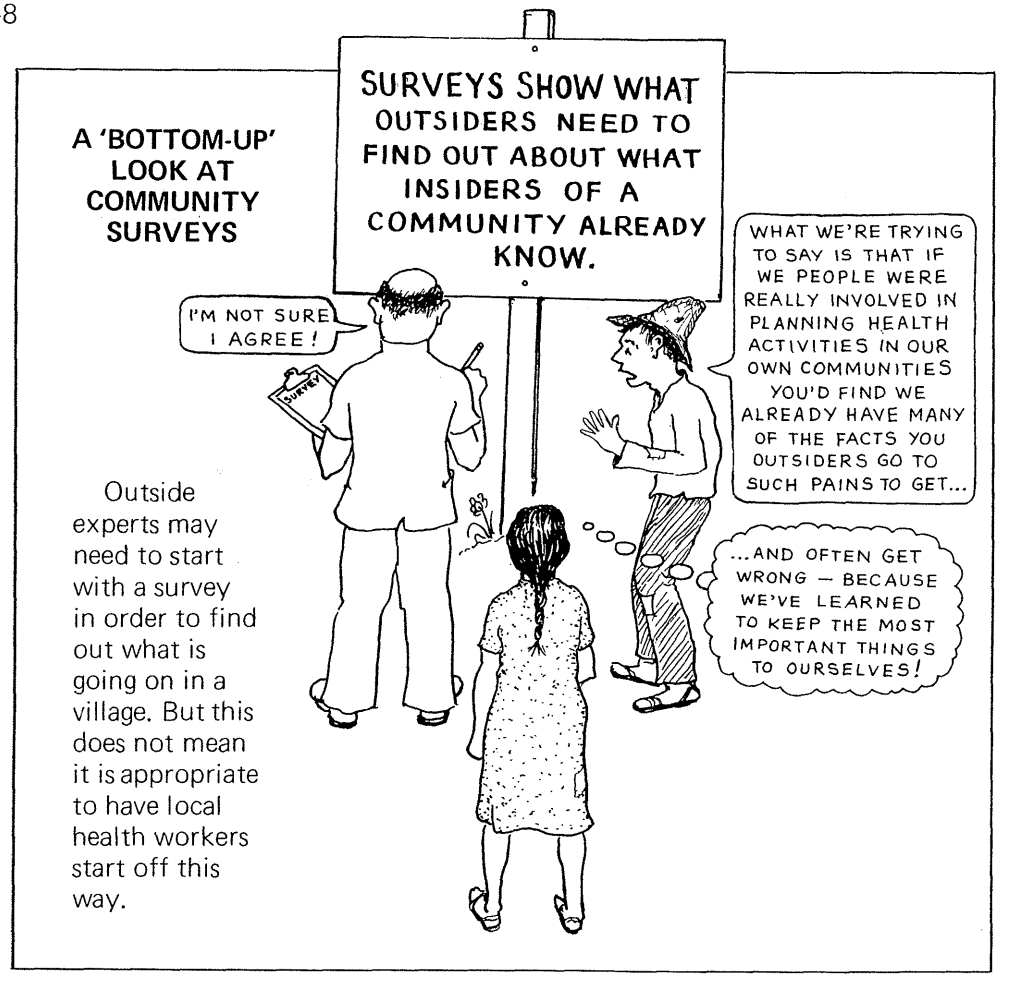
- How do the combined facts of our situation—needs, social factors, and resources—affect our health and well-being?
- How can we work with these facts—using some, changing or reorganizing others—to improve our health and well-being?

The process of looking at these questions in a community group is sometimes called ***community analysis*** or ***community diagnosis.*** At best, this means not only a diagnosis ***of*** the community, but a self-analysis ***by*** the community.

Community diagnosis—whom does it serve?

Ideally, a community diagnosis is a self-analysis by a community of the problems that concern people most. But watch out! The term ***community diagnosis*** is used quite differently by many of the larger health programs. To them it has come to mean a detailed survey, which health workers are required to conduct in their communities after training. Often the information collected through these surveys serves the needs of the health authorities, but means little to the people themselves.

To require a new health worker to conduct a long, complicated community survey can turn people against him from the first. Many people dislike or distrust surveys. This is especially true for the poorest of the poor, who are repeatedly studied but seldom see any real benefits.



Outside experts may need to start with a survey in order to find out what is going on in a village. But this does not mean it is appropriate to have local health workers start off this way.

When does information gathering make sense?

Although starting off with a detailed community survey is often a mistake, there are times when a health worker and the people in his community may want to gather specific information. For example:

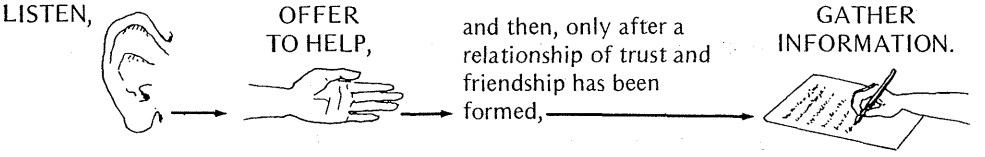
- People may want to see whether many children are underweight (poorly nourished) and therefore more likely to get sick. (See p. **25**-7.)
- They may want to find out if bottle-fed babies in their village get diarrhea more often than breast-fed babies. (See p. **24**-17.)
- They may want to see whether a particular health activity produces results. For example, a village may plan a campaign to control malaria. The people can take a survey before they begin, to find out how many persons have had fevers and chills. Then—after everyone has taken part by draining ditches, sleeping under mosquito nets, and getting early treatment—the villagers can take another survey and compare the results.

Because surveys often show results that would not otherwise be noticed, they can help to renew people's enthusiasm for continuing an activity (or to stop or change an activity that is not working). See Evaluation, Chapter 9, and On-the-spot Surveys, p. **7**-13.

Suggestions for gathering community information

There are no set rules or one 'right' approach for gathering needed information in a community. However, several people-centered programs have come up with the following ideas:

1. Go to people's homes and get to know them. But **do not start by taking a survey.** Information learned through friendly, casual visits is often truer and more useful. Put the needs and feelings of the people first.

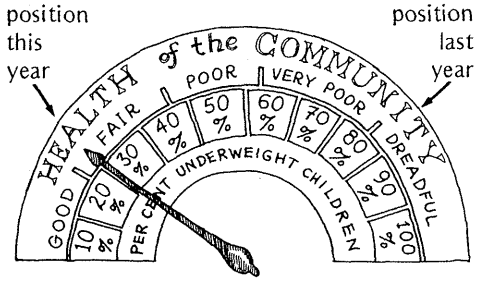


2. When gathering information, try to **find out what problems people feel are most important** or want to solve first. **Learn what ideas they have** for solving them.
3. **Ask only for information that makes sense** (and not simply because you were told to collect it). Be sure you and the people understand **why** the information is needed. For example, be sure parents understand why you weigh children **before** you do it.
4. **Involve local people in gathering the information.** Be sure studies are not *of* the people, but *by* the people. (For simple surveys in which children and non-literate people can take part, see p. **7**-13 and Chapters 24 and 25.)
5. When conducting a survey or community diagnosis, **try to avoid taking along written questionnaires.** Avoid writing notes while a person is talking to you. Listen carefully, remember what you can, and **write your notes later.** Always be honest and open about the purpose of your visit.
6. Look for ways of making the survey a learning, exploring experience for those being questioned. Try to ask questions that not only seek information, but that also get people thinking and looking at things in new ways.

   For example, instead of simply asking, "How many people in your family can read?" follow up by asking, "What good is it to know how to read and write?" "Does the school here teach your children what they most need to know?" "If not, who does?" (For more ideas about this type of question, see *Where There Is No Doctor,* p. w10 and w11.)
7. Observe people carefully. You can find out as much by watching the way people act and do things as you can by asking questions. Learn to look and listen.
8. **Go slowly when giving people advice,** especially when it concerns their attitudes and habits. It is often better to tell a story about how others solved a similar problem by trying a new way. And **set a good example yourself.**

Note: Where official records of births and deaths are fairly accurate, these can also provide important health information without bothering people in their homes. It is a good idea to compare the *deaths in children under five* with *total deaths.* For example, in one area of the Philippines, a rise in children's deaths from 35% to 70% of total deaths between 1975 and 1980 shows that conditions affecting health are getting worse!

Health indicators

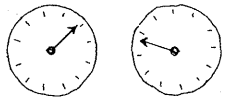


Health indicators are key facts or events that give an idea of the overall **level of health** in a community. Usually things that can be measured are chosen as indicators (see the list below). Measurable or 'numerical' indicators make comparisons and reporting easier, and they appear more accurate. But when only measurable indicators are used, there is a danger of giving too little importance to human factors that are difficult or impossible to measure.

This is a mistake made by many programs—especially large ones. For example, the success of family planning programs is often measured by indicators like: "How many new couples are recruited each month?" But such indicators ignore important human factors like: "To what extent are women pressured into accepting family planning?" or "How do people feel about programs that put more emphasis on birth control than on other aspects of health care?" Failure to consider these less measurable human indicators has resulted in some huge programs and development agencies being thrown out of countries.

In planning or evaluating community activities, it is important that health workers learn to look at the less measurable human indicators as well as the standard measurable ones.

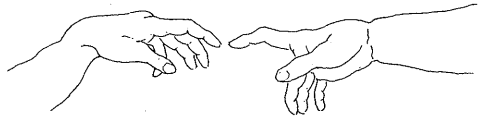
Here is a list of some measurable and non-measurable health indicators. Add to it from your own experience.



Commonly used MEASURABLE INDICATORS of community health

Number or percent of:

- infant deaths
- deaths of children under 5, of adults, etc.
- well nourished or poorly nourished children
- children and pregnant women vaccinated
- children per family (family size)
- couples who plan their families
- families with piped water, latrines, etc.
- attendance at under-fives program
- cases of specific diseases



Less measurable, more HUMAN INDICATORS of community well-being

- attitudes of the people about themselves
- movement toward dependency or self-reliance
- examples of families helping each other (or fighting)
- how community decisions are made
- how well education relates to community needs
- fairness or corruptness of leaders
- extent to which leaders, health workers, and teachers serve as good role models, share their knowledge, and treat others as equals
- social awareness; ability of the poor to express and analyze their needs

COMMUNITY DYNAMICS AND PARTICIPATION

To do their work effectively, health workers need to be aware of many aspects of community life: people's customs, beliefs, health problems, and special abilities. But above all, they need to **understand the community power structure:** the ways in which different persons relate to, help, and harm each other. In the rest of this chapter we explore these aspects of ***community dynamics*** and what is meant by ***community participation.*** As we shall see, 'community' and 'participation' mean dangerously different things to different persons. In fact, the way we look at 'community' can strongly affect our approach to 'participation'.

It is essential that instructors and health workers together analyze the conflicting ideas, and draw conclusions based on their own experience.

What is a community?

Many health planners think of a community as "a group of people living in a certain area (such as a village) who have common interests and live in a similar way." In this view, emphasis is placed on what people have in common. Relationships between members of a community are seen as basically agreeable, or harmonious.

But in real life, **persons living in the same village or neighborhood do not always share the same interests or get along well with one another.** Some may lend money or grain on unfair terms. Others may have to borrow or beg. Some children may go to school. Other children may have to work or stay home to watch their younger sisters and brothers while their mothers work. Some persons may eat too much. Others may go hungry. Some may speak loudly in village meetings. Others may fear to open their mouths. Some give orders. Others follow orders. Some have power, influence, and self-confidence. Others have little or none.

In a community, **even those who are poorest and have the least power are often divided among themselves.** Some defend the interests of those in power, in exchange for favors. Others survive by cheating and stealing. Some quietly accept their fate. And some join with others to defend their rights when they are threatened. Some families fight, feud, or refuse to speak to each other—sometimes for years. Others help each other, work together, and share in times of need. Many families do all these things at once.

> Most communities are not ***homogeneous*** (everybody the same). Often **a community is a small, local reflection of the larger society or country in which it exists.** It will have similar differences between the weak and the strong, similar patterns of justice and injustice, similar problems and power struggles. The idea that people will work well together simply because they live together is a myth!

Elements of harmony and shared interest exist in all communities, but so do elements of conflict. Both have a big effect on people's health and well-being. Both must be faced by the health worker who wishes to help the weak grow stronger.

What is participation?

Two views have developed about people's participation in health:*

In the first, more conventional view, planners see participation as **a way to improve the delivery of standard services.** By getting local people to carry out pre-defined activities, health services can be extended further and will be better accepted.

In the second view, participation is seen as **a process in which the poor work together to overcome problems and gain more control** over their health and their lives.

The first view focuses on shared values and cooperation between persons at all levels of society. It assumes that **common interests** are the basis of community dynamics—that if everyone works together and cooperates with the health authorities, people's health will improve.

The second view recognizes **conflicts of interest** both inside and outside the community. It sees these conflicts as an important influence on people's health. It does not deny the value of people organizing and cooperating to solve common problems. But it realizes that different persons and social groups have different economic and political positions. Too much emphasis on common interests may prevent people from recognizing and working to resolve the conflicting interests underlying the social causes of poor health. This second view would suggest that:

Any community program should start by identifying the main conflicts of interest within the community.

It is also important to identify conflicts with forces outside the community and look at the way these relate to conflicts inside the community.

Which view of participation is taken by planners or program leaders will depend largely on what they believe is the cause of poverty and poor health:

Some believe that poverty results from the personal shortages or shortcomings of the poor. Therefore, their program's goal is to **change people to function more effectively in society.** They think that if the poor are provided with more services, greater benefits, and better habits, their standard of living will become healthier. The more the people accept and participate in this process, the better.

Others believe that poverty results from a social and economic system that favors the strong at the expense of the weak. Only by gaining political power can the poor face the wealthy as equals and act to change the rules that determine their well-being. Programs with this view work to **change society to more effectively meet the people's needs.** For this change to take place, people's participation is essential—but on their terms.

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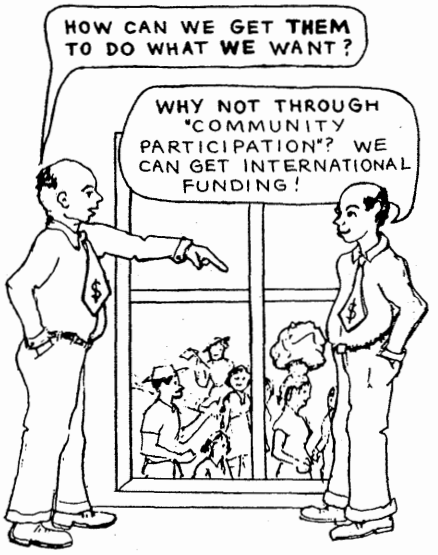
*Many of these ideas are taken from "On the Limitations of Community Health Programmes," by Marin das Merces G. Somarriba, reprinted in ***CONTACT—Special Series #3, Health: The Human Factor,*** Christian Medical Commission, June, 1980.

If we look at different health and development projects, we can see that their approaches to community participation range between two opposites:

Participation
as a way
to control people



Participation
as a way for
people to gain control

Between these two opposites there are many intermediate stages. These vary according to . . .

(1) who really does the participating,

(2) the function of the participation, and

(3) the center of power.

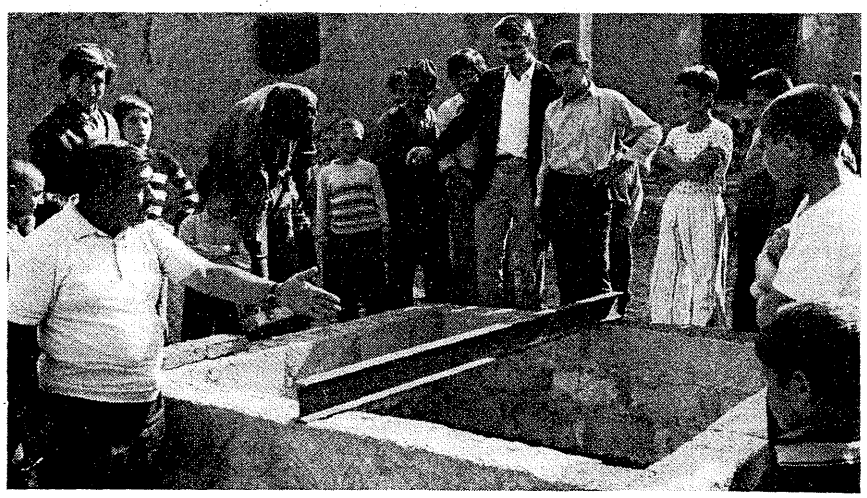
We can get an idea of the degree to which participation is controlled by those at the top (the upper class) or by those on the bottom (the poor) by looking at the program's community-level participants—health workers, committee members, and others. We can ask:

- How were these community representatives selected?
- What is their social background? How wealthy are their families compared to the rest of the community?
- What are their links to those in positions of power or authority, both inside and outside the community?
- How physically big, fat, or well dressed are they compared to most of the people in the village or community?

Often it is easy to observe (even from photos or films) whether community participation is controlled by those on top or by the poor.

Look at the two photos below and ask yourself:

- Who is taking the lead?
- In what ways does that person look similar to or different from the rest of the people?
- Are the poor taking part actively or passively? (Are they working, having discussions, or just listening?)
- How do the building materials used for the project compare with those used for the people's homes?



(Photo: D. Derias/WHO.)

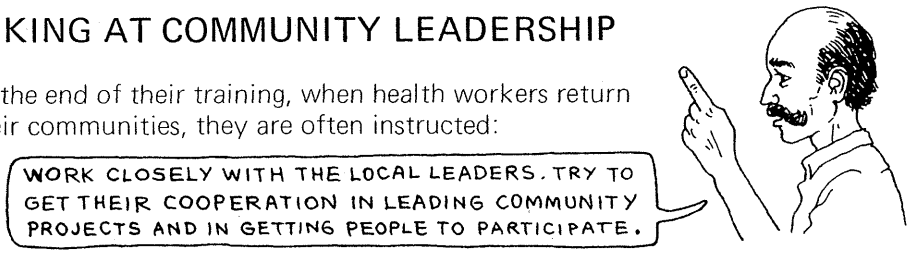
In an Iranian village, a health worker gives instructions on how to cover a well to protect water from contamination.

(Photo: Salgado/Christian Aid.)

Families do weekend work in a low-cost housing reconstruction project at Sakerty, on the fringe of Guatemala City.

LOOKING AT COMMUNITY LEADERSHIP

At the end of their training, when health workers return to their communities, they are often instructed:

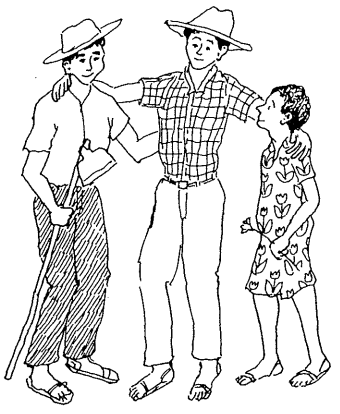


But which community leaders should health workers try to work with? Villages and neighborhoods usually have many kinds of leaders, including:

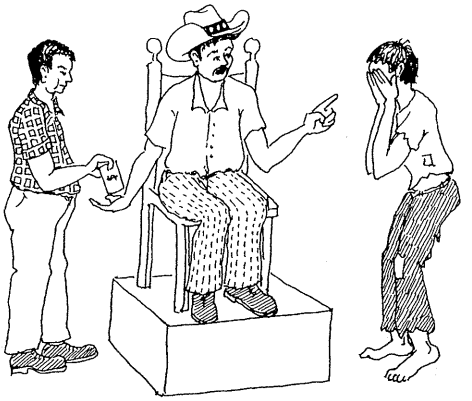
- local authorities (headmen, etc.)
- officials sent or appointed from the outside
- religious leaders
- traditional healers
- school teachers
- extension workers
- club, group, union, or cooperative leaders
- women's leaders
- children's and young people's leaders
- committees (health committee or local school committee)
- those who have powerful influence because of property or wealth
- opinion leaders among the poor
- opinion leaders of the rich

In nearly all communities there are some leaders whose first concern is for the people. But there may be others whose main concern is for themselves and their families and friends—often at the expense of the others in the community.

Some leaders are humble and fair.



Others are conceited and corrupt.



It is essential that health workers learn to identify and work with those leaders who share and defend the interests of the poor.

Too often, training programs (especially government ones) fail to advise health workers to look critically at leadership. They simply tell health workers to "work closely with the local authorities."

If the local authorities are honest and try to deal fairly with everyone in the community, all is well. But when the interests of those in power conflict with the interests of the poor, the health worker is faced with some difficult decisions. Unless his training prepares him for these, he may be at a loss. There is little doubt that . . .

Corruption of local authorities, together with the frustration of health workers required to work with them, helps explain the lack of effectiveness of many health projects.

But frustration can be transformed, at least partly, into a challenge—if the health workers' training prepares them for it. Such preparation is of key importance in regions where corrupt leadership is common.

Learning to identify and work with leaders of the poor

You can start by having the group of health workers list the different types of leaders in their own villages or communities. Be sure they **include unofficial 'opinion leaders'** as well as local authorities.

Encourage the students to discuss each leader, using questions like these:

- How was this leader chosen, and by whom?
- Does this leader fairly represent the interests of everyone in the community?
- If not, for whom does he play favors?
- From whom does he take orders or advice?
- What has this leader done to benefit the village? To harm it? Who benefits or is harmed most?
- In what ways do the actions or decisions of this leader affect people's health?

Next try to get the group thinking about:

- Which leaders should we try to work with? In what ways?
- Should we include unfair leaders in our community health projects? If so, what might happen? If not, what might happen? If we do (or do not) include them, what precautions should we take?
- If local leaders do not fairly represent the poor, what should we do?
  - Keep quiet and stay out of trouble?
  - Protest openly? (What would happen if we did?)
  - Help people become more aware of the problems that exist and their own capacity to do something about them? If so, how? (See Chapter 26.)
  - What else might we do?

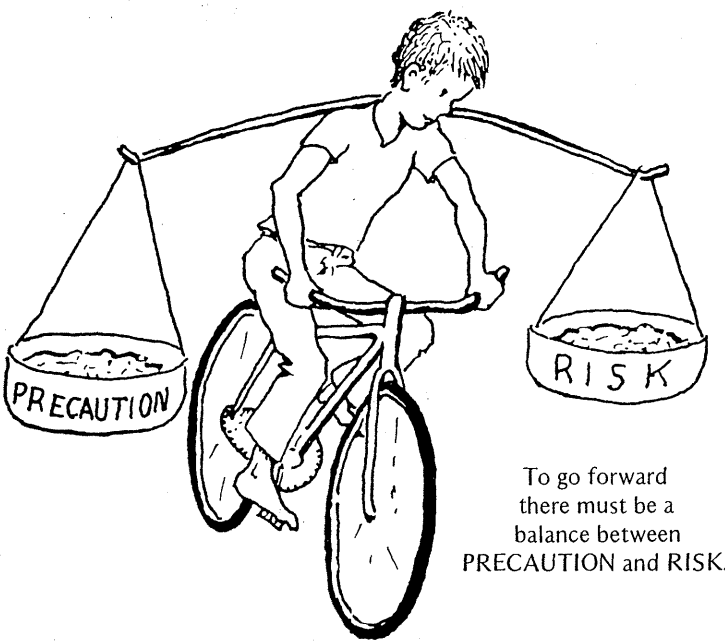
At first some students may find it difficult to look at these questions. Their thoughts may be deeply buried—especially if they come from families that have been taught to accept their situation and keep silent.

Other students may be eager to question established authority and work for fairer leadership. But they may be unaware of some of the problems that can arise. Caution is as essential as courage. To help get health workers thinking about both the possible courses of action and the difficulties that could arise, you might:

- Invite experienced health workers to talk with the group about their own successes and disappointments in working with different community leaders.
- Tell or read stories of experiences from other, but similar, areas. (The three stories on the next pages, about village water systems in different parts of the world, are examples. See also p. **26**-3 and **26**-36.)
- Use role playing to explore problems and possibilities in dealing with different leaders. (See Chapter 14, and also the Village Theater Show on p. **27**-19.)

It is important for health workers to remember that no leader is all good or all bad. One of their biggest challenges is to help bring out the best in any leaders they may work with.

WARNING: It is very important for people's health that health workers help the community look critically at local leadership. But it is important to the health workers' health that they do this with due caution and judgement. Both instructors and health workers need to weigh carefully the possible benefits and risks in their particular situation.



To go forward there must be a balance between PRECAUTION and RISK.

THREE STORIES ABOUT VILLAGE WATER SYSTEMS—for helping health workers look at questions of leadership and power structure

Should the strong help the weak, or the weak help each other—or both? Ideally, perhaps, the answer to this question is "both." The strong should help the weak to help each other. In some places this happens. Here is an example from Indonesia:*

"In the village of Losari, in Central Java, the people were helped by an outside volunteer agency (Oxfam) and an 'intermediate technology' agency (Yayasan Dian Desa) to put in a piped water supply. Looking ahead to the time when the pipes would rust, but outside assistance might no longer be available, a plan was made to raise money for eventually replacing the pipe. Each family along the water line has planted ten mahogany trees. In 15 or 20 years' time, these trees will be cut down and sold to raise money to replace the steel pipes.

"The village headman bought the mahogany seeds from the Agricultural Service and planted them on unused patches of his own land. After 12 months, he gave seedlings to the 85 families living near the water supply.

"If any young trees die, the people can ask the headman for replacements. He makes no charge for the seedlings and asks only that the people look after their trees well."

This is a good example of the strong helping the weak to help themselves. Outside funding and technology, together with the good will of the village headman, made this self-help community project possible. The project has double importance. It not only helps the people in the village to become more self-reliant through cooperative activity, but it also helps them to look ahead and actively plan for the future. What is more, it encourages the strong to share their resources with the weak. In this case the headman, who has more money and land than his neighbors, contributed some of each to benefit the project and the community.

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*From the Indonesian Village Health Newsletter, ***Vibro,*** No. 22, p. 11, December, 1979.

Unfortunately, such harmony of interest between the strong and the weak does not always exist. Here is another example of an attempt by villagers to create their own water system:

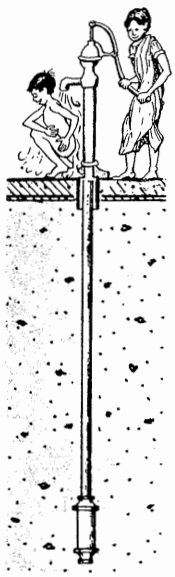
In the mountains of western Mexico, a village of 850 people decided to put in its own piped water supply. After considerable pressure from outside change agents, the richer landholders finally agreed that each family in the village should contribute to the costs in proportion to its wealth. Then one of the landholders, who is also ***cacique*** (headman), volunteered to be treasurer for the water program. Soon he took complete control. He arranged for water to be piped into the homes of the few big landholders before the public water supply was extended to the poorest parts of town. Then the ***cacique*** began to charge so much for the use of public taps that the poor could not afford to pay. So he turned off the public taps. The result was that the water system, built largely with the labor of the poor, was controlled and used exclusively by the rich.

Unfortunately, situations like this exist in many parts of the world. Too often the strong within a village or community offer to help with development projects, and then take complete control or turn the benefits to their own advantage.

The lesson from such examples is clear:

Any program that would help the weak gain power must carefully consider how much help to accept from the strong, and under what conditions.

Some community-based projects have found that extra contributions, leadership, or even any participation at all by headmen or landholders should be avoided. An example comes from the Gonoshasthaya Kendra Project in Bangladesh. Their ***Progress Report*** (August, 1980) states:



"In liaison with UNICEF, the government has given hand-pump tubewells to many villages. However, the majority have been situated on the rich men's property, resulting in limitation of their use . . .

"In our program, one tubewell is to serve 15 to 25 families (none of these having either private or government tubewells on their homesteads). The tubewell is donated by UNICEF, but the digging and platform expenses are borne by the families whom the well will serve. A committee made up of the various family members is responsible for seeing that 100 taka (local money) is deposited in either the bank or post office for the maintenance of the tubewell. All who use the tubewell must contribute equally to this fund. Otherwise, we are likely to run into the same system we are trying to overcome, of one (rich) person bearing the expenses and thus holding the power over who can use the water supply."

As we can see from these three examples, **each community has its own special conditions.** In the first village, participation based on harmony of interests succeeded. In the second, it failed. In the third, people learned (the hard way) of the need to actively deal with the conflict of interest between the weak and the strong.

What can be learned from these three examples? Discuss them with fellow instructors or health workers. Your conclusions may or may not be similar to ours:

1. **Each community needs to find its own solutions to its own problems. There are no easy or 'universal' answers that can be brought in from outside.**
2. **Human factors (more than technical ones) are what make community activities fail or succeed.**
3. **To serve those whose needs are greatest, community programs must make every effort to help the weak gain and keep control. (Sometimes this may mean refusing or limiting assistance from those in positions of power—whether inside or outside the community.)***
4. **To be healthy is to be self-reliant.**

*This is not an argument against government at any level. Rather it is an argument for sensible, flexible self-government at all levels—by individuals, by families, by communities, by nations, and by humankind. It is an argument for small, humane governmental units managed for and by the people. It is an argument for government that genuinely serves people rather than controls them; for government in which the weak are not only treated as human and as equals, but are fairly represented. Whether such government is possible, the world has yet to discover. But surely, the health of humankind rests on this.