

Involving Communities in Public Health Practice

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Good health, as the Buddhist teachings emphasize, is the greatest blessing a person or community enjoys; however, it cannot be experienced without effort. In other words, this status has to be achieved by both individual and community endeavors.

Sarvodaya Shramadana Movement, Sri Lanka's largest, voluntary, non-governmental, development organization, subscribes to this belief—that good health is achieved through intense effort. The objective of the Sarvodaya view of life is health in mind and body. It depends on the individual and community – the psychological, social and physical worlds of a person. It binds human beings to each other, humans to flora and fauna, and humans to the very world in which they live. Sarvodaya, in its development strategy, adopts this holistic view of health.

Health Challenges in Sri Lanka

Compared to other countries in South-East Asia, Sri Lanka has made impressive gains in health status, considering the country's low per capita income. National health indicators, such as the maternal mortality rate (about 24 per 100,000 live births), infant mortality rate (about 16 per 1000 live births), crude death rate (6.5 per 1000 population), and life expectancy at birth (74 years) have all shown consistent and commendable improvement in the last three decades.

Today, however, the health care and social services systems, which contributed towards this unique achievement of "good health at low-cost", is tremendously strained. Many longstanding health problems, such as infectious diseases, still remain, and demographic and lifestyle changes have caused new problems and challenges. Preven-

tive care and service delivery systems are breaking down in the northern and eastern areas, where more than three million people are entangled in the crossfire of a separatist war. In other areas, the socioeconomic consequences of the war have stressed existing infrastructures. Further, migrant work forces; a rapidly aging population (fastest in Asia); multiple costs due to increasing use of tobacco, alcohol, and illicit drugs; and a high suicide rate have tested the "model" health system of Asia. Alarming trends, such as trade unionism in the health sector, involving frequent work halts and strike action by doctors, nurses, and paramedical staff have raised ethical issues. Further, deprived families are affected by the politics of market-oriented development and globalization trends. The advanced technology of private sectors is expanding, while state health sectors are deteriorating. The World Bank has influenced health reforms, and cost recovery concepts are being introduced to health planners, but ordinary citizens have minimal voice for influencing the type of health care they receive.

Organizing Community Participation for Health Development: The Sarvodaya Experience

Sarvodaya believes that poor health can be alleviated with fundamental social changes to eradicate poverty and powerlessness among poor communities. Community health activities are, therefore, integrated into Sarvodaya's other village development activities.

To achieve its mission, Sarvodaya has, over the years, developed multiple programs based on its extensive field experience. Sarvodaya has postulated a five stage process of village community development, as follows.

The first stage concerns *psychological infrastructure building*, beginning simply with a village-level discussion about local needs and an organization of self-help activities. Villages enter the second stage of *social infrastructure building* when citizens have formed one or more community groups of farmers, mothers, children, youth, and elders. The third stage of the process is very critical: the village is organized so that the *basic and secondary needs* of its inhabitants are satisfied. In addition, the Sarvodaya village groups meet and are institutionalized as a legally incorporated body (the Sarvodaya Shramadana Society). This body is entitled to open its own bank account, obtain loans, and initiate economic activities, with support from district and national level Sarvodaya structures. Villages in the fourth stage are expected to become *financially independent* in their Sarvodaya activities; then, they *assist neighbouring villages* in the fifth stage. As village communities progress through these stages, three prevailing principles of self-reliance, community participation, and planned action are observed. Every village community, with assistance, develops into a legally incorporated village society. Then, clusters of ten villages are composed, with two to four clusters forming a division. Finally, ten to fifteen divisions, which make up a district, are all encouraged to build themselves into legally incorporated entities.

The communities that participate in this development process acquire a better understanding of the multiple forces and circumstances which have inhibited their development efforts and gain increasing confidence and skills for self-sufficiency. With Sarvodaya, the community makes the decisions. Sarvodaya's role is to enhance the quality of community-level decision making and to facilitate the implementation of the decisions in various ways, including training village-level functional leaders and providing technical and financial assistance.

By using this integrated strategy, Sarvodaya programs effectively address issues, such as child trauma, child labor, child abuse and sexual exploitation, community-based rehabilitation (CBR), nutrition, early childhood development, water supply and sanitation, reproductive health, STD/HIV/AIDS, and substance abuse.

Sarvodaya Organizational Framework for Community Health

The primary program divisions of Sarvodaya, namely the Social Empowerment Division (SED) and the Sarvodaya Rural Technical Services (SRTS), deal with community health activities. The SED, through its Early Childhood Development Unit (ECDU), initiates community health activities in the village. Usually in the second stage of village development, they establish a preschool/ child development center. These child development services usually begin in a village after the initial *shramadana* phase, in which the village people donate their labor and other resources to satisfy a community need, such as the construction of an access road or a community hall. After this village effort, a mothers' group is formed. The preschool teacher trainees, usually two per village, are selected by this mothers' group. They are given a preliminary two week residential training at one of the Sarvodaya development education institutes, district centers, or at the central headquarters.

After the training course, the preschool teacher returns to her village to open the preschool. According to the latest statistics, there are approximately four thousand preschools served by over six thousand trained preschool teachers who work as either volunteers or employees of their community. Despite the shortage of resources available for the preschool, they are extremely popular because of the following services they provide.

Preschools are secure environments where village mothers can leave their children and go to work. The children enjoy being at the preschool because they can interact with other toddlers, rather than being alone at home or with their grandparents. Secondly, the preschool becomes a "nutrition center," where the mid-day meal, prepared with the most nutritious locally available leafy vegetables, is served. Each preschool child contributes to this meal by bringing everyday a matchbox filled with rice, which is emptied into a pot and is used in the meal. In some villages, a community kitchen is contained in the preschool, and school children, pregnant women, and lactating mothers also receive a mid-day meal.

The preschool teacher monitors the growth of all pre-school children. Regular maternal and child health clinics are conducted, after consulting government health workers, with whom the preschool teacher maintains a close relationship. Also, medical examinations, immunizations, and treatments are performed by these government health workers. The preschool teacher also motivates mothers by increasing their awareness of health issues. Sarvodaya is successfully bridging the existing gap between communities that are often remote and ill-informed and government health services, to help the latter become more responsive to community needs.

In this stage, the village will have other persons in the village trained by Sarvodaya for various other community development activities, such as *shanthisena* (discussed below). Also the village will have seen the emergence of the village Sarvodaya Shramadana Society, a legally independent body that has the primary responsibility for self-help development activities in the village.

Once it is registered as a legal entity, the village society can own land, buildings, vehicles, and equipment and receive loans and grants from any external agency, other than Sarvodaya itself. At this stage, the village receives supplementary technical and financial support from Sarvodaya for a critical area of community health, water supply and sanitation. This support is organized to help strengthen the village's self-reliance and self-confidence. All critical decisions, such as the technology choices, service levels, and facility locations, are made by the community, in addition to decisions concerning financial, material, and labor contributions.

Village savings and credit programs are initiated at this stage, as the foundation for strengthening the economic base of the village, an important determinant for sustaining a healthy community. The Sarvodaya Rural Enterprises Program (REP) assists the village society in developing the capacity to organize savings and credit plans and to manage economic activities. The economic subcommittee of the village society has the primary responsibility for managing economic activities, such as primary credit approval, recommendations for rescheduling, and actions against defaulters.

While working towards eradicating the fundamental causes of poor health and sustaining long-term health gains, Sarvodaya cannot overlook the disease and suffering that already exist in a community. Therefore, wherever feasible, it has promoted provision of basic medical services to under-served communities, including the following:

- Organizing regular medical clinics through volunteer doctors, nurses, and physical therapists
- Providing logistical support to government medical personnel to maintain and operate their regular clinics
- Assisting rural hospitals in underprivileged areas to upgrade their facilities
- Providing limited stocks of essential medicines and equipment through local and foreign donations
- Establishing village-level health posts (*suwadana* centers) operated by trained *shantisena* volunteers (see below)

Sarvodaya also has several independent national units with programs related to health. The *Swasetha Sewa Society Ltd.*, performs welfare work, earlier operated by the main organization, and, at present, maintains homes for malnourished or destitute children, the disabled, and the aged. It also manages the community-based rehabilitation programs (CBR) for the physically disabled and the blind in selected districts, and operates a school for children with auditory disabilities.

Providing specialized services for all Sarvodaya programs, the Community Health and Environment Unit is served by a team consisting of a full-time registered medical practitioner, a physical therapist, and two nursing assistants, supervised by a volunteer medical doctor trained in public health. The services include the provision of a medical clinic for the full-time staff, medical services during emergencies and disasters, medical clinics in refugee camps, ambulance services, a physical therapy clinic, and dental health services. The Community Health Division also manages a special project for AIDS prevention and control.

The *Sarvodaya Shanthi Sena Services* (Peace Brigades) began in response to the need to protect people during intense civil strife in the early 1970's. When tensions diminished, the mobilized youth were trained to undertake general services for the communities, such as providing first aid and disaster relief, assisting in religious festivals and cultural events, visiting hospitals to assist the sick, and participating in environmental conservation activities. These groups are organized at the village-level in groups of ten members with a leader, with different groups combining for various activities. This village-level work includes the maintenance of mini-health posts and herbal gardens, which are a source of home remedies. The group leaders are organized at divisional and district levels, with over seventy-seven thousand *Shanthi Sena* members presently serving in the country. There is a systematic training program for *Shanthi Sena* members who are already serving in the country, as well as for *Shanti Sena* volunteers. The mini-village health posts, known as *suwadana* (gift-of-health) centers, are operated by these volunteers and are very popular and beneficial. They serve as a focal point to help achieve balance between prevention and cure, as well as for a variety of other village-level community health activities. The *suwadana* center is usually a small room in one of the volunteers' residence and is operated by donations received from the community. Only the initial first aid instruments and medicines are supplied by the LJSSS, following the training of *Shanthi Sena* volunteers. However, due to various constraints, such as extreme poverty in some villages, lack of initial capital to buy the basic instruments and medicines, and lack of proper logistical support, not all Sarvodaya villages have *suwadana* centers. Sarvodaya believes that *suwadana* centers are providing a very valuable service to the community, and that this activity should be expanded to all Sarvodaya villages in Sri Lanka.

To supplement this integrated approach to community health, Sarvodaya has a number of important ancillary activities, such as promoting indigenous medical practices, producing and promoting low-cost, smoke-free, energy-saving kitchen stoves to reduce incidence of acute respiratory infections (ARI), and conducting a program for prevention of drug addiction and alcoholism.

In the 1990's, Sarvodaya has intensified and diversified its activities in community health. New programs, initiated for emerging health problems, have included activities for STD/HIV/AIDS prevention and reproductive health, environmental health, programs addressing psychological trauma of children resulting from exposure to war-related violence, and a new initiative concerning globalization on health.

Finally, while working at the community level, Sarvodaya is also actively involved at the national level. Sarvodaya is represented in many important national bodies in the health sector, including the National AIDS Committee (NAC), National Nutrition Coordinating Committee, and the National Core Group on Primary Health Care Services to the North and East. It also maintains close contacts and collaboration with international organizations, such as the World Health Organization (WHO), UNICEF, UNFPA and United Nations Development Program (UNDP).

Conclusion

Sarvodaya believes that the full value and benefits of community health interventions can only be realized within a much broader socio-economic and political framework. Existing community health programs, in most developing countries, have confronted problems of physical isolation of villages, poor communication, and infrastructure services in many regions. Governments have also recognized difficulties in serving these communities through traditional hierarchical health care structures. Sarvodaya has demonstrated that self-help methods can bridge this gap and health improvements can occur. More comprehensive understanding of community health problems and more active participation of the communities in planning interventions are still significant needs. The most effective approach towards achieving these solutions is to hold community organizations responsible for their own village health programs. The emphasis should, therefore, be placed on the communities to develop partnerships with the government, NGOs, and the private sector, to support their own efforts to improve health care.