COMMUNITY PARTICIPATION

THREE CASE STUDIES

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THREE CASE STUDIES OF COMMUNITY PARTICIPATION

Abstract

The theoretical considerations concerning community participation are discussed. Three cases of community participation in a developed country were evaluated using a method devised by Rifkin (1), and this demonstrated wide participation. The cases have achieved this through different techniques: In one case by taking more direct control of providers, in another by blurring the distinction between providers and the community, and in a third by developing areas of interest outside of the medical model.

INTRODUCTION

The Alma Ata declaration (3) and to some extent the Ottawa declaration (2) called for a change in the orientation of health services to focus on the involvement of the community in their implementation and planning.

The implementation of such a strategy has been subjected to a number of significant restraints. There are widely differing interpretations of the meaning of participation in health care in general, and its importance in health care systems. Furthermore, there is some evidence of
significant limitations as to the form participation can take in a health care system. These include the structural nature of health services, the nature of the power relationships in health services, and continued preoccupation with the provision of medical services.

To gain a better understanding of what these limitations are and how they might be overcome, this study focusses on the experience of community representatives in three innovative primary health care projects. A methodology for describing community participation, developed by Rifkin, is used in conjunction with interviews, group discussion and other materials to develop accounts of the different forms that participation took in each of the cases. The mechanisms through which a degree of participation has been achieved in these projects are then discussed.

The Importance of Participation in Health

Leading up to the declaration of Alma Ata(3), was a period of increasing criticism and disillusionment with orthodox health services(4). Health services had taken the wrong path (See Illich,(5)) and the very meaning of "illness ", "health" and "disease" had been distorted to suit the needs of the medical profession rather than the needs of patients. The health denying
effects of medicine and its organisation had been identified, as well as the phenomenon of doctor-induced disease. The direction of health services was seen to reflect the interests and concerns of clinicians and managers, (see Alford(6)) but not the communities they were supposed to serve. More recent trends towards the introduction of for profit criteria have further distorted the direction of health services away from the needs of the communities they are meant to meet. (McKinlay, Navarro)(7).

The growing criticism of western medicine was also evident in developing countries, where it was seen to be even more inappropriate and unlikely to solve the health problems that existed. (8) The Alma Ata declaration itself arose out of the clear failure of traditional medical approaches to improve the health of the people in developing countries. (9)

The response of WHO at Alma Ata to this growing realisation that health care systems were not working, was to call for greater community participation within health care structures. New approaches were sought, in the hope of redressing some of the power imbalances apparent in health care systems, so that the needs of communities' could be better served.
COMMUNITY PARTICIPATION IN PHC IN NEW ZEALAND

Like the rest of the world, community participation is being talked about in New Zealand where a major reorganisation of the public health services is underway. Concern has been expressed (10) (11) that community needs were not well met by the existing system. Doubt has also been expressed as to whether community participation is high on the reform agenda (12). The main strategy being promoted is that of a health planning approach, directed at and from Head Office and Area Health Board level. The primary health care sector is dominated by General Practitioners (13) operating on a fee-for-service basis, with a varying level of government subsidy for a wide range of items. There is a strong community input in the voluntary sector which is mainly organised around specific issues such as asthma or infant health.

There have recently been a number of calls for greater community involvement in primary health care services (14,15) including this statement by a previous Minister of Health:

"The new structure will encourage a much greater co-ordination of our health services, but it will also allow for a far greater degree of community participation in the decision-making process". (16)
There has also been heightened awareness of the need for greater accountability of the medical profession(17), as well as government support for new initiatives in the primary health care area. The Area Health Boards(18) which have been formed to replace hospital boards, have provision to form community committees in their legislation. How these committees will be formed, and their role in the Board's decision making processes has yet to be worked out.

The Maori community is also hoping to participate more actively in all aspects of health services(19) as they attempt to claim some of the rights promised to them in the Treaty of Waitangi.(20)

There is widespread agreement both internationally and in New Zealand that wider participation of the community is desirable in the health sector. However, there is less agreement as to what participation means and how it can be achieved.
DEFINITIONS OF PARTICIPATION

Participation is an elusive concept meaning different things to different people. One way of conceptualising the many forms of participation is on a spectrum from low to high levels of involvement and accountability. (21)(22)

1) Consumer Protection: Insistence on informed consent, professional standards, licensing of medicine and of private sector providers, ethical committees governing research.

2) Public Consultation: Opportunities for public input, consultation with consumers, better marketing approaches.

3) Openness of Managerial Decision-making: transparency in decision making, greater openness and accountability.

4) Full Management Participation by Public Representatives: interactive participation, decisions are seen as a partnership.
5) Heightened Individual and Communal Responsibility and Power: based on a more radical shift in the balance of power towards the individual and the community.

Arnstein (23) developed a definition that focused much more on the power relationships. She saw participation as:

"The redistribution of power that enables the have-nots citizens presently excluded from the political and economic processes, to be deliberately included in the future."

Her analysis saw the levels of participation as rungs on a ladder:

1) Manipulation
2) Therapy
3) Informing
4) Consulting (given a voice but it is not heeded)
5) Placation
6) Partnership (negotiation and bargaining)
7) Delegated power
8) Citizen Control (the 'have-nots' have gained full managerial power.)
Although some of the order is open to question, this
definition has the advantage of placing questions about
the role and degree of participation firmly in the
context of the distribution of political power, but
unfortunately she only considers two contenders, the
providers and the community, as having a stake.

It also addresses the question of who should
participate. Often the assumption is made that
"community" represents a homogeneous single minded group
of people, where as the reality is, that communities
reflect the power imbalances and diversity that is
present in society as a whole. There is a sense in which
community participation in health would almost certainly
reproduce the status quo, as the current arrangements in
health are the result of full participation by powerful
elements in society (including the medical profession).
So to create a new order through participation, one would
need rather more participation from those currently
disenfranchised in the political system, and rather less
participation by those groups that are responsible for
the present order.
This paper looks at community participation in primary health care. Its focus for community is on the 'have nots' or the powerless, and its view of participation centres on power and accountability. So rather than asking the general question, "Is there Community Participation", the focus is "Do the people who are disempowered in the health service have more power in the projects under discussion, and are the powerful made more accountable?"

Participation in Health

Community involvement and participation has, not surprisingly, been subject to a wide range of different interpretations in the health system.

A number of different models of community involvement in health care have been proposed(24)— at one extreme is the public health and the medical model approach where the professionals make all the decisions and the community is involved only under the professional's direction. At the other extreme are the community development and the self-care approaches where participation is seen as a means of creating improved social structures, and self reliance is a primary goal. Between these two extremes is the health planning approach, which sees the involvement of the community as a mechanism for
maximising resources, with effectiveness and efficiency being the primary objective.

The Community development model in suggesting a much more powerful role for the community(25)(26), has not been universally accepted as the logical strategy in implementing primary health care. Much of the activity generated since Alma-Ata has been in the form of "selective health status interventions"(27) which are viewed by many(28) as being in total contradiction with the fundamental principles underlying Primary Health Care. Health care providers have applied some of the technical interventions in primary health care, while ignoring the need for community power.

The Antwerp Manifesto for Primary Health Care spells out clearly how participation is seen as fundamental.

"Since health is only one of the concerns of people, it is self-defeating not to consider them as partners who are able to play a great part in the protection and the improvement of their own health. They thus have to be fully and really involved in the making of decisions which affect their health, including, of course, the provision of health services."(7)
The "selective" approach uses selected primary health care technologies or interventions and applies them. The selection is made by funders, health planners or politicians, often on the basis of their ability to produce a measurable result within a given time frame. It precludes the concept of partnership with the community, and can be viewed as an application of the medical model, but with primary health care technology.

**Participation in Health – Previous Studies**

Klein(29) has written extensively on the role that public participation has played in the National Health service in the United Kingdom. He points to the inherent conflict between consumer participation and the pursuit of equity. "There is an inbuilt tension in the NHS. On the one hand, the real justification of the NHS lies precisely in the fact that it does not respond readily to consumer demands: that it is a device for compelling collective altruism in favour of the least powerful and most vulnerable. On the other hand, it is under increasing pressure to become more responsive. However, the logic of adopting consumer preferences as the guiding principle for the organisation of health care is to abolish the NHS and to replace it by a market system."
Power redistributed on the basis of ability to buy health care will inevitably lead to a more inequitable distribution. The market has proved to be a problematic way of distributing health care resources due to the lack of adequate information, significant externalities, and lack of competition between providers, particularly in a small country(30). However, to propose that need will be the basis of decision making begs the question of who will decide on what needs are important. The NHS has in the past allowed the health professionals to define who's needs are met and how. A community development approach implies that the community collectively would make those decisions, however the necessary structures through which collective decisions are expressed are generally poorly developed. Further more, community decision may not necessarily focus on the needs of the least powerful in the community. Community decision makers may be no more committed to altruism towards the powerless than medical professionals.

Klein restricts the choices to collective altruism in the hands of the professionals, and the market system. A community development approach would envisage collective altruism in the hands of community representatives, and those representatives would need to represent the most powerless groups in the community. A
distinction can be drawn between the definition of community participation, as defined previously, and the term consumer participation that Klein refers to. Consumer participation emphasises the dependency relationship between direct recipients of services and the providing agencies' professionals, and does not concern the broader involvement of community members generally. Focusing on the consumer implies that health is a consumable product rather than seeing health as a state of being, a resource for everyday living. As a consequence it only allows for a much narrower form of participation, where the choice is to consume or not to consume. As the main consumers of medical care are the very young, the very old, and the mentally ill, even that choice about consumption is limited.

What we have is interesting tensions in the move to participation in health. The market as a mechanism is very limited, due to its narrow focus on medical care and the dependency of the majority of the consumers. The NHS solution, of letting the health professionals decide, places big limitations on wider community participation. The community development approach would propose to resolve this dilemma by organising participation according to need, rather than ability to pay. The poor would participate in the power structures so that their
needs are met. However the methods by which these goals could be achieved are not well developed.

More recently, Klein(31) has looked at public accountability in five different public services. He concluded that the subjective sense of accountability of authority members has its roots as much in the social context in which they operate, as in constitutional doctrine. Direct election did not equate with effective practice of accountability, nor was it a sufficient condition for ensuring control. In the study some participants saw themselves as accountable when in fact they also said they did not have control.

The problems of control, according to Klein, reflect service characteristics, the ability of service providers either to appropriate the language of evaluation or to make their activities invisible. (The water authority was the extreme case of having a clearly defined output, and hence lent itself to greater accountability as it had an outcome that was obvious to both the public and the provider.) With health care the outcome of services is seldom easily identified, and the language of its evaluation is rapidly being appropriated by Community Medicine specialists.
The influence that structural arrangements have on allowing differing potential for participation has been further developed by Boaden. He has described the type of public service that would lend itself to a wide degree of participation. It would depend on the:

- selectivity or universality of service
- its importance and sensitivity
- its identification with a particular neighbourhood
- nature of its client and providers.

Because current health care systems are highly professional and most users are in a weak position to assert themselves at the time of use, it can be portrayed as the prototype of a service in which public participation is low, and is likely to remain so.

Fig 1 shows a table taken from Boaden which shows the type of arrangements that hinder or favour participation.

However, taking these criteria and applying them to primary health care alone (as opposed to primary medical care, or medical care generally) and the situation for participation looks to be more hopeful. It is a fundamental service (Level 1 on Maslow's heirachy of human needs), it is universally used and continuing, and it is visible in the community. The client group is all the community members, powerful and powerless, demanding and undemanding, cohesive and fragmented. The nature of
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<th>Hinders Participation</th>
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<td>Nice to have</td>
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<td></td>
<td>Universal</td>
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<td>Nature of Clients</td>
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<td>Nature of Providers</td>
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the provider group is a key variable. They can be both professional and non professional, and are mainly decentralised. Looked at in this way, one can see that a more holistic view of health may allow wider participation. Alternatively a narrow view, restricting health to medical care, may result in a much narrower participation.

Verschure (33) describes a model of care in which he divides primary care givers into three categories, professional care, cover care and self care. See Fig 2. Professional care is dominated by the medical model, cover care is what people do for each other in mutual relationships, and self care is what a person does to maintain and restore his own health. As can be seen from the above discussion, the level of support and activity of each of these levels of care will have an impact on the degree of participation that the system allows. An increase in cover and self care will inevitably mean increased participation. Once again equity issues will be important to consider when there are changes in the level of care. If the move to more cover and self care results in decreased state assistance for communities, the impact may be negative, as the resources available to the poor for these types of care are limited.
Professional Care  "Expert" Care, dominated by medical model, through a service which is paid for, given by people with a specific training.

Cover Care  What people do for each other in mutual relationships - families, friends, neighbours, support groups.

Self-Care  What a person does to maintain and restore his own health.

Verschure's Model of PHC  Fig 2
There are also inherent dangers in the moves to community participation which focus on the democratisation of decision making, as these can lead to a decrease in accountability of the health professionals to the community. In Canada (34,35) the experience of introducing more democracy into the health system at a regional level has resulted in the health professionals taking more decisions outside the public arena. When appointed positions on health authorities were replaced by elected representatives, it had the effect of decreasing the expertise on the authorities and subsequently the professionals then took most of their decisions outside of the authority meetings.

So it is clear that community participation calls for far more than appropriate representation on the appropriate organisational structures. It calls for an analysis of the determinants of power relationships within the health care structure by the participants themselves.

Rifkin on Participation

Rifkin's (36) work on the evaluation of participation provides a mechanism to assist communities to identify those power relationships.
Rifkin puts forward a methodology which defines indicators for participation in health care programmes on a continuum developed for each of five factors that may influence community participation. These factors are: needs assessment, leadership, organisation, resource mobilisation, and management. The five factors were arrived at after an analysis of over 100 case studies (37) of participation in different countries. These indicators focus on the breadth of participation and are not a quantitative measure. The method provides a focus for discussion of the parameters of participation, and may be a useful basis for comparison between different participants. It could also be used within the same programme to compare changes in participation over time. The indicators do not pretend to be a measure of participation in terms of a standard.

It is against this background, with clear identification of the problems within health services, but mixed and at times conflicting interpretations as to how those problems can be addressed, that this paper looks at the actual patterns of participation and their consequences as these have evolved in three innovative New Zealand primary care services.
METHODS.

Participatory vs Empiricist Research.

A Participatory methodology has been chosen for this research, as much of the philosophy in primary health care revolves around the concept of "power sharing" and "enabling".

The dominant model of research, empiricist research, emphasises value neutrality and objectivity, that the researcher controls the entire process and that people are treated as objects of the research. These features are reversed in participatory research. An aim of participatory research is to shift some of the balance of knowledge power. (38)

The common factor in much research is that the "oppressed are identified, measured, dissected and programmed from the outside by the oppressor or the oppressor's representatives. It is the oppressors with the help of their sciences who decide what are the goals of the research and how it will be carried out. The research is done on the oppressed. The problems studied are not the problems of the oppressed". (39)
Knowledge is an important basis of power and control. In participatory research the research problem is often one which the people have identified as something they need to know about: they can see that their position would be strengthened by certain information and they are ready to work with the researcher to gain the findings. Once the knowledge is generated, it belongs to that group and they will decide according to their interests how best that knowledge will be used: it may be acted upon or not; it may be published or not. The researcher plays the role of a facilitator, and contributes any published source material which may be needed, and supplies a theoretical perspective. The analysis is a combined effort.

"The objective of evaluation is not to produce standard statistical data, but to stimulate the educational process whereby the community learns about what influences health and what action can be taken to improve health" (40)

Observer Bias.

The researcher is not an unbiased neutral observer. The researcher in this instance is a general practitioner employed by one of the cases (the Newtown Union Health Service) and had been supportive to one of
the other cases (the Urenui and Districts Emergency and Health Group). This offers the advantage of an intimate knowledge of one of the case studies, but may present a barrier to gaining accurate information. The inaccuracies may arise due to the observer having a strong vested interest in the cases, as well as influencing the way informants response to the observers work role within the system of which they are also a part. The research arose out of a need by the NUHS to further define and facilitate community participation.

Choice of Cases

The three groups involved in this research are:
1) The Newtown Union Health Service Management Committee.
2) The Eketahuna Health Centre Management Committee and Health Action Group.
3) The Urenui and Districts Emergency and Health Group.

These three groups were chosen as they purported to be innovative in their approach to participation in PHC, they had expressed an interest in the research question, and they were geographically close to the researcher. The representative group in each case was chosen as the focus as they are the critical link in terms of accountability and participation. They represent the interface between the community and the professionals,
which is the innovative relationship in Primary Health Care in New Zealand. The links between community representatives and their communities would be equally important, and they are explored by the participants in Rifkin's model.

Research Procedure

Each of the three groups were contacted by letter explaining the purpose of the study and requesting their permission to proceed. A meeting was then held with each of the groups, and the following format was used. A history of the key features in the development of the group was taken, as well as the demographic characteristics of participants. (similar to questions posed in ref (41)) age, sex, ethnicity, socio economic status, (42) and affiliation or relationship (elected or appointed) with the management committee, and relationship with community groups. A list of questions around each variable put forward by Rifkin (43) was presented, in both verbal and written form. The five variables were:
1) Needs Assessment.
2) Leadership.
3) Organisation.
4) Resource Mobilisation.
5) Management.

Rifkin has expanded these indicators with a list of questions around each topic. See Appendix 1. These were modified to conform to the organisational arrangements that existed in the three cases. See Appendix 2, 3, 4.

For each of the five factors, Rifkin develops a continuum with wide participation (community people plan, implement and evaluate the programme using professionals as resources) at one end and narrow participation (professionals take all the decisions, no lay participation) at the other. She then divides the continuum into a series of points and places a mark at the point which most closely describes participation in the health programme being assessed. Upon this basis she defines process indicators for participation in health care programmes as the width of participation on the continuum of each of these factors. When a mark has been placed on the continuum, these marks can be connected in a spoke configuration which brings them together at the base where participation is most narrow. See Fig 3 for an example of narrow participation. The
Fig. 3. Narrow Participation.
difference between the baseline and other assessments will show what movement has taken place and whether it is great or small. As participation becomes broader, the links which cross the sections, fan out and widen. Fig 4 is an example where a base line has been done, then another assessment at a later time (or by different assessors) can be seen, that has wide participation.

Annual reports of the groups were studied as well as minutes of key meetings. Staff members were also interviewed where appropriate, as were other key personnel. The information contained in the two formal evaluations of two of the cases were also used extensively. (44,45)

The results were then compiled and submitted back to the participants for their comments. In discussion the participants were encouraged to indicate ways in which they felt the research could be used, and this resulted in a desire by all the groups to meet together.
Urenui district is in a remote rural area on the east coast of the North Island of New Zealand. It has a population of approximately 1500, 82% pakeha and 18% maori. It has a main highway that passes from one end of the district to the other. Urenui is divided into a number of valleys which sub-divide the community into distinct geographical groups.

In the early 1980's one of the local women became concerned by the fact that victims of road accidents were left lying on the side of the road for up to one hour and a half hours before help would arrive. She expressed her concerns with another woman in the district, and they requested help from the local ambulance association, but it was turned down.

This concern surfaced again at a meeting in 1986 which was called by a public health nurse from the local health authority. The local health authority was under the impression that there were one or two people living in the remote parts of the district with a nursing background. In fact 13 women with a background in nursing attended the meeting. Concerns about the road
crash victims were raised as being a top priority, so the PHN arranged for the women to have a two day training day in first aid to upgrade their skills, as many had been out of nursing work for up to 20 years.

As result of these early meetings a steering committee of six was formed, and they organised a public meeting in May of 1987. This meeting was attended by 50 people representing all sectors of the community, and each geographical area elected a person on to a management committee. The committee comprised a mixture of 'nurse' and other community members. (At about this time the provincial hospital board had been running full page advertisements in the local paper to attract people to a meeting to discuss 'community committees' - five people attended).

With this organisational base established, rapid progress was made. The 'nurses' realised, once they got together, that their communities had been using their skills all along when health matters arose, but prior to this, they had all operated in isolation. They first organised an emergency roster and equipped each area with equipment necessary to assist at road trauma cases. They then became a recognised part of the emergency services, and a group member was notified as soon as an
hit, like the rest of rural New Zealand, by a severe downturn in the rural economy, leading to depopulation of rural areas and the disappearance of infrastructural supports such as sale yards.

Participation (See Fig5)

1) Needs Assessment

The health needs of the community were assessed at the annual general meeting, where they hold a number of 'buzz' groups. Further to this, the group members were also members of a variety of other organisations, such as the playcentre movement and Te Roopu Whitiora, and this allowed them to canvas a wide range of opinion. The group felt that all the people who used the service were involved in deciding on what needs were met, and scored 5 on Rifkin's scale.

2) Leadership

The group felt that all the different groups in the community are represented in the UDEHG and they all have a say in the appointment and the actions of the leaders.

3) Organisation

The group felt that the organisation is very flexible in the way it meets its goals, involving a wide
Fig. 5
section of the community, and many non-professionals. The majority of the committee members are women (16 of 18), and 2 of 18 are maori. 4 out of 18 were currently employed in nursing work, but most had worked as a nurse at some stage. Some members had not been involved in nursing for a number of years, and did not use their nursing skills.

A key point in their perception of community participation was that the members of the group saw themselves as typical community members, and not as professional nurses. The desire not to be seen as health 'professionals' was widely shared in the group. They felt that being seen as "professional" would detract from their role and be detrimental to their work in the community.

The growth of the organisation in response to a defined and widely felt need, (the provision of emergency care) was seen as a strength in their subsequent growth and the trust that the community placed in them.

4) Resource Mobilisation.

Resources were noted to come mainly from within the community, and concern was expressed by the group that this may let the Area Health Board 'off the hook'.
Financial resources were seen to represent only a small proportion of the resources used. The nurse practitioner who ran the clinic received a salary, but the other group members received only expenses and not wages for the work that they did. A formal economic evaluation is beyond the scope of this paper, however it is clear that the groups formation has not been accompanied by any increased funding commitment by the Area Health Board. In fact as the group has taken over the functions of public health and district nurses, the vote health input may have decreased. The community contribution to funding in terms of fee for service and donations is small, (See Fig 6), with a major contribution now coming from outside of the health sector(56%). This is in the form of grants from Lotteries, and COGS, and the group had spent a considerable amount of time and energy making applications for these funds. Grant money needs to be applied for annually, so they do not have a sense of financial security.

5) Management.

Once again the blurring of the distinction between providers and the community meant that they perceived wide participation in the area of decision making in the area of planning and implementation. No formal evaluation had been carried out on the project, so
U.D.E.H.G. FUNDING (%) 

Community Contribution
- Grants 98.8
- Community 1.2

Vote Health
- 43%

Non Health Grants
- Community 1.2
- 56%

Fig 6 From Annual Report 1989
perception of participation in this area of activity was hard to judge.
CASE STUDY 2  NEWTOWN UNION HEALTH SERVICE

The service is based in urban Wellington in an area that is accessible to people of lower socio-economic groups (48) close to a major public hospital and bus routes.

Attempts had been made over a ten year period to provide an easily accessible primary health care service in Newtown, and although these had been unsuccessful, the suburb had a functioning community health group. In August 1986 the Hotel and Hospital Workers Union ran a survey through their newspaper to determine the health concerns of members. This showed that a major concern was the cost barrier of attending general practitioners, as the cost of a ten minute appointment often exceeded what a worker would receive from working a four hour shift. Also at this time, the government set aside a sum of money to fund new initiatives in the primary health care field.

In 1986 these three groups, the government, the unions and the health care association, met together and a steering committee was formed that established the service in May of 1987.
Current Activities

The service has 4954 members. It is run by a management committee which has representatives from patients, unions and staff. The union members are appointed by union organisations, the staff members are elected by the staff, and the patient representatives are either elected at the annual general meeting or co-opted onto the committee by the existing members. See Fig 7. It employs three full time doctors and three full time nurses and three administrative staff and provides primary medical care as well as facilitating self care groups (new mothers support group, asthma support) and provides out-reach services to groups with special needs. It also works with unions in the area of health promotion.

Participation (See Fig8)

Using Rifkin's method the breadth of participation is presented in Fig8. The union service had a significant and clearly identifiable group of providers (a doctor, a nurse, and a manager) on the management committee. There was a difference in the perception of participation by the community between the providers and the community representatives. See fig9. The community representatives perceived wider participation than the providers on the management group.
Fig. 8
1) Needs Assessment

Leading up to the AGM each year, members of the management committee attend smaller meetings of patients who use the service. These meetings are conducted away from the health centre, at places of work or in blocks of flats where groups of patients live. Ideas from these meetings are then taken back from to the management committee. The concept of participating in the implementation and planning of primary health care services was a very new idea and experience for some members, and they saw this as a major barrier to people becoming more involved. Some members felt that the employed staff were more receptive to the idea of ordinary people being involved than people from the community themselves were, however one member felt that the needs of the service (the providers) would often over-ride the needs of the community. The over-all impression was that the management committee was primarily involved in deciding what needs are met.

2) Leadership

The committee felt that the leaders carried out the decisions of the management committee. Some members had difficulty identifying a leader, and others did not know
how leaders were chosen. Most identified a leader from among the service providers, usually the manager.

Organisation

The NUHS is a new organisation formed for the purpose of running the health service. Community members played a significant role in staff selection, and in running self-help groups, such as a new mothers group.

Resource Mobilisation

Funding comes both directly from patients in the form of fees for services and a variety of vote health sources. See fig 10. The vote health funds come through subsidies that are payable only to general practitioners, such as a capitation payment and salaries for nurses. The accident compensation payments are also only payable to doctors. The bulk of the expenditure is on professional and support staff services.

Resources in general, were seen to come from both the community and outside of it. One member felt that financial resources tended to be over-emphasized and not enough priority was placed on releasing the ordinary resources that people had. Members felt particularly constrained by the amount of time that they were able to contribute to the service.
N.U.H.S. FUNDING (%)
Management

Participation was felt to be narrower for management than the other factors discussed. Community members felt they were well informed of major events, but not always involved in important decisions. The ethnic mix in the service as a whole and in the management committee is presented in Fig 11. Women make up 78% of the committee.
NUHS WHOLE Population

- Caucasian: 44%
- Maori: 20%
- Pacific Is: 23%
- Other: 10%
- Vietnam/Kamp.: 3%

MANAGEMENT Committee

- Caucasian: 50%
- Maori: 40%
- Pacific Is: 10%

Fig 11

Ref. Annual Report
Community involvement in the planning and implementation of primary health care was an almost inevitable step given the unique history of this small community. Eketahuna is situated in the northern Wairarapa. It consists of a small town of 630 inhabitants and a rural population of 1,305. (50) The Eketahuna community has a long history of community action over a variety of issues. In a sense it is the rural equivalent of a 'healthy city' (51). On ANZAC day 1964 the town hall burnt down and in less than a year the community had rebuilt a new one from their own resources. In 1968 there was a large fire in which a number of the town's shops were burnt, and the community once again rallied round to keep the businesses running, and they had the shop-keepers concerned functioning again within two days. In 1976 the maternity unit closed and the community formed a trust and turned the building into an old people's home. In 1987 the town's supermarket closed and the local community rallied around and reopened it in October 1988 as a community venture.

So the action the community took when the town's only doctor announced she was leaving in March 1988 came as no surprise. The local authority was already involved in providing a house and consulting rooms for the doctor
to operate from. The departing Doctor and the two practise nurses put forward a proposal to the Health Department to maintain a nursing based service with support from the doctors in a neighbouring town. The local authority called a public meeting to which 90 people came and they administered a survey there to determine the community's needs. There was overwhelming support for the establishment of a community health centre and, on the basis of this, the Health Department gave approval for the scheme to go ahead. At the time of the public meeting a Management Committee was formed. The group members recalled that they "have never seen anything move so fast" as the setting up of the health centre. They felt under intense pressure to have something up and running by the time the doctor left or it would have been very difficult to restart the service. The local authority has played a crucial role in supporting the centre. It was responsible for calling the initial public meeting, and continues to provide the services of the county clerk to act as secretary for the management committee.

Current Services.

The EHC has developed an interesting division of labour within its activities. The primary medical care is provided by two nurses who share a full time job. They are assisted by two visiting Doctors from the adjacent
town of Pahiatua. The doctors are not involved in the other aspects of the service and the community members are very grateful that they are continuing to come to the town. The nurses work for the doctors and are accountable to them for the type of clinical work that they carry out. The nurses also provide the link between the primary medical care and the other side of the service.

The Health Action Group (HAG), has 14 people, describe themselves as predominantly white, middle class women, and five of them are on the management committee as well as the HAG group. Ideas are generated from the nurses as well as the HAG. The health centre and its activities are clearly divided into two distinct areas; The medical service run by the practice nurses and the visiting doctors. HAG run a number of different activities and with the help of a coordinator employed by the management committee. The activities include providing a venue for activities such as reflexology, physiotherapy, and visiting government departments such as Accident Compensation and Social Welfare. They are also directly involved in providing activities such as fitness training, grief counselling, arthritis groups, asthma education and positive parenting. There is an
effort to train local people to learn the necessary skills to run these health education groups.

The HAG has direct contact with a large number of community organisations. The effective networks of a small town where everyone knows everyone else were seen to be important, and many people were on the same committees.

Participation Fig 12
There are two main avenues of community involvement in the Health centre. The Eketahuna Health Centre Management Committee, whose members consist of practice nurses, plunket nurses, and other representatives who are either publicly elected from the local community or appointed by the county council, HAG, or the hospital board. The EHCMC is seen as having financial and administrative responsibilities for the health centre. The local authority provides clerical support for the committee. The HAG on the other hand sees itself as 'health activity 'orientated, in the health arena outside the primary medical care provided by the nurses and doctors. Many of the members of HAG serve on the EHCMC as well. The community representative's perception of participation is presented in Fig 12.
1) Needs Assessment

The representatives felt that there were some aspects of the community that were not well represented within HAG and their activities. Considerable demographic change was occurring in the town, with an influx of unemployed people attracted by cheap housing, and these folk were not well integrated into the community, or represented in the EHC structures. However it was noted that they were consistent users of the doctors and nurses services.

Apart from this group, the EHC had extensive networks into the rest of the community, and all organisations in the town were either directly or indirectly represented. A more formal process of needs assessment was carried out at the original meeting that was called to set up the centre.

2) Leadership

The local authority's prior involvement in providing rooms and accommodation for medical practitioners meant it played a leading role in establishing and maintaining the EHMC and the health centre itself. HAG came together in April 1988, were self selected, and saw their role as working with the nurses to organise health education and
promotion activities. Wide participation was perceived in the leadership of the groups.

3) Organisation

The division of responsibility between the primary medical care and the other functions meant that the members of HAG were able to achieve wide participation in the activities of health education and promotion. See Fig 13. They did not feel that the primary medical care was an area for their participation.

4) Resource Mobilisation

The primary medical care is funded through normal vote health channels, the activities of EHC are funded through a variety of sources within and outside of the health sector. See Fig 14. Note that the major part of the funding comes from outside of vote health, by way of grants from non-health community sources. The direct community contribution comes from fees charged by the nurses to patients, making 23% of the income. The group member's perception also is of a mixture of internal and external resourcing.
E.H.C. FUNDING (%)
5) Management

Once again there was wide perception of participation in management in both HAG members and the EHCMC. The division of responsibilities as mentioned previously was probably significant in this respect.
DISCUSSION

The fact that each of the cases studied experienced a wide degree of participation appears to contradict the limitations on participation predicted in the earlier part of this paper. These limitations included the dominant role of doctors, the structural arrangements with regard to health care, and the impotence of democratisation as a method of significantly affecting the power relationships in health care services.

Dealing with Dominance

Given that the provision of primary health care is dominated by the medical profession in New Zealand it is of interest to compare the way the three cases have dealt with this dominance. The critical areas appear to be how they initially got off the ground, how they are maintained, and finally how they have managed to involve the community in the relationship.

There appear to be some common features in the way the services entered into the primary health care field. Each of the services arose because of a clearly identified and expressed medical care need. In Urenui it was the plight of road crash victims, in Newtown it was the inaccessibility of primary medical care due to cost, and in Eketahuna it was the imminent collapse of
their primary medical care service due to the departure of the general practitioner. In each case there was a gap in the provision of primary medical care that existing practitioners were unable or unwilling to fill. There is a widespread perception that the fundamental problem in the provision of primary health care is the disproportionate amount of resources that are spent on curative medical care rather than the potentially more productive areas of health promotion and disease prevention. Primary health care planners often try and address this by initiating projects which focus on entirely on health promotion, then hope that this will attract public participation. The experience of these projects suggests that addressing people's expressed needs is an important first step, even if these are in the area of primary medical care.

The second significant feature was the existence of organisations that were able to hear and act on these needs, once they had been identified. In Urenui, where no such organisation existed, things did not start moving until a Public Health Nurse brought the people together, and through her, the support of the Area Health Board was gained. In Newtown, the union movement had sufficient resources and organisational capacity to bring together government and community support in the critical stages.
The local authority was able to play a key role in Eketahuna, along with the Primary Health Care section of the Department of Health. The fact that this first clearly expressed need was met by the services that were established made a significant contribution to the communities' perception of wide participation in needs assessment. The strength of these supporting bodies (unions and local authorities) was significant in maintaining this early momentum.

The third key feature is the way that they have gained widespread community support. The point made earlier that it is crucial to start with the expressed needs of the people is relevant here. The dramatic difference in community support between the Urenui group (who called a public meeting to discuss the care of accident victims - 50 attended) and their Area Health Board (who called a meeting to discuss community committees - 5 attended) is a good illustration of this point. Yet a year later the Urenui group are able to involve 500 people at an open day on primary health care, having proven to the community what they can do in the curative field.
Klein and Boaden have stated that the problems of control in health services are related to the provider group, the client group and service characteristics.

All the cases have attempted to influence the nature of the providers. The Urenui group, by attending road crash victims, were in a field that was not the responsibility of the local doctors. The background that many of them had in nursing enabled them to provide a professional style of care, yet at the same time see themselves as non-professionals working in their community. Their present funding arrangement, where they receive expenses but not wages, probably supports their belief in themselves as non-professional professionals. They have then gone on to develop doctor services but they have been able to do this to some extent on their own terms, dictating some of the parameters within which the visiting doctors work. However they have not involved themselves in the most sensitive issue in professional medical care, the means and magnitude of payment.

In Eketahuna, however, doctors, or their absence, were a crucial factor in the establishment of the Health Centre. The community group (HAG) has concerned itself
with areas of activity that are outside the domain of general practice, and the doctors continue to operate in isolation from the other activities in the service, with the practice nurses providing a link between the two. The EHCMC provides the visiting doctors with rooms to work in, and that is the extent of the relationship. The innovative group in the service, the HAG, are separated from the doctor providers by the practice nurses and the EHCMC.

Newtown has gone to the extent of fully employing the doctors and nurses within the service, and this has had some important consequences. The service was seen as a major threat by the medical profession (53) who launched a public attack on the credibility of the doctors employed. (54) and attempted to discipline them within the medical association. Furthermore, the existence of doctors within the structures tends to dominate the service as indicated by the comment of some of the community representatives. The narrower perception of participation in this service may in part be due to the fact that a large part of the resources are devoted to the provision of doctor and nurse related services, with subsequent restriction on the flexibility of resource use.
So although all of the cases has been innovative in their attempts to alter the position and nature of the provider group, it remains a central feature in determining the breadth of participation.

Just as they have influenced the provider group, there has also been changes to the client group. The client group that the Urenui group began with, road crash victims, obviously does not lend itself to wide participation. However they have successfully used this to develop other activities that did lend themselves to wider participation, culminating in the attendance of 500 people to attend a primary health care day.

The Newtown service has attempted to focus on low income clients by only registering people who earn less than or equal to the average wage. This has meant that the number of people with the necessary skills and availability to serve on the management committee has been small, resulting in the provider group playing dominant role.

The community representatives in Eketahuna have identified a needy client group, (the newly arrived unemployed) that only participates in the curative side
of their service, and expressed a desire to work more closely with this group in the future.

The nature of the service provided is also seen as important in encouraging participation. The Newtown service has developed a number of activities outside of primary medical care that have fostered wider participation, such as new mothers support groups, and work-site based health promotion. The Eketahuna service has similarly developed a number of self help and cover care activities that have enabled much wider participation.

Real or an Illusion?

The question remains as to what extent these cases are now participating in the overall provision of primary care services in their areas.

It seems clear that from the case studies the new initiatives have not resulted in attracting increased funding from the health sector to primary care in all the cases. There is some evidence that in Urenui it may have resulted in a decrease in spending on the district by the area health board. Prior to the group in Urenui starting, resources to primary care were automatically committed to the area through employees of the Hospital
board. Now the group has to be involved in raising funds from health and non health granting bodies, and have real problems of financial insecurity.

In Eketahuna, health spending has probably remained the same, but funding is now going into health from other areas, and the group members are also involved in fund raising. Newtown has resulted in increased health dept funding in this area, but the majority of these funds come by way of doctor related subsidies, with resulting limitations on their use.

Funding issues remain crucial to the survival of these initiatives and to the amount of participation. In simple terms, they get Health funding as long as they do what doctors do. They are having to go outside the health sector for funding to develop primary health care initiatives that are not doctor dominated. Considering primary health care sector as a whole and control over financial resources as an indicator of power, it seems likely that these initiatives have made only a small impression on the power relationships in the PHC field in their areas. Taking recent figures for government expenditure associated with general practice even in these initiatives the money that is spent at the
discretion of the general practitioners far out-ways any other resources.

Government expenditure; (57)
Associated with General Practice/person/year= $241
Government expenditure U.D.H.E.G/person/year=$20
Government expenditure N.U.H.S./person/year=$56
Government expenditure EHC/person/year =$8

In other words, the control that the communities have over the total revenue spent in primary health care in their areas is still small. Even in Newtown, the community is directly involved in remuneration of the doctors, yet they have no input into the decisions the doctors make on how the bulk of government funds are spent, in areas such as pharmaceuticals and laboratory tests.

Accountability

In Eketahuna, concern was raised at the initial public meeting about the accountability of nurses if they were to be working without a doctor. In fact the accountability of nurses proved to be quite complex. Clinically the doctors had a strong influence in terms of what the nurses were allowed to do, for example they were not allowed to take cervical smears as this would take business away from the doctor. However they were also
accountable to the Area Health Board, and to some extent to PHC section at Head Office as they had been very important in their establishment. Changed relationships within the health care sector mean that lines of accountability will also change. Interest in accountability was expressed in the two services where nurses played a dominant role as some community members felt less secure than when a doctor was present.

Concern about the accountability of doctors was not raised as an issue in the three cases, reflecting the marginal role they played in Urenui, and possibly the crucial role that they played in Newtown and Eketahuna, where doctors were seen as a scarce commodity and hence the communities leave them to their own devices.

Mechanisms for accountability are also not well developed within the professions themselves, so it is not surprising that the community does not see itself as taking on this task.

Levels of Care

Relating this to Verchure's model of PHC Fig 2, each case appears to have moved in a different direction. The Urenui group has blurred the distinction between professional and cover care, at the same time increasing the amount of cover and self care in the community. In
Ekatahuna their has been an emphasis on the area of cover care and HAG has not involved itself in professional care. The N.U.H.S has taken on all the areas of care, with professional care playing a dominant role. This has had a predictable effect on the level of participation, with the moves to cover care and self care being accompanied by a much wider sense of participation.

Rifkin's Model

Rifkin's model of evaluation of community participation in primary health care has been used in this project as means by which communities can evaluate their own level of participation. Evaluation of it's usefulness in this regard needs to be left up to the participants themselves. My impression is that it provided a focus around which key factors in participation were explored by the groups concerned. The responses will have as much to do with expectation as reflecting any 'standard'. But then the participants perception of participation is probably the most important factor. The definition of participation derived at the beginning of this paper asked "Do the people who are disempowered in the health service have more power in the projects under discussion, and are the powerful made more accountable?" Rifkin's model appeared to help in exploring the key questions: Who are
disempowered, who are the powerful, and who should be made more accountable.

Due to the participatory nature of this research, this report is preliminary as it has not been fully criticised by the participants. A more comprehensive report will be compiled once that criticism is available.

Conclusion

These case studies illustrate the wide degree of participation achievable by communities even in the presence of existing primary medical care services. They have all begun by providing medical care services and used this base to develop a wider range of health initiatives, with a strong perception of community involvement.

Each case has developed a different approach to achieving this degree of participation. This has been through blurring the distinction between providers and the community, by developing in areas that are not covered by existing primary care services, and in one case through directly employing doctors.

Significant restraints in developing participation have been encountered in the relationship with the medical providers and the limitations of funding arrangements.
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APPENDIX I

Questions to help determine the plotting of participation indicators:

Note: The following is a description of the broad framework of each of the five participation indicators. After explaining the two extreme points, a list of relevant questions is presented. These questions are not given as a checklist for finding the position of the indicators. Rather they are given as guidelines for evaluators to enable them to develop their own questions for each specific programme. It will be quickly realised that the answers to these questions are not always easily obtained nor easily analysed. These difficulties should not be underestimated. However, the point to be plotted on the continuum does not have to be precise but rather comparative. As experience is gained, a backlog of knowledge will be collected to make this task easier.

Needs Assessment

The introduction of a health programme reflects judgements about the health needs of people living in a certain area and decisions to act upon those needs. Needs assessment can be made by professionals using their training and past experience either to project possible problems or carry out surveys in order to plan actions. Professional assessment alone places the indicator at the narrow end of the spectrum. It moves toward broader participation with actions that involve community members in research and analysis of needs. Questions to assess participation might include:

—How were health needs identified?
—Did the identification include only health service needs or other health needs?
—What role, if any, was foreseen for community people in conducting needs assessments, in analysing health needs?
—Were surveys used? Who designed the surveys and who conducted them?
-- Were the surveys used merely to get information or also to initiate discussions with various possible beneficiaries?  
-- Were potential beneficiaries included in analysing the results?  
-- Was the assessment used to further involve the beneficiaries in future plans and programmes?  
-- Was only one assessment made or is it an exercise for change, review and further involvement of community people in programme plans?  
-- How were the results of the assessment used in the planning of the programme?  
-- If community people were involved in the assessment, did they continue to be involved in the implementation?  
-- Was the assessment used to strengthen beneficiaries role in decision-making about the programme?  
-- Was it able to include various representatives from the wide range of possible beneficiaries for which the health programme was designed?

Leadership

It is necessary to examine who the existing leadership represents, how does the leadership act on the interest of various community groups, especially the poor and how does the leadership act on the interest of the wealthy minority and continue to act only in their interest. The indicator moves toward the wider end if the leadership represents only the small and wealthy minority and continues to act only in their interest. The indicator moves toward the wider end if the leadership represents the variety of interests present in its constituencies.

-- Which groups does the leadership represent and how does it represent these groups?  
-- How was the leadership chosen and how has it changed?  
-- Is the leadership paternalistic and/or dictatorial limiting the prospects for wider participation by various groups in the community?  
-- Does a charismatic leader exist who might not allow mechanisms for continuity to be developed?  
-- How does the leadership respond to the poor and marginalised people, i.e. peasants, labourers, unemployed, women?  
-- How does the leadership respond to demands of outside organisations in terms of gaining resources for the poor as well as the better off?  
-- Have most of the decisions by the leadership resulted in improvements of the majority of the people, for only the elites, for the poor?  
-- What was the attitude of the leadership toward the introduction of a health programme and what was the attitude of the leadership to health before the programme was introduced?

Organisation

If the health programme is to be community based, the organisations must exist among the community people to implement the programme. If programme planners and professionals do not use community organisations, experience suggests programmes will find it difficult to succeed. Programmes with community organisations created by planners will see the indicator for this activity placed at the narrow end of the continuum. Where community organisations exist, include a broad constituency and incorporate or create their own mechanisms for introducing health programmes, the mark will fall near the broad end of the continuum. Questions which might be asked to determine this point are some of the following:

-- How were organisations focusing on health needs development?  
-- What is the relationship of the health professionals to these organisations--do they have a decision-making role and if so, how important is that role?  
-- If new organisations were created, how do they relate to existing organisation(s)?  
-- How does the organisation(s) get resources?  
-- What kind of input do the resource holders have in the organisation(s), is it a large decision-making role?  
-- Has the representation and the focus of the organisation(s) changed since it was created, if so, how and to whose benefit?  
-- Who staffs the organisation(s)—professionals, beneficiaries and which beneficiaries (elites or the poor)?  
-- Can the organisation(s) meet needs other than providing health services if other needs have been identified?  
-- Is the organisation(s) flexible and able to respond to change or is it rigid fearing a change in control?  

Resource Mobilisation

In the PHC philosophy, self-reliance in terms of both resources and responsibility for programmes is a major goal. While mobilising indigenous resources is a symbol of commitment to a specific programme, all too often it also has been seen as a way in which governments can be relieved of allocating their scare resources to these areas. If this situation exists, the commitment of resources limits the ability of participants to decide on allocations which have been defined by outsiders rather than enhance their control over programmes. Thus the indicator for resource mobilisation not only must take account of the commitment of community resources but also the flexibility which can be exercised in deciding how these resources can be used. A point at the narrow end of the spectrum therefore would be one which showed a programme with a small commitment of indigenous resources (money, manpower, materials) and/or limited decisions about how local resources are allocated. Questions to suggest where the indicator is to be placed must reflect both these concerns. They might include:

-- What have beneficiaries contributed?  
-- What percentage of total requirements come from these groups?  
-- What are the resources being used to support?  
-- Have these resources been allocated for support of parts of the programme which in other circumstances would be covered by government allocations?  
-- Who has decided how indigenous resources should be used?  
-- Do all groups that contribute have a decision-making role?  
-- How do the poor benefit from allocations to which, because of their poverty, they can make little contribution?  
-- Can resources raised to support a health programme be used to support more than health services?  
-- How are mechanisms developed to decide about allocations and are they flexible or rigid?  
-- How are resources mobilised from the community?  
-- Which groups influence mobilisation and how do they do it?  
-- Whose interests are being served in both the mobilisation and allocation of these resources?

Management

Management includes not only the management of the organisations responsible for the programme but also the management of the programme itself. Decisions and management structures which favour the professionals and planners indicate narrow participation and those which favour the wide range of community people widen the scope. To assess this indicator, we may ask:

-- What is the line of responsibility for management and what are the roles of beneficiaries, particularly commu-
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- Have the management structures expanded to broaden the decision-making groups, have they been able to integrate needs which are not health needs?
HERE IS A LIST OF DIFFERENT WAYS IN WHICH YOU COULD BE INVOLVED IN THE EMERGENCY AND HEALTH GROUP.

(A) You could be involved in deciding what "needs" the UDEHG should meet. The UDEHG was originally set up to provide emergency care to road accident victims. This was a 'need' that the local community felt strongly about.

Do you decide now what health needs are met? Does "health needs" mean the Doctors and Nurses providing services or does it mean other things? How do you find out what "health needs" there are in the community? Do you do a surveys? Who decide what questions are asked in a survey and who carries it out? How often should you find out about health needs and who should be involved in deciding how the results are used in future developments?
HAVING THOUGHT ABOUT THESE QUESTIONS ON NEEDS ASSESSMENT
WHAT WOULD YOU SCORE BETWEEN 1 AND 5

tick one number

(1) Not involved at all. The needs are all decided by the paid health workers.

(2) The needs are mainly decided by the paid health workers but they do consider what the communities needs are.

(3) The UDEHG is involved in deciding what needs are met.

(4) The UDEHG management committee is involved in deciding on what needs are met and we discuss this with people who use the service.

(5) All the people who use the service are involved in deciding what needs are met.
HAVING THOUGHT ABOUT THESE IDEAS ON THE LEADERS, CHOOSE A SCORE BETWEEN 1 AND 5.

tick one only

(1) The leader/s just do their own thing and don't consider other points of view.

(2) The leaders make most of the decisions but consider what the UDEHG thinks.

(3) The leader makes decisions but the UDEHG is always involved.

(4) The leader/s carry out the decisions of the UDEHG

(5) All the different groups in the community are represented in the UDEHG and they have a say in the appointment and the actions of the leader/s
ORGANISATION

This question is about how well the Community members are involved in carrying out the policy and objectives of the organisation.

Are community organisations involved in carrying out the programmes?

Are all the programmes run and organised by the professionals involved.

Do the programmes that are run strengthen and involve existing community groups? Do the groups that are most involved in the programme come from a broad cross-section of the community, or do they represent just one group?

Is the organisation able to respond to needs that are outside the health field?
CHOOSE A SCORE BETWEEN ONE AND FIVE TO DESCRIBE HOW THE

ORGANISATION CARRIES OUT ITS GOALS.
1) The organisation just does one sort of activity and this is carried out by the professionals involved.

2) The organisation does a variety of activities carried out by professionals

3) The organisation has some involvement of non professionals in carrying out its aims.

4) The organisation has some involvement of non-professionals and has some flexibility in carrying out its goals.

5) The organisation is very flexible in the way it meets its goals, involving a wide section of the community, and many non-professionals.
WHERE DOES THE MONEY AND THE OTHER RESOURCES COME FROM and
WHO DECIDES HOW IT WILL BE USED?

What things are considered to be resources?
Where do they come from?
How much of those resources come from the community?
Who decides on how these resources are used or spent?
NOW CHOOSE A SCORE BETWEEN 1 AND 5 THAT BEST DESCRIBES WHERE THE MAIN RESOURCES COME FROM AND WHO DECIDES ON THEIR USE.

(1) All the resources come from outside the community and we are not involved in deciding on how they are used.
(2) Most of the resources come from outside the community, but we decide contribute a small part.
(3) Resources come from outside as well as from the community but we are not involved in deciding on how it is spent.
(4) Resources come from outside as well as from the community and we are involved in deciding how the money is spent.
(5) Most of the resources comes from the community and we decide on how it is spent.
MANAGEMENT—HOW ARE DECISIONS MADE?

What were the big decisions made last year?
Were you involved in them?
How were the decisions made?
Are groups from the community represented in the management structure?
Have the way decisions are made changed since the project began?
CHOOSE A SCORE BETWEEN ONE AND FIVE TO DESCRIBE YOUR INVOLVEMENT IN MANAGEMENT:

(1) The community has no involvement in decision making.
(2) The professionals make all the decisions, but they sometimes seek the advice of the community.
(3) The professionals and the community make the decisions together.
(4) The community makes most of the decisions and the professionals make the rest.
(5) The community is fully involved in decision making and just use the professionals involved for advice or as a resource.