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PRIMARY HEALTH CARE: ON MEASURING PARTICIPATION

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Abstract—This paper considers the problems of finding measurements for the two major principles of primary health care (PHC), equity and participation. Although both are of equal importance, the authors concentrate on the assessment of participation. A methodology is put forward to define indicators for participation in health care programmes as how wide participation is on a continuum developed for each of the five factors which influence community participation. These factors are: needs assessment, leadership, organisation, resource mobilisation and management. By plotting a mark on a continuum which is defined as wide and narrow at the extremes and is connected with all other marks in a spoke arrangement, it is possible to describe a baseline for participation in any specific health programme. This baseline can be used to compare the same programme at a different point in time, to compare observations by different evaluators, and/or to compare perceptions of different participants in the same programmes. A case study provides an example of how the indicators might be used. These indicators focus on the breadth of participation and not its potential social impact, an area which is recognised to be critical for future research.

Key words—comprehensive primary health care, community participation, measurements

INTRODUCTION

As the first decade in which primary health care (PHC) has been the accepted policy of over 150 nations grows to a close, the future of this policy is still very much uncertain. The promises of a radically better life for those whose needs were greatest remains an illusive goal and the vision of both authors and signatories of the Alma Ata declaration threatens to remain a mere platitude. There are many reasons for this situation. One of the most important is the unrealistic expectations of policy makers, planners and beneficiaries concerning how health improves [1].

Traditionally expectations about health improvements have been linked to inputs and outputs of medical services (more recently termed 'health services' to include preventive care) and/or impact in terms of health status. The development decades of the 1960s and 1970s which gave birth to PHC and the 'basic needs' [2] concepts, put forward an analysis which related better health not only to health services but also to the existing socio-economic conditions. It was argued that health improved not merely by the provision of health services but in addition by the distribution of available resources based on the principle of equity and by the involvement of beneficiaries in decisions about care based on the principle of participation.

Despite the acceptance of these arguments by those who adhere to the Alma Ata declaration on PHC, traditional views which judge the success or failure of health programmes in terms of service delivery and health status alone remain strong. In part, it may be argued that one reason is that there are few ideas of a pragmatic nature by which to assess participation and equity.

This paper is a beginning to give a form to the principle of participation that might enable policy makers, planners and beneficiaries to consciously include this principle in their programme plans and evaluations. Participation cannot be divorced from equity. As the framework develops, therefore, equity will be a constant, if not explicit, factor.

Is it realistic to believe that an analytical framework to assess participation can be developed? There are arguments to suggest it is not [3, 4]. Whatever the validity of these views, there, on the other hand, remains a major problem. Decisions about allocations of resources for PHC are often in the hands of medically trained people. Until those who have to make decisions about resources also have frameworks by which to understand and judge their efforts to extend PHC beyond service delivery, it is likely they will continue to expect health to be related mainly to the provision of services and choose policies and actions that reflect this view. For this reason, it is important to attempt to develop a framework in which professionals can see benefits of efforts to support participation, alter their expectations accordingly and allocate resources and time to developing this approach. Until those who have control of resources are convinced that participation is a viable and desirable concept, it is likely to remain relegated to rhetoric.

This paper presents a methodology by which assessment of participation in health programmes can be undertaken. It sets out to provide a tool to assist

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those involved in PHC programmes to describe participation in their programme and upon that basis plan their future actions. It takes as its starting point the conclusion of a previous work by one of the authors which suggests that broader participation is gained by developing a wider range of activities [5]. It does not set out to validate the crucial role of equity and participation in PHC as these arguments have been accepted by the signatories of the Alma Ata declaration. Nor does it attempt to present an argument that more participation is 'good' or 'bad' as this tool is descriptive and not judgemental.

The paper is divided into five parts. In the first section, we will review past efforts in measuring PHC by frameworks other than those which only examine the improvement in health status and in measuring participation. Part two discusses the conceptual framework for assessing participation. Part three discusses the analytical framework. Part four presents the methodology. Part five describes a case study using the analysis. The final section presents the conclusions. The appendix includes some questions to suggest how the indicators might be placed.

OF OUTCOMES, IMPACT AND PROCESS INDICATORS

Health improvements, as we have mentioned, have traditionally been measured in terms of causal relationships. Evaluations have described inputs then looked for the results in terms of specific outcomes and overall impact (usually health status). These measurements are characterised as being quantitative rather than qualitative and static rather than dynamic [6]. In other words, they describe a specific situation at a given time in terms of numbers. With the broadening of analysis that linked health improvements to overall economic development, the confines of the traditional approach have become apparent. It, thus far, has proved not possible to give a number to individual perceptions of changes in the quality of life or to quantify the relationship of specific changes such as the correlation of the number of educational facilities to improved income. Nor is it possible, as we have already suggested, to quantify the relationship of available health services with improved health status.

Recognition of these difficulties has been expressed by those involved in evaluating both development and health programmes. There is still no satisfactory method by which to measure social and economic change. Dudley Seers in his classic essay on "The Meaning of Development" discusses in detail some of the problems with identifying indicators highlighting the need to take into account social, economic and political systems. In view of this analysis, it is easy to see why quantitative, static measurements are ephemeral [7].

Attempts to quantify relationships in the health field, for instance, for specific interventions such as nutrition programmes or family planning similarly have been unsatisfactory. The search for direct correlations between interventions and health improvements for large populations based on the biomedical research model so far has proved futile. In their often quoted study of 10 small scale programmes, Gwatkin *et al.* concluded that even though evidence suggested selected interventions improved the health and nutrition of target groups, the effects of these interventions on health improvements did not depend solely on the inputs but also on how the inputs were administered [8]. Isley studied the relationship between rural development strategies and their health and nutrition effects on fertility and also found that direct causal relationships between inputs and effects were not possible to identify [9].

The above studies illustrate the constraints of an approach which uses a tightly designed study to identify critical factors for health improvements. To help overcome these problems, Mosley and Chen offer the "proximate determinants" framework [10] combining social science analysis with the biomedical model. These proximate determinants which include maternal health factors, environmental factors, nutritional factors, injury and personal illness control are quantifiable and combined with socioeconomic measures can be put forward to identify children at risk. Although the framework accounts for non-medical influences upon health, the determinants still remain static as they do not assess changes over time and still view health improvements in terms of defined causal relationships.

The weaknesses of assessing economic development and health improvements in terms of linear causal relationships and/or through tightly controlled studies are magnified when trying to assess community participation [4]. These efforts are complicated not only by lack of a clear definition of the terminology but also by the specific cultural, historical, social, economic and political environments in which they take place. As a result parameters of such assessments, in an attempt to become globally applicable, become merely vague or basically descriptive.

The World Health Organisation, for example, in its publication concerning indicators for progress toward 'Health for All by the year 2000' states that community involvement (the term it prefers to community participation because it implies active rather than passive engagement in health activities) can be assessed by the level of involvement in and the degree of decentralisation in decision-making as well as the development of effective mechanisms for expression of people's needs and demands [11]. When Palmer and Anderson attempted to apply this framework to assessing community participation in WHO's Western Pacific Region, they concluded ways to measure participation are too new and too infrequently used to be precise [12].

In attempting to provide a strong conceptual and evaluative framework, Muller in his analysis of case studies in Latin America uses the 'basic needs' framework and argues that society must be analysed in terms of inequalities [13]. He says that there are those who have full access to the benefits of society, including health services and who fully participate in decision-making. And there are those who are not. Within this framework, the provision of services to and increasing participation in national decision-making of those who had no access to services or to power or control he calls *social participation*. In the development of health care programmes, a more targeted form of participation is present which relates

to involvement in the health care programmes. This he calls *direct participation*. His studies look at the linkage between the two types of participation. In developing the latter concept, however, he relies on the description of the development of situations specific to a given community. His work gives case study comparisons which cannot be generalised to programmes in different areas.

Agudelo [14] building on Muller puts forward an analysis for comparing participation between programmes. By assigning numbers to rank participation in a specific range of activities in the areas of (1) management, (2) the range and completeness of participation in terms of the number of community 'agents' present and operating and (3) community support and financing, he suggests that a standard of participation can be articulated. With a standard, programmes can be compared. Agudelo, however, leaves no means by which to assess participation in decision-making, a crucial factor in PHC, and no way by which to assess the process by which participation takes place. In addition, his framework is not flexible enough to account for change or reverses in the programme with the probable result that many of these will be overlooked by those using the evaluation. In his attempts to quantify the problem, he becomes entrapped in the limitations found in the bio-medical research model which we have discussed above.

This wide range of experiences in seeking to evaluate both health improvements and community participation suggests that an alternative is needed. Rather than looking for measures which show where programme development is in relation to a specific, static standard, it is perhaps better to seek a relative measure. Studies have suggested that a method by which to assess the process of programme development is needed [15–17]. The development of process indicators is critical to the understanding of health improvements and community participation defined in the 'basic needs' and PHC strategies of the recent UN development decades.

DEVELOPING A CONCEPTUAL FRAMEWORK

To assess participation in a health programme we can suggest the use of indicators which in any specific programme will tell us whether participation has become narrower, broader or remained unchanged. The development of these indicators depend, firstly, on a clear understanding of the use of the terms 'community' and 'participation'.

Midgley [18] suggests that community has had two meanings in the health/development literature. The first is that which defines community in geographic terms. Community is a group of people living in the same defined area sharing the same basic values and organisation. This definition is the one most often used in the health literature.

The second definition is that which says a community is a group of people sharing the same basic interests. The interests change from time to time with the consequence that the actual members of the 'community' change from time to time. This definition of community and its implications for health policy has been explored by Ugalde in an article [19] where he suggests that this definition is critical if health plans are to be more realistic and effective.

A third definition of community which is important to health professionals is that of target populations or 'at risk' groups. This definition is rooted in the epidemiological view of community. In PHC, in terms of equity, effectiveness and efficiency, groups of people need to be identified so that resources can be allocated to the greatest effect. It is therefore important to take into account this aspect of health concerns in seeking a realistic definition.

The term participation also has a wide range of meanings [20]. In reviewing these definitions, three characteristics appear to be common to all. The first is that participation must be active. The implication is that the mere receiving of services does not constitute participation. (We have noted previously WHO's use of the word 'involvement' to place emphasis on this characteristic.) The second is that participation involves choice. Participation implies the right and responsibility of people to make choices and therefore, explicitly or implicitly, to have power over decisions which affect their lives. The third is that the choice must have the possibility of being effective. This suggests that mechanisms are in place or can be created to allow the choice to be implemented.

Based on these considerations, we can suggest a definition of community participation which takes into account the geographic, common interests and epidemiological meanings as well as the characteristics of participation we have described. Community participation is a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs. In the context of PHC, this process is one which focuses on the ability of these groups to improve their health and health care and by exercising effective decisions to force the shift in resources with a view to achieving equity.

DESCRIBING THE ANALYTICAL FRAMEWORK

On the basis of this definition and in recognition of the need to examine process rather than impact of community participation in health programmes we can suggest the following framework.

We can take the factors which influence participation identified by Rifkin [5] in a paper which analysed over 100 case studies. These factors are: (1) needs assessment, (2) leadership, (3) organisation, (4) resource mobilisation, (5) management, (6) focus on the poor. For each factor, except the last, we can develop 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 decisions, no lay participation) at the other. We then can divide the continuum into a series of points and place a mark at the point which most closely describes participation in the health programme we are assessing. Upon this basis, we can define process indicators for participation in health care programmes as the width of participation on the continuum of each of these factors. We can use these

indicators to compare differences in participation (1) at a different time in the same programme, (2) by different assessors of the same programme, (3) by different participants in the same programme.

A word needs to be said about the sixth factor—focus on the poor. It is difficult to convert this factor to an indicator for two reasons. Firstly, as an indicator for participation it also must be viewed as an indicator for equity. The whole question of the assessment of equity is recognised as key to PHC but is beyond the scope of this paper. As we later note, it is a vital area for future research. Secondly, based on personal field experience of the authors and of others, it is very difficult to firstly, identify the very poor in any given community and secondly, to define activities which truly reflect a long term shift of resources to improve the plight of the most impoverished. For these reasons, the sixth factor is not included as a factor in assessing participation in the present framework.

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 the most narrow. The first point at this end of the continuum is not at the point where the spokes connect because we recognise that in any community there already exists some participation which people undertake to meet their health needs. Figure 1 gives an illustration. By placing the appropriate mark on each continuum and connecting these marks, we can show the degree of breadth of participation to describe a baseline which provides for a comparative assessment either at a later time or by other assessors. The differences between the baseline and other assessments will show what movement has taken place and whether it is great or small. From the narrow links near the base, as participation becomes broader, the links which cross the sections, fan out and widen.

Figure 2 shows a programme where the baseline has been done. Figure 3 is an example where difference between the baseline and another assessment either over time or by different assessors can be seen. In the penultimate section, the indicators have been used for an actual case study to illustrate this analysis.

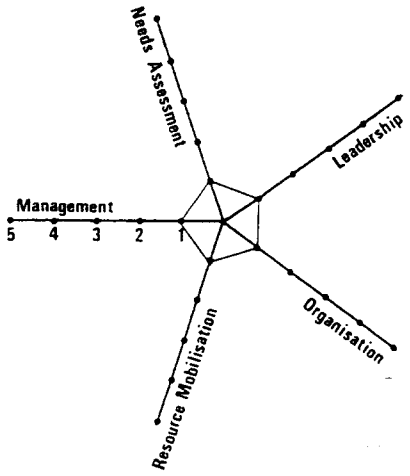

Fig. 1

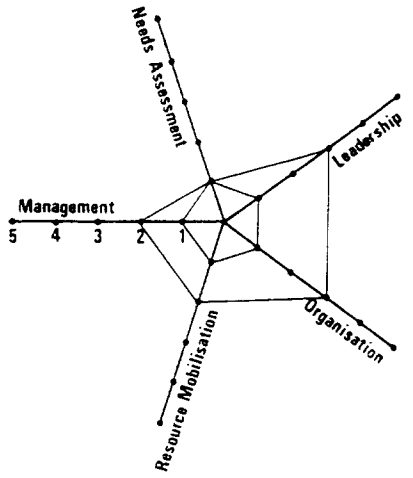

Fig. 2

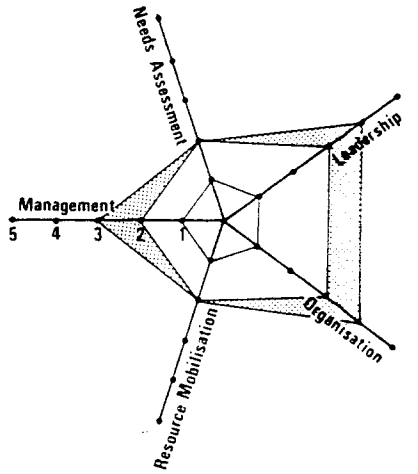

Fig. 3

Rather than assessing community participation in health care in a linear relationship or in terms of a standard, these indicators allow us to assess health programmes in a varied relationship accounting for both progressive and retrogressive periods and analysing relative change.

To re-iterate, these indicators do not value wider community participation as 'good' or 'bad' nor do they correlate community participation with improved health status. They are intended to describe changes and show the processes of participation in specific health programmes. They take as their starting points that health improves through community participation and that broad participation builds on a wide range of activities and involvement of many different community groups.

These indicators are developed to assess participation in health programmes. Increasing the breadth of participation along the continuum means increasing involvement of the community in health programmes in terms of *direct participation*. Whether

or not this means increasing *social participation* depends on the nature of existing inequalities in a given society which may be along the lines of economic classes, social classes, tribes, gender, etc. In other words, this question focuses on the question of equity. Muller has in his work suggested some indicators for *social participation* [13] which include awareness of the interpretation of health problems and their causes, awareness-building, and the existence of organisation(s) to change the unacceptable existing situation. As social realities are different among communities and countries and as theoretical frameworks for analysis are also different, a global conceptual analysis is difficult to make. The indicators discussed in this paper do not link the breadth of participation to *social participation*. We again repeat that we are aware to the importance of making this linkage and define it as a critical area for future research.

DEFINING THE METHODOLOGY

As we stated, the purpose of this assessment is to define the movement of the process of participation in health care programmes. Using the definition of participation we have earlier suggested and recognising limitations which may be imposed on participation by the government [18] a mark will be placed along the continuum to tell us how wide or narrow the process is at any given time.

To collect information which will decide where the point will be plotted, 'action/research' [21] may be used in which the programme planners, the health team and the beneficiaries all play a role. Through 'participant/observation', data can be collected. We have included in the appendix a list of questions which might be useful to help define each indicator in a specific health programme (Appendix 1).

Once information is obtained, a decision as to where to place the mark needs to be made. The discussions about this decision can be as valuable as the final decision. *It is not crucial to find the precise point for the mark.* Rather the objective is to find a point which can be used as a point for comparison at a later time. Once all the marks have been placed, they can be connected to give a broad picture of the extent and scope of participation in the programme.

The first phase of the assessment is now completed. The process indicators for participation provide the baseline by which future assessments can be made. These assessments can be carried out by the same team, by a new team or a new assessor. As a means of developing participatory evaluation [22], they also can be carried out by a range of programme participants to see if the assessment by programme planners differs from community assessment.

The new assessments will show changes in participation in the programme or will show areas where no perceived change has taken place. They will also show where participation has tended to become more broad or more narrow. Based on these assessments, planners and beneficiaries can decide what next programme steps might be in relation to participation. They also may reflect on this assessment as a learning exercise to better understand the process of participation and how it develops or why it does not develop in a given health programme.

USING PARTICIPATION INDICATORS: A CASE STUDY

In his fieldwork in Nepal Bichmann [23] made experimental use of the process indicator framework described above.

The setting

Rural health programmes in Nepal are not unlike those in other parts of the world, where village health committees and community health workers form the main formal mechanisms for community participation in health care. Health services of a western type have been evolving in Nepal only slowly until the thirties [24]. A Ministry of Health was created in 1956, but Nepal's health sector has been characterised for a long time by the existence of poorly coordinated vertical programmes and the involvement of a multitude of foreign donor agencies [25]. The need for integration of all these programmes promoted the concept of 'integrated health services' and a special division was formed in the Ministry of Health for that purpose. The Sixth Five Year Plan, furthermore, announced a country-wide system of locally recruited employed village health workers (VHW), who, later on, were supplemented by voluntary community health leaders (CHL) and traditional birth attendants. Several studies revealed, however, that there existed a large gap between the villagers' perspectives on health and those of national PHC planners and international consultants [25, 26]. The low quality of curative health services in remote areas has been a long standing concern in many communities.

In the present government health system, curative and preventive health services are modelled according to the district health care approach [27]. In contrast to the situation in many other developing countries, however, Nepal's Decentralisation Act (1982) is a clear committment to the decentralisation of government structures as it establishes the legal prerequisites for decentralised planning. In the health sector health committees have been created at different levels of the administrative system in order to guarantee community involvement—especially at health post and ward level, i.e. in the basic administrative units of the communities. Whereas the Ward Health Committees (WHC) in the district studied on average were not busy, the Health Post Committees—under the strong leadership of the local Health Post-in-charge—met regularly, a fact which therefore might not be an indication of strong community involvement but rather one of consequent management by the professionals.

Data collection and analysis

Using participant observation and semi-structured interviews with carefully selected key informants from both the health services and the community, Bichmann drew a profile of the breadth of community participation present in the Kaski District of Nepal in a poor mountainous part of the country. As already mentioned, wide community participation was an aim of the health programme. Individual

Indicator [range]	RANKS				
	Narrow, nothing 1	Restricted, small 2	Mean, fair 3	Open, much good 4	Wide very much excellent 5
1. Leadership (L) [wealthy minority–variety of interests]	One-sided (i.e. wealthy minority; imposing ward-chairman; health staff assumes leadership; or: inexistence of hetereogeneous WHC.	WHC not functioning, but CHL works independent of social interest groups.	WHC functioning under the leadership of an independent CHL.	Active WHC, taking initiative.	WHC fully represents variety of interests in community and controls CHL activities.
2. Organisation (O) [created by planners–community organisation]	WHC imposed by health services and inactive.	WHC imposed by health services, but developed some activities.	WHC imposed by health services, but became fully active.	WHC actively cooperating with other community organisations.	Existing community organisations have been involved in creating WHC.
3. Resource Mobilisation (RM) [small commitment + limited control–good commitment + commited control]	Small amount of resources raised by community. No fees for services. WHC does not decide on any resource allocation.	Fees for services. WHC has no control over utilisation of money collected.	Community fund raising periodically, but no involvement in control of expenditure.	Community fund raising periodically and WHC controls utilisation of funds.	Considerable amount of resources raised by fees or otherwise. WHC allocates the money collected.
4. Management (M) [professional induced–community interests]	Induced by health services. CHL only supervised by health staff.	CHL manages independently with some involvement of WHC. Supervision only by health staff.	WHC self-managed without control of CHL's activities.	WHC self-managed and involved in supervision of CHL.	CHL responsible to WHC and actively supervised by WHC.
5. Needs Assessment (NA) [professional view–community involved]	Imposed from outside with medical, professional point of view (CHL, VHW, HP-staff); or: Latrine building programme imposed on community.	Medical point of view dominates an 'educational' approach. Community interests are also considered.	CHL is active representative of community views and assesses the needs.	WHC is actively representing community views and assesses the needs.	Community members in general are involved in needs assessment.

VHW = village health worker; WHC = ward health committee; CHL = community health leader; HP = health post.

Fig. 4. Ranking scale for six process indicators for community participation.

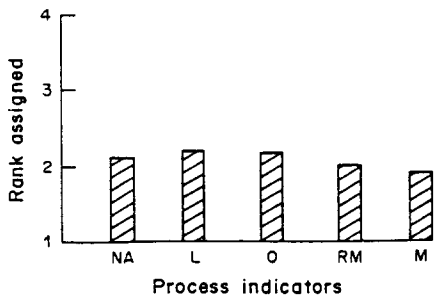

Fig. 5. Degree of CI achieved in Kaski district

interviews were carried out with 20 CHLs and 21 elected community leaders in the hamlets of the health post areas served. The interview data were analysed using a matrix (Fig. 4), which assigned relative ranks to each of the five above-mentioned factors using a 5-point scale. Thus every single interview produced a subjective measure of the degree of participation achieved as reflected in the five factors considered.

Averages of the ranking of indicators were calculated per group of respondents, per health post area and per district. Interesting differences in the assessment by different groups of community informants were obvious and could later on be analysed in depth. The district average of the degree of participation achieved—as expressed by the totality of community key informants—was visualised using a bar chart (Fig. 5). Using the visualisation developed above, the plotting of data of Fig. 5 would result in a spider's web as shown in Fig. 6.

In this case study, the conclusion to be drawn from using this framework of process indicators was that the degree of community participation achieved was still rather low, even though the structure, organisation and management of the district health services was excellent in comparison with the situation in other parts of the country. It was suspected that reasons for this low achievement have to be sought in factors such as social structure, lack of financial committment of the government, suppression of community initiatives, attitudes of superiority of health staff, previous negative experience with community development programmes, and lack of orientation, sensitisation and training of both health professionals and community members.

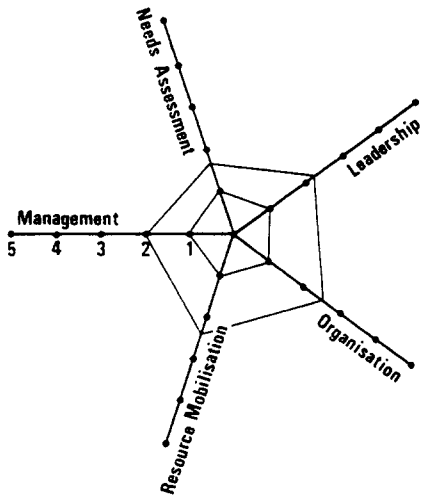

Fig. 6

Limitations

It was not possible to get interviewees to recall how the participation in the programme might have looked at its inception. For this reason changes in the participation process could not be assessed. However, it was possible to describe the present situation thus providing a baseline for future assessments which focus on changes.

Conclusion

The cited case study provides an example of how the assessment of process indicators of community participation in health might be used. Although programmes vary widely, for each specific situation similar matrices can be developed in order to identify formal and informal mechanisms of participation. The result of the case study provides a useful baseline assessment which can be used by other persons, assessors, health staff or community members, when planning for a comparative assessment at a later stage. This baseline might also stimulate debate within other concerned groups. The assessment uses relative values. It does not pretend to be 'correct' and therefore, does not pretend to be a method for defining participation in terms of a standard.

CONCLUSION

In this paper, we have presented a framework and methodology for assessing community participation in any specific health care programme. We have defined process indicators as indicators which show how wide participation is on a continuum of each of the major factors which influence participation. We have described how to identify and use these indicators to assess participation in these programmes. Finally, we have presented an example of how these indicators can be used in practice.

As we have continually stressed, process indicators are not used to quantify or standardise changes. They do not tell us whether community participation is 'better' or 'worse'. Rather their value is two-fold. Firstly, they describe differences in community participation in a health programme over time and by different people. Secondly, and equally important, they serve as a departure for discussions about community participation which can help us to understand the process better and which can help the people involved in the programmes to achieve better results by allowing for greater involvement.

This presentation is one of the first steps in beginning to develop practical, useful tools for understanding community participation in health programmes. We would very much appreciate hearing from those of you who try it in your own programmes. We would also appreciate any comments and criticisms.

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APPENDIX 1

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 colleced 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, it 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 involved 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 responsive are the leaders to change. Narrow participation is present 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-

nity health workers (CHWs) if present in the programme?
—For instance, are the CHWs responsible to community organisation(s) or programme managers?
—Has the decision-making structures changed both from the beginning and from the baseline to favour certain groups and which groups are favoured?
—Have the management structures expanded to broaden the decision-making groups, have they been able to integrate needs which are not health needs?