CF/HST/1985/034/Anx.04/05

A STRATEGY FOR BASIC SERVICES

CF/HST/1985-034/Anx.04/05

SUMMARY

The strategy is based in the village or the urban neighbourhood. The villagers choose from amongst themselves people who could be "community workers"; the individual they regard as the best farmer, for example, or the person they most trust for health care, or one they naturally turn to for advice about raising their babies. These people are given brief, simple specialized training with other workers chosen from nearby villages or neighbourhoods. They return to their communities to provide basic services and to help their neighbours learn new ways of doing things: how to grow more and better foods, which local foods would be more nutritious for small children, how to dig a well or latrine, why it is important that water be safe and used for keeping the home clean, simple measures for preventing and treating diseases common in the area.

The workers are of the community and provide their neighbours with services they want. Their neighbours, therefore, support them and participate in the activities. Something like this is going on, here and there, in many countries. In a few, this approach has evolved into a strategy for social development, either countrywide or in specific development zones.

Community workers alone could not function effectively or for long, however. They must be part of a "system"—part of the network of government services which have been augmented by auxiliaries, and reoriented to support delivery to the periphery. They are the outer ring of the national system for extending basic services into unserved or underserved communities. They are, in fact, the final step by which existing national services can be extended out to reach all those they are intended to serve.

How community workers can be organized as part of government services can be discerned in some of the common features of the successful experiences already under way:

1) Community participation is the key to organizing and sustaining these essential services in the rural village or poor urban neighbourhood. The people of the community are encouraged to participate from the outset in identifying their needs, deciding priorities, planning the sequence of implementation and choosing from amongst themselves those to receive training as community workers. This helps take into account local traditions and establishes the responsibility of the community for supporting its own services.

2) The priorities of the villagers or slum dwellers will suggest a natural sequence for beginning different community services. They should be planned in relation to each other and implemented as an integrated whole as soon as possible. These essential services include such activities as growing and storing more and better quality foods, nutrition education, safe water supply and waste disposal, simplified health care and health education, maternal and child health, family planning, measures to meet the basic educational needs of the community, and the introduction of simple technologies to lighten the daily tasks of women and girls. These various activities are mutually supportive. Piecemeal, fragmented services do not work as effectively. Often they are allowed to fall into disuse by villagers who do not fully understand them or are not caught up in the enthusiasm of self-development for their community.

3) The government, in undertaking the extension of essential services to those not yet served, usually builds on the existing network of services or on existing programmes in zones or development regions of the country. These can be expanded, using the community worker approach, based on community participation and support. Local situations will suggest opportunities for making the best beginnings.

4) Building on existing services will require a reorientation of the government infrastructure to become supportive of the community services. The existing network of services comes to provide the direction, training, supervision, technical and logistical support, and referral services for the village and community workers.

5) The network of regular government services will then need greater numbers of auxiliaries to free professional personnel for supervisory, training and other roles, and to support the community workers.

6) While community involvement from the outset is essential to success, one stage obviously must precede this first step of implementation: commitment on the part of the national government to this strategy. There may be resistance, for example, from those who believe that services can only be delivered by fully trained professionals. If the approach is to succeed, there must be political will and determination to carry it through. Usually the programme can best be started in some areas, but the final goal should be to adopt it as a massive approach with the aim ultimately of reaching all those not yet served by essential services.

While this approach draws upon experiences in a number of countries, there is no single model for developing basic services. Local customs and traditions must be taken into account in the entire process of planning and development. Opportunities must be sought in local situations. However, much can also be learned by exchange of information about current and future experiences.

"As the ultimate purpose of development is to provide increasing opportunities to all people for a better life, it is essential . . . . . to expand and improve facilities for education, health, nutrition, housing and social welfare, and to safeguard the environment."

Resolution of the General Assembly, 2626 (XXV) International Development Strategy for the Second United Nations Development Decade, para 18, adopted 24 October 1970.

The General Assembly:

"1. *Urges* the developing countries to incorporate the Basic Services concept and approach into their national development plans and strategies; . . . .

3. *Urges* the international community to recognize its responsibility for increased co-operative action to promote social and economic development through its support of Basic Services at the international and the country programming level."

Resolution adopted 21 December 1976

RATIONALE FOR A STRATEGY OF BASIC SERVICES

The concentration during the First Development Decade on economic growth assumed that eventually all the people would benefit as the nation attained its industrial and agricultural goals. In many countries this is not happening rapidly enough, and the resultant disparities are a source of tension and conflict.

Originally it was thought that the existing pattern of governmental services would be extended out to more and more people as economic progress allowed. Though many governments have invested considerable resources in health and other services, this has not occurred. Services based on older models of industrialized countries do not spread far beyond the modern sector or scattered small areas where political pull has succeeded in installing them. The industrialized countries are themselves finding that, as salaries rise, it is necessary to use more lay workers in order to serve all the people.

In the developing world as a whole, some three-quarters of the population is not being effectively served. New generations are being born, growing up, and living out their lives without minimal services or basic education, contributing much less than they could to national development, and with some becoming a burden to themselves and to society.

Some countries, however, have evolved ways for meeting minimal needs by providing basic services. The World Health Organization and UNICEF studied various experiences, focusing on approaches for meeting basic health needs. They observed that common to most was a minimally trained lay person or persons, resident in the village or community, whom they called the "primary health worker". Such workers are chosen by their neighbours, trained and retrained locally in specialized tasks and simplified techniques, are supported technically by the health infrastructure and work part-time in their previous occupation or are supported by the community. A similar system can provide other essential services to meet basic needs.

Many simple measures that can improve conditions of life in the rural countryside or poor urban areas are well known. Information about improving dwellings, which local foods provide better nutrition and how to store them, the need for keeping the household clean, why good sanitation is important to health, how to pipe water from the mountainside or protect wells, all these and many others are the very subjects of basic education most needed by villagers or new urban dwellers. What is lacking is the means for diffusing this information. Village or community workers not only provide minimal services but serve as the network for conveying this kind of basic knowledge to the people.

Basic services may be criticized as offering second-rate services. This is mistaken. Community workers are trained as technicians and become expert in precise tasks. In mass immunization campaigns, for example, lay vaccinators became more expert at giving a shot than supervisors who have wider professional training. As local people, community workers make more approachable and knowledgeable home visitors than outsiders. Community planning and supervision makes the system more responsive to local needs than does distant bureaucratic control. Community workers offer a way of beginning services which can be progressively upgraded as workers' skills are improved by regular re-training and as resources grow.

This approach helps overcome the problem "where are the resources to come from?" Basic services are labour intensive. They mobilize the resource that is abundantly available but substantially neglected—*human resources*. A choice need not be made between activities aimed at economic growth and measures for social development. Both are necessary and mutually reinforcing. Involving rural villagers and urban neighbours in organizing their own essential services can be the initiating point for vitalizing the rural countryside or educating urban dwellers to become skilled producers.

In the sequence of measures for stimulating people to become productive workers, activities leading to their own improvement have a natural priority. When they find that they can themselves take measures to improve their family and community living conditions, a more modern attitude toward problem solving replaces the ages-old fatalism that blocks progress. Upon this new attitude can be built improved agricultural productivity and other measures benefiting national development. Once the urban poor become involved in neighbourhood projects to improve their own lives, their new energies and skills can be channeled into other constructive activities.

Many countries cannot soon extend expensive governmental services out to reach all their people. The resources are just not there. Now, however, the experience of areas where the people themselves are the principal resource for their own improvement can be drawn upon. It is possible to make them a self-generating force for economic growth and to do this with minimal start-up costs and at long-term recurrent costs the community and nation will be able to afford.

ORGANIZING BASIC SERVICES

There is no single model for providing basic services. Numerous countries are using some elements of this approach for meeting the basic needs of their people (for some examples see pages 15-29). The approach can be made to work in different political or social settings, provided the will is there to begin and to sustain the effort.

The undertaking should be thought of as a "process" by which—through experience and the exchange of experiences—the nation gradually finds the best way to reduce rural and urban poverty by helping villagers and city dwellers take responsibility for essential services at the local level. A programme of this nature and dimension can only be developed over a period of years, but should be carried out within a time-frame that sets national and local goals.

There are places to begin, in rural development zones or other programmes already under way. Existing services offer the organizational structure upon which to build. Most government services at present consist of the national or ministerial level; the supervisory level in the provinces or districts; and the present network of government workers making direct contact with the people. To extend this core infrastructure so that it effectively reaches the unserved or underserved communities, a fourth tier of village or community workers is added. This requires reorienting the existing government services to provide direction, training, supervision, technical and logistical support, and referral services for the new workers.

Starting programmes of basic services country-wide is usually too ambitious for the initial stage. Various countries have begun in development zones or in a single region, as in the province of Puno in Peru or in the highlands of Chiapas in Mexico. Experience in one region or zone then provides the basis for extending services to other regions of the country, as is already being done in Mexico.

Initiation of services in an area previously unserved may come about quite naturally. During the Sahel drought, for example, the health centre at Yako, in Upper Volta, began treating children suffering from severe malnutrition. The mother or an older sister was taught how to bring about the child's recovery with a gruel made from locally grown foods. His return to the village he had left only weeks before, on the verge of death, had great impact. The mothers then became teachers of other women of what they had learned about nutrition and local foods. To this were added such measures as development of home gardens and nutrition surveillance. The "Yako experience" is now being extended to other districts of Upper Volta and to other countries in the region.

In planning basic services, the final objective should be to establish them on an

integrated basis, so they will be mutually supportive While it may be advantageous or necessary to begin them sequentially, the intention should be to implement essential services for each village or neighbourhood as soon as possible. An approach that remains piecemeal, wastes resources and ill serves the intended recipients.

This is recognized in many programmes already under way, such as the Jamkhed village project in India where health care is being developed along with measures for improving agricultural production, increasing water supply, extending electricity for irrigation pumps, constructing roads and buildings for schools and grain storage. Health is considered part of "total development". Extensive community involvement at the local level and use of the community's own resources are stressed.

The "Salud Comunitaria" programme in Panama in addition to establishing health posts, training local volunteer health workers and carrying out immunization campaigns, supports cultivation of community gardens, and undertakes water supply and latrine construction. The emphasis is on activities that create a healthy environment for the community.

Community participation

While it is important to plan for basic services on an integrated basis, it will often be advantageous to initiate services in a community sequentially, beginning with a priority need established through discussion with the people. Water supply, for example, may be a felt need in some places which will activate villagers to undertake first this, then other measures for improving their community. This was the case in Malawi, where villagers enlisted in piping pure water down from the mountainside became motivated to begin activities of health, nutrition, sanitation and education. They are now participating directly in over-all development programmes. A good deal of experience confirms that joint work by representatives of government services and community to meet a real need is one of the best ways to develop community participation.

The people of the community should be involved from the outset in identifying their needs, choosing the sequence for beginning village improvements and in implementing them. This helps take into account local traditions, customs and agrarian cycles of activity. Government workers at the next level above the community should be able to be responsive to these initiatives. Development policy and support should be flexible enough to follow leads in several acceptable fields.

Points of entry may be sought by some sort of survey of needs and aspirations, preferably carried out by villagers trained for this purpose. A "community self-survey" is being used in Indonesia to learn the needs and wants of the villagers. A

questionnaire is worked up and tried out on people from the community Some members of the test group are then selected to carry out the survey. After brief training, they survey the needs, existing resources and aspirations of their fellow villagers.

Community participation is often easy to begin but is also often neglected. In organizing "Project Compassion" in Quezon Province of the Philippines, for example, the training of *barrio* leaders was received with such enthusiasm that, at their request, the organizers conducted supplementary training involving all of the people in the community. In another country, however, where local health promoters are being trained to provide "simplified medicine" in remote communities, villagers are not being effectively included in organizing or helping to carry out health activities.

Choosing the village workers

Community participation should also be invited in choosing the community workers. The people of the community will place greater trust in their workers and turn more naturally to them when they participate in choosing from amongst themselves those who are to receive training. Consultation is advisable between the community and the governmental services responsible for training and technical support. Formal requirements, educational or other, must not be set so high as to exclude too many community candidates. A village might have such workers as the village farm adviser, a midwife, a basic health worker, a nutrition and child care adviser, and a basic educator. When chosen by their neighbours, they can serve with more understanding than a better educated townsman who is unhappy with his rural assignment.

Villagers in the Thiès region of Senegal, for example, select from amongst themselves the person to take a three-month course to become the volunteer pharmacist and health worker for the community. In the Puno region of Peru the communities are electing the young rural leaders who receive training to run the "initial education" centres. In Niger, the choice by the villagers of their community health worker is based on certain criteria: he or she must be a volunteer, live in the village and be willing to undergo training. The "worker doctor" in China is chosen by fellow factory workers to become the health worker in their shop. The same is true with the "barefoot doctor" in the commune.

Training the workers

The closer to their own community the village workers can be trained, the better. However, it is obviously more convenient to train a number of workers simultaneously from a number of nearby villages—sometimes an existing facility may serve as a training centre. Village workers in Botswana, for example, called "family welfare educators", are being trained at a rural training centre near the capital. They receive

eight weeks of classroom work and three weeks' field experience in such subjects as nutrition, home economics, gardening and poultry raising, community development and social problems.

The length of training may vary, depending on the subject and resources available. "Barefoot doctors" in China most often receive a three-month formal training in either the county or commune hospital, divided between theoretical and practical work. This is followed by a period of supervised, on-the-job experience. As many have good educational backgrounds and all receive regular training and upgrading, they become progressively more skilled; some becoming fully qualified doctors.

On the other hand, the courses in the Niger health programmes last only ten days in the nearest dispensary, organized by the nurse in charge assisted by the chief nurse of the district. The training of these village health workers covers general health concepts, measures against epidemic diseases, health education, elementary health care, emergencies and referrals. After this brief training, the village workers become the frontline link between the people of the village and the national health service. Every year, they attend a retraining course of ten days which gradually introduces new topics, such as preparation of weaning foods and instruction about their use.

In addition to regular re-training each year, other ways can be found for regularly upgrading the capabilities of the workers or augmenting their capacities for instructing their neighbours. In the nutrition programme in the Philippines, local leaders receive new information each day through radio broadcasts in five local languages providing educational and cultural programmes, project orientation, and language instruction.

A way of integrating services at the community level might be to provide the different members of the village or neighbourhood "team" with a basic training before they go on to receive more specialized training in their specific tasks. This is being done in Indonesia where it was found that, at first, training of local leaders was too theoretical; now the training focuses on specific problems of the villages from which local leaders come. They are receiving basic training to work together as an "integrated team" to lead the villages in solving problems of nutrition, education, environmental sanitation, family planning, and non-formal education for school leavers.

This may be more elaborate training than some countries can undertake during the initial phase of organizing basic services. Where training of village or community workers must at first be brief, however, it can be repeated and upgraded in courses given every year and through on-the-job supervision and instruction.

Simplified techniques and technology

Much modern technology and many techniques are inappropriate or irrelevant to the immediate needs of villages or shanty-towns. Intermediate technologies, developed out of local experience and making use of local materials, are better suited to the immediate tasks of community workers. These might be thought of as "next step" techniques and technology—starting out from where the villagers are right now, rather than trying to impose modern methods and equipment upon them.

In the area of health, the World Health Organization is circulating information about simplified medical techniques suited for basic health workers trained for specific tasks. UNICEF is collaborating with other UN agencies in developing village-level technologies, such as the simple hand-operated milling and husking machines that have been made available to villagers in Senegal to lighten the workload of women. Other measures being tried include:

- improving traditional methods of crop storage to reduce losses in quality and quantity, which sometimes run as high as 30%;
- manually operated cereal and legume grinders and millet threshers;
- improving cooking arrangements to reduce fuel consumption and dangers to children;
- using sunshine for drying crops, treating water, and cooking food;
- manually operated oil extraction presses to enable communities to extract oil from their locally produced oil seeds;
- using wind and water power for pumping water, grinding cereals and legumes and for small-scale production of electricity.

Community support

In addition to helping plan their community's activities and selecting their fellows to be trained as workers, the villagers or urban neighbours participate in the initial costs and in supporting local costs of basic services on a continuing basis. It is an essential feature of the system of basic services to keep local costs to a minimum. In some cases, village councils or individuals appointed for the purpose may manage the local services.

For the capital costs, community support may take the form of providing a building or contributing labour and materials for construction. The rural maternity at Touba Tou, in Senegal, was built by the villagers as a community effort. The community leader urged them to make the centre as home-like as possible for the new mothers, so the straw-thatched, mud-walled huts are copies of the village homes, except for concrete floors installed for easy cleaning.

Community support towards running costs may be provided by the local administrative unit, that is from taxation; by a co-operative; from health insurance payments; by fees or gifts for services, and by payments for medicines. Community workers may contribute their part-time services on a voluntary basis while they continue to support themselves from their regular source of income. Alternatively, they may be paid directly or with individual gifts in return for services.

The rural maternities in Senegal are supported by fees—if the new mother's family can afford to pay cash, a week's stay costs 350 Senegalese francs ($US1.50). Fifty francs goes for maintenance of the maternity centre; the remainder is accumulated and every six months divided amongst the village birth attendants who run the centre. For those who cannot pay in cash, the family brings some eggs, a chicken or two, sometimes a leg of lamb.

Community support of basic services can bring them within recurring costs that the nation will be able to afford. A cost-benefit analysis would probably show that the investment is repaid many times over in a growth of the national economy as the people become motivated to participate more effectively in rural and national development, not to mention the direct contribution of the services to raising the level of living.

Auxiliaries - the link to the next level

Community workers need a good link to the national infrastructure, to be able to refer cases they cannot deal with, and to receive technical information, logistical support, and supervision. Many systems provide for a visit to the village every week or two weeks. Such a programme can only be fulfilled by auxiliary workers, with a much less frequent visit by professional staff.

Most countries are now using auxiliaries—auxiliary nurse-midwives, sanitarians, health visitors, community development workers, promoters, *animateurs*, monitors and others with local denominations. The basic services system means using them, as well as other parts of the present infrastructure, in a different way. They would not make the *primary* contact with the client for the delivery of services, hence serving only a small proportion of those in need. Instead, auxiliaries should become part of the support system for the community workers—guiding and helping them, bringing them supplies, dealing with cases and problems that the community worker refers upward because he is not qualified to handle them.

In addition, more auxiliaries will usually be needed. With the great expansion of coverage made possible by the basic services programme, the workload of support services and referrals will be greater than the primary contacts they handled previously.

Referral / Supervisory levels

The next level in the system is the support echelon or the first referral level. It may be the health centre in a larger village, or the provincial or district office of the department of agriculture, of public works, of education, etc., situated in the district town. It is directed by fully trained professionals, and provides the base for the auxiliaries who are travelling out for regular visits to the community workers.

Supplies reach the village workers through this point. Community workers, trained in simplified techniques to provide basic medical treatment, refer more serious illnesses or injuries on to the health centre or major clinic operating at this next level. A major function of this level will be the training of community workers, technical guidance, direction and the supervision of their performance. The province or district provides an important level of co-ordination among the services of the different ministries concerned. The needs of different areas in such fields as drinking water, access roads, expansion of production, health and educational services, are so concrete that it is easy for those responsible for each of the sectors to see the greater return to be obtained by making their services mutually supporting. The interest and support of the population can be fostered more effectively, and the educational and developmental messages going out to them will not be contradictory.

There may be several referral and supervisory levels between the village and the national government, depending on the administrative structure of the country and the service concerned. A federation has an additional state level. Health and educational services will usually have more levels than agriculture. However, similar principles apply.

Success in developing village services will generate increased workloads at the referral and supervisory levels. Some expansion of professional staff will be necessary, along with a major expansion of auxiliary staff. Personnel already in position will need in-service training to reorient them to their changed functions. In order to bring referral services within reasonable distance of communities, it will usually be necessary to open some new centres or offices of the district type.

A common weakness is to give too little attention to the reorientation and training of staff at these intermediate levels, including in an appropriate way the senior administrators. Without a change of outlook and work plan of the supporting staff, the community-level workers will be under-trained, under-supported, and under-supervised. Good reorientation usually includes exposure to working systems at field level, and work in groups similar to the teams of different professions and levels that need to work together. It is frequently said that the necessary reorientation of the supporting services must occur first in the minds of the government officials.

National Level

Basic services should be integrated at the village or community level, and at the district level, but support for this has to come from the national level. While the local level should contribute substantially to the cost of services with visible benefits, the centre has to provide the cost of training, direction and supervision, and much of the cost of equipment and supplies that come from outside the area.

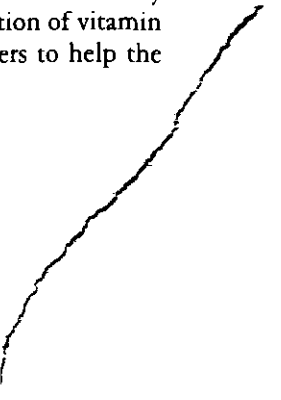
The main responsibilities at the national level will be to provide long-term planning of basic services integrated with development, to give impetus to the implementation of agreed policy, to provide budgetary support, to ensure co-ordination, and arrange for some continuing monitoring or evaluation with the objective of achieving maximum effectiveness.

The concept of basic services involves a number of ministries and cuts across conventional departmental or sectorial planning and budgeting procedures. Common planning can be accomplished through an interministerial committee, by the social division of the planning commission in contact with the planning cells of the different ministries, or by the office of the president or prime minister. As can be seen in the experiences which follow, the national plan can provide for a programme of basic services either country-wide or starting in one region, then extending that experience.

The Young Child

In developing basic services, special attention must be given to the needs of the young child. The first five years of life are the formative years. Whether an individual survives the first few years and how, determines whether he or she will grow up into an energetic, productive adult. Malnutrition can make mild childhood diseases fatal. Prolonged poor nutrition can leave the child retarded or lacking in curiosity, energy and capacity of learning. Lack of calories, vitamins and minerals, prevent the child from growing fully or leave him or her blind. Many of the diseases of childhood can leave the individual permanently crippled or ill.

On the other hand, improved conditions of family and community life help overcome these many dangers of childhood. Improved midwifery, minimal preventive health measures, improved water supply and sanitation, cleanliness in the home, basic mother and child health care, knowledge on the part of the parents of family planning, better nutrition, campaigns for immunization and distribution of vitamin A to prevent blindness—all can be carried out by basic village workers to help the small child grow to his full potential.



THREE EXPERIENCES

Planning zones

Recent experience in Indonesia suggests how basic services can be planned and implemented as part of economic development in planning zones. The regional planning process in that country aims at overcoming inequalities in the rate of development between different regions and different segments of the population. The National Planning Board created 10 regional zones with four urban growth centres. Within these regions, areas were selected as development zones. The Government's goal is to achieve basic services in the rural villages and urban neighbourhoods of these zones.

The Government set about through the National Planning Board to create planning boards in each region and city planning units in most of the urban centres. The capacity of these sub-national planning units is being built up by involving the new regional and urban planners directly in formulating the plans for the selected development zones. From the outset, the regional planners in addition to a six-week training course have been involved in collecting data, conducting surveys and analyzing needs, helping to formulate zonal plans, and implementing these in the field on an experimental basis to assess their suitability for wider adaptation.

The basic services are being developed in a "converging" way—that is, those that already existed are being pulled together and others established to fill in the gaps so that minimum services will be delivered in a co-ordinated manner to all families in each development zone. These include: basic health services, water supply and sanitation, nutrition and growing of more nutritious foods locally, schools and non-formal education.

How this is being done can be seen in one of the first development zones of the new regional planning programme, the *kabupatan* of Indramayu on the north coast of West Java. This area, with more than a million people living in 184 villages, suffered from recurrent food shortages caused by alternating floods and drought. The principal crop was rice. Under-nutrition and malnutrition were serious, especially amongst infants and small children. Infant mortality was high; life expectancy low, the birth rate high, health facilities remote and underused, most households were getting water from unsafe sources, waste disposal was unsanitary, and a third of the population illiterate. A large part of the work force was composed of landless farmers, with severe unemployment and underemployment; many went to Jakarta in search of work as seasonal labourers.

Development of the infrastructure within the area was unbalanced. While there

were government services, they were fragmented, concentrated in some areas and not reaching all the people of the area. The purpose of planning was to pull these existing services together, to augment and extend them more uniformly throughout the countryside. The numbers of personnel were not sufficient to maintain contact with the communities, and most activities were not co-ordinated in a way that would contribute to development. Community development activities, where they existed, relied chiefly on departmental field workers.

The Government set about to change these conditions through the regional planning mechanism. Until the regional planning board was sufficiently developed to function on its own, the National Planning Board provided a multi-sectoral team from the various ministries to give leadership in preparing the plan for the development zone. The regional planning trainees, after initial formal training, participated in data collection, survey of needs, assessment, and preparation of the plan. The planning process involved interaction between ongoing activities in the field, and the survey and analysis upon which the plan was formulated. Seminars and workshops for regional planners from different zones provided opportunities to exchange ideas and experiences between the various regions of the country, which differ both in needs and in possibilities for social development. In addition, regional planning personnel from Indonesia visited Malaysia and the Philippines.

In Indonesia, the people have a tradition of mutual help—*gotong royong*—so that community participation is natural to them. Previously, community development had largely concentrated on strengthening the professional capacity of departmental field workers and supervisors. Village leaders were receiving some training, but during the planning process their training was assessed as too theoretical and classroom-oriented. Both the methods and content of training were revamped so as to focus on the specific development activities designed to solve problems similar to those in their own villages and to enable various village leaders to act as "volunteer community workers" in the way described in the preceding section. Most of the training now takes place in the field. This change in the content and style of training applies to the community development programme as a whole.

Greater numbers of departmental field workers (auxiliaries) are being trained to support the activities of the village leaders and to serve as the link between the communities and the government services provided by various departments. The auxiliaries and community leaders, after receiving basic training together, now work as integrated teams, catalyzing community action in planning and implementing village projects. These include: rural drinking water supply and sanitation; nutrition and local food production; basic health services; community school projects; non-formal education and pre-vocational training of young people. Developmental activities include: water for irrigation; diversification of agricultural production; soil con-

servation, marketing and small holders' credit facilities, environmental sanitation, and human resources capability development.

Most of these activities rely heavily on community support in the form of money, material and volunteer labour. The Government now provides an annual subsidy directly to each village for capital investment aimed at physical and economic development of the community. The village leaders have been trained in various aspects of community management and development.

Countrywide

Tanzania is an example of a country in which the Government is committed to a policy of establishing minimal essential services for all the people of the nation as soon as possible. The Arusha Declaration placed the emphasis in development on "the people and their hard work" and stated that "this is the meaning of self-reliance". As more than 90 per cent of the population lives in the countryside, the stress is on human development in rural areas.

As much of the population was scattered, the Government proceeded on a course of "villagisation"—to bring people together into larger settlements so that basic services could be developed more effectively. This is being done through either Ujamaa villages or other development villages. Top priority is given to provision of water, basic health services, and universal free primary education. Goals have been set: basic health services to all the population by 1980; a good accessible water source for each village by 1980; universal free primary education by 1977.

The principle of self-reliance led to decentralization, with community involvement in planning at the start of each project. Mass mobilization is used to raise the consciousness of the people to make them responsible for meeting their own needs. The guidelines of the TANU party state that it is not the leaders and a few experts who decide the plan and then urge the people to implement it, but the leaders and experts must implement plans agreed upon by the people themselves. Responsibility for their own development and much of the power to marshall resources towards that end have been devolved upon Village Councils.

The party organization extends down to the village level. At each administrative level—village, district, region and nation—planning committees include elected representatives of the people as well as departmental experts. The people of the community are involved not only in planning but in implementing projects.

In the newly settled villages—consisting of 100 to 500 families—the people of the community are being helped to create their own basic services. Specially trained de-

velopment workers assist the villagers, but the villagers choose from amongst themselves those who are to become basic health workers, teachers, the village agriculture leaders, water pump attendants or day-care centre leaders. All become "village action leaders".

Attitudes of mutual respect, co-operation and equality are fostered in the villages, and emphasis is placed on local contributions to developing the village services. For example, village health posts and dispensaries are constructed by the villagers with the Government contributing materials, equipment and services which cannot be supplied locally. Sometimes an existing building is used. The villagers also help construct the water supply system and build their own sanitation facilities. Simple tools and methods are devised and local production encouraged for meeting local needs.

The way village medical helpers are trained and carry on their activities with the support of the community suggests how village workers are being developed to help the villagers provide their own basic services. The training is a three to six month practical course at a health centre or district hospital. While the Government would prefer that those chosen have seven years primary education, this qualification is relaxed in training—as local medical helpers—healers, medicine men, traditional birth attendants or herbalists.

A village medical helper can treat minor illnesses, dispense simple medicines from the local dispensary and provide emergency medical treatment for injuries, but he refers more serious cases to a rural health centre. Health education is carried on by informing the people of the village about such matters as nutrition, hygiene and sanitation. This is an important part of the work of mobile health teams, as well as the local medical helpers. The village medical helper is not paid; his service is regarded as his contribution to the work of developing the village.

Above the local dispensaries, rural health centres and mobile health teams, are district hospitals, under the supervision of the District Medical Officer. At the next level, there are regional hospitals, under the Regional Medical Officer. These activities are co-ordinated by Regional and District Development Directors and, at the national level, the Ministry of Health co-ordinates with the Ministry of Agriculture and Cooperatives and the Ministry of Labour and Social Welfare. Nationwide health campaigns are carried out, providing information through radio, magazines, booklets, posters, and newspapers about specific diseases and preventive health measures.

Similar approaches are being used to provide water, education, improved nutrition and agriculture at the village level. In all of these the element of self-help is of primary importance.

Village teachers are being trained and retrained in formal and non formal education techniques. The philosophy of "Education for Self-Reliance" calls for Basic Education for adults as well as children, to give them the role of agents of change in their community. It includes learning more suitable methods of farming as well as other aspects of rural development.

Basic Education is regarded as an essential component of other basic services and helps to co-ordinate them at the village level. Nutrition education, for example, is incorporated in mother-child health services, schools, day-care centres and in agricultural instruction. The co-ordination of the various services results in their being mutually supportive,so that a heightened understanding on the part of the people strengthens the basic services in the villages.

Starting in one or a few regions

The project under way in the department of Chuquisaca, in southern Bolivia, is an example of basic social services being developed in co-ordination with rural development in a region to provide experience for replication later throughout the rest of the country. The Government aims at bringing the *campesinos* (who make up two-thirds of the nation's population) into national development. In 1972, it chose Chuquisaca and another province to carry out the first regional economic and social development programme. Among the reasons for choosing this region:

- the existence of Provincial Committees for Development (created originally in 1938 to administer oil revenues);
- existence of an infrastructure of social services which, though inadequately developed, offered a basis for implementing the plan of action; and
- the variety of local situations were ideal for an experimental project, from which experience gained could be adapted to other regions of the country.

While the mortality rate was high, the ten major causes of disease were susceptible to control by preventive measures. Malnutrition was high among children under five; food consumption *per capita* was estimated at only 73.2 per cent of daily requirements; 82.4 per cent of the population had no safe drinking water supply and 92.5 per cent no sewage disposal system. Of 235,200 young people of school age, only 85,857 were enrolled in school. Unemployment, particularly affecting youth, was approximately 25 per cent. Though agriculture was the principal economic activity in the region, 45 per cent of land suitable for farming remained unused.

The area has oil reserves but *per capita* income remained at approximately $110 per year. It was recognized that revenues from oil would flow into the region for only a limited number of years, so they must be invested in a way that would bring long-term development. The Provincial Development Committee had attained a high level of managerial capacity and offered a decentralized provincial government

authority, with its own financial resources, through which to carry out economic and social innovations. The aim was to improve living conditions at the same time that the people in marginal rural areas were being brought into development. A division of Social Development was set up to help the Committee deploy—in a mutually supporting way—the activities of departments dealing with works (for access roads and water), agriculture and animal husbandry, education, health, etc. At the provincial level, where the departments are in touch with the specific local needs of communities, practical co-ordination has been achieved more easily than at more remote levels.

Typical villages were selected in which to begin activities. Using the local government structure, the people of the communities were brought into the development process. The realities of the villages and the needs and wants of the people were the basis for agreement on how to proceed. Initial activities concentrated on building needed structures, for health posts or schools. The people contributed labour and local materials while learning basic skills. This led to community involvement in various activities aimed at creating the basic infrastructures for economic as well as social development.

These activities include construction of access roads, increased production of fruits and vegetables through small-scale irrigation, community crop storage, sheep raising, both production and consumer co-operatives, and handicraft workshops. Young people are being trained in construction work or in improved techniques for introducing new crops. Efforts are under way to improve rural housing, and community participation is being stimulated to provide health services, water supply and environmental sanitation, and education.

The inter-sectoral approach is being furthered at the community level by using the "nuclear school" as a community centre. (Bolivia, along with some other Latin American countries, has been developing for thirty years the "nuclear school" system, which has a central school with outlying satellite schools grouped around it and supported by it.) Villagers of all ages are being trained to participate actively in development tasks. Basic instruction is given in such subjects as health education, education to improve the rural economy, and home economics. To aid in construction of such facilities as health posts, schools and access roads, short courses are given in masonry and carpentry. Other courses explain the objectives of the rural economic and social programme to school teachers, and they are being motivated to participate actively as agents of change in their communities. Each community is choosing its own priorities and setting the sequence for implementation. While in the preliminary stage organization at the community level tended to be weak, a constant process of consultation with the people aims at reformulating activities so as to gain community support. The strategy of rural economic and social development being evolved in this region of Bolivia has now been incorporated into the five-year development plan for 1976-1980.

BRIEF EXAMPLES

The following examples illustrate the many different experiences that can be drawn upon by countries wishing to extend basic services. Not all present initiatives are included. Most of the examples described have not reached the stage of comprehensive basic services, but are still developing:

BANGLADESH. A rural health insurance scheme centered in the *thana* of Savar (population 200,000) illustrates community involvement and support, the use of village-level workers, and growth from basic health services into agricultural and home economics extension at the village level. Families subscribe the equivalent of US 25 cents per month for out-patient treatment, vaccinations and family planning services, and receive hospital treatment at a reduced charge. There is a hospital, 11 sub-centres, and part-time health workers in each village. Some of the latter have been recruited from among senior students in the schools.

The health services scheme is seen as part of general development, and it has come to provide an extension system giving information and demonstrations about better agricultural practices, local crafts, family gardens, home improvements, etc.[1]

BOTSWANA. Offers an example of village level auxiliary workers called "family welfare educators" who are promoting child care, family health, family planning, and nutrition and home economics. Candidates for training are primary school leavers, at least 20 years old, who live in and have the approval of the community they will go back to serve. Training is given for two months at a rural training centre with practice areas. Upon completion of training they are employed by District Councils. They receive a supervisory visit at least once a month, usually by a nurse.[2]

BRAZIL. The work done by the Brazilian Association of Credit and Rural Assistance (ABCAR) and its affiliated state associations, offers an example of an unusual starting point for what grew, for practical reasons, into rather comprehensive services. From its primary concern, when founded in 1948, with small agricultural credit and extension, ABCAR has added water supply and health services, better food and nutrition, education, and rural youth activities. This has come about with involvement of the rural population and co-ordinated support of government agencies in these fields. ABCAR's local offices are at the level of local government (*municipio*), and the staff

1. Zafrullah Chowdhury, The mother and child in Bangladesh - a view from the People's Health Centre, Les Carnets de l'enfance, No. 33, January-March 1976, UNICEF, Geneva, pp.68-77.

2. Marit Kromberg et N.N. Mashalaba, La formation des monitrices en mieux-être familial au Botswana, Les Carnets de l'enfance, No. 33, January-March 1976, UNICEF, Geneva, pp. 97-108.

always includes a woman trained as a teacher or in home economics, social work, or nutrition. At the level below, community leaders are trained through short courses and serve as volunteers, working with local groups and individuals.

CENTRAL AFRICAN REPUBLIC. In Basse-Kotto (population 110,000) a number of communes are developing basic services with support coming in the first place from the national community development organization, and based on rural community development centres. (An economic base is provided by the development of fish ponds and market gardening.)

Health services have been drawn in, and new health centres and health points established, substantially staffed by para-medical personnel. MCH services and immunizations are being emphasized. Teachers are being given refresher training as part of a reform of education designed to make it relevant to village life.

COLOMBIA. A scheme for extending services to some shanty-towns around Cartagena is taking as its initial activities day care, health education and preventive health services, literacy training and family life education, recreation and sports. The services are based on neighbourhood development centres. Low-cost loans are given for purchase of tools and materials for house improvement and for job training for young persons.

COSTA RICA. Primary health care delivery has been extended into the unserved areas of the north of the country since 1972. Services included vaccinations, improvement of environmental sanitation, family planning, school and family gardens. New health centres have been opened. The number of auxiliary health workers has been expanded and a new category of local community volunteers has been established. Because this system is regarded as working successfully, the government has decided to use the infrastructure to extend other basic services to the village level. [3]

EGYPT. Experience in providing urban basic services is being gained in projects under way in Boulak Eddakrour in the Giza Governorate, Shubra El-Kheima on the outskirts of Cairo, and Darb El-Ahmar in the inner city of Cairo. Citizen participation is being encouraged through citizen committees concerned with meeting specific physical needs of the communities. In the early stages, citizens groups dealing with water and sewerage, for example, were having greater success than those concerned with women's activities and youth affairs. The active participation of citizens committees in programme implementation has been an important stimulus to the Government in developing a national policy for meeting the needs of the urban poor.

3. William Vargas Gonzáles, Programas de nutrición aplicada en zonas rurales de Costa Rica, Les Carnets de l'enfance, No. 35, July-September 1976, UNICEF, Geneva, pp.80-91.

INDIA *Andhra Pradesh, Hyderabad* Urban community development, under way for eight years, now reaches 60,000 out of 300,000 slum dwellers with a wide variety of improvement programmes—from primary health care and pre-school programmes to house construction and environmental upgrading. A small experienced staff works mainly with groups of slum dwellers who organize and act on their own behalf. The staff is committed to the principle of linking physical improvement of the slums with human services. An extension is under consideration to provide a broad spectrum of basic services to all children in the 0-6 age group.

"Indo-Dutch" Project. Originally, a project aimed at delivery of integrated health services only, it is gradually moving towards community participation and inclusion of other services, notably pre-school education and nutrition (with emphasis on the use of local foods for weaning).

"Crisis". A voluntary organization supports this project, so called because it starts in crisis situations, usually where simple house construction is the first need after floods or other disasters. With trained volunteers the project extends community self-help with very little material aid to other areas of concern to the villagers.

Gujerat, Vasna, Ahmedabad resettlement project. The Ahmedabad Study Action Group (ASAG) has built a colony for 2,250 families whose slum colonies were destroyed by floods. These were the significant aspects:

a) the successful collaboration of municipal, state, centre, international agencies, and local voluntary organizations;
b) the involvement of the slum dwellers from the outset to make this a total development project rather than simply a resettlement one;
c) the fact that the people are buying their own houses over a period of 18 years at $2.50 per month.

Haryana, Narangwal. A well established model of primary health care services in a small area is administered by the All India Institute of Medical Sciences, as a pilot area for primary health care training. The AIIMS advocates the use of village level workers in primary health care, and plans to go beyond the field of health as soon as possible. It also plans to extend the pilot area to cover an entire district.

Maharashtra, Jamkhed in Ahmednagar District. An experiment in primary health care services was started in 1970 in a rural area of 30 villages (40,000 population). It trained female village health workers and brought the Ayurvedic doctors and traditional midwives and healers into the system. Auxiliary workers from the next echelon visit each village once a week. Two doctors guide the services and man the health centre at Jamkhed.

Through close contact with the people, the village health workers found that their priorities were not health services but an increase of agricultural and food production, access roads, electricity and the provision of irrigation and drinking water and housing. The project responded to these needs in various ways within its means, e.g. by renting cultivating machines, deepening wells, providing better seeds, etc.

The community participates in decisions, provides land and buildings, gives foodstuffs for supplementary feeding, builds roads, mobilises the population for vaccination, etc. [4]

Kasa development block. With the support of the paediatrics department of the Institute of Child Health, Grant Medical College, Bombay, services are being developed in 60 villages served by the Kasa health centre, which constitute a tribal development block. To the professional and auxiliary staff of the health centre has been added a further level of link workers with the villages, comprising 28 "part-time social workers". They are recruited from the villages and serve two villages or about 2,000 people each, receiving an honorarium of Rs. 80 or US$ 9 per month. They deal with basic child care including monthly weighing; nutrition education and distribution of nutrition supplements made from local foods to the seriously undernourished young children; immunization; family planning; and referral of those needing the attention of the health centre. They are trained to detect and give particular attention to those "at risk" among the under-sixes and married women. The PTSWs meet with the villagers and their leaders and inform them of the nutritional and immunization status of their children. They also inform them about those who are "at risk" and the social problems involved. Local government at the village, block and district level is beginning to share the cost of the PTSWs. [5]

MALI. In part of the Ségou region there is a 15-year plan for expanding rice production with bilateral assistance. In 1973, a social service component was added, including functional literacy; MCH and health protection; projects for lightening women's work (through wells, mills for grinding cereal, hand carts); and the participation of youth in development (provision of land for them to work and workshops for rural crafts).

A cell has been set up in the National Directorate of the Plan to work in close liaison with the different ministries providing support services at the local level.

4. Alternative Approaches to meeting basic health needs in developing countries, WHO, Geneva, 1975, pp.70-77.

5. P.M. Shah, Community participation and nutrition - The Kasa project in India, Les Carnets de l'enfance, No. 35, July-September 1976, UNICEF, Geneva, pp.53-71.

Women's clubs are an important channel of community participation This cell is co-ordinating efforts to extend this approach to other regions with different economic basis.

MEXICO. In the highlands of Chiapas, comprehensive services at the village level are being extended to the predominantly Indian population, until now outside the mainstream of national development. This programme has the strong support of the Governor, who seeks a co-ordinated deployment of the departmental services. When the programme began in 1970 one of the first steps was the establishment of a network of radio communications between the larger villages and the operational centre in the chief town in the highlands. This greatly increased the possibilities for local participation. Activities were then undertaken to increase income in the area and to deliver health and education services.

Auxiliaries are used in extension (rural promoters) and health (auxiliary nurses). Auxiliary nurses with three months training are provided with food and lodging by the community. School teachers receive refresher training as part of a programme to use schools also as centres for non-formal education.

At the village level, community leaders are being trained and have become a source for many programme initiatives. Lay midwives have been drawn into the health system; women's and youth clubs provide additional links with the community.

An Indian community radio broadcasts in the four Indian languages, and includes information about agriculture and home economics, family planning, nutrition and local food production, water supply, health, education, youth clubs and women's clubs.

The programme is now being extended to backward areas in a number of other states.

NIGER. In the department of Maradi, a primary health care delivery system has been considerably extended since 1966, with the joint support of the ministries of health, *animation rurale*, and education. The starting point for any locality is a discussion between the inhabitants and high-level representatives from these ministries and the political party, held under the chairmanship of the prefect or the sub-prefect.

Health services are extended by training of village first-aid health workers who are provided with a "village pharmacy" containing simple and "safe" medicines useful against the region's most common illnesses. The first-aid and health workers are volunteers, working part-time and receiving some food from the community. They attend a ten-day refresher course each year at the nearest health centre. Village midwives are also receiving training and refresher training. A village management committee oversees the work of the health team and the pharmacy. More women exten-

sion workers (*animatrices*) are being trained Help is being given for family food production. The programme is being extended to other departments. [6]

PAKISTAN. A "country health planning exercise" undertaken with WHO's assistance during 1975, is leading to application of the primary health care approach to different degrees in various provinces. In the Northern areas under federal administration, there are already some 1,600 "health guards". In villages of the North West Frontier Province, as part of an integrated rural development programme, a modest start has been made in the delivery of elementary health services by some of the religious leaders. The province of Punjab has begun training medical assistants. Baluchistan has started training health auxiliaries. The province of Sind has pioneered polyimmunization of children; a service which will be extended by all provinces.

The provinces are also giving technical and material support to localities for the extension of a safe water supply, according to the widely different hydrogeological conditions. In the field of education, the Government has set a policy objective of delivering basic education to the outlying villages. [7]

PANAMA. Earlier experiences with health and water programmes led to two different organizational patterns for extension of basic services, in different areas of the country.

The *Salud Comunitaria* programme aims at promoting and protecting all aspects of community health. Its components include: mother and child health care, adult medical services, health education, and nutrition measures. An extensive water supply and sanitation programme was carried out during an earlier phase. As a first step, the Government promotes community organization. Local health committees are formed, and the people participate actively in nutritional and agricultural measures. The Government provides technical advice on agriculture as well as in health matters. The health committees are in charge of distributing the food harvested for local use; they sell the surplus produce and administer the revenues to provide for the health needs of the community. [8]

The other organizational pattern has led to a programme of integrated basic services in the nine least developed *municipios* of the country. The administrative unit is the electoral district and the elected representatives from these districts in the

6. Alternative approaches, op. cit., pp. 78-83.
7. K. Zaki Hasan, The rural Health Guards in the northern areas of Pakistan, Les Carnets de l'enfance, No. 33, 1976, pp.78-87.
8. Cútberto Parillón Delgado, La producción alimentaria a traves de huertos comunitarios en Panamá, Les Carnets de l'enfance, No. 35, pp.92-99.

Assembly assist in directing the programmes Teachers also serve as volunteer community workers, as well as being concerned with agriculture and rural crafts.

PERU. In the province of Puno, a programme for delivery of services has a number of interesting features—a provincial development planning committee; the revival of traditional Indian community ownership and responsibility; and the strategic importance given the young child.

Economic development is based on revival of silver mining and improvement of pastoral industry, crafts and local family food production. There is a policy of communal and "social" property. Part of the revenue from social property must go to support community services.

The extension of services has begun with "*educacion inicial*", a non-formal programme for pre-school children. The decision to start services for young children was based on modern knowledge of child development and the belief that this would be the best way to overcome fatalism so as to improve initiative and enterprise in the Indian communities.

There has been a good response from the communities and parents. They choose the person ("promoter") who will be responsible for the pre-school programme in their locality, and support him. He receives short-term training and refresher courses every year. In 1976, the programme has been adopted by 122 communities.

The next step is to improve formal schooling as these children reach the school-entering age. Health services are being extended and 50 health promoters have been trained. Radio programmes have been started in the Aymara and Quechua languages.

PHILIPPINES. "Project Compassion", launched in mid-1975, aims at intregrating four programmes reaching into the community - the green revolution, the Philippines Nutrition Programme, and population and environmental programmes (clean water and waste disposal). These are to be linked into one delivery system reaching one million of the high-risk households in ten selected provinces, based on a combination of government and private agency work.

The Philippines Nutrition Programme is already reaching into communities with a common approach of all government and private agencies concerned. At the centre is a National Nutrition Council, including six cabinet ministers and three representatives of private agencies. There are nutrition committees at the regional, provincial, municipal and *barangay* levels.

The municipality is the focal point, in 1976 there were 1,500 municipal nutrition programmes throughout the country. The final link between the nutrition agencies and committees and the families is provided by the *barangay* network. Under the guidance of a *purok* (zone) leader, who is called a "teacher-co-ordinator", volunteer community workers are each responsible for watching the nutrition of twenty families. (This is an adaptation of a village system developed during World War II.) The nutrition programme revolves around five intervention schemes: health protection, food assistance, food production, nutrition education and family planning. The help and co-operation of the traditional midwives has been obtained. The schools have been drawn into health and nutrition education and the promotion of school and family gardens. [9]

SENEGAL. A scheme for administrative decentralization beginning in the Thiès region has, since 1973, been the base for extending village-level services to groups of rural communities each with about 10,000 population. The Khombole health demonstration unit has been working for many years in this region, and health services were one of the starting points. One of the first priorities was "rural maternities" constructed in the traditional way and staffed by trained traditional midwives or auxiliary midwives. Auxiliary workers (*monitrices rurales*) promote child-care, hygiene, and home crafts at the village level. Small community pharmacies are provided and volunteers are trained to staff them. Wells are being dug and protected. Simple milling machines are one of the means of alleviating the tasks of women. A malnutrition prevention and rehabilitation programme is being introduced following the 1975 regional seminar in Upper Volta.

These services are now being developed in the second decentralization region, Sinê-Saloum, and a third region Ojourbel is being added.

SUDAN. A "country health planning exercise" undertaken with WHO's assistance during 1975 is leading to the adoption of a "primary health-care services" approach.

THAILAND. In Lampang province (population 600,000) a pilot project is being used to try out new methods of delivery of health services before they are applied to the rest of the country. The object is to increase the output without an extraordinary increase in the government health budget, and to serve at least two-thirds of the women of child-bearing age and children under six. There is a focus on maternal and child health, family planning and nutrition services. The existing health structure is being extended by the introduction of "paraphysicians" for the health centre and sub-centres; "health post volunteers", one to each village; volunteer "communicators", one for every 10 or 12 households to provide a link between the patient-con-

9. Florentino S. Solon, The Philippine Nutrition Programme - A government and private effort. Les Carnets de l'enfance, No. 35, pp.72-79.

sumer and the government provider, and the training of indigenous midwives

After orientation meetings with officials at the various levels and the village councils, village advisory committees have been set up to participate in health planning, personnel selection and management decisions, and to provide feedback on performance. [10]

UPPER VOLTA. In the district of Yako, response to child malnutrition during the Sahelian drought led the health services to open nutrition recovery centres. Under the guidance of auxiliary personnel *(monitrices)*, mothers were shown how to restore their children to health with a gruel made from locally available foods (millet, *niébé* and palm oil). Mothers stayed at a centre, on an average, for three weeks—"old hands" instructing new arrivals—then carried the new knowledge back to their villages.

This method of preventing and treating malnutrition has now been incorporated into the health services. A volunteer "gruel *monitrice*" works in each village, supported by auxiliary nurses in the health centre system, supervised by the sector doctor.

Community response led to growth of the system to include training of traditional midwives and of volunteers capable of giving first aid in the villages with a "village pharmacy". Women mobilize the families for vaccination and for malaria prevention treatment.

The slogan of the child health committee of Yako is "health - nutrition - development". In some villages, development has gone on to well digging, increased production of the *niébé* bean, and improvement of access roads. Following a regional seminar, this approach is being extended to other parts of Upper Volta and is being taken up by neighbouring countries. [11]

YEMEN ARAB REPUBLIC. Local development councils are involving villagers in their water supply projects, to educate them about the importance to their health of clean water and environmental sanitation and to encourage them to maintain the water system. The water projects serve as focal points for community participation in starting other services, especially the rural primary health care programme which is getting under way as part of the Second National Development Plan.

10. Somboon Vachrotai and Lampang Project Staff, The Lampang Project, an alternative approach to rural health care in Thailand, Les Carnets de l'enfance, No. 33, pp.88-96.

11. Cyrille Niameogo, Les monitrices de bouillies en zones rurales de Haute-Volta, Les Carnets de l'enfance, No. 35, pp.31-40.

FOR FURTHER INFORMATION

Following is a selection from the many publications bearing on different aspects of basic services. UNICEF field offices can assist ministries and training and research institutions in obtaining them. When translations are available, this is indicated by E.F.S. for English, French and Spanish respectively.

Health

"Alternative Approaches to Meeting Basic Health Needs in Developing Countries", edited by V. Djukanovic and E.P. Mach, a joint UNICEF/WHO study, World Health Organization, Geneva, 1975, 116p., F.S.

"Health by the People", edited by Kenneth W. Newell, World Health Organization, Geneva, 1975, 206p., F.S.

"Paediatric Priorities in the Developing World", David Morley, Butterworth, London, 1973, 470p.

"Health". Sector Policy Paper, World Bank, Washington D.C., 1975, 83p., F.S.

"Alternative Approaches to Health Care", Les Carnets de l'enfance/Assignment Children, No. 33, January/March 1976, UNICEF, Geneva, 136p. E.F.S. summaries.

"Health Services and Medical Education, a Programme for Immediate Action", report of a Group on Medical Education and Support Manpower, Ministry of Health and Family Planning, India, Indian Council of Social Science Research, New Delhi, 1975, 56p.

"Action for Children: Towards an Optimum Child Care Package in Africa", edited by Olle Nordberg, Peter Phillips, and Göran Sterky, Dag Hammarskjöld Foundation, Uppsala 1975, 238p.

"The Primary Health Worker, Working Guide, Guidelines for Training, Guidelines for Adaptation", Working document HMD/74.5, World Health Organization, Geneva, Rev. 1976, 338pp. F. ("L'agent de santé communautaire")

"The child in the health centre, book one: A manual for health workers and a component of a child care package", Lembaga Kesehatan Nasional, Indonesia, Government Printer, Jakarta, 1974, 554p., E.

"Child health care in rural areas, a manual for auxiliary nurse midwives", Rural Health Research Centre Narangwal, Asia Publishing House, Bombay, New York, 1974, 364p.

"Donde no hay doctor, una guia para los campesinos que viven lejos de los centros medicos" David Werner, Editoral Pax, Mexico, revised 1975, 300p.

"A model health centre, a report of the working party appointed in 1972 by the Medical Committee of the Conference of Missionary Societies in Great Britian and Ireland" R.K. Hudson, London. 1975, 16p. (appendices 1-52).

"Low Cost Rural Health Care and Health Manpower Training", an annotated bibliography with special emphasis on developing countries by Shahid Akhtar, International Development Research Centre, Ottawa, 1975, 164p.

"The training of auxiliaries in health care, an annotated bibliography" compiled by Katherine Elliott, Intermediate Technology Publications Ltd., London, 1975, 110p.

"Manuel de Reference Destiné aux Auxiliaires Sanitaires et aux Enseignants Chargés de leur Formation" World Health Organization, Geneva, Revised 1976.

"A composite list of equipment and supplies for peripheral health facilieies, UNICEF guide list "Rani", UNICEF, New York, 1976, 90p.

"Provisional Reference List of Equipment and Supplies for Peripheral Health Services" (SHS/75.2) WHO, Geneva 1975, 82p.

Water

"Water and community development", Les Carnets de l'enfance/Assignment Children, No. 34, April-June 1976, UNICEF, Geneva, 136pp. E.F.S. summaries.

"Village Water Supply, a World Bank paper", World Bank, Washington D.C., 1976, 96p., F.S.

"Village Water Supply, Economics and Policy in the Developing World" by Robert J. Saunders and Jeremy J. Warford, published for the World Bank by Johns Hopkins, Baltimore, 1976, 279p.

"Water Treatment and Sanitation", a manual of simple methods for rural areas of developing countries. Intermediate Technology Publications, London revised edition 1976.

"Rural water supply and sanitation in the developing countries", UNICEF guide list "Olga", prepared in consultation with WHO, UNICEF, New York, 1975, 324p.

Nutrition

"Manual on Feeding Infants and Young Children", Margaret Cameron and Yngve Hofvander, 2nd edition, PAG, United Nations, New York, 1976, 184p.

"The Feeding and Care of Infants and Young Children", Shanti Ghosh (an adaptation and extension of the above manual for India) UNICEF, New Delhi, 1976, 110p.

"Nutrition in Preventive Medicine" edited by G.H. Beaton and I.M. Bengoa, WHO Monograph, No. 62, Geneva, 1976, 590p.

"Nutrition in the Community, a text for public health workers", edited by Donald S. McLaren, John Wiley, London, 1976, 393p.

"National Food and Nutrition Policies", (tentative title), edited by Jean Mayer, Oxford University Press, New York, 1977 (in preparation).

"Nutrition for Developing Countries, with special reference to the maize cassava and millet areas of Africa", Maurice King, Oxford University Press, Nairobi, 1972, 234p.

"Nutrition and Village Resources", Les Carnets de l'enfance/Assignment Children, No. 35, July-September, 1976, UNICEF, Geneva, 136p. E.F.S. summaries.

"Control of Nutritional Anaemia, with Special Reference to Iron Deficiency", Report of an IAEA/USAID/WHO Joint Meeting, WHO Technical Report Series 580, Geneva, 1975, 72p.

"Vitamin A Deficiency and Xerophthalmia", Report of a Joint WHO/USAID Meeting, WHO Technical Report Series 590, Geneva, 1976, 88p.

"New Food Policies", Les Carnets de l'enfance/Assignment Children, No. 31, July-September 1975, UNICEF, Geneva, 136pp. E.F.S. summaries.

"Village nutrition studies, an annotated bibliography", compiled by Sue Schofield and edited by C.M. Lambert, Village Studies Programme, Institute of Development Studies, University of Sussex, 1975, 285p.

Education

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