CHAPTER I

Introduction

When I arrived at the College of Public Health I wanted to learn more about community participation in health programmes. Initially, the literature took me on a "classical" community participation course. I read about definitions, justifications, conditions under which community participation can work, etc. But I felt that something was lacking in this literature: the practical touch. This link with the practical, I found it when I read about Participatory Action Research (PAR). For me, it had the potential of providing the communities about which I had been reading with the means to analyze their situation and resort to action to improve their lives.

Still, my focus – planning of health services – was too broad, and therefore I picked up the suggestion to take a more narrow focus and concentrate on a health issue on which I could apply the principles and ideas of PAR. I chose Acute Respiratory Infections (ARI), because worldwide they are a major cause of mortality in children under five years old, and because they also had been a major concern in the health programmes where I had been working before. But my strongest motivation was that I sensed that communities can do a lot about ARI themselves, in terms of preventive measures.

From then on I followed two different paths in my reading. The first path introduced me to technical matters about ARI. The other path not only allowed me to explore PAR more in detail, but also led me into reading about topics such as empowerment of communities, the Freirian method of education, and health promotion viewed as people's efforts to control health hazards in their environment.

When I read three articles about pneumonia in children in developing countries I was struck by a common finding of the three authors (Malik Kundi et al., 1993; Hudelson et al. 1995; McNee et al., 1995). Even if caretakers are well aware of the type of health care their children with pneumonia need, they may face too many obstacles in their environment to provide it. This convinced me that PAR, with its focus on learning and action, might be the right answer to help communities in developing countries to combat a major cause of mortality in their children.

The issue of my essay is that caretakers of children less than five often bring their children with pneumonia too late to a trained health worker, possibly with fatal consequences. Fatal delays can be attributed to caretakers not recognizing the danger signs of pneumonia (especially fast breathing), their preference for health care from a traditional practitioner, or social and economic obstacles. The solution I propose is to use PAR as a tool that allows caretakers to empower themselves, so that they can remove whatever problem lies in the way of their attempts to bring a child on time to a trained health worker. PAR can be used in health education (e.g. to help caretakers understand the factors that lead to ARI and appropriate measures), and to acquire

practical skills that help them to solve problems or remove obstacles when caring for their sick children.

After this theoretical introduction I venture in some hypothetical description of a PAR project in an ARI context. I use the different phases of a PAR project to explain how I would proceed in reality. The hypothetical character of this chapter also reflects the unpredictable elements of any PAR project.

In my proposal I develop a framework to implement the project I described in the last part of the essay. Since I did not know my future professional environment I could not avoid writing a proposal set in a hypothetical situation. The main objective is to increase the number of caretakers who bring their children with fast breathing in time to a trained health worker. This objective should be met using PAR in ARI-related health education and skills development with the aim of solving concrete problems. Before the project starts a baseline study should be carried out, using the Rapid Participatory Appraisal method. This baseline study will help understand the factors that influence the set-up of the envisaged project. It will also facilitate access to the target population (all women above fifteen) and give useful information for the selection of the participants.

My data collection exercise is linked to the issue that caretakers need to present their children with fast breathing in time to a trained health worker. It started when I met some officers of the Chonburi provincial Ministry of Public Health, Division of Acute Respiratory Infections in Children (MOPH-ARIC). I was interested to hear that

they had a concern for an issue similar the one of my thesis. They suspected mothers of children with ARI to be the main cause of over-consumption of antibiotics in health centers. However, they did not have any information on caretakers' knowledge and practices with regard to ARI in their children in Chonburi province. They expressed the need to carry out a survey. For me, such a survey would be a good opportunity to explore the problem issue of my thesis in a real world setting. I wanted to know if caretakers of children in a province in Thailand did recognize fast breathing, and if so, what was their response. Did they bring their child in time to a trained health worker, or not? I found it exciting to acquire my own data in addition to the secondary data from the literature. That I would be able to do this in cooperation with local officers of the MOPH, and in the process gain a better understanding of their perspective, made the survey more attractive to me. I also considered a survey as consistent with the PAR methodology, which offers a framework that allows a group of people to carry out research, whatever the data collection methods. Furthermore, carrying out a survey would allow me to acquire valuable experience in working with a data collection tool that would be useful in any future working situation, within a PAR context or any other. Therefore, I was pleased when the Ministry officials accepted my offer to carry out a survey jointly. But my main satisfaction was that such a survey, carried out as a student with the aim of obtaining an academic degree, would also have a practical use for health managers standing with both feet in daily practice.

We followed a participatory approach in the true sense of the word: the concept and implementation of the survey was the result of a joint effort, in which we tried to reconcile two slightly different interests. First, a general focus on ARI in the whole

province, and second, a narrow focus on fast breathing as a danger sign of pneumonia. Carrying out a survey in the whole province was beyond my means, but I felt it was realistic and useful to carry out a pilot survey in one district, which could possibly be extended to the whole province at a later date. Therefore, the survey was also the test of a data collection tool.

Although we did not meet the full sample coverage we came to some conclusions, which – with some caution -- I would call interesting. First, people in Chonburi's Muang district seem not to consult health volunteers when they have a health problem. They routinely seek assistance from health centers or hospitals. Second, even though people of all educational backgrounds do recognize some danger signs of pneumonia, they do not always act adequately from a bio-medical perspective, which can cause delays when presenting their sick children to a trained health worker. That most respondents did not complain about a lack of means to reach a trained health worker would imply the need for more health education efforts. But here we have a problem: the health volunteers, whose function it is in Thailand's Primary Health Care System to give health education, seem to be on the margin of the health scene. If this trend would be confirmed for other districts in the province, then the officers of the MOPH-ARIC would face the challenge to work out alternative ways of reaching the mothers.

As a conclusion of my study, I believe that PAR can be applied in developing countries to combat unwarranted delays in presenting children with pneumonia to a trained health worker. My project proposal offers a framework for this. It can be

applied in any situation where communities have limited access to resources. It proposes to use the PAR methodology to assist caretakers in acquiring knowledge on ARI and improve skills that would enable them to overcome practical obstacles when presenting their children with pneumonia to a trained health worker.

I also drew an important personal conclusion from the experience of the data collection exercise. I found it very stimulating to work in a participatory way with the officers of the Chonburi MOPH. With their interest, support, knowledge of local circumstances, and access to resources, we obtained a better result than in case I had worked on my own on a data collection exercise, which served my purposes only, and in which I had been an outsider investigator. I hope that in the future I will have more opportunities to work in a participatory spirit with government officials.

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