

Doris Schopper, MD, MPH is lecturer in the Department of Community Medicine at Tufts University, Boston, and Dr PH (candidate) in the Department of Population Sciences at the Harvard School of Public Health. Previous to that she was medical director and head of the Swiss branch of Médecins Sans Frontières.

Alberto Torres, MD, MPH is medical inspector of the ministry of health of Spain and Dr PH (candidate) in the

Department of Population Sciences and International Health Programs of the Harvard School of Public Health, and was previously a Secretariat member of the International Commission on Health Research for Development.

*Correspondence:* Stephen Tollman, International Health Programs, Harvard School of Public Health, Boston, MA 02115, USA.

## Mawas Diri: a tool to stimulate community participation

MARY JOHNSTON

The term 'community participation' is popular development rhetoric yet it tends to remain a topic of discussion around conference tables rather than a reality in most communities of the developing world. Political will may be guaranteed but the tools which can facilitate the process of translating community participation into reality are scarce. To help fill this gap an Indonesian non-governmental organization, Yayasan Indonesia Sejahtera, developed a problem-solving tool called *Mawas Diri*. The tool is employed by representatives of the target group and uses indicators directly related to their situation. It is used by village health workers (VHWs) or others who have been trained in its use, to evaluate the healthiness of homes and the neighbourhood in general.

With this tool, VHWs have succeeded in collecting reliable data which are used for village planning activities and monitoring the progress of programmes. It has also proved to be an effective motivational tool for stimulating people to initiate a wide variety of activities aimed at creating a healthier environment and life-style. More fundamentally, this problem-solving tool has reversed the usual procedure of 'outsiders' determining a community's problems and providing programmes for their solution. With *Mawas Diri* the community members are more aware of the nature and extent of their problems and can then determine which of these they can solve using their own resources, and which require government or other outside participation.

Experiences with *Mawas Diri* in Indonesia have illustrated that village communities can play a significant role in planning, implementing and monitoring programmes leading to healthier lives.

### Introduction

Community participation is perhaps the most popular current term discussed in development circles. The literature abounds with examples of community participation in the implementation of programmes and, to a lesser extent, in their planning and monitoring. Government rhetoric is filled with appeals for greater participation by the community. The Indonesian government, for example, speaks of an increase of up to 60-80% in community involvement in the programme for the current Fifth Five Year Development Plan; it has set ambitious goals, with expectations that the community will take part in all stages of programme development.

Discussions with policy-makers, and even some practitioners, become vaguer, however, when

they turn to the actual content of community participation. How can the community participate actively and effectively in planning, monitoring and evaluating activities? On a micro-level, in family life, people are constantly involved in such planning and monitoring in their daily lives; but they are rarely, if ever, given the opportunity of planning or monitoring and evaluating programmes of village scope. How often are village planning bodies - if they exist - given the opportunity, for example, to prioritize their problems and, on the basis of these priorities, plan what actions they will take? Would they in fact be capable of performing such a task? It is this vicious circle of lack of opportunity/lack of experience/lack of skills that is so often used by policy-makers to justify the continuation of a 'top-down' imposition of

152-90MA-8955



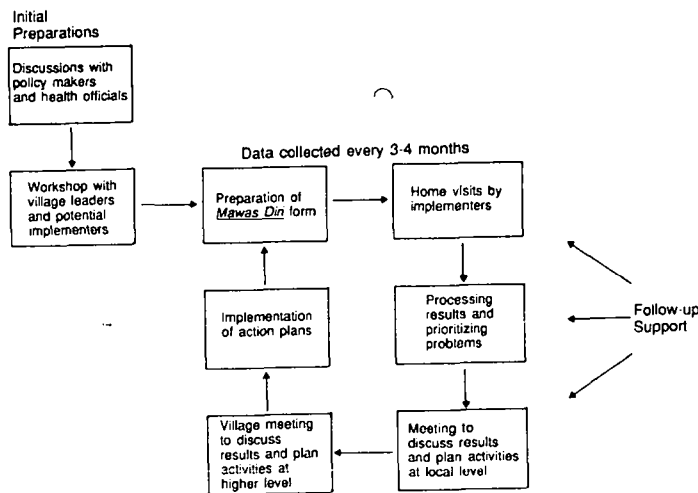


Figure 1. The *Mawas Diri* process.

In this way *Mawas Diri* has been used as a tool for planning actions that aim to improve the health status of families. However, the tool can also be used in the monitoring of activities, often a weak element in programme implementation. Data are collected every three or four months and can be compared with data from the previous three months. If the number of 'not goods' decreases it is apparent that some progress has been achieved. Once again it is the community which is implementing the monitoring (Figure 1).

With its focus on specific problems, *Mawas Diri* can also assist in educational activities. Messages can be specific and directed at problems that are being experienced at that particular time. Too often educational messages are either too general or else too abundant so that they lead to confusion and fail to motivate people to change.

#### The role of preparations and support

It is clear that *Mawas Diri* is just a tool. It is only as effective as the preparations and follow-up

which accompany its use. A community needs to be thoroughly prepared. This includes discussions with the formal leaders followed by the training of all those who will play a role in determining the success of the planning and monitoring activities. Subjects on which training has so far been given include problem-solving, the aims and uses of *Mawas Diri*, designing the form, implementation of *Mawas Diri*, processing and analysing *Mawas Diri*, and 'working together'. The methodology has been participatory, with the focus on role play, discussions and trials in the field. Motivation has run high and this momentum has been used to encourage the village leaders and VHWs to draw up plans of action during the final sessions of training. These plans deepen commitment to future implementation.

For many communities *Mawas Diri* will involve introducing a number of new concepts. It was found in Central Lombok, Indonesia, for example, that the high level of community participation, the new planning responsibilities bestowed

on local groups, and the concept of government and other donors responding to requests from the community, were all new. This situation was a reversal of the usual tendency for 'outsiders' to determine the community's problems and provide programmes for their solution. In such circumstances it is crucial that there should be a strong support system to ensure the continuing implementation of the problem-solving process. In Lombok the subdistrict heads have requested quarterly reports from the villages that are implementing *Mawas Diri*, and village heads remind the data collectors of implementation dates. Community health centre staff and community development workers from a local NGO also give encouragement and advice if required. Such support provides the VHWs and village officials with recognition and back-up when they need it. These are essential elements in any support system. In areas where support has been weak *Mawas Diri* has only been implemented spasmodically, which is clearly not as effective.

#### *Mawas Diri* in action

No mention has yet been made of the beneficial results of *Mawas Diri*. A few anecdotal examples will illustrate its ability to motivate communities into action. In Central Lombok it was discovered that, two weeks after implementation, several villagers had moved their cows out of their houses. Many families had put in simple windows. Another group had built a 300-metre drain. Still others were collecting materials to build three public toilets. When asked why they had been spurred into action the answers were all similar: it was the first time that someone had approached them at home and discussed problems with them. They claimed that on thinking about it they were amazed that they had not taken matters into their own hands before. These people live under very poor conditions and in the past have waited - usually in vain - for government or other outside intervention. Now they have discovered their own potential for changing their situation.

In another area, one of the poorest in Central Java, Indonesia, *Mawas Diri* has been implemented by many villages for at least three years, and results have been impressive. In one village that had severe water problems the people

focused on the need for cleanliness around the home. They built drains and fenced their homes. With a subsidy of just \$A 75 they built 175 toilets. Home improvements such as ventilation and windows were financed by each family. They then progressed to constructing a water pipe that would bring water to their village from a spring 2.5 km away. This village and several other villages in the same subdistrict that have undertaken similar ventures have achieved marked changes in their health and, to a lesser degree, economic situations. Government technical services have also responded by allocating funds and programmes to meet definite needs that have been revealed through the *Mawas Diri* data.

It is also interesting to observe that in several villages that have been implementing *Mawas Diri* for some time, the people have gained experience and confidence through their successes and, as a result, have had the courage to tackle more difficult problems. They have also learned to adjust the *Mawas Diri* form so that the indicators become more refined and appropriate to current needs.

The *Mawas Diri* problem-solving tool has proved attractive to a variety of people. Policy-makers take note of its potential for increasing community planning skills and, therefore, the effectiveness of the government's 'lower level-upwards' planning procedure. It also has possibilities for promoting institution building by strengthening the functions of local planning bodies. Village heads consider that the tool can help them obtain reliable and relevant data, as well as motivating the community to tackle some of their many problems. VHWs feel that they have a clearer idea of their role, and are given more direction on specific group activities.

Officials from the government technical services say that *Mawas Diri* can assist them, too, in a number of ways. Monitoring by the community may increase the probability of sustaining activities. The tool can also stimulate VHWs by providing them with new activities, thus, hopefully, reducing the attrition rate. It may also provide government departments with specific data on the extent and location of problems in a subdistrict. This will enable better allocation of government funds for programmes.

Most important of all, *Mawas Diri* increases the quality of community participation by including the people in all stages of the planning process, from collection of data and prioritizing problems, through to monitoring the implementation of activities which they have planned. It proves without doubt that it is highly appropriate to give village communities the opportunity to participate more fully in the development process. We can have confidence in the peoples' decisions provided they are given the skills and appropriate tools. We also know that programme preferences will be appropriate. They will not only be founded on reality; they will be the choice of the people.

#### Reference

Yayasan Indonesia Sejahtera. 1988. *Mawas Diri*. Alat Pembinaan Kesehatan.

#### Biography

Australian Mary Johnston, BA, Diploma in Social Studies, spent 21 years in Indonesia working with non-governmental organizations in community health and community development. She was a member of teams which pioneered community health activities, some of which are now implemented at national level by the Indonesian government. For the last 14 years she has been involved in community development training activities, programme development and publishing with Yayasan Indonesia Sejahtera. Mary is currently in Australia writing about her experiences in community health and development.

*Correspondence:* Mary Johnston, 34/57 Gloucester Avenue, Berwick, Victoria 3806, Australia.

## 'Indicators of staffing need': assessing health staffing and equity in Papua New Guinea

RIITTA-LIISA KOLEHMAINEN-AITKEN<sup>1</sup> AND PETER SHIPP<sup>2</sup>

<sup>1</sup>Department of Health, Boroko, Papua New Guinea and <sup>2</sup>Management Sciences for Health, Boston, USA

When government health services in Papua New Guinea (PNG) were decentralized to the 19 provinces in the early 1980s, no generally accepted staffing standards existed. There were major staffing inequities between provinces which the department of health could do nothing to redress, since it no longer retained a direct role in decisions on provincial health budgets and staffing. The department of health continued to seek such a role. However, before it could effectively contribute to resource allocation decisions, it needed an objective method of identifying and quantifying staffing requirements and inequities. A methodology called 'indicators of staffing need' (ISN) was developed to assess the staffing requirements for health services and hence the equity of staff deployment.

This paper describes the development of the ISN methodology. The methodology consists of identifying the major components of a health worker's job, estimating the standard workload for that job (that is, the amount of work which one person in the job could do in a year), and then using the workload standards and the service statistics to derive the recommended number of staff for a health activity or facility. Examples are given from the analyses of rural and hospital nurses, pharmacy personnel and doctors, and the main methodological difficulties are discussed.

The ISN methodology has been designed as a managerial tool, which offers - using data already available - a direct comparison of staffing between provinces, districts and individual health facilities. It was incorporated into the PNG government's budgetary and resource allocation system in 1989.

#### Introduction

In accepting responsibility for the health of all the people, health managers in many countries have become increasingly concerned about evident inequities in resource distribution between different geographic areas and client groups. The most expensive resource, health care workers, consumes more than 60% of a country's total health budget in salary costs alone, and maldistribution of health staff between geographic areas and facilities is common. Various indicators have been used to quantify the extent of staff maldistribution, for example, population ratios and ratios between staff employed and standard staffing schedules. Both of these methods have serious limitations.<sup>1</sup> They both ignore the effect of such external influences as the pattern and levels of morbidity, health care access and patient attitudes, which control the demand for services. With the second indicator, the distribution of the facilities themselves is also a major factor; a district may

have well-staffed facilities, but far too few of them.

In Papua New Guinea (PNG), 'indicators of staffing need' (ISN) have been developed to assess staffing requirements and the equity of staff deployment by using standard workloads. This method takes account of utilization and the impact of external influences in a practical and direct way by concentrating on the services actually delivered and the staff required to deliver them. The ISN method has proved to be a valuable tool for health care planners and managers both at the national and provincial levels in their efforts to improve the equity of staff deployment in the country.

This paper describes the ISN method and its development in PNG. Examples are given from the analyses of nursing staff, which consists of registered nurses (called 'nursing officers'), and nursing auxiliaries of various types (jointly called