

The Role of "Theatre for Development" in Mobilising Rural Communities for Primary Health Care: The Case of Liwonde PHC Unit in Southern Malawi *

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ABSTRACT

This paper argues that the most important element in health care strategy is community participation. If social welfare is to be effectively improved it must involve the people in making their own decisions and taking their own actions. Using popular theatre as a means of communication and education, the Liwonde Primary Health Care Unit in the Southern Region of Malawi has succeeded to motivate residents of two rural communities to actively involve themselves in primary health care activities. The impact of this innovative approach to communication and education for health has been remarkable. Recent data indicates that cases of deaths due to preventable diseases such as cholera and severe diarrhoea have been dramatically reduced especially in the under-five age group. The construction of pit latrines and improved water supplies have been vital to the improved health situation.

Introduction

The success of development in every country must be reflected in the health and socioeconomic well-being of its people. This implies that, as a nation develops, the incidence and prevalence of infectious and killer diseases must be eradicated or curtailed, resulting in the decline of both infant and adult mortality rates, morbidity rates, and in the improvement or increase in life expectancy at birth. Health is both a prerequisite to and concomitant of development. The provision of Western-styled health facilities may not necessarily result in improved health conditions. Of critical importance is the motivation of the local people to help themselves in health matters. This can be achieved if health information and education is disseminated

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The aim of this paper is to demonstrate one inexpensive way in which information and education about health and sanitation can be innovatively disseminated in rural settings. The paper documents an effective strategy that was used in three villages in Southern Malawi to inspire the local communities to do something on their own about their precarious health status during the latter half of the 1980 decade. These were the villages of Mbela and Mwima located close to the Shire River and Chisi Island located on Lake Chirwa (see Figure 1). First, the paper briefly reviews the current strategies used for the dissemination of primary health care information in Malawi and notes how these strategies have failed to reach out to the majority of the people in the rural countryside. Second the paper examines the health situation that existed in Mbela and Mwima areas before the introduction of the Liwonde Agricultural Development Division (ADD) Primary Health Care programme. Third, a conceptual model of the main approach that has been used to motivate the people of these areas to assist themselves in primary health care activities is briefly described. Finally, an evaluative discussion of the strategy used in these three villages is offered.

Health Information and Education in Malawi: An Overview

In Malawi, primary responsibility of the Health Education Services of the Ministry of Health is the health education of the public (both rural and urban). This activity is accomplished through books or magazines (eg, Moyo, Family Health Newsletter, Boma Lathu, Za Chikumbi, posters and child spacing booklets) written in both English and Chichewa, the national language. Moyo and Family Health Newsletter are published by the Health Education Unit of the Ministry of Health. Za Achikumbi (Farmers' Forum) is published by the Ministry of Agriculture and deals with matters related to agricultural production while Boma Lathu (which specialises in providing general news and information to the literate rural community) is published by the Ministry of Information and Broadcasting. These magazines contain information on ways to prevent diseases such as malaria, bilharzia, diarrhoea, tuberculosis, AIDS, leprosy and many other common ailments. Education is also effected through regular radio broadcasts of health messages prepared by various ministries and government departments (Chilivumbo, 1975). For example, the radio programme 'O Phiri' is a joint venture between the Ministry of Health and the Ministry of Agriculture and it deals with health and agriculture issues. 'Umoyo ndi Chitukuko m' Malawi' (Health and Development in Malawi) is another jointly prepared radio programme between the Ministries of Health and Community Services and deals largely with issues relating to health and development. These broadcasts are in both Chichewa, the national language spoken and understood by the majority of Malawians and English – the official Government language.

Another channel for information diffusion is the use of visual aids: posters, pamphlets/leaflets which carry selected health subjects. Furthermore, prior to 1990, joint efforts among the Department of Agricultural Communications of the Ministry of Agriculture, the Ministry of Community Services and the Department of Information included the "yellow van" mobile units equipped with film projectors and puppet shows (see for example Kamlongera, 1986). Unfortunately the "yellow van" mobile film unit programme has been discontinued due to financial difficulties. The mobile film unit used to travel to schools and those villages that were readily accessible to present free film shows on health education and other development related issues.

Private agencies such as the Christian Hospital Association of Malawi (CHAM) and religious institutions are also active in one way or another in the dissemination of health information. For example, the Christian Hospital Association runs outreach programmes at its larger hospitals. Functional literacy centres and home craft centres also play an important role in disseminating health and nutrition information to rural communities. Daily health talks at clinics, health centres and hospitals are an additional important source of information. In brief, this constitutes the information communication set up in Malawi.

In spite of the commendable multi-pronged efforts directed at the rural population, coverage is limited due to a combination of factors, particularly insufficient health extension personnel, high illiteracy rates and low ownership of radios. About 88 per cent of the population in Malawi is rural and a large proportion of this population is illiterate. The results of the 1987 Population and Housing Census reveal that slightly less than half of the population aged 5 years and over had some education. About 42 per cent of the population aged 5 years and over had attended only primary school education. When this is broken down by gender, about 55 per cent of male population aged 5 years and over had some education compared with about 36 per cent for females (National Statistical Office, 1991). In as far as literacy is concerned, about 42 per cent of the population aged 5 years and over was able to read and write Chichewa, English or both languages. However, more males than females are able to read and write Chichewa, English or both languages, ie, 52 per cent of males are literate in one or both of the languages compared to only 32 per cent of females (National Statistical Office, 1991). These figures are certainly an improvement over those of the 1977 census in which only 30.6 per cent of the males and 14.5 per cent of the females in Malawi were literate (National Statistical Office, 1984). However, by African standards, the current literacy rates are lower than the average for sub-Saharan Africa which was 60 per cent in 1990 (UNESCO, 1992). In terms of rural/urban differentiation, it must be kept in mind that the majority of the literate population is concentrated in urban areas. The implication is that the bulk of the population based in rural areas cannot read the health information in the various pamphlets and magazines.

Secondly, only a small proportion of the total population has access to the radio. In 1987 about 19 per cent of the persons living in households had access to a radio in working condition. In rural areas about 15 per cent of the persons living in households had access to a radio as compared to 50 per cent of the urban population living in households (National Statistical Office, 1991). Clearly the health information broadcast on the radio does not reach the intended target population. Thus, there is a clear need to involve the rural people and their leaders; to motivate them to help themselves. In other words, the diffusion of health information and education should not only come from above but should also include a bottom-up grass root level component as documented in this paper through the use of the "Chancellor College Theatre for Development" which appears to have been very successful in motivating people within the areas of Mwima and Mbela in Liwonde ADD PHC programme.

Primary Health Care in a Rural Setting

Mwima and Mbela are rural trading centres with basically rural characteristics. Each centre has a market that meets once a week. Present at these centres are a few grocery shops and tea-rooms. These centres are in a sense central areas surrounded by rural villages engaged in subsistence agricultural activities and some cash cropping. The main food staples are maize and sorghum and cotton is the main cash crop. Each of the areas has an estimated population of 10,000 people. Mwima is located along the main Liwonde-Mangochi road about 16 kilometres from Liwonde Township and Mbela is about 15 kilometres away from this road (see Figure 2). A secondary road which becomes impassable during the rainy season (November to February) passes through Mbela trading centre from Balaka to join the Liwonde-Mangochi road. These areas are within 20 kilometres from the Shire River, outlet of Lake Malawi located within the Great East African Rift Valley. Temperatures range from a minimum of 60°F during the cold season (May to July) to well over 100°F during the hot and rainy seasons. Rainfall is adequate to allow the growing of both food and cash crops.

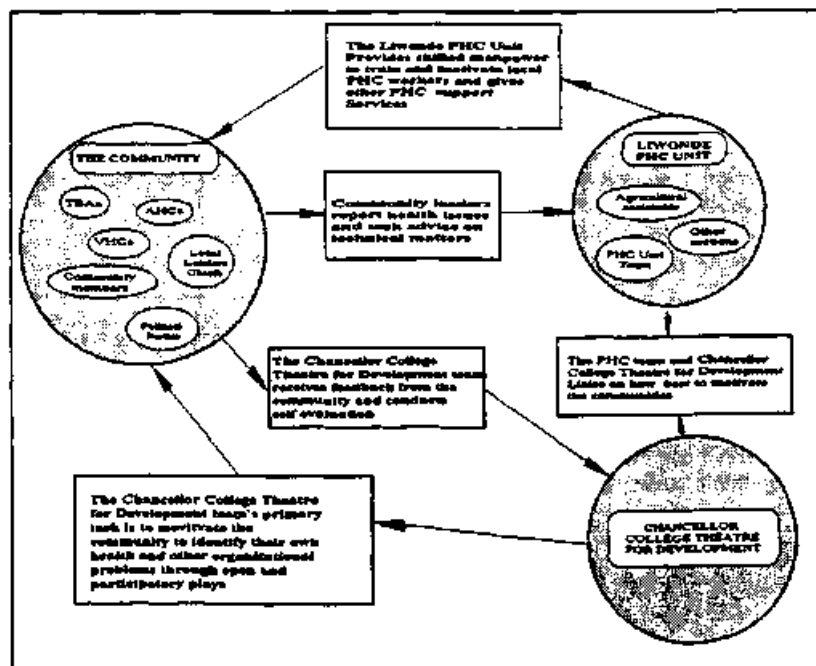
On the other hand Chisi Island is on Lake Chirwa (a mostly swampy inland basin lake with no outlet). An estimated population of 3,500 people live on this island in small fishing village communities. The island is about 15 square kilometres in area and is reachable by small boats and canoes whose capacity is 2 to 6 persons per trip. Twice a day the largest boat (with a capacity of 6) ferries people to and from the island to the main land. There is a full primary school on the island which is in a dilapidated condition. For the nearest health centre people have to travel over 20 kilometres to the General Hospital in Zomba.

the interest of the people of Mwima and Mbela areas to engage in locally determined primary health care activities. The principles guiding the introduction of primary health care in these areas are as follows:

- i) People's concerns and priorities are the main starting point.
- ii) The motivation and participation of the community in its own health care is the only basis on which an enduring and comprehensive programme can be built.
- iii) Primary health care must be linked to the overall national programme but must not be seen as an imposition from above and should include a strong bottom-up grassroots level component in the planning process.
- iv) Health is one factor in the total development of the people. Involvement of other development sectors, such as education and agriculture is a must.

The Liwonde ADD PHC Unit has three independent components working hand-in-hand to promote community health and social well-being. The first and most important is the community itself; the second is the PHC Unit team led by an experienced medical doctor; and the third component is the "Chancellor College Theatre for Development". There is no rigid hierarchical arrangement in the provision of PHC services in this rather unique programme. The components can be arranged in a set of three interacting but independent circles (see Figure 3). The functions of each of these are described in the following about the conceptual strategy of the "Theatre for Development".

Figure 3: Organisational Structure of Liwonde ADD PHC Unit



The Conceptual Strategy

The Community Involvement

As Bennet and Cole-King (1982) point out, Malawi has a long tradition of community involvement in development through "self help" projects. Communities are organised according to a combination of traditional and political structures. Traditional chiefs, village headmen and elders act as the decision-making authority in villages. They deal with social and cultural administrative issues such as land distribution and use, land and other disputes and traditional ceremonies. Parallel to this structure, are the political party organisations at district and village levels. During the Banda regime, both traditional and party authorities were combined in what was known as the Area Action Committee, the traditional leader being the chairman. The Area Action Committee included some Government field workers such as agricultural, community development and health personnel, as well as community elected members. The Area Action Committee was supported by the District Development Committee and it, in turn, supported and coordinated the village or Branch Action Committees. Generally, a Branch Action Committee covered one or several smaller villages and, like the Area Action Committees, their members were drawn from the party and traditional structures. With the new democratically elected government, the political structures may have been modified to a lesser or greater extent but the role of the traditional leaders remains unaltered. It should also be noted that even during the Banda regime, Action Committees largely existed on paper with communities preferring to set up project committees as and when the need arose.

While Action Committees were mainly concerned with specific development projects for generating community resources, mobilising labour and materials, etc, they also served as a channel of communication on official, political and developmental matters. Thus it can be safely concluded that in Malawi there exists a well-defined community organisational structure, which links traditional and the modern political system and which provides opportunities for communication and dialogue with government officials at different levels. How effective this channel of communication has been remains to be evaluated.

The Liwonde PHC Unit utilised this opportunity of an already existing organisational structure in the communities. The Unit advised the people to select their own village and area health committees in Mwima, Mbela and Chisi Island areas at the beginning of the project. The size of each village health committee was to be no more than 10 members with a chairman, secretary and treasurer. The members of the health committees were elected by a show of hands at meetings of the whole community attended by the Liwonde PHC Unit team. In Mbela area there were 12

village health committees and one area health committee. In Mwima there was a total of 10 village health committees and one area health committee; and on Chisi Island there were 5 village health committees and one area health committee.

The functions of health committees were to report on infectious diseases, organize people for health campaigns and health education meetings, and identify health problems in the village. They were also responsible for making sure that the community provided itself with and maintained safe water supplies through the protection of wells. The committees were further charged with the duty of promoting the use of health facilities, especially for maternal and child health care and immunisation; and the promotion of latrines and refuse disposal and improved housing.

To ensure the committee effectiveness, two members of each village health committee were selected to receive training in health matters. These two volunteers attended a very concise training course of one or two days which was held at the local primary school in each village. This ensured that all participating volunteers were able to reach the training places on foot. Teachers and local leaders were also invited to these training sessions. These trained members then took the role of the community volunteer health workers (locally known as "community doctors") and were able to administer first aid and basic medical care, especially for prevalent diseases such as diarrhoea, malaria and conjunctivitis which mostly affect young children. Training in sanitation comprised part of the curriculum.

Role of Popular Theatre

The most unfortunate thing about primary health care activities is that there is very little involvement of communities in the early stages of planning. The tasks and job description of primary health care workers are conventionally developed by a government appointed committee at the national level without consulting the concerned rural communities. The end result is that a diagnosis of needs and assessment of the organisational potential to support and manage health activities at the community level is most often lacking in most PHC plans. Usually communities are "told" about the intended programme, and asked to cooperate without any constructive input on their part. It is the usual top-down approach.

The three villages covered by the Liwonde ADD programme (Mwima, Mbela and Chisi Island) were selected based on their level of underdevelopment and lack of accessibility to modern health care facilities. As noted earlier, there are no modern health facilities within the vicinity of these villages. Under these conditions intensive preparation of communities for an impending health care programme is difficult, requiring good social and communication skills on the part of health care providers. Furthermore knowledge about health matters has to be

carefully combined with sensitivity to local cultural values. Unfortunately, agencies involved in health care matters usually do not have the capacity, skills and time to learn more about the cultural specificities of the local people. The tendency is to "tell" or "order" rather than to probe, stimulate and draw out ideas, and build on and learn from existing knowledge and expertise.

The function of the "Chancellor College Theatre for Development" was to fill this vacuum, to probe, stimulate and tease out ideas from the community itself. It is on these ideas that the PHC Unit builds its PHC activities in each area. Before the PHC team started the implementation of its activities in Mwima and Mbela areas, the "Theatre for Development" was called upon to go to these areas and make an assessment together with the community about their health problems and needs and what they thought should be done to alleviate their plight. After preliminary discussions with the people, the "Theatre for Development" team found out that in this area especially during the rainy season the rural population is particularly susceptible to diseases notably cholera and diarrhoea. The latter is particularly serious for the under-five year age group. When the people were first contacted by the "Theatre for Development" the major problem was the poor quality of health of the population and their main desire or perceived need was the establishment of a health facility within the areas. Further discussion, however, revealed that many members of the community were reluctant to use the health centres for a whole variety of socio-cultural reasons. Among other problems identified they had to walk long distances and spend all day in order to get to such facilities, often to find the medical superintendent out or to find relatively unhelpful personnel as pressure of work often led them to make snap and unhelpful diagnosis. Some of them found such centres both imposing and threatening.

Furthermore, many of the diseases they were suffering from could either be prevented or treated much earlier, much more cheaply and much more efficiently within the local community. Thus the role of the "Theatre for Development" was to provide community awareness, to motivate the people to diagnose their own specific problems and to stimulate them to find local solutions to the problems on a self-help basis. This was effectively achieved through the medium of loosely structured plays and sketches in which local community problems were examined and potential local solutions explored. At certain points of the drama the villagers were asked to participate in the play by determining in what direction the play should develop. Under such conditions it was frequently discovered that traditional barriers toward local authority could be broken down and issues freely and openly debated democratically. Thus, through local entertainment, local awareness was heightened and the villagers motivated to help themselves. The detailed design and process of the "Theatre for Development" is given in the following section. Unfortunately, the "Theatre for Development" did not carry out these preliminary

activities on Chisi Island where the introduction of PHC activities was left to the PHC team alone.

Role of the Liwonde ADD PHC Unit

The role of the three-man team in Liwonde was to render technical assistance and supervision to the volunteer village health workers. The team avoided the temptation to exercise authority over the community volunteers and did not want to be perceived as superiors. Rather, the central objective of the team was to act as a backstop by encouraging the people in the villages to solve their own problems (health or health related) through the self-help concept.

The Process of "Theatre for Development"

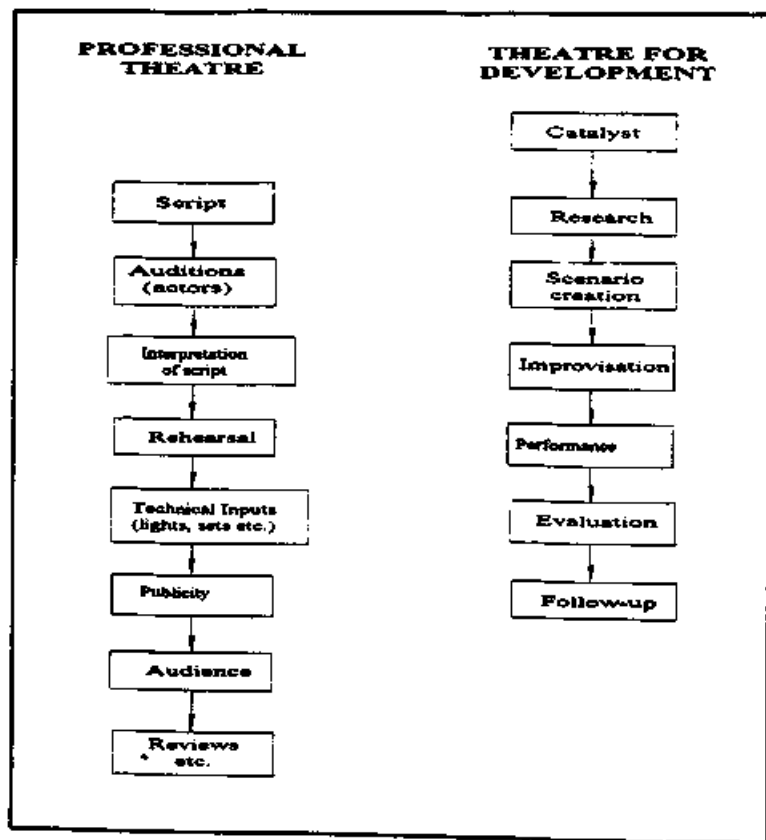
The use of theatre for educational purposes is not strange to Malawi. Women in the country have been known to employ drama during initiation rites when they wish to impart knowledge on matters of sex, motherhood, personal hygiene, etc. to novices undergoing initiation upon reaching puberty (Kamlongera, 1984; Helitzer-Allen, 1994). Use of theatre as a tool for development is becoming widespread in Africa as a whole (see Kidd & Gnat, 1980; Eyoh, 1986). The strategy in "Theatre for Development" work is to shift emphasis from script as happens in conventional "professional" theatre to the process of creating the drama and what happens thereafter. The differences are shown in Figure 4 on the following page.

Whereas the script and the actor dominate in the "professional" theatre, it is the creative process – which is dependent on research – that is central to "Theatre for Development." This is research carried out by both the theatre practitioners and the villagers amongst whom they work; in other words, participatory research. A description of the work carried on at Mwima provides a good picture of what actually goes on in this work.

Theatre for Development at Mwima

The drama team is made up of drama students and lecturers of drama from the Department of Fine and Performing Arts at Chancellor College. The team goes out fully aware that they know nothing about primary health care and the situation regarding this issue in the villages. The understanding between the primary health care 'experts' and the theatre team is that the latter are to work as an advance party in the villages. They go out to scout on problems that exist in the villages. The approach here is to let the villagers participate in the scouting by providing them with a forum to analyse and articulate the health problems as they understand them. When the team arrives in the village – following advance notice of an impending

Figure 4: Differences in Approaches Between Professional Theatre and Theatre for Development



visit – the team makes it very clear from the outset that they bring nothing to the village. What they come for is to learn from the villagers themselves what and how they see as 'their' problems related to health. Very often these go beyond mere 'health' issues to cover agricultural, economic, social and sometimes even political ones.

The "Theatre for Development" project at Mwima lasted about a month. During this period 'theatre' work intermingled with setting up the primary health care machinery in motion. The effect of this was that the two parts of the work were never seen as separated from each other, but as an integrated whole.

First Visit: Research

The Medical Adviser in-charge of the PHC programme in the area explained the purpose of the visit. A member of the Theatre for Development team took over from the Medical Adviser explaining the "theatre" aspect as the immediate goal, not the provision of wanted facilities as the case might be. Here the emphasis was to get the villagers to understand that the visiting team was in the village to 'learn' about the village from the villagers themselves. During discussions, the villagers articulated their grievances and requirements. A few comments on their representatives at both local, district and parliamentary levels were raised. Villagers were told very clearly that information gathered here was going to provide material for dramatisation on issues relevant to health. A list of 'grievances' by the villagers was noted which included the following things:

- a) absence of a nurse/clinical officer;
- b) lack of good protected water;
- c) lack of proper market in the place;
- d) existence of various diseases e.g. diarrhoea, measles, scabies, and anaemia;
- e) lack of leadership in matters of health;
- f) hospitals being too far; and
- g) lack of general information.

After the discussion the team, together with the villagers, went on a tour of the village to see instances of health hazards in the area. This tour was led by the villagers themselves, who explained what they felt was wrong with what they saw. Usually these explanations were defensive and so provided an opportunity for brief discussions which led to a balanced and revised understanding of the problems. The discussions were not formal, but were carried on an *ad hoc* basis as people walked about. The first visit ended here with the promise of another visit the following week.

The most immediate and obvious health problem recognised by both the visiting team and the villagers was the condition of the wells that people were drawing water from. The wells were not taken care of by anyone and did not have aprons around them. Discussion on this problem led to the agreement that it was one which could be remedied quite easily. The villagers agreed that they could have the aprons around the wells done if they had cement. The Medical Adviser promised to get them the cement the following week. This work involved clearing the area surrounding the wells and gathering bricks and stones.

Back to campus the theatre team together with the PHC team held a plenary session to discuss the following:

- a) problems identified and worthy of consideration for dramatisation; these were availability of water and water hygiene, sanitation, and the formation of village health committees and the education of the people on the need for such committees; and
- b) action to accompany the theatrical presentation.

Following these discussions the theatre team went to improvise around the issues raised during the visit and the plenary session back on campus. The idea of the improvisation was to prepare a 'demonstration' sketch which would be further developed on site together with the villagers as both commentators on and participants in the play.

Group visits to Mwima were supplemented by longer stays by members of the theatre team. This was to allow the group to get close as possible to the people, their living habits and their problems. Through these stays further information of grievances was collected, ie, the relationship between the villagers and health personnel at hospital and how the former felt about it was explored to the full; such information was gathered informally in chats with individuals. Later on this was put to good use in trying to get the people to see the need for establishing village health committees.

The Play

The play that was presented to the village was a mixture of drama and open discussion. The procedure here was as follows:

Phase 1:

A mother comes to complain to her chief before his elders that she has lost her son in a drowning accident. Further discussion of the accident leads to a decision that the villagers should dig a well from which they can draw water instead of using the river which is not only dangerous, but infested with all sorts of diseases.

Having agreed that they should have a well another problem comes up. Where do they site it? The chief dictates that it should be close to his house, but the elders object and suggest alternative sites which are also objectionable. One is too close to a graveyard and therefore culturally unacceptable. The other one is too far away although at the centre of the shopping area. The chief then opens the debate to other villagers present (the audience that is) to express their views on the subject. At this point the play becomes a real discussion rather than just entertainment. The villagers join in the debate. They point out that a well close to the chief's house will inevitably be difficult to approach at will as the chief will expect people to treat it as if it was his own personal property. Their choice happens to be somewhere in the middle of the village. In real terms this is in fact where the village's well is located. The discussion moves on to touch on how the village should actually take care of the well once it is dug and what people should not do in order to make it clean. This part, although imaginary is built on the villagers' own observation of what they themselves do at the well, eg, cleaning baby diapers and washing clothes etc close to the well instead of away from it. Most articulate in this part of the

discussion/drama are women for they are more knowledgeable about usage of wells than men. Several problems related to the question of water are brought out.

At this point the theatre group opens up the participation in the dramatisation to the villagers by encouraging the latter to act in a repeat of the sketch just presented, but incorporating ideas and arguments that came along as it was first performed. In this way more arguments, discussion on the issues relevant to the question of the well and its maintenance evolve. After the village's dramatisation, a summing up session is gone into. All this is done by the theatre team and the villagers. The PHC team just watches as a passive audience; if ever they participate in this it is either as actors or audience, NOT as experts.

Phase 2:

Building on complaints about the way hospital personnel treat the sick, a sketch is developed whose thrust is to get the villagers to find alternatives to the hospital when faced with simple ailments. This leads to a discussion of selecting among themselves people who might take care of their immediate health needs (ie, health committees).

Having developed this part of the sketch the whole play is then taken to the market square where a larger audience is in attendance. The play here substitutes details relevant to the village set-up by those referring to the market place. Instead of just wells, the question of digging garbage trenches and general cleanliness of the market are incorporated into the drama. The performance once again is a mixture of acting and discussion of issues raised. By the end of the performances sufficient ground has been covered to prepare the people to select their village health and market committees. This latter part is left in the hands of the PHC team.

The "Theatre for Development Approach" may be summed as follows. First, the theatre group consults with PHC field workers and discusses rather than simply accepts issues raised by health people. The idea here is to acquaint the theatre practitioner with PHC needs. Second, out of consultation and discussion with PHC workers a sketch is improvised and taken to the village. The purpose of this visit is to first of all establish the theatre for development idea and to extend discussion of the problems of PHC in order to tease out the villagers' point of view. Third, the scenario is prepared using findings of the first meeting in the village and rehearsals. Fourth, the play is presented to villagers. The presentation style emphasises an open-ended approach to allow for discussion as performance is going on. A result of this is frank participation between health workers, villagers and theatre people in the discussions that arise out of an on going performance. Finally, the PHC team comes in with technical details and assistance as per issues pertinent to the occasion.

"Theatre for Development" and the Focus Group Approach

Although this study concentrates on the "Theatre for Development" approach to motivating rural people into self-help projects, it must be acknowledged that there are other equally effective ways of achieving this same goal. The focus group approach, otherwise known as group interviews (ie, interviewing people in groups rather than individually) has become a popular approach in highly developed societies for marketing research. This approach has its origins shortly after the Second World War and was introduced in developed countries such as the United States as part of "motivation research" (Wells 1974). As Wells (1974) notes, the focus group, in essence, is a small, temporary community, formed for the purpose of the collaborative enterprise of discovery. The assembly is based on some interest shared by the panel members, and the effort is reinforced because panelists are paid for the work. "Grouping" fosters the kind of interaction that penetrates impression management and uncovers more basic motivations, even when the group is unaware of impression management or of the need to penetrate it.

Usually the convener of the focus group is some advertiser or advertising agency, or a political entity that is looking for help in selling a product, a service or like entity. Like most motivation research this approach has been condemned by the conservative research establishment as "unscientific" and therefore untrustworthy (Templeton, 1994). In spite of the many criticisms that have been levelled against the focus group approach, it has prospered, and today in many marketing research organisations, group interviews are nearly as common as interviews done by traditional survey questionnaires. The primary advantages of the focus group technique include the ease with which it can be carried out, the time taken to do so and the relatively inexpensive nature of such a strategy of collecting information. Other important but largely subjective advantages include group synergism, the snowballing effect and stimulation.

Although in certain types of research the focus group approach is effective in gathering the required data, it may not necessarily be successful in motivating people for self-help projects. In a recent study, Yelland and Gifford (1995) illustrate the cultural inappropriateness of the focus group interviews in developing countries. However, when this approach is combined with other more conventional or novel ways of collecting information or motivating people then its advantages become apparent (see for example Egan, et al, 1995). The "Theatre for Development" approach is in many ways akin to the focus group approach, but goes beyond the limitations of the focus group. It takes into consideration the cultural context of the communities concerned and involves all members of the village throughout the process rather than a select group of individuals that are paid money for

motivation as is the case in marketing research in developed countries. In developing countries, researchers have used the focus group approach to collect more detailed qualitative information missed during large scale structured surveys. While it may be able to 'tease out' problems in a community setting and generate some insights for the researcher, it lacks the power of theatre in arousing interest and motivation in the populace.

The Relative Success of the "Theatre for Development" Approach

In Malawi, the most common causes of death in the 0-4 age group include measles, pneumonia, nutritional deficiencies, malaria, anaemia, diarrhoeal diseases, tetanus and diseases of the nervous system (Kalipeni, 1993). Relatively few diseases are responsible for the bulk of infants' and young children's death. It can also be noted that all the important causes of illness and death in Malawi are preventable, or at least treatable, by means of the primary health care approach, particularly immunisation and early case detection and treatment. Consequently, primary health care programmes which influence mortality are those which address nutritional problems in children who are not brought to child clinics, promote nutrition in the homes and ante-natal screening, distribute iron and folate to pregnant mothers, strive to immunise infants against tetanus and other maladies such as measles, encourages sanitation to curb diarrhoea in children, and provides prophylactics and easily available treatments to the vulnerable age groups and pregnant women.

Interestingly, the villagers of Mwima and Mbela identified health problems of mothers and children as the most critical health problems. As observed by the primary health care team, the following were among the most common health conditions in these villages: nutritional deficiencies, malaria, measles, diarrhoea, cholera, conjunctivitis, hookworm, schistosomiasis (bilharzia), scabies, and other common respiratory symptoms. Estimates of infant mortality rates according to surveys carried out in the areas at the beginning of the programme ranged from 170 to 200 deaths per 1,000 live births. Well over 50 per cent of the infants were underweight. On Chisi Island almost all the children aged 4-13 were infected with schistosomiasis. Less than ten per cent of the households had a pit latrine. Wells and springs supplying drinking water were generally unprotected and in a deplorable condition. Deaths from severe diarrhoea and cholera were a common seasonal occurrence, particularly severe during the rainy season.






While it is hard to make an evaluation of the effectiveness and/or success of a newly instituted programme, data gathered from these two villages during the 1985-1990 period indicate that the "Theatre for Development" approach has been

substantially effective as a catalyst to self-help and good health. The village health committees, have been very active in trying to do something about the villagers' precarious health conditions. The immediate impact of the programme can be clearly seen in the detailed data that is collected by members of the village health committees and forwarded to the PHC Unit office at the Liwonde ADD main office as monthly returns (see Table 1 for a copy of the health register for compiling monthly returns kept by the chairman of each village health committee). The basic pieces of health information collected monthly include the number of deaths occurring in young children and adults each month; the number of cases of diarrhoea each month, the number of families with latrines and the number of families using safe water supplies. In addition, volunteer PHC workers record additional information in their registers which includes cases treated and referrals and monthly nutritional and weight surveillance for children. In general the effectiveness of the programme on the health and living conditions of the people within the three areas can be gauged by looking briefly at statistics on sanitation and water, maternal care and reported infant deaths, and provision of basic medications. We briefly provide some data for two periods, namely, pre-intervention (1986 and before) and post-intervention (1987 and after). The data presented in the tables that follow was largely compiled from the monthly returns registers as shown in Table 1.

Sanitation

As far as sanitation is concerned, the number of hand-dug wells and latrines increased dramatically within a short period of time. By 1988, three years after the onset of the programme, the villagers in Mbela and Mwima areas had over 40 protected shallow wells of about 4 to 7 feet in depth. Concrete slabs have been constructed around the wells so that surface water should flow away instead of lying stagnant around the well and potentially polluting the water supply. Mwima has a village community workshop for producing concrete slabs for latrines. The materials and technical advice are provided by the PHC team from Liwonde using a limited amount of resources from a German Technical Aid grant. Before the arrival of the PHC team in 1985 only ten per cent of the houses had pit latrines. A few months later, in June 1986 49 per cent of the households in Mbela and 51 per cent in Mwima had constructed pit latrines to the recommended standards. In February 1987, about 71 per cent of the families in Mbela and 81 per cent of families in Mwima had decent pit latrines (see Table 2 for data on pit latrines for Mbela area villages for June 1986 and February 1987). A simple statistical analysis of the differences of means test in the increase of pit latrines between June 1986 and February 1987 turned out to be statistically significant at the 5 per cent level

Table 1. Health Register for Liwonde PHC Unit

KHADI YA BUNGWE LA ZAUMOYO (HEALTH REGISTER)						
Area.....			District.....			
Dzina la mudzi (name of village).....			Mwezi (Month).....		Chaka (Year).....	
Dzina la kumpando wa zaumoyo (village health committee chairman's name).....						
Nambala ya nyumba (number of houses in village).....						
Nambala ya zinbudzi (number of latrines).....						
Nambala ya ana amene anabadwa mwezi uno (number of children born during this month).....						
Odwala amene analandira mankhwala kapena anamwalira (patients treated or died during this month)						
age group	malungo  malaria	kutsegula mimba  diarrhoea	matenda amaso  eye diseases	otumizidwa kuchipatala  referrals	died  omwalira	matenda ena other diseases, specify below
ana azaka 0-4 (0-4 age group)						
ana a zaka kuposa 4 (Age > 4 years)						
akulu (adults)						

experienced significant increases in households with latrines a couple years after the inception of the programme. A few people we interviewed in Mbela area pointed out a number of advantages for building latrines. Among them were self-respect for the individual and family and prevention of diseases to attain or promote better health.

This is in contrast to the experience of Chisi Island where the PHC team went in without the assistance of the "Chancellor College Theatre for Development" troupe (see Table 3). In June 1986 only 20 per cent of the houses had latrines and this increased to 30 per cent by February 1987. A difference of means t-test indicated that, on average, the increases latrine construction experienced by villages on Chisi Island was not statistically significant at the 5 per cent level of significance (see note in Table 2).

Table 2. Number of Latrines in Mbela Area

Village	Number of Houses	Number of Latrines			
		June 1986		February 1987	
		Number	% Houses with Latrines	Number	% Houses with Latrines
Mtira	262	107	41	123	47
Said-Son	58	32	55	52	90
Chipole	168	65	39	75	45
Kalambo	62	44	71	48	77
Mbela	150	106	71	136	91
Pyoli	320	95	30	253	79
Makuta	319	203	64	263	82
Herbet	118	54	46	108	91
Abudu	239	133	56	150	63
Nsanja	139	50	36	62	45
Kabona	107	37	35	80	75
Total	1,906	926	49	1,350	71

Note: Estimated population for Mbela area: 9,530

Results of paired sample differences of means test:

Mean per cent of houses with latrines in 1986: 49.45, standard deviation: 14.75

Mean per cent of houses with latrines in 1987: 71.36, standard deviation: 18.41

Paired differences t-value: -4.24, p-value: 0.002 (i.e. the difference between the means 49.45 and 71.36 is statistically significant at the .05 level of significance).

Source: data compiled from Liwonde ADD Primary Health Care Unit, *Monthly Returns*.

Once the PHC programme in Mbela and Mwima areas was introduced using the novel approach of "Theatre for Development", there were remarkable strides and gains. The village health committees motivated by the "Theatre for Development" performances, became very active and membership of the committees remained intact with just a couple of drop-outs. In contrast, the people of Chisi Island were not exposed to the "Theatre for Development" approach and seemed to lack motivation. The village health committees on the island, just like in many rural areas, appeared to inactive and unconcerned about the communities' plight in as far as sanitation was concerned. The lack of motivation in Chisi Island and the enthusiastic adoption of PHC in Mwima and Mbela provides more credibility to the potency of the "Theatre for Development" approach.

Table 3. Number of Latrines on Chisi Island

Village	Number of Houses	Number of Latrines			
		June 1986		February 1987	
		Number	% Houses with Latrines	Number	% Houses with Latrines
Maluwa	170	13	8	34	20
Tchuka	45	8	18	15	33
Chilima	30	10	33	12	40
Kotamu	159	43	27	42	26
Mkumbira	152	23	15	30	20
Chigwere	83	28	33	26	31
Khumali	42	4	9	17	40
Total	681	129	19	176	26

Note: Estimated population for Mbela area: 3,405
Results of paired sample differences of means test:
Mean per cent of houses with latrines in 1986: 20.46, standard deviation: 10.64
Mean per cent of houses with latrines in 1987: 30.00, standard deviation: 8.43
Paired differences t-value: -2.24, p-value: 0.066 (i.e. the difference between the means 20.46 and 30.00 is not statistically significant at the .05 level of significance).

Source: Liwonde ADD Primary Health Care Unit, *Monthly Returns*.

Maternal Care

As far as maternal care is concerned, the programme selected a number of traditional birth attendants (TBAs) who commanded respect in the community. The TBAs were then trained to provide basic antenatal care including iron supplementation, malaria treatment and high risk screening. Furthermore, commu-

nity 'doctors' were selected and trained to diagnose common conditions and administer basic medications such as chloroquine, aspirin, eye ointment, scabies ointment and so on. The community 'doctors', in collaboration with the TBAs, take up the tasks of nutritional and health surveillance of children (including the identification of children that require immunisation for the next mobile PHC team visit, or to encourage mothers to go to the under-five clinic on appropriate days), the distribution of chloroquine, first aid and treatment of minor ailments, the management of diarrhoea in children, and treatment of malaria and selected common conditions in children and adults. They also educate families and community groups on the prevention of these conditions. The efforts of these dedicated, community based (unpaid volunteer) PHC workers have been amply rewarded.

Incidence of Disease

Statistics from the PHC unit in Liwonde show that the seasonal outbreaks of cholera declined considerably between 1985 and 1986 when the PHC project was in progress (Table 4). Furthermore, immediate reporting of suspected cholera and severe diarrhoea to health institutions by the community and improved water supplies by provision of sanitary structures at wells/springs have been vital to the improved situation. There has also been a significant reduction in monthly infant and child deaths caused by diarrhoeal diseases. The incidence of diarrhoea in both children and adults experienced a remarkable reduction during the 1985-1990 period (see Table 5). However, we must caution that the data in Tables 4 and 5 could be on the low side for several reasons including under-counting due to parents not taking their sick children to the village health worker. It may also be due to the fact that the year 1987 was somewhat drier than the year 1986 in terms of rainfall. Diseases such as diarrhoea are most intense during the rainy season and drier than normal season may reduce the incidence of diarrhoea and/or cholera. However, the trends in the data were obviously encouraging. Similar data for Chisi Island was not available due to noncooperation of the village health workers charged with the responsibility of collecting such data.

In addition to the reduction of communicable diseases such as diarrhoea, Mbela and Mwima experienced substantial declines in monthly infant mortality figures between the 1984/85 and 1987/88 periods as shown in Table 6. The current estimated infant mortality for Mbela and Mwima areas is 150 compared to 180 and above before the PHC project in this area. These are a few examples which illustrate the positive impact of this unique programme as evidenced from the health and sanitation data collected by the programme. It is unfortunate that comparable data on disease incidence was not readily available for Chisi Island with the exception of latrines which could be easily counted in surveys by the PHC team.

Table 4. Reported Cases of Cholera and Severe Diarrhoea Incidence in Liwonde Area

	1985			1986		
	October	November	December	October	November	December
Total No. of Cases	92	116	155	46	29	15
Total No. of Deaths	2	0	1	0	0	0
Total No. Positives	16	15	8	1	0	0

Source: Liwonde ADD Primary Health Care Unit, *Cholera Quarterly Returns*, October-December 1986.

Table 5: Incidence of Diarrhoea in Children and Adults in Mbela Area

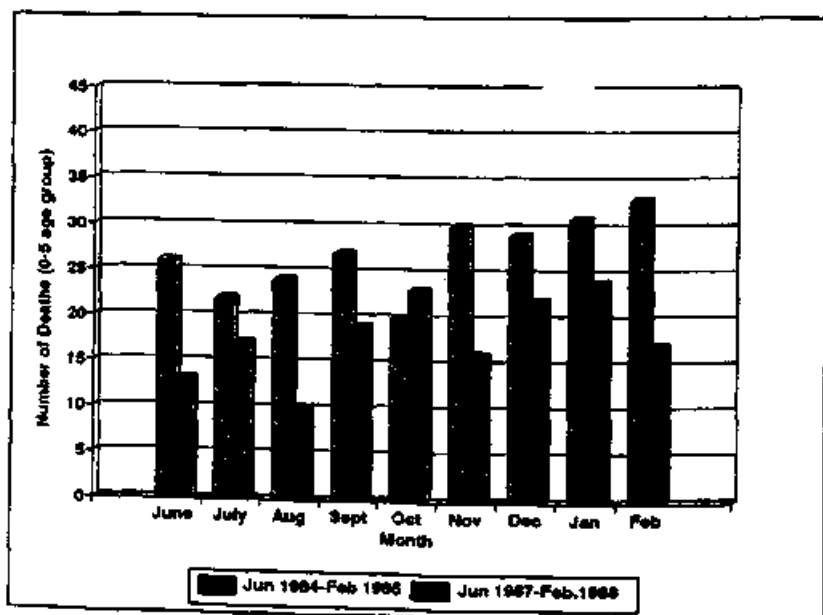
Village	June 1986				May 1987			
	No. of Cases		No. of Deaths		No. of Cases		No. of Deaths	
	0-5 age group	Adults	0-5 age group	Adults	0-5 age group	Adults	0-5 age group	Adults
Mtira	21	0	1	0	9	5	1	1
Said-Son	0	0	0	0	7	1	1	0
Chipole	11	0	1	1	4	1	1	0
Kalambo	111	76	1	1	21	6	0	1
Mbela	7	7	3	2	1	5	2	0
Pyoli	33	2	0	0	6	3	0	1
Malakuta	93	64	1	4	4	1	0	1
Herbert	13	1	2	0	1	0	0	0
Abudu	30	16	4	0	6	3	0	0
Msanja	38	34	0	0	2	7	0	0
Kabota	10	3	0	0	2	5	2	0
Total	367	203	13	8	63	37	7	4

Note: Number of deaths reported were NOT due to diarrhoea alone but to any other disease.

Source: Liwonde ADD PHC Unit, *Monthly Returns*.

By concentrating the PHC activities in a number of selected villages, the Liwonde PHC Unit hoped that these villages would serve as centres of information diffusion to other nearby villages where the programme had not as yet been initiated. The model for diffusion was through village contact. Indeed this approach appears to have yielded the intended results. At the time we carried out this evaluation, surrounding villages were requesting the PHC team to initiate PHC activities in their areas. Villagers from surrounding areas were coming to Mwima and Mbela to observe and receive basic first aid care and treatment from the community 'doctors'.

Table 6: Number of Deaths Among Children Aged 0-5 in Mbela Area for the periods 1984/85 and 1987/88



Notes:

Results of paired sample differences of means test:

Mean number of deaths 1984/85: 26.88, standard deviation: 4.31

Mean number of deaths 1987/88: 17.89, standard deviation: 4.65

Paired differences t-value: 4.53, p-value: 0.002 (this denotes that the difference between the mean monthly number of deaths for the under-five age group, ie 26.88 and 17.89 is statistically significant at the .05 level of significance).

Source: authors, data from Liwonde ADD Primary Health Care Unit, *Monthly Returns*.

Conclusion

The case study discussed in this paper confirms the assertion that PHC planning ought to be socially and community oriented, aimed at improving the well-being of rural communities. The communities should be mobilised and motivated to diagnose their own problems and find their own solutions. Popular theatre like the "Chancellor College Theatre for Development" could be employed creatively for this purpose. PHC planning has tended to adopt the rather narrow view of accessibility relating it to the maximum distance people are willing to travel to obtain a particular health service. Consequently much emphasis has been placed on building new facilities at great capital and recurrent cost to the state without necessarily improving absolute access to rural inhabitants. In reality accessibility to health services is concerned with more than just proximity to these services; it involves various social, cultural and community health education issues. Active community participation and involvement is vital in the success of any PHC programme. As shown by the Liwonde PHC programme's relative success over a short period of time, there is a clear need to involve the rural people in the planning process. In other words, the planning process should not only come from above but should also include a bottom-up grassroots-level component.

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