Disparate Views of Community in Primary Health Care: Understanding How Perceptions Influence Success

The importance of community in primary health care (PHC) is evident in the role of community participation and in the types of programs that are routinely implemented (community health-worker [CHW] programs, community clinics, community-based disease-control programs). Few health care providers and program administrators, however, have considered the meaning of community. Instead, they frequently impose their own definition of community and assume that it corresponds to local realities. This is problematic because target populations may have different ideas about what a community is and how it functions. When disparate ideas of community exist, they can affect the implementation of PHC programs, leading to low rates of acceptance, participation, and utilization. Using two examples, a community clinic in El Alto, Bolivia, and a CHW program in Rio Branco, Brazil, this article discusses some of the problems that arise when local definitions of community do not correspond to programmatic definitions. [community, primary health care, Brazil, Bolivia]

One of the novel aspects of primary health care (PHC) when it was first introduced was its focus on communities instead of centralized health care facilities as the key to improving health among the poor. Anticipating that significant improvements in health would result from relatively simple changes in socioeconomic and environmental conditions, policy makers concentrated their efforts on providing access to basic health care information, meeting basic needs, and creating a healthy environment in low-income communities. The community’s central role in PHC is evident when one examines the Alma-Ata Declaration and the types of programs that policy makers routinely implement. Community-based clinics, community health workers (CHWs), and community-based disease-control programs are fundamental components of PHC programs throughout the world.

PHC rhetoric calls for the active involvement of community members in the various stages of program development, implementation, and evaluation. Although the degree and type of participation vary from program to program, policy makers have expected community members to help identify priorities, to volunteer their time as CHWs, and to provide financing for the PHC programs that they use (e.g., American Public Health Association 1982; Morgan 1993; Rifkin 1985; Tatar 1996; Ugalde 1985).

Given the centrality of the “community” concept in PHC, it is striking how little time and effort policy makers have devoted to identifying and working with locally defined communities. After over two decades of PHC, only a few health care organizations and programs have critically examined the concept (Tarimo and Webster 1997). More commonly, a number of PHC programs have imposed their own definition of community on the populations with which they work (Jewkes and Mucrot 1996). These definitions are often based on Western, romanticized models that assume individuals living in the same area share the same aspirations, values, and organization (Rifkin et al. 1988). At times, this definition is at odds with local ideas of community, where social and cultural criteria may take precedence over spatial proximity.

The way that target populations and administrators define community can affect the implementation of PHC programs. Disparate ideas of what a community is can contribute to low rates of acceptance, participation, and utilization. In support of this argument, this article presents two examples, a community PROSALUD clinic in El Alto, Bolivia, and a community health worker program (PACS) in Rio Branco, Brazil. Using these examples, this article explores how local ideas of community differ from official programmatic definitions. It then discusses how these disparate definitions relate to some of the problems each program has encountered. Finally, it concludes by discussing the impact of contested definitions of community for PHC in general.

Conceptualizing Community in Primary Health Care

Although discussions of the importance of community are ubiquitous in the PHC literature, extended discussions of the meaning of community are difficult to find (for exceptions, see Jewkes and Mucrot 1996; Silimper 1995; Tatar 1996). In their review of the relevant health literature, Jewkes and Mucrot (1996) report that
there is a singular lack of specificity and agreement regarding the construct of community. A similar situation prevails in the social sciences, where scholars have debated the conceptual definition of community for decades (Anderson 1991; Cohen 1985; Gallaher and Padfield 1980; Hillery 1955, 1968; Willis 1977). Unlike social scientists, however, many health care professionals assume the meaning of community to be self-evident, thereby negating the need for definitional debates. An early exception to this was the 1978 WHO–Alma-Ata Declaration, which offered a conceptual definition, stating:

A community consists of people living together in some form of social organization and cohesion. Its members share in varying degrees political, economic, social, and cultural characteristics, as well as interests and aspirations, including health. Communities vary widely in size and socioeconomic profile, ranging from clusters of isolated homesteads to more organized villages, towns and city districts. [World Health Organization 1978:49–50]

Because this document introduced PHC, this definition of community has likely served as the template for many subsequent PHC programs. Because of its influential character in projects the world over, a closer examination of some of the assumptions contained in this definition is warranted.

The WHO definition of community includes three dimensions (spatial, social, and political) that subsequent PHC programs have included, to varying degrees, in their design and implementation. The extent to which each dimension is emphasized or ignored has implications for PHC programs. First, communities are frequently assumed to have a spatial or geographic dimension. The spatial dimension emphasizes that individuals residing in a community live in a close spatial proximity, often in a defined geographic area. As such, communities are often thought to be commensurate with neighborhoods, slums, or villages. It is true that some programs have expanded, redefined, or disregarded the spatial dimension (e.g., sex workers or substance abusers as a community) (e.g., Baksj et al. 1998; Kegeles et al. 1999; Sedyaningsih-Mahatih 1997; Somlai et al. 1999). Many PHC programs, however, continue to incorporate geographic criteria into their definition of community. In fact, this spatial dimension is frequently a key component of operational definitions of community. The use of geographic criteria facilitates the identification of communities and the administration of community-based projects, especially when resources are scarce. Delineating a village or neighborhood on a map is a quick, easy, and comprehensible way to identify the target population and to make possible the allocation of health care resources (Rifkin et al. 1988).

The WHO definition also includes a social dimension that is discussed in the PHC literature. This dimension refers to the idea that members of a community share similar socioeconomic characteristics. For example, clients of PHC programs often live in similar economic conditions (usually poverty), may be members of the same ethnic, racial, or religious group, and/or they may share kinship ties, style of dress, or language (Silimperi 1995). The assumption within PHC is that these shared characteristics, in some way, relate to shared health problems. At times, policy makers presume that these commonalities lead community members to have similar and overlapping problems, interests, values, and aspirations (including health). This social dimension tends to emphasize the homogeneity of communities, highlighting similarities and often ignoring differences.

The final dimension included in the WHO definition is political. This dimension refers to the idea that communities contain a social infrastructure that will lead people to organize around and act on their shared aspirations. Embodied in this dimension is the idea that community members operate together (or at the very least assist one another) to overcome their common problems and pursue their mutual interests. The underlying assumption is that what benefits the community, by extension, benefits the members of the community. Ideally, it is this political dimension that makes possible the participation that is so important in PHC (Rifkin et al. 1988).

One theme that crosses all of these dimensions is sharing, either residence, socioeconomic characteristics, or political structures (Cohen 1985; Rifkin et al. 1988; Tatar 1996). For example, program administrators may assume that individuals who live in an area (shared geography) also share a number of common characteristics that lead them to want the same things (shared goals) and that this will lead them to work together to achieve these goals (shared political infrastructure). In PHC this notion of sharing is important because it underlies the assumption that people will identify with and work together as a community to improve health.

This assumption, however, is problematic. There is no intrinsic reason that individuals who live together will share socioeconomic characteristics that lead them to act together in pursuit of a common goal (Rifkin 1987). There may be instances where the few commonalities that individuals share (such as poverty and residence) are overshadowed by a number of other attributes (like race, ethnicity, religion, etc.). By emphasizing that communities are aggregates of individuals with shared characteristics, the PHC image of community ultimately homogenizes what may be heterogeneous groups (Schwartz 1981). It seems that the PHC literature would benefit from feminist studies that point to the dangers of emphasizing similarities while ignoring differences (Guillt and Shah 1998; Hooks 1982; Johnson-Odim 1991; Mohanty 1988).

An emphasis on the shared nature of community also obscures the importance of power struggles and ignores the existence of differing wants, needs, and desires. It is perhaps more accurate to view a community as a "set of power relations in which individuals are grouped into different categories" (Navarro 1984:472). The diversity within communities, noted above, may mean that community members confront different problems and have different needs and aspirations. As a result, individuals pursue their own interests, at times to the detriment of their fellow community members, instead of acting together in pursuit of a common goal (Foster 1982; Rifkin 1987). This may be especially true in low-income neighborhoods, as "poverty...discourages cooperation, leads to suspicion of the motives of fellow villagers, and encourages a primary commitment to self and family" (Foster 1982:190). In fact, a number of studies demonstrate that communities do not always act together, especially in times of stress (e.g., Howard and Millard 1997; Lewis 1961; Turnbull 1972). Therefore, the idea that communities will work together in pursuit of a shared value like health is not always a valid assumption.

One reason why the WHO definition of community is problematic is that it is an image imposed by individuals who are outside the "community." Based on romanticized, Western models of community, this definition does not always hold true for the areas where it was developed. In fact, numerous studies in the United
States and Europe have questioned the validity of this image of community (e.g., Gallaheer and Padfield 1980). It should therefore come as no surprise that in non-Western contexts, local versions of community do not always conform to this ideal.

In addition, policy makers may not attempt to verify that their definition of community corresponds to the local reality. Instead, they may impose their own (at times faulty) meanings and assume that local groups will agree with and conform to programmatic definitions. In one of the few studies of how PHC providers construct community, Jewkes and Murcott (1996) found that administrators and health workers in London devised their own definition and assumed that everyone, including the target population, shared such meanings. Investigating and understanding what community means to its members, however, would produce a more accurate and meaningful definition (Cohen 1985). Local meanings of community draw on and incorporate the three previously discussed dimensions of community to varying degrees. Stilimperi offers that

one urban community may define itself along ethnic, cultural or linguistic similarities ... another may forge a new identity based on common environmental problems which threaten all members ... and yet a third identity may be dependent upon common function or workplace. [1995:12]

If PHC administrators explore local understandings, they may encounter alternate ideas of community or they may find an absence of community as understood in PHC. As the following examples demonstrate, this disjuncture between programmatic and local definitions can influence the implementation and, ultimately, the success of PHC programs.

Data Collection

Data on the PROSALUD health center were collected over the course of 16 months, between April 1995 and July 1996, in El Alto, Bolivia. As part of this research, formal interviews were conducted with 93 randomly selected households in the neighborhood of Huayna Potosí. During these interviews, families discussed recent illness episodes, local health care providers, and PHC services in the neighborhood. Four hundred two patients were also interviewed at the PROSALUD health clinic. These interviews collected information on patients' demographic characteristics and their reasons for visiting the clinic. In addition, doctors, nurses, administrators, and bureaucrats in El Alto were formally and informally interviewed about the PROSALUD clinic and about the residents and history of El Alto. These interview data are supplemented by extensive participant-observation conducted at the PROSALUD clinic. These observations included following an opportunistic sample of patients throughout their entire visit, observing staff meetings, and following CHWs on their rounds in the neighborhood. Finally, six families in El Alto were observed and interviewed over an eight-month period. Data were collected on their health problems, the treatment decision-making process, and the PROSALUD clinic. A minimum of eight formal interviews were conducted with each family; the maximum was 15. Moreover, numerous informal interviews occurred with these families during unscheduled visits.

Data on the PACS program were collected during 13 months of fieldwork in the city of Rio Branco, Brazil, from November 1995 to November 1996. During this period, PACS administrators and CHWs were individually interviewed about PACS policy. These interviews collected data on the history of PACS, each individual's responsibilities and experiences in the program, their understanding of PACS policy, and the successes and problems they experienced implementing the program. Additionally, five training sessions were observed where administrators and CHWs discussed program priorities and problem areas. CHWs from the neighborhood of Triunfo and their direct supervisor were present at one of the meetings, the same supervisor and all of the CHWs he supervised (including the four from Triunfo) attended two other meetings, and all of the PACS personnel (supervisors and CHWs) in Rio Branco attended two additional meetings. Extensive participant-observation was also conducted in Triunfo. This included accompanying each CHW during household visits and attending monthly weighings and community meetings. During these observations, CHWs informally discussed the PACS program, their jobs, and the difficulties they experienced doing them. Finally, 25 families in Triunfo shared their experiences, opinions, and expectations regarding PACS during semistructured interviews.

Disparate Ideas of Community: The Examples

A Community Clinic in El Alto, Bolivia

Huayna Potosí, one of the largest neighborhoods (250 hectares) in the city of El Alto, Bolivia, is currently home to over 10,000 Aymara-speaking migrants (Instituto Nacional de Estadísticas 1992). More than half of Huayna Potosí's population has lived there for five years or less, while one-quarter has been there for 15 years or longer. In the past 20 years, both the neighborhood and El Alto have grown exponentially, as peasant farmers and their families arrive in the city seeking gainful employment in the market economy. Despite its prominence, its large and growing population, and its proximity to La Paz, El Alto cannot support its residents with adequate utilities, an issue decision makers in the capital do not consider worth addressing (Antezana 1993). El Alto's rapid growth has contributed to a number of public health problems, such as a lack of potable water and insufficient waste disposal, leading to generally poor sanitation. These conditions compound the already precarious health situation for residents of Huayna Potosí, who commonly suffer from respiratory infections, gastrointestinal illness, and malnutrition.

At the time of the research, the only viable Western-style health clinic operating in Huayna Potosí and the five surrounding neighborhoods was the PROSALUD health center, a private, nonprofit organization sponsored by the U.S. Agency for International Development (USAID). While PROSALUD has been operating in Bolivia for more than ten years, the seven PHC clinics in northern El Alto opened in 1991. Following their mission to "support human development by contributing to the health and well-being of the population, especially those with few resources," these clinics are the best equipped and staffed biomedical health centers in the city, providing service to all surrounding residents. Furthermore, PROSALUD "provides integrated, comprehensive and continuous Health Care through decentralized, multipurpose and permanent delivery units. Primary Health Care
and community participation are the basic concepts" underlying PROSALUD’s mission (Fidler 1990:168).

PROSALUD’s primary goal is to provide “communities” with free preventative health care, vaccinations for children, family planning services, and prenatal care consultations. They promote these services via one CHW, who canvasses the six surrounding neighborhoods daily, encouraging people to use the clinic for health ailments, prenatal exams, births, and family planning. In fact, PROSALUD purposely hires locals as a means to improve “community” relations. Each PROSALUD health center also generates revenue, recuperating its costs by providing curative care services to all those who request them. Revenue generated by the clinics helps the system become self-sustaining, ultimately allowing the network to be financially independent of USAID.

The way that administrators measure success (the number of clients that utilize the clinic) shapes PROSALUD’s operational definition of community. Specifically, each PROSALUD clinic must enumerate all births, prenatal consultations, and curative care visits to illustrate its viability in the areas it serves. As a result, PROSALUD uses geographical criteria in its operational definition of community, drawing on municipal maps of the area and demographic statistics from national census data. Administrators utilize these data to calculate the population required to provide, on average, enough resident visits to generate sufficient revenue to support the clinic, which, in turn, demonstrates “success” to granting organizations. By using geographical criteria and statistical figures to identify “communities” and to measure “success,” PROSALUD equates communities with catchment areas for the clinics.

From a Western perspective, this operating process is pragmatic, but in northern El Alto this definition of community is not meaningful for residents who use the clinics. This is because PROSALUD does not consider how residents define community for themselves. Instead, PROSALUD assumes that, because they are all Aymara (a shared ethnicity) migrants and live in the same area, their clients organize themselves along similar political boundaries and shared mutual interests. As one health administrator reflected, “For the most part these people are Aymara peasants from the countryside; they wear the clothes, speak the language, and look like everyone else who lives there.” It is, however, myopic to treat the residents of Huayna Potosí as a homogeneous group simply because they wear similar clothes and speak a common language (assuming that they really do). Indeed, it reflects a basic misunderstanding of how residents live, what they need, and how they go about surviving in the city.

This is illustrated by a resident named Alvaro, who commented on why he and his family moved to El Alto and how doing so affected their lives. “We moved up here when La Paz became too expensive for us to raise our children. We do the best we can with what we can afford. Our house here is supposed to be our home, but instead, we just live here.” Although he has lived in El Alto for some time, Alvaro’s disparited comment on the neighborhood reflects his sense of separation from his neighbors. Further discussions with Alvaro and his neighbors revealed that although residents of neighborhoods like Huayna Potosí carry on their daily activities in a shared geographic space, few feel a connection with the place or their neighbors. While some residents commented that they moved (from countryside or city) to be closer to family, economy tends to be the common denominator for all those living in Huayna Potosí. Alvaro’s comment also reflects the heterogeneity of the Aymara living in the city. They are not one distinct group of urban Aymara-speaking migrants but, rather, individual households operating within the context of a larger, inhospitable neighborhood.

Other residents felt that because neighbors come from all regions of the altiplano, they cannot be trusted. Because everyone competes for jobs and security, having personal information on anyone else conveys an advantage. Valvin, a local taxi driver, discusses his dislike for his neighbors but evaluates the need to get along with them:

I don’t know these people who live here very well [pointing to houses across the plaza], but I know enough about them by living here. I see them come and go, and I know I wouldn’t trust them with things that are important to my family. They don’t need to know about how much I make or where I come from, all the rest they will figure out or hear through gossip. I prefer that they know as little about me as possible, although somehow everyone ends up knowing something in the end. Since we live here in this place, we have to make it as nice a place as possible, so our kids will be comfortable and life will be good. If we share anything, it is our political interests to make life better for all of us here.

As this quote illustrates, while residents of Huayna Potosí may share cultural traits, economic constraints, and geography, they do not share the sense of solidarity that is often assumed to be synonymous with community.

Instead, for residents of northern El Alto, community is a construction of their sanguinal, affinal, and fictive kin relationships. Not precluded by physical barriers such as distance or space, family ties serve migrants as a primary source of security, sustenance, and solidarity. Nuclear and extended family relationships provide individuals with outlets to share personal information, and family members rely on and support each other consistently. For example, Suárez stated that it is difficult to find people who we can trust with personal information, other than family. In the end, you can only trust family; they will not lie to you and will always try to help you when you need them. If they are not family, who knows how others could use personal information against you?

Most importantly, extended families provide support networks, connections for finding jobs, advisors in times of trouble, extra hands during construction, or even shelter and food while members save money and search for their own place to live. Another resident, Maria, explained that even though I don’t get along with all of my brothers and sisters, aunts and uncles, when there is a crisis we come together to help, just like my parents and grandparents did in [their village]. Around here, I don’t expect my neighbors to help me unless it helps them, too. You can’t trust anyone who doesn’t have a tie to family, because they only care about themselves.

In the city, family networks transcend physical parameters as extended relations travel between barrios to help each other survive in the urban environment. Community is not limited to geographic terms and neighbors but is inclusive of residents’ family across the city.

In Huayna Potosí, Aymara “community” reflects an urban construction of the Andean social organization called ayllu. Residents do not refer to their support
network as an ayllu but, rather, a family. However, from an anthropological perspective, the network closely represents what Murdock (1949) calls a *deme* and Andeanists consider an ayllu (Bastien 1978; Guillet 1981; Knowlton 1982; Schaedel 1988). When specifically applied to the city, some of its rural features disappear, but kinship and trust remain.

These disparate ideas of community (the catchment area model versus the kin-based model) have implications for PROSALUD clinics. Local residents seek health care based on whom they trust, often using home remedies, the advice of family members, indigenous healing specialists (found in the city or countryside), and corner stores before patronizing formalized health care centers, such as PROSALUD. Consulting outsiders entails trusting someone with personal information about the family or one’s self, balanced with the fear that that information may be detrimentally used against one in the future. When residents do use PHC facilities, they are willing to travel across town to a clinic with personnel they do not know, instead of consulting at the local PROSALUD health center. Residents stated that this was because they preferred someone they knew would not share information about them with their neighbors. Under these circumstances, it is preferable to consult with strangers about health care.

Because PROSALUD felt it necessary to include neighborhood residents as members of their clinic staff (to promote a sense of community), locals feared that personal information would be leaked to individuals beyond their family circle, allowing others to take advantage of them in the future. Instead of garnering support from residents, the policy of hiring community members backfired, discouraging residents from using the clinic. Their distrust of the CHWs outweighed their need for local attention, and they went elsewhere, to clinics where they were not known.

Because PROSALUD defined residents of Huayna Potosí and surrounding neighborhoods as a homogeneous group of Aymara migrants (based on ascensive characteristics, i.e., language, dress, etc.), they did not understand the microdivisions and heterogeneity among residents. While these misunderstandings did not keep the health clinic from operating (although less than 10 percent of the total client base resided in Huayna Potosí), it did contribute to the residents resorting to more familiar and distant resources before considering the PROSALUD center as an option for health care.

Deemed “successful” by the PROSALUD system, in that the staff regularly met its numerical patient goals, by residents’ terms, the clinic did not adequately address or understand their health concerns. Because clinic administration and residents defined community so differently, it is not surprising that the clinic (and its staff) was so unpopular with the target group of migrant, Aymara-speaking residents. By ignoring local conceptions of community and misunderstanding its role in the neighborhood, the clinic incorrectly assumed that cultural similarities would be the key to gaining access to the residents. Instead, by superficially reflecting cultural sameness (hiring locals), the clinic demonstrated to the residents that it did not understand local constructions of community.

Community Health Workers in Rio Branco, Brazil

Triunfo is one of over 60 peri-urban neighborhoods in Rio Branco, the state capital of Acre, Brazil. Triunfo began as an urban land invasion in the early 1990s and by 1996 encompassed approximately 1,000 households. As is true for most recently settled urban shantytowns, substandard housing conditions, inadequate infrastructure, and high rates of under- and unemployment characterize Triunfo. Most of the houses in Triunfo are one-room wooden dwellings shared by entire families. Triunfo’s residents dispose of their refuse by burning it or by tossing it into a vacant lot, ditch, or pond. None of the households in Triunfo has running water, and a series of wells, which dry up between July and September, is the only source of water in the neighborhood. In addition, there are no city sewer connections, and few households have septic tanks. These conditions, combined with the environmental hazards indigenous to the Amazon, pose a serious threat to health, which is reflected in high rates of intestinal and respiratory illnesses and malnutrition.

The goal of PACS, a national CHW program sponsored by the Brazilian Ministry of Health, is to extend PHC coverage to children under the age of five and pregnant women residing in low-income neighborhoods, like Triunfo. PACS has been active in Triunfo since the inauguration of the program in Rio Branco in 1993. In 1996 there were four CHWs in Triunfo, each attending between 200 to 250 households, which was expected to visit once a month. PACS attempts to improve health in low-income neighborhoods by equipping CHWs with the knowledge and skills to combat the most common health problems at the community and household level. It is assumed that CHWs will then impart this knowledge to neighborhood residents. Ideally, this is accomplished during monthly household visits, when CHWs measure the nutritional status of children under the age of two and pregnant women, register malnourished children and pregnant women for the municipal milk program, distribute hypochlorite solution to treat drinking water, and educate family members on basic health issues (e.g., breastfeeding, oral rehydration solution preparation). Administrators also hope that residents will consult their CHW when a child or any other family member falls ill (Ministério de Saúde 1993).

The PACS program in Rio Branco uses geographic criteria to operationalize its definition of community. For example, Triunfo is a spatial agglomeration of houses with arbitrary boundaries that were defined for administrative purposes. The communities that PACS works in can be clearly and easily identified on a map. In fact, each PACS supervisor has a series of maps that define the territories she or he is responsible for overseeing. When the first author asked the regional PACS administrator how she defined communities, the woman did not immediately answer but instead pulled out a map of the city with various peri-urban neighborhoods outlined in red. Pointing to the map, she then responded, “These are the communities we work in,” indicating that anyone living in a delimited area was considered a member of the community. As discussed above, this operational definition is frequently used in PHC.

While administrators use geography to define communities, they make a number of assumptions about the social infrastructure of these communities that underpin the logic behind PACS. For example, policy makers assume that because CHWs live in the same neighborhood as the families they serve, they share the same values and priorities. This, in turn, is linked to the idea that, as members of the same community, residents will see that what benefits the community benefits everyone. It is this sense of community that supposedly leads residents to support
the work of CHWs, both morally and in terms of participation. Nevertheless, PACS administrators can only assume that this social infrastructure exists. It is important to ask how meaningful this idea of community is in neighborhoods like Triunfo, a product of rapid, recent urbanization. Is it valid to assume that residents in neighborhoods like Triunfo share a sense of solidarity that leads people to work together?

Although it is true that the residents of Triunfo share the same basic socioeconomic characteristics (i.e., urban poor), co-residence in the same neighborhood does not bring with it the sense of community envisioned by PACS administrators. In fact, residents imbue the term community (comunidad) in Portuguese with a very different meaning. When asked to define community, residents responded that it is where a person lives, a shantytown, a slum, the periphery, or a neighborhood. Nobody mentioned cultural or political characteristics. Talking to residents, it is apparent that there is no sense of a common bond, a shared identity, a sense that “we are in this together.” In the words of Sorina, “No, we are not united. Sure, I have some friends here; my sister and aunt, Rose, and Ana. But I usually keep to myself... I care for my family and friends. What goes on in other houses is not my business.” Rifkin’s discussion of urban neighborhoods aptly describes the situation in Triunfo:

Urban communities are comprised mostly of people who have been thrown together because of circumstances, rather than choice. The mobility of urban dwellers, particularly the poor, contrast sharply to rural communities which are composed of people who often have century-old roots, traditions, social structures, values, behavior patterns and thus a much greater sense of identity... They (urban dwellers) have little perceived common interest or framework for collective action. (1987:58)

In this context, the statement “we just live here” sums up the attitude of Triunfo’s residents toward their neighborhood. These differing ideas about what a community is and how it operates have implications for PACS.

One of the assumptions of PACS is that residents will more readily accept CHWs, as opposed to doctors and nurses, because they know and identify with them as members of the same community. This identification with CHWs is supposed to foster the communication that is crucial to health education and illness consultations. In fact, this is one of the reasons why administrators insist that CHWs reside in the areas where they work. One PACS administrator clearly expressed this view when she explained that residents in peri-urban neighborhoods “are more honest and open with health agents. They (CHWs) are their neighbors and friends, not a stranger like a doctor in a hospital or clinic.” This administrator also believed that shared residence and poverty create a common bond between CHWs and the populations they serve. In her words, “With health agents, their reality is the same, there is nothing hidden. People look forward to visits from health agents.”

In Triunfo, however, the absence of a cohesive social infrastructure means that residents do not view a CHW as one of their own. Instead, the CHW is just another face in the crowd. Because of the large number of households (200 or more) that a CHW attends, each family receives at best one visit per month. In the absence of other social interactions, limited by the sheer number of people in Triunfo

(over 3,000 in 1996), residents rarely feel they share a common identity with CHWs. Consequently, residents do not feel comfortable talking to CHWs about ultimately personal health-related matters. This leads them to resist and at times reject the work of CHWs. They do not consult CHWs when their children are ill, and they do not welcome CHWs into their homes during monthly visits. In fact, many residents told me that they were unwilling to discuss personal matters with CHWs because they were “strangers” and that they viewed their monthly visits as intrusive. Given the choice, Triunfo’s residents choose to speak with doctors and nurses because, even though they are strangers, they at least have the medical knowledge necessary to deal with their problems. This is ultimately problematic because people are not receptive to health education and do not consult CHWs when family members are sick, both of which are fundamental tenets of PACS.

Numerous conversations and observations in the field confirm that residents do not automatically accept CHWs and that they view their visits as intrusive. For example, Socorro was incensed after a home visit during which a CHW tried to discuss the care of her three-month-old son. “I don’t know that woman! Who is she? Coming here, telling me how to screw, how to breastfeed, how to clean my house? She says and asks things I would not even say to my friends!” Socorro stated. Her sister Elizabeth then shared her strategy for dealing with CHW visits: “I just tell them what they want to hear. Yes, I breastfeed. Yes, I use pills. Yes, I treat the water. They are crazy if they think I am going to discuss this with some unknown person.” When asked whether any of the information the CHW shared was valuable, they both replied, “No.”

“When my son gets sick I take him to the clinic. That woman (the CHW) cannot do anything, she cannot help,” Socorro stated. In this instance, both women viewed the CHW’s visits as those of a stranger intruding into their personal lives. In another incident, Iris, who was five months pregnant, told a CHW that she was not expecting but, instead, that she was well nourished (an obvious lie). When asked why she lied to the CHW, Iris replied, “It is none of her business. If I tell her I am pregnant, she will be here every week telling me, ‘Do this, don’t do that.’ Think if someone came up to you in the street and started telling you this. Imagine!” Iris then explained that she turned to her mother and sister for advice and the maternity hospital for health care. From Iris’s perspective, turning to the CHW for help and advice is the equivalent of turning to a stranger.

PACS administrators also assume that residents will participate in projects designed to improve health conditions at the community level because, as members of the community, they themselves stand to benefit. For example, programs where residents are called on to clean garbage out of the streets and improve drainage in the neighborhood benefit everyone by removing sources of contagion. However, CHWs report that the few times they did sponsor community improvement programs, they received little support. For example, during a campaign to remove brush and garbage that had accumulated around the neighborhood well, only three CHWs (and no residents) showed up, even though this event had been well advertised. When the first author asked two residents who used the well why they had not participated, one said he was too busy removing brush and garbage from his own yard, and the other said there was no point because the area would be overgrown and littered with garbage again within a week. In fact, when asked if they had ever participated in one of these programs, all residents responded, “No.”
Triunfo’s high turnover rate, which contributes to the absence of a cohesive social infrastructure, is one of the reasons for this lack of participation. The peri-urban population in this city is highly mobile, and people frequently migrate back to rural areas or move to other peri-urban neighborhoods. In Triunfo, 31 percent of the population has resided in the neighborhood for less than one year, 21 percent between one and two years, and 21 percent between two and three years. Add to this the fact that many residents aspire to leave Triunfo, which is an urban slum, to live in a better neighborhood. As a result, people do not see the point of developing relationships or investing time and resources in community projects because they anticipate their stay in Triunfo will be short. Because residents do not identify with their community, they do not work to improve it. Therefore, projects that require community participation are usually hampered by a lack of it.

It is also interesting to examine a counter example of residents actively participating in PACS. Of all the CHW responsibilities, the delivery of hypochlorite solution is the one carried out most frequently. It also appears to be the only service that most residents view in a positive light. In fact, some residents complained about not receiving enough hypochlorite or that it had been too long since their CHW had delivered it. In Triunfo, hypochlorite solution is used to treat drinking water and to do laundry (not PACS’s intended use of it). Although residents were receptive to this aspect of the PACS program, they still did not want to discuss hygiene and food preparation with CHWs. Instead of engaging in a discussion about water treatment (the reason for distributing hypochlorite), residents preferred that CHWs simply drop off the hypochlorite and be on their way. On a number of occasions, people sent their children to intercept the CHW in order to avoid a conversation with her. In this example, while residents are participating in the PACS program, they are not doing it in the manner envisioned by PACS.

In summary, the population of Triunfo shares residence in an urban slum and grinding poverty, both of which they are trying to escape. These commonalities have not led them to develop a “sense of community.” It therefore appears that PACS administrators’ assumptions about the nature of community in Triunfo are unfounded. Residents do not identify with one another, nor do they invest resources in improving the area. In this example, disparate ideas of community contribute to the low rates of acceptance and participation that plague PACS in Triunfo.

Conclusion: Reconsidering the Role of Community

The question of how to and who defines a community is not merely academic. Disparate ideas about what a community is and how it operates can influence the success of PHC programs (including community-oriented primary care in the United States). As the previous examples demonstrate, when policy makers define communities in ways that do not correspond to local realities, the services they provide may experience low rates of utilization and even outright rejection. Both the PROSALUD clinic and PACS assumed that members of Huyna Potosí and Triunfo shared a common identity that would lead them to accept and/or support the work of fellow residents. While the PROSALUD program assumed that employing CHWs from the community would encourage residents to utilize the clinic and its services, this practice had the opposite effect. Residents of Huyna Potosí preferred to travel across town for health care, where they could anonymously consult practitioners. PACS administrators made a similar mistake in Triunfo. Residents did not identify with their CHW simply because she lived in the same neighborhood. As a result, they resisted the health education efforts of CHWs and preferred to consult at the local health post. Disparate ideas of community can also have an effect on community participation. In Triunfo, there was little participation in or support for community works programs because people did not identify with their community.

It is important to note that disparate ideas of community are not the sole reason these programs experience problems. For example, like many PHC programs the world over, PACS is underfunded and understaffed. Also, the programmatic goals of PACS and PROSALUD are not entirely in accord with the residents’ goals (Wayland in press). As this article shows, however, disparate ideas of community are a contributing factor to some of the problems experienced in these programs.

The suggestion that disparate ideas of community influence the success of PHC programs is also relevant beyond these two examples. Community clinics and CHWs are fundamental components of PHC programs throughout the world. There is a substantial body of literature that discusses the problems associated with these types of programs. Research on community clinics and CHWs has shown that even when health care is affordable and available, target populations do not always utilize and support these services. This lack of utilization may be the result of conflicting worldviews, negative experiences, or differing priorities (e.g., Bastien 1990; Crandon-Malamud 1991; Gilson et al. 1989; Wayland in press). Few PHC policy makers, however, have questioned how their own assumptions about “communities” could be the source of the problem. This is true for the two examples discussed in this article. In El Alto, administrators and health care providers attributed PROSALUD’s problems to the supposed fatalism, ignorance, and superstition of their clientele. In Río Branco, PACS supervisors believed that CHWs in Triunfo simply were not working hard enough to reach Triunfo’s residents. A critical examination of the community concept could also inform the substantial body of literature on community participation (Midgley 1984; Rifkin 1985, 1987; Rifkin et al. 1988; Tatar 1996). To date, however, little attention has been paid to how definitions of community structure understandings and expectations of participation in PHC.

Because community figures so prominently in PHC rhetoric, administrators need to critically examine their use of the concept. This will require them to reflect on a number of assumptions embedded in various PHC programs, asking, among other things: What are the assumed characteristics of a community? How do they influence the operationalization of community? How do community characteristics relate to health? What are the assumptions about how a community functions? Policy makers should also explore locally salient definitions of what a community is and how it operates in the area where they are implementing a program. The answers to these questions will vary, both regionally and programatically. They will also be complex. In fact, they may be more prudent in some cases to move away from the idea of community and work with interest groups, catchment areas, or target populations. As a result, this article does not make specific suggestions about how to engage alternate views of community. Instead, policy makers need to examine their specific goals and devise their own answers. It is only after administrators have critically examined these two perspectives, the programmatic and the
local, that they can identify disparities between theory and reality. Administrators will then be able to use this information to prevent, or at least deal with, some of the problems that arise when groups have disparate views of community.

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Correspondence may be addressed to Coral Wayland at Department of Sociology and Anthropology, 9201 University City Blvd., University of North Carolina-Charlotte, Charlotte, NC 28223.

1. For an extensive review of the use of community in the social science and health literatures, see Jawkes and Murcott 1996.
2. The goal of this article is not to define community. Instead, it examines some of the assumptions that underlie this term in PHC literature and practice.
3. This is especially true for PHC programs that deal with HIV/AIDS. A number of these programs focus on social characteristics first and loosely incorporate (if at all) geographic aspects of community.
4. Although operational definitions that privilege spatial criteria are often about resource allocation, the conceptual definition from which they are derived encompasses assumptions about the characteristics and cohesion of communities. It would therefore be inaccurate to assert that catchment area models of community are distinct from social models of community in PHC.
5. The term resident refers to individuals who live in a defined geographic area. As it is used here, it does not imply shared cultural or political characteristics. Although administrators in PROSALUD and PACH confine residents with community, the authors acknowledge a difference.
6. Although the distrust of neighbors and lack of social cohesion observed in Huayna Potosi is a feature of Lewis’s culture of poverty argument, the authors are not advocating this position. In fact there are some collectivities in both Huayna Potosi and Triunfo, such as evangelical Protestants, who share a sense of solidarity. We do not address these collectivities, however, because neither PHC program targets these groups.
7. A close-knit kin group whose solidarity is formed by affinal, work, territorial, religious, and consanguinal ties that were then part of larger rural villages. When asked, urban residents denied knowing or using the term at all.
8. Ayllu is a controversial term in Andean studies, as it is a term defined by researchers but not necessarily described by the people. Local Aymara residents do not envision or speak of an ayllu in the city. Here it is used only as an analytical structure to clarify the importance of the family unit and its dependence on others as a strategy for urban survival. Recently, the term has become politicized and is popular among politicians and those discussing land rights in the Andes.
9. Because the majority of CHWs in Rio Branco and all of the CHWs in Triunfo are female, we use the feminine third person to refer to CHWs.

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