

Improving Community Capacity

Rajanikant Arole, Beth Fuller and Peter Deutschmann

Introduction

Community capacity building is a philosophy that is growing in health promotion circles both in developing and developed countries. It states that with proper support, people and communities can manage their own concerns. Improving capacity is about strengthening the ability of a community through increasing social cohesion and building social capital. In 1997, Mattesich and Monsey wrote that with strong community capacity, members of a community can work together to develop and sustain strong relationships, solve problems and make group decisions, and collaborate effectively to identify goals and get work done.

The role of the community in promoting good health is vital. Communities become healthy when people foster the talents and leadership of the community, work together to build on community potential and grapple with challenges facing the community.

This chapter is written from the author's experience in facilitating community capacity building in Jamkhed, in rural central India. The Comprehensive Rural Health Project (CRHP) was started in Jamkhed in 1970 and has become a recognized model of successful primary health care. This chapter presents the evidence for building community capacity, describes key elements in the process, presents a model of assessment, analysis and action for community capacity building and explains key steps for practitioners. Practical considerations are explored, including how community capacity building varies in different settings and how practitioners can develop partnerships with appropriate individuals and organisations. Two case studies are presented to illustrate how community capacity building works in reality - from the perspective of both developed and developing countries.

The rationale and evidence for improving community capacity

Most illnesses that poor and marginalised communities suffer from are due to basic poverty and life style. Chronic malnutrition underlies much of the morbidity of women and children in villages. Discrimination against women, female children, lower castes or people from other ethnic backgrounds results in these groups being prevented from securing basic resources such as equal access to water, food and services. Low wages, long hours of work, child labour and occupational hazards also contribute to ill health. Diarrhoea, dysentery, malaria and typhoid fever are caused by contaminated water due to poor sanitation and lack of access to safe drinking water. These situations neither need learned professionals nor sophisticated equipment and expensive medicines for diagnosis and treatment. Communities who are organised and empowered can improve nutrition and access to clean water and deal with social injustices such as caste and class structures and the status of women and children. Health professionals need to recognise that social action through community participation has a greater impact on rural health than injections, medicines and expensive diagnostic procedures.

Community capacity is about sharing skills and resources to achieve outcomes that are not possible without cooperation. Community collaboration in all sectors of development is essential for the health of the people. Community members work together to improve farms, animals and village sanitation. They achieve better distribution of food and access to clean water, thereby relieving malnutrition and reducing water borne diseases. Harmful traditions and deep-rooted superstitions that affect health can be eradicated by community action, although patience and time are often needed whilst communities accept change.

It is almost impossible to maintain good health with little money. A health programme that advocates increased intake of nutritious foods and boiling water to prevent diarrhoea, but does not address the fact that nutritious food and firewood for boiling water may cost more than a poor household can afford, is next to useless. Alleviation of poverty must be part of any health program. Improving community capacity facilitates improved economic situations for people in the community, thereby allowing improved health. Readers are referred to Amartya Sen's "Development as Freedom", which discusses this relationship, emphasising freedom as both the end and the most effective means of sustaining economic life and confronting poverty (Sen 1999).

In Jamkhed, India, the organisation and empowerment of farmers' clubs improved health initially through agricultural productivity and the production of more nutritious grains and legumes. By coming together for seminars and meetings, ideas and resources were shared. The members gradually looked at social issues in the village beyond agriculture, for example rural indebtedness. Through cooperation the clubs realised they had the power to improve life in the village, both in terms of constructive work and social change. They became empowered to deal with professionals and bureaucracy that was previously daunting for individual farmers. Through involvement in village concerns they began to understand the problems of women and realised the importance of involving women in village improvement. This example is illustrated in greater detail in the case study from a developing country later in this chapter.

In many developing countries there is a dire need for improvement in the situation of women, and especially poor women. The infants of mothers with post-primary education are 2-3 times more likely to survive infancy and early childhood than uneducated mothers (UNICEF, State of the World's Children, 2001). 'Male preference' drives many families to selective abortion or to infanticide or to neglect the female child by not providing adequate nutrition and limiting opportunities for education. With information and support, communities have the capacity for examining and changing this widespread gender discrimination. Women's organisations have proved to be a strong force for empowerment and liberation of women and consequent improvements in community-wide health.

Building community capacity allows responsibilities of primary health care to be taken on by the people in the communities. This reduces morbidity and expensive curative costs that many people cannot afford. Involving communities in planning, implementing and evaluating programmes ensures that they are totally involved in each stage of a programme and allows priorities to be set by the people.

What are the key elements that need to be understood when improving community capacity?

Improving community capacity must focus on helping marginalised people to become self-reliant and capable of addressing the root problems affecting their lives.

The goal of any assistance must be self-sustainability, whereby people are empowered to choose their own objectives, find their own solutions and organise their own programmes. Investment in building self-reliant communities is vital to sustain improvements in health.

The perceptions of poor and marginalised people may be different from the educated and wealthy. In situations where people are struggling for survival, health may not be a priority so much as food, water and shelter. These priorities, determined by communities, are often major indirect contributors to illness and conversely to improved health. Programmes for nutrition, access to safe drinking water and clean environment become health programmes in themselves. Gradually as communities become more capable of ensuring reliable access to these basic requirements, they will become more open to specific health programmes such as immunisation or specific disease control.

Equity and empowerment are key principles that are central to developing community capacity for health. In most cultures, and especially in developing countries, it is the women who are involved with establishing the foundations for good nutrition, safe drinking water, a clean environment, and a rational attitude towards illness. Women, and other marginalised groups in the community, need to be represented on all decision-making bodies.

Community capacity building is empowerment. It recognises that human beings, regardless of their education, position in society, or socioeconomic status, have inborn capacity for unbounded achievement. Through the processes of information, training, and imparting medical, economic and social skills, individuals and communities gain in self-esteem and self-confidence and come to realise that they have the capacity within themselves to determine their own lives. Sharing knowledge and skills and instilling self-confidence must be central at all points within the empowering process. People contribute to a much greater extent if they feel a sense of self-worth and value.

Trust and delegation are key principles in empowering communities. Diagnosis and treatment of diseases that are simple and repetitive can be taught to personnel with fewer academic qualifications than medical doctors. These workers are often stimulated by the extra responsibilities and they strive to do the job well. Involving recipients of programmes in leadership deconstructs the traditional role of people as passive recipients and puts them in positions of authority and control. Education and consciousness-raising is liberating for people who may never previously have been given the opportunity to assert their opinion or needs, particularly in the mystified world of health.

Health planners must identify the most effective channels for communicating with people in communities. Trusting relationships are the key elements in communicating new messages. Rather than accepting the opinion of outsiders, communities often listen to peers with whom they have lived and had dealings. There is trust on the part of the community and accountability on the part of the communicator. The local communicator can also give messages in a language and manner which the community accepts. Approaching a community initially can be difficult. One has to be known to the leaders or decision-makers, or be part of a power group or an organisation that local people trust. It can often be beneficial to work with the existing leaders until leadership emerges among the people. It is important to realise that the needs of the leaders or decision-makers are not necessarily those of the poor and marginalised people in the community that a programme is attempting to benefit.

Community participation does not occur inherently. The interest of people in their own health has to be fostered. When people understand why illnesses occur, they

are more likely to take on the responsibility of introducing and maintaining efforts to prevent the problem. For example introducing and maintaining tubewells¹ for safe drinking water in an effort to reduce diarrhoea, or building soak pits² to reduce malaria.

Socially minded people exist in most communities. There are frequently also community groups attached to churches and temples, youth clubs, farmers associations, and such organisations like Rotary and Lions Clubs. These people are often already involved in, and can be very useful in empowerment of communities for improved health.

Enthusiasm for involvement in programmes waxes and wanes and health planners must take advantage of the times when enthusiasm is high. It is common for people's participation to be proportionate to the severity of the problem. If there is a sudden epidemic of cholera or measles, participation in community health related activities may be very high compared to participation in programmes aimed at stopping people from smoking. Planners need to take advantage of opportune times to start programmes. For example a drought was the opportunity to start a nutrition programme in Jamkhed, which was the starting point for child development programmes.

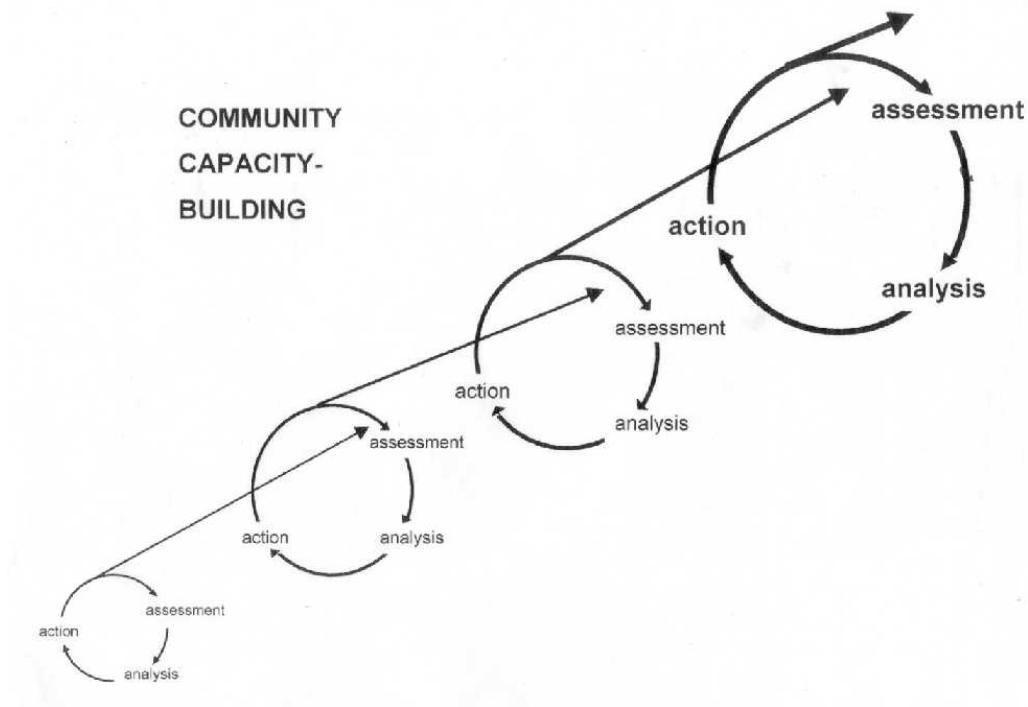
Community capacity does not happen overnight. Programmes need to start off small, and as the people learn to work together and develop skills of decision making and self-determination, the activities expand. It is important for people to have enough time to develop their own self-confidence and to coordinate themselves. Personal and community development takes time that practitioners often do not plan for.

Rural communities are capable of planning and maintaining their own health. They can contribute to health care substantially, provided they are taken seriously, are not treated with an attitude of superiority, and that medical knowledge and procedures are demystified. Planning needs to be flexible and programmes should be constantly reviewed and evaluated. Whenever failures are noticed, immediate corrective measures should be instituted. Poor and marginalised people are adept at making decisions concerning priorities for use of money. Vigilance in the use of scant resources leads to the cost effectiveness of each programme. If the programme is not cost effective, discussions with the community members allow them to decide on whether to modify or discontinue it.

Through a process of Assessment, Analysis and Action, community members are able to make considered decisions about the inputs needed to improve the community. Community members can meet with health practitioners and discuss various health problems they observe. They are then taught how to analyse and are encouraged to take corrective action. The community begins with small issues and as the capacity to Assess, Analyse and Action improves the community members deal with more complex issues. This whole process puts the problems and solutions in the hands of the community members, empowering them to make decisions about their future, thereby increasing their capacity to improve their own lives.

¹ Tubewells are hand pumps that draw fresh water from deep underground.

² House drains opening into the streets mean that waste water mixing with rubbish heaps forms dirty puddles, fostering the breeding of flies and mosquitoes. A pit 1 x 1 x 1 metre dug in front of the drain opening, then filled with porous material such as sand or broken bricks and covered with planks, successfully allows the water to soak underground.



What are the key steps practitioners should be undertaking when improving community capacity?

The role of the practitioner

Health promotion practitioners must first address their own role in the process. They must resist the temptation of being the ‘provider’, and instead assume the role of ‘enabler’.

Gaining access to the community

Practitioners need to establish who are the decision-makers in the community, what groups exist and where power structures lie. Although it is important to consult with community members themselves, it is difficult to get these people together as a group without going through proper channels to gain entry into the community. Various community leaders need to be consulted and, whilst their interests may not represent those of the poor or marginalised, entry into the community is more likely to be accepted if one is known to the leaders or decision-makers, or part of a group or an organisation that local people trust. Practitioners are likely to come across factions within leadership, and it is important to remain neutral in political affiliations.

Situation analysis

An assessment must be conducted to find out the resources and strengths of the community as well as the needs. This should be done by talking to community leaders, formal and informal health and social workers in the community, clubs and organisations and people from poor and marginalised sectors. Leaders of various groups within the community can introduce the team to the community members and arrange meetings at which people are encouraged to share their opinions. The timing of meeting with people must be considered carefully. Poor people in villages may only be able to meet after dark when their work in the fields is complete. Current health practices and health care providers should be identified.

Starting point: Health clinics

Entry into a community with a health clinic, provided it is in response to an expressed need, allows a visible presence in the community, a point of reference and provides back up and support for grass roots health workers (discussed below). These workers must have the confidence that they can approach a secondary or tertiary care centre for help when needed.

Organisation of groups

The organisation of groups provides the start of platforms through which individuals can voice their opinion and through which community action can be achieved. Groups will often form around common interests, for example the farmers' clubs in Jamkhed and the women's groups that were initially concerned with income generation and later became the cornerstone for health in the villages. These groups are a forum for building community capacity through education, starting with issues that the group needs, for example agricultural information and access to seeds and equipment. Individuals slowly become aware of the power that they have as a member of a group, and the achievements that communities are able to attain through group cooperation.

Introducing health issues to the groups

Group meetings are the avenues for introducing issues related to health to the community. Education on illnesses related to lack of adequate nutrition and inadequate water supply can be turned into programmes for the groups to encourage the entire community to work towards. Once members become aware of the impact they can have on the health of the community members, the process of empowerment continues, opening them to think more broadly about the possibilities of acting for change. Education provided to women's groups about social injustices made them aware of injustices existing in their own lives and in their villages. Directly addressing women's self-image and raising consciousness liberated women to question why they treat their daughters differently from their sons. As men's groups endeavoured to improve health, they began to understand the difficulties that women face and the important role that women play in the health of the family and community. These realisations are the seeds of the process of breaking down gender discrimination.

The manner in which education should be imparted

Practitioners must be willing to impart information slowly, without thrusting it on the people. By using language of the community and examples from their day-to-day life, the education process will be enhanced. At all times the practitioner must be a good listener who respects the knowledge, beliefs and experiences of the community. The teaching should be made interesting by demonstration, group discussions and fieldwork.

Village health workers

A fundamental part of the well-being of developing countries is in the capacity of the community to deliver health to its people in a way that is accessible to them. Curative care is often prohibitively expensive for many poor people and avoidable for the majority of illnesses in poor communities. The Village Health Worker (VHW) plays an important role in bringing health education and primary care to the villages in an affordable and accessible manner. VHWs must be chosen by and from the community so that they will be accepted and trusted. The women are often chosen for their attributes of social mindedness and ability to learn and communicate. It is more appropriate for the workers to have experienced childbirth themselves and to come from poor households, so that poor village women will relate and listen to them. The

VHW has the advantage of being able to readily communicate with people and understand and change their attitudes and harmful practices. A properly trained VHW can take care of child nutrition, simple childhood illnesses, safe delivery and management of chronic illnesses. VHWs must have supervision periodically to ensure that treatment is appropriate and that they are supported in their work.

Household surveys

Facilitating community members to conduct household surveys allows them to plan programmes and make informed decisions about what they emphasise. Being involved in the survey increases their interest in health and gives them control over the processes of prioritising and determining the direction of programmes.

How does improving community capacity vary in different settings, population groups?

Different communities have differing problems and various needs for development. Building community capacity will often start through groups that have a common interest, which will vary from setting to setting. In rural settings, groups may often be based on agriculture, whereas in city or slum areas this may be through groups of factory workers, street vendors or sex workers. Groups at which capacity building is targeted may vary enormously, such as youth, women, older people or people with learning disabilities, to name a few. Community capacity building in small villages may target the entire village, whereas in cities the target may be sub-groups within the population.

The needs of communities vary between and within groups. Communities in developing countries may focus on primary needs such as food, water and shelter. The underlying social problems may be inequality related to caste or gender. While in developed countries, the form of community capacity building may vary significantly. The emphasis may be on helping minority ethnic groups support their members through the significant psychological and cultural transition into a new society, or empowering women suffering sexual abuse to prevent further attacks by increasing their individual and collective power and awareness of rights and alternative options.

For some villagers in India, the health of their animals was of more importance to them than to discuss the health of their families. So, by identifying this priority and training village representatives in veterinary skills, the prevention of deaths of farm animals from epidemics was facilitated and the village economy was improved. Increased milk supply and better incomes coupled with proper health education improved the nutrition of mothers and children.

In women's groups, seminars were held about issues related to the betterment of women. This raised their awareness and provided information that helped them improve their livelihoods and health. The women met face to face with government officials, who became more sensitive to their difficulties. The women became advocates for the poor in the village. They learned about bank procedures and worked as a group to get loans for individuals who otherwise would not have had this ability. Gradually, as communities feel empowered and established, they are able to take on more complex issues such as deforestation, air pollution, and ultimately global warming.

How can a practitioner develop partnerships with appropriate individuals and organisations to assist in improving community capacity?

Communities are not homogenous structures. Different social strata exist due to ethnicity, economics and power structures that prevent a truly representative community existing. Practitioners need to find means of developing partnerships with individuals and groups from a variety of sectors in the community to enable equitable representation in planning for health programmes. However, surpassing the need for the practitioner to gain access to diverse members of the community, is the need for the lines that segregate the community to be dissolved in order for true community participation to occur. Finding means of commencing the process of breaking social barriers in communities requires creativity and an opportunistic approach. In one Indian village this was initially through volleyball competitions. These became a forum at which issues about improving agricultural livelihood were discussed. The common point of interest allowed people of different social strata to get to know each other and work together towards common interests.

Adverse events affecting the entire community, such as droughts, political emergency or disease outbreaks can be used to elicit community participation at the grass roots and establish a broad base for primary health care. When the Indian government established housing colonies for the homeless in the villages during the famine, the health programme ensured a safe drinking water supply in these settlements. This in turn became an entry point to initiate health activities for these vulnerable people.

A practitioner can facilitate the formation of community groups or can assist in arranging education or sessions with relevant speakers or politicians to attend group meetings. Practitioners can assist or facilitate the needs of groups, for example holding seminars where farmers can learn about credit, methods of farming, and access seeds and fertilisers from reliable sources, or where women can learn about income generation or small-scale loan processes. The seminars can become a platform for discussing various issues related to health and development. The members of these clubs share what they learn with people in their own and neighbouring villages.

Involving group members in health surveys of their own villages can enhance their engagement in health programmes. Initially the group members can introduce the health team to the village people and assist in collecting information. The health team helps the club members understand medical terms. Soon, with the help of one or two paramedical workers, club members are able to survey their own villages and analyse the survey results. In this way they gain understanding of the health status of the village and become involved in formulating health programmes. Through discussions at meetings about common illnesses and high infant mortality rates, club members are enabled to understand relationships between the environment, sanitation, water pollution and insects, and the prevalence of disease.

The partnership between the Village Health Worker and the practitioner is fundamental in the success of community capacity for health. The practitioner is involved in training and supporting VHWs as they conduct their work in the villages. Training includes many technical aspects of health as well as understanding social factors that influence health. The VHW is taught to analyse her own life as a woman and her self-esteem and confidence are improved. The training at the centre is ongoing and this provides support and updates knowledge and skills.

Communities have different beliefs and traditions and ways of maintaining health. Capacity building therefore requires sensitivity to, and incorporation of, these differences. Elderly women and members of religious groups are appropriate

individuals for health practitioners and VHWs to be working with in order to tackle harmful beliefs and practices. There are certain issues that are politically or religiously sensitive, such as family planning and sexual education. The damaging effects of excessive population growth on the family, community and environment, and the detrimental effects of multiple and early pregnancies on the health of women and children may need to be explained to religious leaders or elders. It is necessary to involve respected people and leaders, including both men and women, in the solution of these issues.

Case example - perspective from a developed country

The following case study is from a community enterprise program in Canada. This and many other examples of successful community capacity building are accessible at: <http://www.participation.net/english/hrdoc14.html>.

The community enterprise program supported a project called ‘Growing Prospects’ that began in a high school biology lab. Students at R.B. Russel High School who conducted experiments with hydroponics, were so successful with their small-scale project that they began to supply the school cafeteria with vegetables for the lunch program. The teacher involved with the project knew that the students were enthusiastic about the potential for a school-based revenue generator. The enterprise program was contacted to assist with the development of a business plan and, through the Winnipeg Development Agreement, funds were provided to research a potential market for the product.

The vegetable market proved to be too daunting for this small-scale community-based enterprise. However, with over half a million dollars spent annually on Californian herbs, a niche was identified in upscale Winnipeg hotels. But the project was undercapitalized and, even with the support of federal and provincial funds, the students could not afford to purchase the amount of hydroponics equipment required to meet production goals. The local Winnipeg police department was contacted and a plan to use hydroponics equipment, confiscated from the illegal drug trade, was hatched to supply the project with the tools they needed to begin production. The project has outgrown the school's capacity to house the production facility and has relocated to Winnipeg Forks where it operates at a 40% capacity and employs 18-20 high school students.

One worker from the enterprise program commented: “These are high risk kids that would otherwise be spending their time on the street. This project is an excellent example of capacity building from within the community. We took our lead from the individuals who live and work in the community and simply made a few contacts, helped them access resources to build a business plan and focus on a market. Projects of this nature build linkages and validate the aspirations, ideas, and strengths of individuals in the community.”

Ghodegaon is one of the thirty villages where the Comprehensive Rural Health Project (CRHP) encouraged community based health programs. Ghodegaon was a poor village, as it was drought prone and the community depended on agriculture and because of lack of water could not eke out a living. Most young people migrated seasonally to harvest and transport sugarcane to the factories elsewhere. Due to lack of adequate food most women and children suffered from under nutrition and showed signs of vitamin and mineral deficiencies.

Case example – continued...

A large open well with steps was the main source of water supply, which was grossly contaminated, and there were epidemics of diarrhoea, cholera, typhoid, jaundice and guinea-worm. The average number of children per family was six and women delivered without trained health workers in attendance. There were many leprosy patients with ulcers and deformities and they were forced to live in the open fields away from homes. Alcoholism was common as many villagers made a living by illegally brewing liquor.

In a male dominated society CRHP decided to organize men to start the community based health programme. Young men were organized into Farmers' Clubs around their self-interest of better agriculture. CRHP helped the farmers to procure bank loans, to buy better seed and fertilizers. Doctors and paramedical workers provided information through regular weekly meetings on nutrition, environmental sanitation and how to prevent infections.

The Farmers' Club members initiated community kitchens to provide daily nutritious meals to women and children and weighed the children regularly. They also produced grains and vegetables rich in protein, minerals and vitamins on their farm.

They cleaned the open well, removed the steps and provided clean water to the village. With the help of OXFAM (donor agency) they drilled two tube wells fitted with hand pumps to provide safe drinking water. These measures brought down infant deaths, malnutrition and infections.

The Farmers' Clubs continued to get more information from CRHP on harmful practices, social factors affecting health and family planning. The Farmers' Club members acquired skills in communication through stories, songs, dramas, street plays and puppet shows. Through these media they promoted family planning, good sanitation and prevention of illnesses. They also persuaded families to provide medicine and care to people affected by leprosy and to integrate them in their own families. They controlled social problems such as alcoholism, wife beating and discrimination against women and people from low castes.

Farmers' Club members realized that they needed someone to continuously care for the community. They selected a socially minded, middle-aged, outgoing woman as a village health worker (VHW). She joined a group of thirty other women health workers and attended regular weekly training sessions at CRHP health centre in Jamkhed. She and the Farmers' Club organized Mothers Clubs (Mahila Vikas Mandal) to support her in health activities. These Mahila Vikas Mandals were formed around the groups interest of income generation. Whatever the VHW learnt at CRHP she shared with these two organizations regularly. The group members assisted the VHW in health activities such as weighing the children regularly, immunizing and promoting oral rehydration solution and other simple remedies for childhood illness.

The Farmers' Club and Mothers Club members also visited CRHP periodically to update their knowledge and skills. Both the VHW and the Ghodegaon community have developed health programs in villages by using the triple A cycle – Assessment, Analysis and Action. With initial assistance and training, the community members have learnt how to collect health information from each household regarding health status and different incidences of illness. They record household problems and monitor the health of the community.

Case example – continued...

The Mothers Club identified the need for women to have skills for income generating activities. As the women gained economic independence they gained confidence and began asserting themselves. By grouping together, they addressed problems such as bus conductors cheating women passengers. Working closely with the Farmers' Club, some of the real barriers to health in the social structure were confronted, such as alcoholism, illiteracy amongst female children and environmental degradation.

Today Ghodegaon is a prosperous village. The Infant Mortality Rate is very low, all children are immunized and a trained health worker delivers all women. Very few children die of diarrhoea or pneumonia, the main cause of death being accidents and birth defects. Chronic illnesses like leprosy, TB and AIDS are totally integrated (both socially and economically) in the community. Ghodegaon community manages 75% of health problems, 20% are referred to CRHP and 5% are referred to higher centres elsewhere.

The Ghodegaon community members along with health workers have gone to several surrounding villages and have promoted Community Based Health Care not only in Maharashtra but also throughout India. They have shared their experiences with trainees from 100 different countries who receive training at Jamkhed Institute of Training.

Five key points/principles for the reader

- 1) Community members must be involved in planning, implementing and evaluating programmes. The most vulnerable must also be involved in all elements of a programme, for example marginalised women becoming VHWs. Community capacity building is about working in partnership and supporting community decision making.
- 2) Improving community capacity increases health by empowering communities to address underlying causes of ill health such as lack of adequate nutrition, safe drinking water, and a clean environment.
- 3) Increased community capacity occurs through opportunities for increased networking and information exchange. Information sharing enhances community knowledge and methods of working together and allows community gaps to be identified and addressed.
- 4) Skill and knowledge transfer that supports capacity building is enhanced by relationships of mutual respect between the practitioner/programme and the individual/community. One must respect the inherent capacity within all people and recognise that knowledge transfer is a two way process. There is an important interplay between the community representative and the health practitioner. The practitioner needs to understand the context in order to know how to work effectively and the community representative needs to be confident in the practitioner in order to believe the new knowledge.
- 5) Skills are best learnt in practice, as distinct from the communication of a skill in an abstract or conceptual way. Practice in the context of needs assessment, analysis of a situation, planning of a programme and implementation of activities.

References

Mattesich, P. Monsey, B. (1997). *Community Building: What Makes it Work: A Review of Factors Influencing Successful Community Building*. Saint Paul, MN: Amherst H. Wilder Foundation.

Sen, A. (1999). *Development as Freedom*. New York: Anchor Books.

UNICEF, *The State of the World's Children 2001*, <http://www.unicef.org/sowc01>

Further reading

Arole, M & Arole, R. 1994. *Jamkhed: A Comprehensive Rural Health Project*. Archana Art Printers, Bombay.

Frank, F. & Smith, A. (1999) *The Community Development Handbook: A Tool to Build Community Capacity*. Labor Market Learning and Development Unit, Human Resources Development Canada. Minister of Public Works and Government Services Canada. Copies available on <http://www.hrdc-drhc.gc.ca/community>