

COMPREHENSIVE HEALTH CARE FOR POOR MASSES A GRASSROOTS STRATEGY OF DEVELOPMENT

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Prologue

Existing health service does not provide comprehensive health care to poor masses. Likewise development strategies have not made any substantial impact at the grassroots. These two are related matters. Moreover, Devolution of power has not empowered the poor masses. From local body elections it appears that same old well entrenched political groupings dominated by extended families, clans and tribes have assumed power through their progeny. General elections are in the offing this year. Discredited political panics with the same perennial leaders who did not achieve much are again jostling for power. It is important to remember that poor masses bear undying loyalty to their extended families clans and tribes, because it is their most important survival mechanism without this loyalty there is hardly any chance for survival in the harsh and merciless environment in which they subsist.

Their voting patterns are almost invariably determined by their loyalty to their social groupings. Luxury of democratic choice only comes with economic emancipation. Therefore there is no democratic government worth its name in developing countries including the so called 'most populous democracy in the world' it is almost invariably the selfish predatory social groupings or leaders who inflame religious and ethnic passions who wield power. Uplift of masses hardly ever crosses their blinkered vision and closed minds. Without economic emancipation true democracy can not prevail. Prevalent unrealistic thinking puts the cart before the horse.

It is the most critical juncture in our country's history. We have survived thanks to president Musharaf's sagacious policies. Substantial funds have been made available for administrative infrastructure has been offered once in a life time opportunity of development with substantial economic assistance. Its power wielding social groupings are not very different from our own, viz., extended families, clans and tribes headed by chiefs who are also war lords and thus far more powerful and predatory than our own. Our fate is inextricably linked with that of Afghanistan. If we cannot effectively use our development funds for grassroots development, how our dirt poor devastated neighbour can.

We have to present them a model. This requires a radical review of our development strategy and mechanism which have not made substantial impact at the grassroots during the past fifty years. Consequently our masses remain poor and deprived existing on subsistence economy.

Following grassroots oriented development strategy and methodology is based on well documented national and international experience, which unfortunately has been almost completely overlooked by national and international development experts, due to bureaucratic malaise which severely afflicts them whereby they unconsciously opt for the easiest way out which enables them to remain continued to their offices churning out elaborate plans without ever bothering to assess concurrently their impact at the grassroots.

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Basic Concepts of the Proposed Development Strategy

It will be a grassroots campaign implemented by a well known campaign methodology. A campaign is launched when there is a serious law and order situation, a natural disaster or a disease epidemic. Resources are mobilised, insular bureaucrats come out of their cherished offices and study the situation at ground level and devise methods for overcoming it. The Government hierarchy from top to bottom becomes oriented and focussed on the troubled spot. The only difference in proposed strategy is that it will be a total coverage, long term campaign conducted with undiminished vigour and thoroughness till goals are achieved and efficiently maintained. Campaign strategy was formalised and documented in detail by WHO Founding Fathers in the Fifties, almost the same time as Mao Tse Tung's grassroots revolution. China's development strategy was spearheaded by health care provided by so called 'Bare Foot Doctors' trained on the job by city medical specialists who had compulsory tours of duty in the villages and lived there for a few months every year. WHO Founding Fathers launched worldwide malaria eradication campaign. Malaria is a rural disease and cannot be tackled without a total coverage grassroots campaign. The first ever disease eradication campaign spread with amazing rapidity in all the poor countries and by 1960 it had encompassed the entire developing world. It was a time limited campaign of five years and at the end of this period the campaign organization was to merge with existing health service revitalising and reorienting it and become the basis of all future development as happened in China.

Development campaign will start from small grassroots units and extend horizontally and grow upwards from ground level. This crucial principal of growth of a campaign from grassroots upwards and NOT above downwards was discovered by us in Pakistan and used most successfully for total coverage of the entire population of more than hundred million in united Pakistan. Result of this grassroots upwards approach was that Pakistan became the only country in the world

to interrupt transmission of malaria in both wings of the country in stipulated period of five years of the time limited campaign. In the late Sixties at our urging the methodology of building the health system from grassroots upwards was included in WHO health care Bible 'Health to the People; by the People; For the People'. However this crucial methodology being painstaking was anathema to bureaucrats and was never used anywhere else nor was fully propagated by the WHO. The result was that time limited goals of the worldwide malaria eradication campaign were not achieved in any other country and finally WHO ditched the campaign. At this stage international experts opted for community based development, which strategy was adopted by WHO also. This involved channelling all funds and effort through communities at the grassroots. This strategy of development still holds sway although it has made no substantial impact at the grassroots. The reason is that there are no communities of western concept with civic consciousness at the grassroots in poor countries. There are only social groupings described above in the context of Pakistan and Afghanistan, who are perpetually involved in cut throat competition for scarce resources.

Hardly any development activity can be entrusted to these social groupings. It is forgotten that the western developed world had also the same social groupings till the Industrial Revolution, more than two hundred years ago. There was great upheaval and mass shifting of the rural population to the cities where it lived in great poverty and deprivation. It took another hundred years starting with Bismarck's health care and social security initiative at the end of the nineteenth century for prosperity to reach the grassroots and obliterate the rural-urban divide and for communities with civic consciousness to evolve gradually. This evolution is not yet complete. Urban and rural poor are still alienated, in rich countries devoid of civic consciousness and responsibility. Prosperity on the top does not seep down to the grassroots. According to surveys published in the press, the economic gap between rich and poor in USA since Ronald Regan, the greatest proponent of 'seep down' effect of prosperity, the economic gap

between rich and poor has increased instead of decreasing. Prosperity must start at the grassroots and grow upwards. Poor countries will never go through this long evolution in the present geopolitical context. The only example to follow is China's development. A country devastated by foreign invasions, civil wars. Its carbon copy is present day Afghanistan. Since 1949 it has risen from its ashes and has attained a near super power status in a few decades. According to current 'Davos' Economic Forum in New York *'China will continue to be stand out performer this year'* (IHT, 2 February, 2002).

Health care is the only development activity which can bypass the impediments of bureaucratic conundrums, political vested interests and social chieftdom and involve every individual at the basic level and secure their cooperation. It can create health care consciousness micro communities who then willingly take up other development tasks.

We covered the entire United Pakistan with the grassroots campaign in less than two years. With present resources and political will total coverage with health care can be achieved in less than a year. It is most important to know strategy of development practised by China. The following extracts give a glimpse of its essence.

'Prior to coming to power in 1949 the Communist Chinese, under siege by the Nationalists, led an arduous existence in the remote mountainous areas of the interior of China, where they witnessed and often fell victim to the ravage diseases flourishing there. They were made personally and acutely aware of the obstacles presented by lack of medical facilities and personnel. The constitutional documents issued by the Communist Chinese in the pre-1949 period reflect their desire to alleviate the physical suffering of the masses of Chinas poor and to lay a groundwork for the recovery of 'East Asia's sick man' by restoring and guarding the health of its citizens.

The regimes public health policy and programs were ambitious ones, but their success was crucial to even

more ambitious economic policies and programs. Further, one succeeds in bettering the health of the masses, one has a tangible achievement which one can put on display as evidence of one's genuine concern for the people's lot and thus perhaps win support in other policy areas where success comes more slowly, with greater exertion, and I with less personally felt benefits.

Although sometimes more systematic structural and functional descriptions are found in legal documents than in other types of materials, the Communist Chinese leaders have far from felt constrained to precede the creation of an institution or program with an elaborate statement in black and white of its structure and functions, purpose, aims, funding, etc. In the Chinese system, the point of delivery of health care has been taken down to the 'Production Team', which in rural areas comprises one village or a group of hamlets. Each Production Team has its health office and a family maternity hospital. Primary contact is by auxiliary workers such as 'barefoot doctors' in the villages. 'Worker Doctors' in the urban areas, 'Red Guard Doctors' in the urban areas, and public health workers, all derived from the local workers, drawing the same wages, and living under the same conditions. The next level of administration, the Production Brigade, with approximately 200 households, has a Branch Hospital, a Branch Maternity Hospital, outpatient department, and a health station. The People's Commune with approximately 80,000 population has a central hospital and a central maternity hospital, and the commune health centre for preventive work. (Hsia, T. edited by Quinn, J.R., *Medical and Public Health in the People's Republic of China*, 1972. NIH, US Deptt. Of Health Education and Welfare, pp 109-111, 132 et al)

Formative Methodology of Comprehensive Health Service (CHS) and Its Coordination and Merger with Established Health Service {EHS}

The Comprehensive Health Service (CHS) will be launched with the following methodology and at all

levels of its hierarchy its coordination and merger with the Established Health Service (EHS) will be supervised by the elected representatives. However, the interests of CHS will reign supreme. Its grassroots orientation, outreach and coverage will be protected and promoted. EHS will be moulded and adapted for this purpose. This process will involve following steps.

- i. Cabinet level Government decision for an all out effort to provide CHS to all.
- ii. Selection of a public health trained civil or military physician as CHS chief. This is one of the most important steps. Much depends on personality, sagacity, integrity, dedication and drive of the incumbent. Following dictum will be kept in view: 'organization or set up is as good as its chief', and Napoleon's famous aphorism that 'there are no bad soldiers only bad generals'.

The incumbent chief will be provided with an advisory committee of three national and/or international experts. He will have a modest office and a skeleton staff of four provincial chiefs will be selected with the same criteria in mind by respective provincial health ministers in consultation with central CHS chief and provided with skeleton staff and modest offices and advisory teams.

- i. Central CHS chief will be given full financial and administrative autonomy from top level to grassroots including hiring and firing power. Strict concurrent audit and financial oversight will be arranged. He will be personally answerable for all failings, and any financial irregularities in CHS organization from central level to grassroots. There can be no effective accountability unless responsibility can be fixed clearly and squarely on the chief of an organization. So called autonomous bodies often fail miserably to deliver the goods due to this reason. We obtained complete autonomy of the above type by a presidential ordinance before launching our grassroots scheme. (Please refer to Malaria Eradication Ordinance, 1960). If this course is adopted for CHS scheme the ordinance should clearly define relationship and power of CHS chief to over rule any provincial interference or EHS resistance or other

impediments to grassroots interests of CHS except through authority of central health minister in writing, who will then be answerable for any shortcomings of the scheme.

- ii. Central CHS chief will have direct access to central health minister and will be answerable only to him. So will provincial CHS chiefs to their respective health ministers. A central CHS board will be constituted, presided over by the central health minister and provincial boards under the respective provincial ministers. These boards will perform supervisory limitations on CHS. Respective CHS chiefs will act as secretaries of the boards.
- iii. CHS will be financed by pooled contributions of central and provincial governments. Its expenditure at the grassroots can be easily financed by compulsory Islamic charitable taxes viz. Ushar (1/10th of agricultural produce) and Zakat (1/40th of savings) which are supposed to be spent where these are collected. If these taxes are properly collected and administered these can easily cover grassroots expenditure on health and also provide social security. CHS will be essential first step in this process. It should be noted that social security in the context of this plan only means financial assistance in the event of an accident, illness, disability or natural disaster to tide over the crisis.

Our poor masses are very resilient and recover quickly by self help with minimum assistance at critical periods. Moreover they do not raise mind boggling and ear splitting clamour for government action as the people in rich countries do after a major or minor disaster. In Italy houses shattered by an earthquake 20 years ago are still not built and people live in temporary accommodation provided by the government clamouring for government action. Moreover, our people do not claim unemployment benefits they help themselves nor do they clamour for treatment by Harley street specialists, they feel lucky if they receive life saving emergency treatment. It is a matter of timely assistance at critical periods which can be effectively organized by a grassroots primary contact organization described hereunder.

With considerable diffidence I beg to submit that the idea of a grassroots primary contact organization should be considered by rich countries also for application *mutis mutandis* in certain situations for uplift of poor sections of their population. Original ideas of 'cradle to grave' security, and universal health care on equal footing for all are unravelling due to rising expectations of the people fuelled by consumerism and rising disparity between rich and poor. In USA 20% of population in the lowest levels of poverty has no access to Managed Health Care. Medicare and Medicaid have failed to till this void. The poor and deprived are so alienated and antithetic that long ago the affluent quitted the 'down towns' and moved to suburbia. In such situations, some variant of a grassroots set up staffed by the poor people from ground upwards to a higher echelon maybe worth considering. In Europe due to their long egalitarian traditions such situations may be rare but may become common if present trends continue.

First Tier of Primary Contact

Geographical and Demographic Reconnaissance (GDR)

These will be conducted by relevant Patwaris and Tapedars under the direction of UC Nazims. (i) Maps will be prepared showing location of every village and hamlet; (ii) Paved and unpaved roads and tracks to villages and hamlets showing distances will be marked on these maps; (iii) Number of households and number of inhabitants by household in every habitation will be recorded. Without GDR total coverage of the population cannot be achieved. Moreover without distances and nature of communications regular programmed visits cannot be arranged. We prepared GDR maps of the entire united Pakistan. These should be available in provincial and district offices of malaria control and can be upgraded.

Primary Contact Workers (PCW)

Simultaneously with above mentioned preliminary exercise all union council Nazims will be directed to select Primary Contact Workers (PCWs), i.e. one worker

for fifty to a hundred households. Selection will be made by consensus of all householders of this primary unit.

1. Primary unit of fifty to a hundred households will be designated as a Comprehensive Health Community (CHC).
2. PCWs will perform regular house visits to deliver preventive and prescribed curative care.
3. They will refer ambulant patients to the designated physician and arrange evacuation of non-ambulant patients.
4. PCWs will be matriculates residing in the CHC. If a matriculate is not available in CHC their educational qualifications can be lowered or a PCW from an adjacent area can be appointed with consensus of CHC residents.
5. Initially PCWs will be trained on the job. Later when facilities are available they will be given a short course not exceeding six weeks. On the job training initially will be given by CHS central chief and/or provincial chiefs and their advisers to familiarise themselves with the tasks involved and thus draw up their country wide job descriptions and duties.
6. Initially PCWs will be probationary workers for six months and receive a daily wage of fifty to a hundred rupees. If their performance is satisfactory they will be awarded one year renewable contracts.
7. Comprehensive Health Community (CHC) of fifty to a hundred households is the basic unit to which all development tasks will be eventually entrusted. Its delineation and selection of PCWs will therefore be carefully supervised. A local CHC committee will be formed in every CHC to supervise health care and any other development task entrusted to it. When a CHC under the stimulus of health care coalesces into a collectively responsible unit with civic consciousness, other development tasks will be entrusted to it by adding more PCWs. A midwife will also be responsible for social and population activities, PCWs for literacy, agricultural development, cottage industries. Micro finance banking etc. Some of these

PCWs can cover more than one CHC. CHCs will eventually generate their own funds for sustaining and promoting their uplift.

By this process CHC'S at the grassroots will empower the poor masses in the real sense and will nurture development oriented leadership at the grassroots level as happened in China's case quoted above.

Qualified Medical Practitioners

Concurrently with above arrangements, union council Nazims in consultation with sub-district (Tehsil/Taluka) Nazim will nominate one or more qualified medical practitioners in the nearest market town to whom patients can be referred by PCWs. These physicians will be designated as CHC Doctors. CHC doctors will be directed to prescribe after making a provisional diagnosis which will be written on the prescription. They will not prescribe vitamins unless there are clear signs of vitamin deficiency (Vitamin deficiency in wheat eating adult population is rare). No calcium supplements (osteoporosis is unknown in poor labouring population). No glucose infusions which are given without any rational indication and are very popular. No parenteral administration of medication which can be taken orally.

In Sindh, patients demand injections due to lack of faith in per oral medication. Physicians instead of countering this superstition ply them with expensive injections administered by repeatedly used syringes and needles. They often write blunderbuss prescriptions often comprising half a dozen or more drugs and costing up to Rs. 500 for easily treated ailments. CHC doctors will be provided with a list of 300 essential drugs recommended by WHO or better still a copy of Oxford Handbook of Clinical Medicine which is a very useful, easily referred compendium with concise diagnostic and other relevant information and prescribes only essential drugs. Gift of this book may be used as a once only honorarium if the CHC physician agrees to mentioned conditions. Reimbursement of cost of treatment will be arranged for indigent patients recommended by CHC committees.

Reducing Costs for Patients

Union council Nazim together with relevant PCWs will visit hospitalised patients and ensure that patients are not asked to buy medicines and to pay lab expenses etc. which is a common practice even in teaching hospitals. If some medication or some procedure is not available locally a certificate will be obtained from the treating physician and its cost paid or reimbursed from above mentioned funds if the patient cannot afford it. Measures noted in paras 3 and 4 above are very important and urgently required for immediate relief of poor patients. I have used these since 1966 when I took over management of an ancestral family farm in Deh Bhareri, Tapo Bhit Shah, Taluka Matiari, District Hyderabad. Thereby I secured such loyalty of local population that I have been administering it from abroad without any difficulty with ever increasing production on the farm. A pointer to efficacy of simple health care measures to overcome all impediments.

Second Tier of Primary Contact

When all the CHC'S in a sub-district are functioning satisfactorily, sub-district (Tehsil, Taluka) office of the CHIS will be established.

1. All sub-district EHS personnel together with health centre and sub-centre will be brought under the jurisdiction of CHS. A CHS sub-district chief will be selected out of these. EHS personnel and will be fully oriented by actual experience at PCW level.
2. A training centre will be established and all sub-district health personnel given short orientation courses and practical experience by actually working there along with PCWs.
3. Short courses for PCWs will be arranged in which potentially suitable candidates will be earmarked for promotion to second tier of primary contact.
4. Inspectors will be selected preferably by promotion of suitable PCWs and appointed in the second tier. They will have regular, programmed inspection visits to all CHCs. Reports will be written for every visit.
5. Staffing of second tier will be set up together with sub-district Nazim who will administer the set up

together with his counterpart the CHS sub-district chief however it will be ensured that the Nazim will not over rule advice of his CHS counterpart otherwise favouritism, tribalism and corruption will rapidly permeate the entire grassroots set up and ruin it from its very inception. Any difference between the Nazim and his counterpart will be settled by provincial chief of CHS along with the district Nazim. Decisions will always be in the interests of CHS without any fear or favour. This level is most crucial. It is here that vested interests of social groupings reign supreme and ruin any grassroots initiative. If any unfavourable decision is taken CHS chief will use his hiring and firing authority without hesitation otherwise he is not worth his salt. I used to do this on the spot hiring and firing all over united Pakistan and remained unscathed and appreciated due to the highest level support. This in fact is the key to the building of a really dynamic and dedicated organization. Weed out the unsuitable individuals at all levels without fear or favour and set an example by own integrity and dedication. No one can harm you if there is no chink in your armour.

6. Close coordination and support will be ensured of the entire sub-district administration who will be oriented to unstintingly support CHS in every way. This again is the level where vested interests of social groupings come into play often with irresistible force. If full administrative support can be ensured at this level, a major obstacle to the success to the scheme will be removed.
7. Below the second tier following additional activities should be launched:
 - i. Agro-based, labour intensive industries should be set up closest to CHCs to provide employment.
 - ii. industrialists should be persuaded to invest in these industries. Their investment should be protected and these industries should have all the incentives given to new industrial projects in backward areas.
 - iii. Exportable agricultural projects such as fruit orchards, large scale vegetable farms, large scale animal husbandry should be declared as industries and provided all the relevant incentives. industrialists

should be persuaded to invest in these and their investment capital should be protected. These ventures also provide large scale employment at basic level.

8. Above all law and order situation should be strictly controlled below sub-district level. If there is no security grassroots development is out of the question.
9. *Insaf (justice)* Committees at CHC level will be formed to settle local disputes. CHC supervisory committee should also function as *Insaf* committee. Inter-CHC disputes should be settled in a *Deb* or *Mauza* ad hoc committees under the union council Nazim comprising representatives of relevant CHCs.
10. Strict accountability of grassroots level, police, revenue and irrigation personnel should be organized. There is most predatory type of institutionalized corruption in these departments at grassroots level which extends from grassroots upwards. At the grassroots the primary contact personnel of above mentioned departments collect illicit funds by old, traditional, finely tuned corrupt practices such as openly proclaimed seasonal levies. Illicit funds are then channelled to higher echelons of the department. In final analysis the ultimate burden falls on poor landless peasant because land owners pass on the expenses to share-croppers as shopkeepers pass on taxes to consumers.

Third Tier of Primary Contact

When CHS in all sub-districts of a district are organized and working satisfactorily a district office of CHS will be established. District CHS chief will be selected out of the sub-district chiefs. At this level specialists will be appointed for supervision and on the spot training after giving them grassroots orientation.

1. District office of CHS will be administered by the district Nazim together with CHS district chief. CHS chiefs advice based on CHS interest will be binding on the district Nazim.
2. Grassroots orientation will be imparted to district HQ EHS institutions. Close coordination will be

- established with these by the district Nazim.
3. District health officer and his staff will be provided grassroots orientation and they will function in coordination with and in support of CHS so that there is no duplication of effort.
 4. In every such instance interests and programs of CHS will reign supreme and all those working alongside it will conform to these whether EHS field staff such as health officer and his staff or NGO's or any other relevant government or private agency. Coordinating authority will be the district Nazim.
 5. At any level of the CHS, appointment of an EHS bureaucrat to chief authority of any tier will be strictly avoided otherwise bureaucratic attitudes and methods will creep into the organization and result in complete destruction of the organization. Central idea being to keep the organization totally free from bureaucratic methods and red tape and thus preserve its grassroots orientation which does not exist in any existing government set up.

Fourth Tier of Primary Contact

When all districts have been covered satisfactorily with CHS a provincial office of CHS will be organised. Provincial chief of CHS will be by now fully experienced and seasoned in grassroots work and he will work directly under the provincial health minister who will also coordinate orientation and transformation of provincial EHS institutions for grassroots activities. Provincial health minister will only reject the advice of provincial chief in writing stating reasons thereof in which case he will be answerable for any adverse effect on CHS due to his decision.

1. Service rivalries and other impediments such as resistance of professional associations will be equitably settled by the health minister keeping in view interests of CHS.
2. Curricula of teaching institutions will be modified to conform to CHS interests.
3. Provincial office of the CHS will be staffed by national experts and international advisers for all activities being undertaken at CHC level. Other staff will comprise a carefully selected chief of

- administration under whom will be
- i. financial advisor cum chief auditor.
 - ii. Budgetary and account staff.
 - iii. Transport officer.
 - iv. Provincial chiefs of relevant UN agencies will be briefed and familiarised with functioning of CHS by arranging visits to grassroots levels and their cooperation secured.

Fifth Level of Primary Contact

1. At this level the resident and/or prime minister should focus the entire government set up on grassroots development with the same priority as accorded to external defence of the country. Because the two are related, a country's security and integrity are not impregnable without each other.
2. A development board should be constituted presided over by the president or the prime minister comprising provincial chief ministers and advised by national and international experts.
3. A Primary Contact Ministry may be created to coordinate and supervise all development activities under which central offices of CHS and other grassroots development activities will function with a vertical axis down to ground level. This ministry will be different from its other counterparts because it will remain focussed on primary contact and will avoid as much red tape as possible and replace it with personal contact at all levels of vertical axis of primary contact. It will involve Govt. institutions at all levels to support grassroots development. It will involve professional associations, chambers of commerce and industry, philanthropists, charitable institutions and NGO'S in grassroots efforts. Primary contact ministry will have important role in planning commission to design annual plans of action for grassroots development. National Bureau of Reconstruction may be upgraded and designated as Ministry of Primary Contact and National Reconstruction.
4. Planning commission may eventually become a subsidiary wing of Primary Contact and Reconstruction Ministry. A study of forty years

of five year plans should be undertaken. Five year plan preparation involves unceasing labour of hundreds of bureaucrats and experts. The study should determine the utility of five year plans on the basis of cost benefit ratio. A slimmed down Planning Commission engaged only in preparation of yearly plans of action after reviewing the progress made may conceivably serve the purpose. External assistance from the International Consortium could be obtained on the basis of these yearly plans of action. This process will not only ensure proper utilisation of external assistance but will also diminish the increasing debt burden. A slimmed down Planning Commission will save multimillion Rupees. Proposal in para 4 is in line with planning strategy practised by China.

5. Health being a provincial subject, this is likely to be the greatest hazard and impediment to unified and uniform countrywide direction of the scheme. But no constitutional provision can provide justification for dismantling and disrupting a humanitarian effort shor of any political objective. Be it by the federal government or an international

organisation or even by an NGO. Building the organisation from the grassroots upwards rather than imposing it from above is essential tor this purpose also. But this also requires spirit of dedication and focussed effort on the part of the organisation which is *sine qua non* of grassroots humanitarian work.

Epilogue

The proposed strategy of development purports to replicate China's self reliant and self financing development strategy in Pakistan's environment. Above presentation should be considered a Plan of Action as well as a general description of principles for grassroots development. More detailed methodology will develop by trial and error and on the spot adaptations without compromising basic aims.

Throughout the presentation the designation primary contact has been used to emphasise undiminished focus on grassroots from highest level down which is *sine qua non* of the proposed strategy of development.