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9. ABSTRACT
This is the second quarterly report for the second year of a health manpower development project conducted by the School of Medicine, University of Hawaii, under sponsorship of USAID. The principal objective of the program is to recruit and develop a health manpower development staff to serve as a resource and response capability for LDCs designated by AID in the planning and development of mid-level (MEDEX-type) health manpower programs. During the project period, staff members consulted with the DEIDS/Thailand program in the areas of preceptorship training, evaluation, and module development; participated in the first annual review of the DEIDS project; consulted in Seoul in response to a request from USAID/Korea; participated in an HMDS-led curriculum development workshop in Pakistan; addressed Asia Foundation representatives in Manila; in response to a request from USAID/Philippines, provided a week of consultation to the government of the Philippines; worked with representatives of the Ministry of Health of Guyana to develop a proposal for MEDEX in Guyana, for submission to the Kellogg Foundation regional office in Rio De Janeiro; held discussions with TOMKIRP in Amsterdam and WHO's Manpower Training Group in Geneva pursuant to locating additional audiovisual material to be used in the STEM modules as they are developed; held further discussions with the Inter-Mountain and Northwest MEDEX programs regarding collaboration in the development of programs overseas; co-produced a five-minute film on MEDEX in Micronesia; and provided three days of briefing to the visiting Associate Director of Health Sciences, International Development Research Centre, Ottawa, with the expectation of future collaboration.

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HEALTH MANPOWER DEVELOPMENT STAFF

SECOND QUARTERLY REPORT, -02 YEAR

09/20/75 - 12/19/75

(Contract Number ASH 74-277)

The quiet that characterized the last quarter has ended. During the present reporting period, three tangible outputs have resulted from efforts of the Health Manpower Development Staff. The first was the development of a proposal for an expanded rural health system using MEDEX-type manpower which we helped two senior officials from the Guyana Ministry of Health prepare (they were sent to Honolulu on direct orders from the Prime Minister of Guyana to begin a MEDEX program there. See Appendix A).

The second and third outputs are Project Review Papers for Pakistan and Lesotho. The stimuli for both these documents were previous visits by HMDS to these countries to consult with the Ministries of Health regarding expanding health services to the rural areas. As a direct result of these visits, USAID requested these documents as a first step towards development of new health programs in these countries. The HMDS provided significant on-site input into these documents.

- a. *Recruit and develop a health manpower development staff to serve as a resource and response capability for LDC's designated by AID in the planning and development of mid-level (MEDEX-type) health manpower who shall provide basic health services (including preventive medicine, nutrition, and family planning).*

Janice Hamada resigned on October 31. Our request to refill the Clerk-Stenographer II position has been approved by the State of Hawaii. This position will be filled in January.

- b. *Provide AID regions through HEW/AID technical assistance and support, competence in the task of MEDEX-type manpower development for planning staff recruitment, program implementation and management, training, and evaluation of health manpower programs.*

In late September, O'Byrne, Coles and LeSar consulted with the DEIDS/Thailand Program in the areas of preceptorship training, evaluation, and module development. Responding to a request from USAID/Pakistan, McPherson spent

the month of October as a member of the team sent there to develop a Project Review Paper for a health sector loan. In early November, he joined Smith in Thailand for the first annual review of the MEDS Project. Smith and McPherson then proceeded to Seoul on a request for consultation from USAID/Korea. This was in response to growing interest in Korea for improvement in rural health services. (See Appendix B.) Smith then continued to Pakistan where he was joined by O'Byrne and Lyons for an HMDS-led curriculum development workshop. This workshop, in collaboration with WHO and its country-health-programming exercise, is part of the larger effort underway to develop a national consensus for a MEDEX-type program to expand rural health services in Pakistan.

On invitation by the Asia Foundation, LeSar delivered a talk on rural health systems to the Foundation's representatives from all over Asia convened in Manila. As a result of this meeting, LeSar was asked by USAID/Philippines to remain in the country for an extra week to provide consultation to the Government of the Philippines. The Philippines Developmental Academy was in the process of developing a "Barefoot Doctor" scheme in isolation from the rest of the health care system until they heard LeSar's speech. After a week of work with USAID and representatives from the Academy, the linkage of the peripheral village health worker with the larger health care system through the mid-level medex became apparent and important to their thinking. (See Appendix C.)

The Ministry of Health of Guyana sent Dr. Robert Baird (Chief Medical Officer) and Ms. Yvonne Eleazar (Chief Administrative Officer) to Honolulu to work with HMDS during the second week of December to develop a proposal for MEDEX in Guyana. This proposal is being submitted to the Regional Office of the Kellogg Foundation in Rio DeJaneiro. This is the result of the HMDS visit to Guyana in April of this year and two brief sessions with the Minister of Health of that country who has been hospitalized in England for the past few months.

We anticipate being asked to provide technical assistance to Korea and the Philippines in the near future. We have been asked also if we would assist in a health sector planning and implementation effort in Syria.

- c. *Develop, field test, refine and evaluate a problem-oriented System to Train Essentials to Medex (STEM) module utilizing protocol-based training packages which can be adapted into multiple LDC settings to train new types of health manpower, in accordance with the specifications set forth in Exhibit I.*

STEM Module development continues. Working drafts of the Dermatology and Nutrition modules are nearing completion. On his way home from Pakistan, O'Byrne held discussions with TOMKIRP in Amsterdam and with WHO's Manpower Training Group in Geneva. The purpose of those visits was to locate additional audio-visual material to be used in the STEM modules as they are developed. Along with Coles, O'Byrne is trying to locate relevant audio-visual materials here in the United States. This turns out to be an immense job since there

are so many people interested in this area, few knowing what the other is doing. We hope to determine the appropriateness to SIEM of material that has already been developed for training mid-level manpower.

- d. *When requested by the Project Officer -- provide HEW/AID with technical assistance and support in the additional kinds of health manpower relating to total health care systems development.*

From our discussions in Pakistan, Lesotho, Guyana and the Philippines it is apparent that we must become involved with the development of basic health workers who are the most peripheral of the newly emerging non-physician providers of health services. Medex are the natural links of this *village health worker* to the larger health care system in a developing country. It is imperative that we spend some of our time in the future in the development of this category of health worker since it has become obvious to us that the village health worker is an absolute necessity in most countries if governments want to provide maximum coverage to their populations. We must discuss this issue with TA/H and the regional bureaus as soon as possible since it has implications for our staff requirements as well as USAID program directions.

- e. *With HEW/AID concurrence, develop linkages among the Health Manpower Development Staff at the University of Hawaii and other institutions, U.S. and LDC.*

Further conversations have been held with the Inter-Mountain and Northwest MEDEX Programs regarding collaboration in the development of programs overseas. The University of Washington has made substantial progress in setting the stage for such collaboration. The University of Utah has developed a mechanism for participation in overseas programs in collaboration with IMDS. O'Byrne and Coles will be visiting these two programs early next quarter to begin discussions about specific tasks that need to be performed by the groups in preparation for participation in overseas program implementation.

Other:

The John A. Burns School of Medicine at the University of Hawaii in collaboration with George Tahara and KMGB Television has produced a five-minute film on MEDEX in Micronesia. We will be bringing this film to Washington in the near future for viewing by interested parties.

Dr. Yolande Mousseau-Gershman, Associate Director of Health Sciences of the International Development Research Centre in Ottawa, spent three days with IMDS in mid-December collecting first-hand information on our planning, implementation, and training competencies. She is beyond a doubt one of the most competent professionals in International Health the IMDS has met to date. She indicated she would like to collaborate with us in the future if opportunities arise.

See Appendix D for IMDS Fiscal Status information.

HEALTH MANPOWER DEVELOPMENT STAFF
Second Quarterly Report, -02 Year
09/20/75 - 12/19/75

APPENDIX A

"Interim Progress Report, Guyana"
Memorandum from Dr. Smith to Ms. Vogel

UNIVERSITY OF HAWAII

School of Medicine

Office of the Dean

December 4, 1975

MEMORANDUM

TO: Linda Vogel, Office of International Health
Department of Health, Education and Welfare

FROM: Richard A. Smith, M.D., M.P.H.
Director, Health Manpower Development Staff

SUBJECT: INTERIM PROGRESS REPORT, GUYANA

A direct result of the HMDS reconnaissance visit to Guyana in May 1975 has been increasing interest in applying the MEDEX approach to expanding rural health services through the development of mid-level and lower-level village health worker type of health service providers. Adaptation of this technology to Guyana, which would then serve as a regional training site for the Eastern Caribbean, has also been an interest of the Kellogg Foundation. Following a recent communication with the Minister of Health, who is presently in a London hospital, I received a phone call on November 26 from Mr. Hamilton Green, Minister of the Interior, in Georgetown, Guyana. He informed me that the Prime Minister had asked him the night before to contact me to determine the next step in developing a MEDEX Program for Guyana. Heavy staff commitments prevent HMDS from traveling at this time; and I suggested that the Government of Guyana send a senior health official to Hawaii, and we would assist the Government in the development of a project proposal for their country.

Yesterday, we received a cable informing us that Dr. Robert Baird, Chief Medical Officer, Minister of Health, and an Administrative Officer are due in Honolulu on December 6 for a week of work in the development of such a proposal.

I feel it necessary to document this type of output of our past efforts since they are so extremely difficult to measure. I also think that it is imperative that TAI be informed of this, since I am sure that they will want to keep LA apprised of that situation.

HEALTH MANPOWER DEVELOPMENT STAFF
Second Quarterly Report, -02 Year
09/20/75 - 12/19/75

APPENDIX B

Report of trip to Seoul, Korea
November 9-15, 1975.
Smith and McPherson.

TRIP REPORT: Richard A. Smith, M.D., M.P.H. (T-18420)
Director, Health Manpower Development Staff

Archie McPherson, M.D., M.P.H. (T-18415)
Associate Director for Planning
Health Manpower Development Staff

A Meeting Dates and Place

November 9 thru November 15, 1975; Seoul, Korea

B. Purpose

To meet with officials of the Government of the Republic of Korea, representatives of the Korean Public Health Association and the Korean Medical Association, the nursing profession in Korea, and representatives of various educational institutions in the Republic of Korea. The purpose of these meetings was to sensitize the above officials to the current activities in other country settings to the use of non-physician health care providers in the strengthening of basic health services in rural areas. This activity is being carried out in relation to a health sector loan granted to the Government of Korea for the strengthening of rural health services. The AID Mission desired a detailed explanation of activities in the use of physician extenders in various areas and some explanation of the MEDEX system being utilized in other developing countries.

C. Substance of Meetings

The preliminary meetings on arrival in Seoul were with Dr. James Brady and members of his staff. The purpose of these meetings were primarily an orientation of Drs. Smith and McPherson to the health problems of the Republic of Korea and the organization of delivery of health services in this country. Mr. Frank Harlen, a member of the Westinghouse health planning team in Seoul played a continuing role in the discussions at the time of the preliminary meeting and intermittently throughout the period of the following six days.

A general roundtable discussion of the use of physician extenders and the specific use of the MEDEX methodology in strengthening health services was carried out with a number of members of the Ministry of Health and Social Affairs. A detailed presentation of the experience of a number of countries in implementing programs utilizing non-physician health care providers was made including discussion of the general principles which need to be considered in developing a successful program for the expansion of health services utilizing non-physician providers of primary health care. There appeared to be excellent appreciation of the issues involved in such a program and a very relevant discussion was carried on with key members of this Ministry. It was apparent that there was a clearcut interest in and a desire to improve health services to the rural population of the Republic of Korea. It was also clear that there was strong interest in doing this via the mechanism of utilizing physician extenders. Important political issues appear to need resolution before the successful implementation of such a program and the issues involved appeared to be keenly appreciated by the group.

C. Substance of Meetings (con't)

A brief orientation meeting was held with Mr. Eun, Hong, Director of the Saemaul Undong Project and members of his staff. This project is a village development program and addresses issues of economic development primarily, but also concerns itself with issues related to environmental health. In some regions there has been additional activity in the area of improving personal health services via the mechanism of mobile health clinics. The activities of the entire project were briefly outlined by members of the project staff. The members of this project staff indicated a clear interest in the possible relationship between an effort to strengthen basic health services and the new village movement. They indicated, however, that the lead would be expected to come from the Ministry of Health and Social Affairs and that the Home Affairs Ministry of which this project is a part would be the coordinating agency. It is apparent that the new village movement could serve as an excellent vehicle for the strengthening of health services since it has a great deal of political support at this time.

Field trips were carried out to rural health centers and to Guns in Korea. Both of these project sites visited were attempts to strengthen basic health services in rural areas. One of these projects was assisted by the World Health Organization while the other received support from Yonsei University. The major activity of the WHO supported program at Yong-in Gun was the integration of three vertical programs and the workers participating in them to produce a multi-purpose worker. The three types of workers were TB, family planning, and an MCH workers. Their initial training had been nine months with an add-on of two weeks to convert them to multi-purpose workers. Little primary care was rendered in this project. An effort was being made in this project to enumerate all of the households within the project region to develop baseline data on the entire community. The second project site visited was the one supported by Yonsei University. It was a community medicine project in Kang Wha. This project's major purpose was the training of medical students and nursing students in community health care. A unique feature of this project was the utilization of "family health workers". These are village residents selected by the community and paid by the project to carry out limited health surveillance and health education activities. These workers receive only two to four days training. It was the impression of the project staff that although considerable problems still existed in the continuing function of this program that it showed a great deal of promise. In addition to the family health worker, efforts were being made to convert the uni-purpose nurse aide to a multi-purpose worker. This was to be done in a fashion similar to that outlined in the Yong-In Gun Project.

A series of meetings were held with representatives of various educational institutions. This included representatives of the National Medical College School of Nursing, the Yonsei University College of Nursing, and a nurse aide training center. In addition the School of Public Health and the School of Medicine at Seoul National University were visited. During the course of these meetings the training of the various types of health workers in the Republic of Korea were reviewed with the directors of these programs.

C. Substance of Meetings (con't)

A luncheon meeting was held with John W. Keeton, Peace Corps Director, the Peace Corp physician for Korea, and three Peace Corp Volunteers. The members of the Peace Corp staff in Korea were interested in the physician extender movement and the possible role that the Peace Corp in Korea might play in the development of this program.

A brief meeting was held with the Director of the Economic Planning Bureau of the Economic Planning Board, Mr. Kang, Kyong Shik. He expressed an awareness of and a concern for inadequate rural health services. He was aware of the problems in deploying physicians to rural areas and the probable necessity for deploying other types of primary health care providers to rural areas in lieu of physicians. He was aware of the stance of the Korean Medical Association relative to the training of other health care providers but felt that there was no alternative but to proceed with programs to train and deploy physician extenders.

On Friday, November 14, 1975, a symposium sponsored by the Korean Public Health Association was attended. The program consisted of a discussion of the use of Allied Health Workers and the delivery of medical care in Korea. At this symposium, Dr. Richard A. Smith discussed the difficulties encountered by most developing countries in their attempts to extend reasonable basic health services to their rural populations. A general review of various countries' efforts to resolve these problems via the mechanism of utilizing physicians' extenders was included in this address. A discussion of relevant problems encountered in attempting to implement programs utilizing physicians' extenders was followed by a brief general discussion on the MEDEX system. It was pointed out that the problem of delivery of rural health service in the Republic of Korea would require a Korean solution. No panacea for the resolution of all of the problems which would be encountered could be given and that careful attention must be paid to all of the essential problem areas if such a program was to be successful.

D. Contacts

I. USAID

Mr. John W. Roxborough - Mission Director

Dr. James Brady

Mr. Frank Harland

Mr. Lee, Yong Hwan

Miss Martha McCrae

II. Ministry of Health and Social Affairs

Mr. Park, San Yeol - Director General for Planning and Coordination

Dr. Ahn, Sung Kyu, Chief - Planning Section

Dr. Joo, Shyn Il - Planning Section

II. Ministry of Health and Social Affairs

Mr. Joo, Kyong Shik - Planning Section

Dr. Oh, Yong Il - Medical Affairs Section

Mrs. Kim Jin Soon

III. The Economic Planning Board

Mr. Kang, Kyong Sik - Director, Economic Planning Bureau

IV. The Korean Development Institute

Dr. Koo, Bon Ho - Vice President

V. The Korean Public Health Association and Members of the Academic Community

Dr. Kwon, E. Kyock - Dean, Seoul National University College of Medicine

Dr. Park, Hyung Jung - Dean, Seoul National University, School of Public Health

Dr. Yang, Jae Mo - Dean, Yonsei University College of Medicine

Dr. Koo, Yon Chol - Professor, Ehwa Women's University College of Medicine

Dr. Chon, Sang Cho - President, Korean Nursing Association

Dr. Kim, Chong Kun - Professor, Seoul National University, School of Public Health

Dr. Roh In Kyu - Professor, Seoul National University, School of Public Health

Dr. Kim, Tae Ryong - Professor, Seoul National University, School of Public Health

Dr. Kim, Il Soon, Yonsei University

Dr. Lee, Kyong Shik - Professor, Seoul National University, School of Public Health

Dr. Kim, Mo Im - Professor, Yonsei University, College of Nursing

VI. Korean Medical Association

Dr. Ju Young Jae

Dr. Sohn, Choon Ho

VII. International Agencies

Dr. Chong, Chun - Hian, WHO Country Representative

Dr. McBean - UNICEF Country Representative

E. Followup Action Necessary

The purpose of the visit of the Health Manpower Development Staff to Korea this time was primarily to assist the AID Mission in appraising key decision makers in Korea of the efforts other developing countries have taken to improve rural health services utilizing physician extenders. The mission was hopeful that this visit would help to precipitate discussion among various groups within Korea and to help them focus on the specific problems related to rural health and the problems which will undoubtedly arise as they move in the direction of implementing programs for training and deployment of non-physician health care providers. The consultation visit was therefore successful in stimulating this dialogue. Followup activity at this point lies primarily therefore with the AID Mission in Korea and various factions within the Republic of South Korea.

An outline of preliminary program steps will be drafted by Dr. McPherson and forwarded to James Brady to assist them in formalizing their plan for development of the programs to be supported by the health sector loan which was recently signed.

HEALTH MANPOWER DEVELOPMENT STAFF
Second Quarterly Report, -02 Year
09/20/75 - 12/19/75

APPENDIX C

LeSar and Li, "Informal Consultation
to the Development Academy of the
Philippines on Their Proposal to
Develop a Basic Health Worker"

INFORMAL CONSULTATION

to the

DEVELOPMENT ACADEMY OF THE PHILIPPINES

on their

PROPOSAL TO DEVELOP A BASIC HEALTH WORKER

John W. LeSar, M.D.
Health Manpower Development Staff
School of Medicine
University of Hawaii
Honolulu, Hawaii, USA

Diane Li
Documentary Film Producer
"Barefoot Doctors of Rural
China"
Stanford, California, USA

November 6-12, 1975

C O N T E N T S

- 1.0 Introduction
- 2.0 Background of the Problem
- 3.0 Conceptual Issues
 - 3.1 Concepts in Planning
 - 3.2 Factors Enhancing the Health Status of the People
 - 3.3 Concepts in Offering Preventive and Educative Services
- 4.0 Organizational Issues
 - 4.1 State of the Health System Now
 - 4.2 Strengthening the Rural Health Unit
 - 4.3 Extending the System Beyond the Rural Health Unit
- 5.0 Operational Planning for a Better System
 - 5.1 Planning Training Based on Operational Needs
 - 5.2 Planning Incentives
 - 5.3 Planning Supervision
 - 5.4 Planning Professional Development
- 6.0 Political Issues
 - 6.1 Perceptions of Rural People
 - 6.2 Perceptions of Vested Interest Groups
 - 6.3 Commitment of Policy Makers
- 7.0 Strategies for Implementation

INFORMAL CONSULTATION TO THE DEVELOPMENT ACADEMY OF THE PHILIPPINES
ON THEIR PROPOSAL TO DEVELOP A BASIC HEALTH WORKER

1.0 Introduction

At the request of interested Development Academy of the Philippines (DAP) personnel, the USAID Mission in Manila asked the authors to spend 3-4 working days with DAP on their early draft of a proposal to train a basic health worker for the rural barrio's of the country. The authors were in Manila attending a conference of the Asia Foundation at the time of this request.

2.0 Background of the Problem

The present Philippine medical care situation is unsatisfactory to most government officials, health professionals, and development specialists. There is a heavy disease burden in the rural areas where 70% of the people live, and the medical care system, based largely in the urban areas, is not sufficiently equipped to deal with rural health problems. In the country as a whole, there is an inadequate number and a maldistribution of physicians and medical facilities. There is also an underutilization of certain existing services since most people are unable to pay for medical services at present rates; and, due to inadequate financing, the government cannot provide for everyone's medical needs.¹ The health project proposed by DAP is an attempt to address some of these problems.

The DAP approach is to train a basic health worker or the barefoot doctor type to work at the barrio level. The use of paramedical workers is not new in the Philippines, but the DAP is introducing the following innovations which they hope will lead to a health impact at the barrio level:

- 1) The development of the Barrio Association to involve barrio people in developing their health care system;
- 2) the development of a health insurance scheme for hospital care and a fee-for-service scheme to pay for the basic health worker.

Other considerations of this project include furthering of institutional linkages with the most peripheral units of the Department of Health principally, the Rural Health Unit (RHU).

1. Agbayani, B. F., et al, Paraprofessional Health Workers, pp 4-5, U.P. Postgraduate School of Medicine, Manila, Mozar Press, 1975

3.0 Conceptual Issues

3.1 Concepts in Planning

Modern planning concentrates on analyzing the tasks of the system and their designing an organization to accomplish those tasks - the management by objectives approach. In health, this means that one should analyze health demands, needs, and constraints; set objectives, and then design training and human resources to accomplish those tasks. This process will determine the roles of all workers on the health team.

In the past, pilot projects have attempted with varying degrees of success to strengthen the effectiveness of the RHU through the use of paramedical or auxillary health workers, but no national impact on health care organization has seemed to result from these efforts.

3.2 Factors enhancing the health status of the people

The basic health worker (BHW) is conceived to help improve health at the barrio level. Health services research has shown that the major factors in improving health are increasing the income of the people, increasing the education of the people, improving the environment, and providing medical care. The basic health worker's role, therefore, must not only be to provide curative medical services, but also to educate the people about health matters in such a way as to motivate the community to improve the overall conditions contributing to good health. These are called preventive/educative services.

3.3 Concepts in Offering Preventive and Educative Services

Curative services are usually demanded by patients because the cause and effect relationship between symptoms and cures is easily identifiable and understood by the people. These services can therefore be provided by a person or group with little organizational back-up because the consumers' willingness to pay for such services enables the provider to be financially self-supporting and independent of outside assistance. The private sector in the Philippines is evidence for this and most doctors are independent operators of these "cottage" types of business.

On the other hand, preventive services, primarily educative in nature, requires much more. The nature of education is that people receive stimuli from many sources. The more conflicting these messages, the less effective the educational process becomes. To educate people for better health requires a balanced approach including mass media techniques as well as person-to-person contact. Therefore, preventive services must have a large organizational back-up to be effective. Consequently, the basic health worker, to be successful as a provider of preventive services, must be strongly linked to an effective organization which focuses heavily on communicating health information to rural people.

4.0 Organizational Issues

4.1 State of the Health System Now

In the Philippines, medical services are provided by the private sector as by the government. Primary care is offered by private doctors in urban areas and most municipalities. Secondary care is provided by private hospitals, but these also are to be found mostly in the urban areas. To assist in the provision of medical services, the government health system maintains at least one hospital in each provincial capital. It also offers primary services at the municipal level through the Rural Health Unit, professionally staffed by a physician, nurse, midwife, and sanitarian.

It is widely acknowledged that government services are perceived as inferior to private services from Makati in Metro Manila to the RHU level. Less than 4% of the government budget is devoted to health compared to more than 6% for Great Britain, 8% for the USA, and more than 10% for Cuba and the Soviet Union. In the Philippines, less than 30% of government health monies go to rural areas even though 70% of the people live there. As of now, a national commitment to rural health matched by adequate financial resources and well-trained human resources is not in evidence.

The RHU, the most peripheral and forgotten unit, suffers most. Its range of effective service is less than 5 kms. from the poblacion. It does not reach the people. If improved health is a function of improved knowledge about disease, which needs to be communicated synergistically by effective communications networks, one can see why rural health has not improved.

The RHU in its present form, does not and cannot be expected to carry the entire burden of improving rural health, but it is a crucial link in the health and communications networks in the countryside. Therefore, to promote better health for rural Philippines, strengthen the RHU first. Any more peripheral extensions of the system cannot be effective if the RHU is ineffective.

4.2 Strengthening the RHU

By analyzing the rural health situation of most developing countries, one finds relatively similar problems. Physicians, if present, are unhappy because they are trained to care for difficult problems but see simple problems. The physician function in the RHU is to manage a group of people and to plan and implement health services for a population of 10,000-20,000, but physicians are trained in caring for individuals not populations.

Nurses are inappropriately trained as well. Should one expect a hospital-trained sickness-oriented nurse to have job satisfaction assisting a doctor with injections and filling out records?

Analysis of rural maternal problems shows 5 "risk-factors" for pregnant women. When these are present, the probability of pregnancy problems is high and the best quality care is needed. These women should be treated at a hospital by a physician. If these risk factors are not present, the complication rate for the pregnant woman is low and a hilot can safely attend the delivery. Thus, the midwife is not well utilized as the rural people understand maternal risks very well.

The Sanitarian is supposed to convince people to drink safe water and dispose of their feces in a sanitary way. Under the present conditions, he is expected to communicate this information without any effective mass communications network to complement this difficult effort. Is he trained as a communicator? Does he have resources to use as incentives? If not, should we not expect a cynical, ineffective and unhappy worker?

A first step in strengthening the RHU is to analyze the tasks in the RHU and train appropriate people for these tasks. Another early step is to see if the health system can become part of an effective communications network for health. If this can be done, workers can be trained to

complement this activity at local levels to help accomplish the health development of the rural areas. If not, preventive care is more difficult and improvement in health status will be small.

4.3 Extending the System Beyond the RHU

The barefoot doctor of China has caught the attentions of the world. He or she is not a magical solution to rural health problems but is, in the People's Republic of China, part of a massive effort to develop all necessary components of a strong and effective rural system. The Chinese began this rural development effort with the formation of administrative units - communes, brigades, production teams, and small groups - as well as the development of an effective communications network.

Thus, the barefoot doctor, first trained in the late 1960's, is part of the health effort, which is itself only one aspect of a total commitment to rural development begun in 1958.

The lessons to be learned are that one cannot begin at the periphery alone. The basic health worker must be linked to an effective rural health unit.

/rls

5.0 Operational Planning for a Better System

5.1 Planning Training Based on Operational Needs

Studies in the Philippines have shown that rural people will travel less than 5 km. for common illness care. For this reason, DAP has planned one basic health worker per barrio. To maximize effectiveness of the BHW, he or she should not be overtrained in curative care. Many experts feel that a BHW should be limited to 10-15 common curative conditions and that a full-time BHW should have a curative caseload requiring less than 1/2 day's work (if part-time, probably less than 1/4 day's work) to allow concentration on preventive/educative care. Ten-fifteen curative conditions usually will be around 50% of the caseload of an average day so (around 3-6 cases) the referral rate would then be 3-6 people/barrio/day. Since travel time is such a critical determinant, one might consider establishing primary care units away from a strengthened RHU to meet this need. These could be staffed from existing RHU personnel (one or two more people may be needed) who would have been appropriately retrained and their skills upgraded to offer primary curative care for 50-60 conditions (allowing them to care for 95% of all cases), supervision, and continuing education of BHW's, and management of the preventive program. This would allow an effective primary care process close to the people and the physician could then see the very difficult cases for which a physician is trained. As well, an appropriately retrained physician could plan, manage, and evaluate the health program for the municipality.

5.2 Planning Incentives

People will make sacrifices and expend resources to get services or materials they want or to invest in something which has a well-known and desirable pay-off. Planners should consider this in designing incentives for behavior change.

Workers will perform tasks which have a strongly positive psychological or monetary reward. If the community rewards curative care, a worker will maximize curative care behavior. If preventive care is not rewarded by the health system in some culturally appropriate way, it will

not be done for long as the community will not reward this behavior in the short run. However, if prevention becomes a high priority of the system and is communicated effectively, the people will begin to request these changes and thus the worker will get rewarded for preventive work.

5.3 Planning Supervision

The basic health worker is a "boundary spanner" between the community and the health system. This role is encouraged by a dual management approach with administrative supervision by the barrio organization and technical supervision by the health system. For effective technical supervision, the span of control should be less than eight supervisees to one supervisor. The responsibilities of the supervisor include quality assurance, assessing progress toward objectives, continuing education, logistical support, and a strong, supportive commitment to the personal needs of the basic health worker.

- 5.4 In planning health services, it is logical to expect that services will expand as time progresses. The expansion of these services should be part of the ladder of barrio development. Services need people and the workers in the barrio should expand their skills as the barrio develops. They should not be encouraged to have a career ladder out of the barrio but should be part of the barrio as it climbs the ladder of development. Professional development should focus on adding more skills needed in the barrio-curative, educational, organizational - with only a slight possibility of vertical movement out of the barrio. If moving from the barrio is perceived as desirable, the implication is that the barrio is inferior. This is counter productive to development!

6.0 Political Issues

6.1 Perceptions of Rural People

The desire to improve the health of rural people is strong. However, rural people want equal treatment with urban people. If urban people use doctors, will rural people be satisfied with less? One should avoid the potential political impact of "second class" care. Both rural and urban people should have a health system designed to meet their respective needs, but they should view workers as part of a health organization designed to provide equal quality care.

Rural people also have seen many programs come and go. To enhance the image of the government as an increasingly effective organization dedicated to the welfare of all people, careful project design and sensitivity to rural concerns are important. Should a project be undertaken without full government involvement in making it succeed? What would failure of this project mean to further efforts in this field?

6.2 Perceptions of Vested Interest Groups

Powerful vested interest groups usually genuinely believe they are offering the best solutions to problems. If change is needed, it is wise to change the perceptions of these people by collaborating with them if possible. Resistance is often due to lack of information and lack of involvement in the decision-making process. Lack of involvement in the decision-making process implies that there will be a lack of involvement in the implementation of the solution.

6.3 Commitment of the Policy Makers

True political commitment to increase rural health services means a financial commitment and a use of good talent in implementing such a program. A national commitment should be sought that matches words with resources.

7.0 Strategies for Implementation

1. Plan health services not health manpower.
2. Plan a communication network based on existing socio-cultural patterns of interaction.
3. Strive for a true national commitment to rural health by involving and educating top decision-makers on rural health and enlisting their public support.
4. Integrate all health sector efforts and build on existing strengths in the present health system.
5. Stimulate the bureaucracy to support these efforts.
6. Develop appropriate imagery for your workers and your "new" system and begin a national community orientation via the mass media.
7. Build up weak links in the system first or concurrently.
8. Involve physicians in the training process. They will both teach and learn.
9. Develop curricula based on the needs of an integrated health approach.
10. Build in appropriate incentives and link career development to the ladder of barrio development.

PEOPLE INVOLVED IN DISCUSSIONS

Mr. Horacio R. Morales, Executive Vice-President, DAP

Mr. Jaime A. Cura, Vice-President, DAP

Mr. Jose P. de Jesus, Vice-President, DAP

Dr. Rosendo R. Capul, Basic Health Workers Project, DAP

Dr. Efren Palabyab, Basic Health Workers Project, DAP

Mr. Romulo Manlapig, Basic Health Workers, DAP

Mr. Manuel C. Lapena

Mr. Sonny Aledia, DAP

Mr. Tony Pangilinan, DAP

Dr. Gerold van der Vlugt, USAID, Population and Health

Dr. Theresa van der Vlugt

HEALTH MANPOWER DEVELOPMENT STAFF
Second Quarterly Report, -02 Year
09/20/75 - 12/19/75

APPENDIX D

HMDS Fiscal Status Report.

HEALTH MANPOWER DEVELOPMENT STAFF

SECOND QUARTERLY REPORT, -02 YEAR

09/20/75 - 12/31/75

ASH 74-277

A P P E N D I X D

Fiscal Status

<u>Category</u>	<u>Allocation</u>	<u>Expenditures To Date</u>	<u>Funds Remaining</u>
Salaries	265,282	257,197	8,085
Fringe Benefits	53,137	40,339	12,798
Consultants	14,500	11,238	3,262
Materials & Supplies	11,200	6,528	4,672
Communications	11,761	10,082	1,679
Travel	72,960	64,593	8,367
Freight & Delivery	200	63	137
Printing & Publication	2,000	143	1,857
Rentals	4,576	4,076	500
Repairs	3,800	1,907	1,893
Other	4,000	3,656	344
Equipment	<u>10,150</u>	<u>7,056</u>	<u>3,094</u>
Sub-Total	453,566	406,878	46,688
Indirect Cost @ 8%	<u>36,285</u>	<u>32,550</u>	<u>3,735</u>
TOTAL	489,851	439,428	50,423