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HEALTH FOR HUMANITY;
THE PRIVATE SECTOR IN
PRIMARY HEALTH CARE

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HEALTH FOR HUMANITY: THE PRIVATE SECTOR IN PRIMARY HEALTH CARE

CONFERENCE PROCEEDINGS
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Dr. Russell E. Morgan, Jr.
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ABBREVIATIONS

AID	Agency for International Development
ASECSA	Guatemala Association of Community Health Services
CARE	Cooperative American Relief Everywhere
CIDA	Canadian International Development Agency
CRS	Catholic Relief Services
CUSO	Canadian University Service Overseas
HKI	Helen Keller International
MAP	Medical Assistance Programs
MCH	Maternal and Child Health
NCIH	National Council for International Health
NGO	Non-governmental Organization
OPG	Operational Program Grant
PAHO	Pan American Health Organization
PVO	Private and Voluntary Organization
RFP	Request for Proposal
WHO	World Health Organization

PREFACE

Over the past two decades the international health field has expanded in scope as the number of newly independent countries striving to improve their nations' health systems has increased. Approaches to health care delivery have been fragmented and changes in health status, particularly in the third world, have been slow. While no one offered a panacea, many thought the situation could be improved.

In 1971 a task force on international health recommended the creation of a committee for the specific purpose of improving communications within the international health field. From this effort the National Council for International Health (NCIH) was born. The NCIH is a 501(c)(3) tax exempt organization. Its membership includes individuals, professional organizations, private and voluntary organizations, universities, foundations, and government agencies. In short, the Council is the forum through which the private and public sectors meet and act on the problems associated with improved health care.

To facilitate this communication, the NCIH, since 1973, has sponsored several conferences. Past conferences have concentrated on such topics as "The Health of the Family," "Child Health in a Changing World," and "Health in Community Development." The focus for this, our Sixth Annual Conference, is "Health for Humanity: The Private Sector in Primary Health Care" and is presented in cooperation with The American University.

As with so many volunteer activities, the meeting would not have been possible without the diligent efforts of many of our Council members and friends. The NCIH most especially wishes to thank Dr. William Nute, Jr., and his program committee for the many long hours that they have contributed toward the presentation of this Conference. Dr. Nute has been a Council member since its inception in 1971 and has loyally pursued the Council's objectives. His experience in the field and his attention to detail are unsurpassed. Dr. Nute's expert leadership has enabled the Council to continue, despite the lack of a sustained support staff. We also wish to acknowledge Ms. Jeane Cox-Meuser for her energy and efficiency in assisting Dr. Nute with the Conference preparations.

The NCIH also thanks The American University and Professor Darrell Randall for their unceasing interest and toil. The University generously provided the space and facilities for this Conference as well as guidance as to subject matter. This particular Conference is an outgrowth of The American University's World Human Needs Program. There can be no question that the University is committed to quality education and training for field practitioners.

INTRODUCTION

In the past five years, a quiet revolution has been occurring throughout the developing world. This revolution remains unknown to the vast majority of Americans. Specifically, there has been a revolution in the provision of health services, and the result has been a marked improvement in the health status of the world's poor. The Council is fortunate in that some of the key leaders of this movement are participants in this Conference.

One of the Council's principal objectives is to continue this revolutionary--or evolutionary--activity; not in a theoretical way, but experientially. The Council endorses the World Health Organization's definition of primary health care. In 1978, the Alma-Ata Conference considered primary health care "to be essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals...in the spirit of self-reliance and self-determination."

Primary health care includes health education; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization, and appropriate treatment of common diseases and injuries. The initiation of such services has, to date, remained largely with the private sector. The problems of implementing such health delivery schemes, though, are many.

Most private and voluntary organizations (PVOs) are managed on a shoestring. Funding is insufficient for the goals at hand, and the traditionally generous public is tightening its financial belt. Therefore, PVOs are, more than ever, faced with issues of cost-benefit, cost-effectiveness and efficiency. Programs built on the reputation of one dedicated expatriate can no longer survive intense scrutiny. Rather, such programs must demonstrate community involvement in both decision-making and administration, as well as replicability on a broader scale.

PVOs that have been forever short-staffed must now rely on local personnel for assistance in primary health care. Thus, PVOs are expanding their concept of training by organizing on-site seminars and intermittent hospital study programs. The result has been greater acceptance of health care delivery; this because locals trust their own.

The PVO presence at the local level insures a greater probability for program and community integration. There are problems to be sure--does one access the community directly through primary health care, or indirectly through the introduction of some other "felt" need, such as education and schools or agriculture and food co-ops? The final determination depends on the PVO, its mandate, and its sensitivity to local conditions.

The politics associated with primary health care cannot be underestimated. International organizations must respond to the dictates of national governments. Regional governments remain politically sensitive to public demand for high cost, tertiary health care. Provinces, overburdened by burgeoning populations, must make the unnoticed felt. Each arm of government must satisfy the expectations of the medical profession in-country; expectations which often result in the skewed distribution of health care services.

Finally, PVOs must convince their fellow nationals of the worthiness of their projects. No one likes to hear that his or her money and effort is contributing to mal-development, increased population, or the like. PVOs have had to mount public relations campaigns to educate their publics as to the benefits of primary health care, and it is in that spirit that we have gathered our membership, here, this year.

These proceedings reflect the participants' concerns in defining the role of the private sector in health care delivery. The speakers' backgrounds cover a wide spectrum of activity and their analyses vary. We would like to express our appreciation to Ms. Sarah Becker for her patience in editing and to Ms. Teresa Gottlieb for her expert typing.

Do read on and enjoy.

Ned Wallace, M.D.
Chairman
National Council for
International Health

December, 1979

I. KEYNOTE ADDRESS

RISK TAKING AND THE PRIVATE SECTOR

Frank L. Goffio

I must tell you that I feel a little uncomfortable addressing this audience. Although I know the private sector, I can tell you that I am no expert in primary health care. However, I was happy to hear Dr. Wallace say that we are not going to spend a lot of time defining primary health care. In my experience, I think that we, in the voluntary sector, spend too much time defining things and too little time implementing what we know to be correct overseas. Way back, twenty-five or twenty-six years ago, when CARE began to get out of what was then the package business, into what we called self-help, self-help was great. Self-help described it all. Later somebody used the term "development". Oh, the money that we spent defining development. The conferences that were held seeking a definition of development and are still being held. I don't think you have to know the precise definition of development to do the job that needs to be done.

Something happened to us, professionals, in the private voluntary agency sector, when CARE and MEDICO merged. For the first time we were not moving things. Rather, we were moving people. As I was new to the job of Executive Director, I was concerned about this. We were mutually suspicious--the medical professional and the agency professional. We felt we didn't understand each other. For the first ten years of operation we kept our distance and merely smiled at each other. I think it took fifteen years before we embraced and began to talk about our mutual problems in the field. We have overcome that now. Perhaps it existed, or might still exist, within all of the agencies that are combining the work of the "PVO" and the medical profession. It has taken us a long time to get together and understand what it is that needs to be done overseas, and to respect each other's abilities in the field. Hence, out of this meld--this crossbreeding--comes the kind of professional that we so desperately need to implement proper primary health care in the less developed areas of the world.

There is such a scarcity of that kind of personnel. In the old days, we moved people overseas and it was accepted. For example, we came in and said, "We are going to move in so much wheat; we are going to move in so much of this or bring in plows." Today there can be no second-raters; no more warm bodies to move around as we bring in things. This is important to remember. Less developed countries want your skilled personnel; not the second-raters or the warm bodies. Sadly, there are too few skilled personnel. It is difficult to find the people that can go overseas and spend the necessary time. By that, I do not mean the person who goes in for a week and comes out for a year, and then goes back for another week. What is needed is someone on-site

for the duration of the project, who can remain and develop local expertise. Given our limited expert personnel, we must develop local personnel to do the job.

When CARE began its self-help operation several years ago, our principal premise was that people must be self-sufficient. I was in procurement at the time. In India, we decided that we were going to provide a plow. We assembled a group of experts together to tell me, the buyer, what kind of a plow I should put down in India. We had sixteen experts. These experts sat for three days and deliberated the problem. I was downstairs waiting for the answer, so I could go out and buy the plows and get them into operation in India. At the conclusion of the three day session, sixteen different plows were recommended. I responded with eney, meny, mini, mo, and bought two hundred plows. It was not a good plow, but we got it overseas. We distributed the plows and put them to use. That is how we found what was wrong with the plows. Then, we began to develop a plow, until finally we developed several different plows for use in India. There is no one plow appropriate to the whole of a country like India. We developed them by taking the risk of putting down the first plow.

We can find the answers if we can take the risks that make things happen. We must not be afraid to make mistakes. We have all the learned papers in the world to read. The people of the American Council provided me with a lot of literature on primary health so that I would be prepared when I talked to you today. After reviewing the material, I decided I would not talk about primary health; it has all been said. You all know what you have to do overseas.

Years ago, we did not call it primary health, but CARE was involved in primary health or parts of it. Nutrition, clean water--all are vital to the improvement of the human condition in the field. We in the private sector, too often rely on jargon. We have an opportunity before us. Some of us may think that we are experts in primary health. We have been in health a long time. But, we have very few success stories in primary health. Those that exist are limited in scope. How do we go about improving on our record?

We have to begin by putting our energies, our personnel, our finances and our resources into health care delivery. I think what this Conference offers is an opportunity for crossbreeding and the exchange of ideas.

Through MEDICO we have been heavily involved in hospital-based, curative care programs. Only now, have we started out-reach programs. I have heard our medical advisory board give great lip service to primary health. It has only been within the last two years that I have been convinced that the Board means for us to get into primary health care. The medical profession has been very cautious about putting people out in the field who may not have all of the training they feel necessary to get the job done. Well, we are going to have to compromise, and the medical

profession is beginning to realize that as fact. Para-medicals, even less than paramedics, are available to move health care out of the boondocks. We have been successful in implementing food distribution programs. We must develop similar programs for health care delivery.

One thing has troubled me as I look at your conference agenda. Fund-raising is a major problem for private voluntary agencies. The months and the years ahead are going to be very difficult ones for our voluntary agencies. We depend on the donating public for support. I fear that the federal government is reducing incentives for giving. How many of us are working, here in Washington, to talk with people on Capitol Hill? Tax shelters for overseas voluntary agency personnel are being taken away. This makes it very, very costly for agencies to operate abroad. We are going to be in serious trouble unless the private sector continues to secure funding from the compassionate, generous public-at-large. If we are not heard, we could end up talking to ourselves. Fund-raising should be at the top of our agenda.

It is imperative that voluntary agencies tell their story to more people in more places. Programs must be improved. It is costly to be in the voluntary business today. Nobody likes to talk about money, but there is no way around such discussions. We are all familiar with the problems accompanying direct mail solicitation. It costs one dollar for every four replies received. If we continue to take away the incentives for the donating public to give, then more and more of us are going to be lining up in front of the government funding trough. Do not misunderstand me. I am all for getting whatever amount possible from donors. As far as CARE and I are concerned, the United States government has been a donor. As long as you are doing your thing well, you can ask anyone for money. The NCIH was established to assist the PVOs currently active in health to perform their functions better. Will the NCIH help us to spread the word within government?

In a sense, government funding requires that an agency prostitute itself. Do your thing. Don't twist yourself upside down. Government is a bully; it will tell you what the government wants you to do. If government funding is your only source, then you are not going to be doing a thing. Government is a great partner, as long as you remain independent. We, in the private sector, have been very fortunate to preserve the independence and integrity necessary to convince the donating public. The public is skeptical of government agencies. It is for this reason that I ask you to include the subject of money in your deliberations.

I do not have anything profound to say this morning, except that my thirty-two years with voluntary agencies have been thrilling ones. There is a payoff that cannot be measured in monetary terms. Change occurs because you care enough to make it happen. It is who we represent, the

people of the United States, that make it possible for us to remain in the business of helping the world's poor. We must never become so smug as to say to the donating public, "You do not understand; particularly the costs." Tell them why it costs so much. Do not fudge it. Keep your costs as low as possible, but tell them why it costs what it does. If CARE is a good organization, it is because we have a lot of people overseas who are cognizant of the logistics involved in getting things to the right place on time. There is no way in the world you can do that with only an envelope to depend on. You have to have people at the ports to unload ships and put supplies down. You have to have people to meet your doctors, your nurses and put them into an environment where they can live and operate effectively. It all costs money. If the government removes the incentives and takes away that which we used to be able to offer overseas employees, then it is going to be extremely difficult to move forward. So, if you have a spare minute, knock on your Congressman's door and explain the financial problems now facing the PVO community.

Let us talk together and become more familiar with the problems. Let us also remember the men and women who make possible that which we represent. We are not a little society that insulates itself from the people who send us money. I am almost embarrassed to discuss money. However, I am going to be doing a lot of talking in the next year because I am worried. Some say that there is no way that we can do all the things that need to be done overseas. Together we must speak out for that which we believe in. We are going to help if we can. We are going to marshal the resources. We have the know-how and we are going to accomplish our goals.

II. THE ROLE OF THE PRIVATE
SECTOR IN PRIMARY HEALTH CARE

THE ROLE OF THE PRIVATE SECTOR
IN PRIMARY HEALTH CARE

ECONOMICS AND REPLICATION

C.R. Cronk

I would like to concentrate your thoughts on the economics of the developing world. Economics is the biggest problem that Project Concern faces when working in a third world country. I would like, also, to echo Frank Goffio's comments regarding the economic constraints imposed upon private voluntary agencies, here, in the United States. Raising volunteer dollars is, and has been, getting more and more difficult. The donor public is becoming more critical, and hence, more selective about its contributions.

For too long, Project Concern has failed to adequately forecast the economic realities of the developing world. We have not been professional enough in evaluating the economic ability of the third world. For example, three years ago Project Concern negotiated for a primary health care project in Cobija, The Pondo, Bolivia. The Bolivian Ministry of Health's emphasis was on investment--how much money could Project Concern contribute? Our objective was not cost, but rather project replication.

We were also aware of our advocacy responsibility. The Ministry was committed to a high cost, sophisticated health care delivery system. We not only had to demonstrate the efficacy of our program, but also to argue that the Ministry budget new dollars for future primary health care programs. We did not anticipate the economics of Bolivia accurately. Inflation has wracked her economy. Our model program in The Pondo is proving effective, though not without problems. Our primary concern, however, is the faltering economic ability of Bolivia.

I know there are some PVOs who look down their noses when we talk about evaluation systems. These systems, though, are the very instrument through which sound statistical data can be generated and presented to the Ministries of Health. If our case for primary health care is to be convincing, then we must produce measurable results that indicate improvement in the health levels of the people. This is a responsibility we have yet to fulfill.

Finally, there is the problem of replication. The value of the Bolivian peso is shrinking daily. Therefore, responsible investment suggests increased budgeting for primary health care, not expensive hospitals. I am one of those people who believes that hospitals in the developing world do more to kill than to save. Hospitals do so for two reasons. First, hospitals take money away from the much more highly effective primary health care programs, and second, those hospitals which do continue to operate are often understaffed, poorly organized, and inadequately supplied.

Time pressures suggest that we are going to have to be more critical of our activities. It is not easy to admit to the Ministry of Health that a "perfect" plan does not work. But frankness pays, and it sets the stage for collaboration.

For primary health care to succeed in the developing world, it is going to have to be taught in every medical, nursing and graduate health school. In Bolivia they are turning physicians loose to work in the rural areas who have no public health experience or education. These physicians are really a detriment to our primary health care program. Their frame of reference is to cure. The physician's education must be broadened if primary health care programs are to succeed.

Finally, I would like to suggest that the PVO community actively involve itself in policy formulation. Our development dollars are too often subordinated to the day-to-day dictates of United States foreign policy. Again it comes down to economics.

Hopefully, we can demonstrate to our government how and where to invest its money. I believe that it is most important, in the long-term, to put development dollars directly into development causes rather than into developing markets for U.S. production or responding to political pressures.

There have been many changes in the last few months in terms of primary health care programs. The Alma-Ata Conference has brought dramatic changes within Ministries of Health. Just a few years ago, I was spending most of my time trying to convince the Ministries that primary health care systems were not disrespectful. Alma-Ata has greatly changed that attitude. The battle is not won. We must advocate working with their people, training in their country and developing systems appropriate to their environment, if we are going to have significant impact in the developing world.

THE ROLE OF THE PRIVATE SECTOR IN PRIMARY HEALTH CARE

HIGH EXPECTATIONS

Rajanikant Arole, M.D.

I would like to address the whole question of government spending on health, and I will use India as an example. India is a developing country; it is democratic and fairly well-organized. Ninety percent of India's health budget is allocated for institutions that are located in the cities. These urban areas encompass, roughly, 30 percent of the Indian population. Only 10 percent of the budget goes to cover the vast majority of people living in the countryside. I will give you a concrete example.

In the city of Bombay, they spend two dollars per head, per year, on health care. In contrast, the villages on Jamkhed will spend one cent per person, per head, on health care. The rich in India live, probably, better than the rich in America. The wealthy live as long as we live, about seventy-two years. They eat as well as we eat, and the rich die of the same kinds of diseases that kill rich America.

The disparity that exists between the wealthier Indians and those 60 percent living below the poverty line is staggering. What is the condition of these 1,450 million poor? Life expectancy is 35 years. Infant mortality is 200 per 1000 live births. This compares to 16-18 per 1000 for the rich in India. Who are the people for whom we are sacrificing our careers? How do we identify the poor and what are we sacrificing in order to reach them? Are our resources going to the right or wrong places?

In the villages, you cannot really depend on government spending loans. It is a cent. It will not stretch much. You cannot even buy enough ice cream for five patients. Many studies, such as those conducted by John Hopkins University in India, indicate that the government cannot serve more than five percent of the population effectively. The maximum allowance that the government has sent to rural areas will reach up to twelve percent.

Fortunately, only 15 percent of the rural population is exposed to modern medical care as practiced by the doctor of modern medicine. Eighty percent of the village people do not go, as a first effort, to such doctors. Villagers still depend on their healers; they rely more on those people who have traditionally provided medical care. This is very good, because it means that the poor are not exposed to some of the negative influences that modern medicine brings. India's pharmaceutical industry is a prime example.

Today, the pharmaceutical industry in India is worth seven million rupees, or one million dollars. By 1985, the industry hopes to expand to 220 billion rupees, or roughly to three times its present size. Where are these pharmaceuticals going to dump all these medicines? The Indians

are going to have their doctors selling the medicine to the poor. What does it mean? It means that an expenditure of nearly thirty-three rupees per person, per year, will be required to absorb the supply. Remember, the government currently spends one cent per person, but industry projections are suggesting that they can dump medicines worth thirty-three rupees, or four or five dollars, into that same individual. We must protect the poor from such obvious manipulation. We must protect these people from the professionals who profess to be the doctors of modern medicine. Why? These doctors are the ones who are going to be used as agents by the pharmaceutical companies to sell these additional drugs.

What are the real problems in these rural areas? The problems are related to deprivation--food, clean water supply, and, most importantly, social injustice. Social injustice exists within all the various groups, be they religious, government or the financially secure. If we are to give health care to the poorest people, then we really must involve the local healers. We must provide the healers with a body of knowledge that will give them a rational, helpful attitude. Barriers which interfere with good health must be removed. Nutritious food needs to be accessible to both mother and child.

Ninety percent of our effort has to go toward health education. Disease is caused, to a large extent, by ignorance; that is insufficient knowledge of food or drinking water, and too much reliance on the wrong tradition. For example, if a villager has a snake bite, it is more likely that he will be taken to the temple, be forbidden to touch a woman or denied a river crossing. The villager most certainly will not be brought to the hospital. His death will be assured. It is the educational process that will help the poor to understand. Who are the best educators, doctors or nurses? I am not sure.

Culturally, we are worlds apart. We are not on the same wave-length. Communication is poor. Many times a doctor will come to me and say, "Well, you know I went to the village and I talked for a half an hour and nobody listened. These people are stupid." Then, I have to ask, "Who really failed to understand? The villager's perception of health and disease is very different from yours. Doctor, perhaps, you are culturally insensitive."

What can these poor people do? They can just act dumb. And, they can sit and listen to a physician. The villagers may even be tolerant of the physician's work. Ultimately, though, the villager knows that the doctor, or nurse has come to give a lecture, and that when he finishes he will go home to the government to collect his salary.

The villagers must have tangible evidence of our concern. In the past, the do-gooders have come; they are used to this. The do-gooders of the past, though, demonstrated very little respect for their culture. There was no understanding of the villagers experienced "truths." To

deal with health problems is to be sensitive. The poor assume a different body of knowledge. They rely on observation. Villagers use their eyes and their ears, much more than we do; we are preoccupied with books. If we want to really do something for these people, then we ought to be humble enough to say, "I will go, listen, and learn from them." Respect these people as human beings.

How often have we used groups of villagers as guinea pigs? How many people in Europe and the United States have depended on these people for completion of their doctorates? Villagers have neither forgotten, nor forgiven us. It does not take very long for a keen villager's eye to size you up. He knows if a person is genuinely interested in him. Of course, the villager will ask for many things that are incorrect. He may wish that a house fly be squeezed into a child's sore eye. But, if he senses your concern, he will cooperate.

When we first went into these villages we wanted to do surveys. Of course, we were suspect. We asked about abortion. The villagers denied using abortion techniques. Today I can walk into the same village and they will bring the abortionist to me for conversation. The abortionist will demonstrate her technique and ask for advice or instruction. I can now ask, "Are you sure that the stick is going in the right place? Are you sure that you are boiling it adequately?" The delivery of primary health care, today, is not just pills and injections.

The biggest dog in the manger today happens to be the medical profession. The technology to deal with diseases like polio and tetanus is simple, cheap, and available. We need to disseminate this information to the people. We, doctors, though, say that this knowledge must go to us. We will sit and expect the people to come to us. We build little hospitals, and we believe that a man, living five hundred miles away, will come to our doorstep to receive our care. It is quite possible, however, to simplify this knowledge and to train the local people in its application. Our own experience suggests that it is possible to make local people responsible decision-makers. Villagers prefer fellow village health workers, despite their illiteracy. There is tangible evidence that these health workers do impact, positively, on health care delivery.

In one area in India, properly trained midwives reduced infant mortality from 200 per 100 live births to 40 per 1000. No obstetricians or pediatricians were required, and there has been no maternal mortality in the past two years. Diarrheal related deaths have declined in children under five. These women have been able to identify and treat diarrhea quickly. We have not needed fluid or broad spectrum antibiotics. Only sulfur tablets have been dispensed.

Primary health care can achieve tangible results, if only we, in the medical profession, will let go. The villagers are smart. Somebody asked me, "Can the village

people weigh a child?" I said, "These villagers are used to weighing gold. Do you think they will make a mistake in weighing a child?" These people possess enormous potential. Let us not be too protective. Help these people to gain the right kind of knowledge. Believe in them. There is no difference between my gristle and their gristle! It just so happens that we have different proportions.

I want to bring you a message of hope. Primary health care can be a reality, if we, medical professionals, will allow it to happen. I started with the government. When I talk to the government bureaucrats, I remind them that we have had one independence movement from the British; now we need a second declaration to free us from the bureaucrats. Therefore, when you work in the developing countries the biggest problem is not going to be the people, but rather the government bureaucrats and the medical profession. The success of your work will depend on how diplomatically, and how properly, you can deal with these two breeds.

THE ROLE OF THE PRIVATE SECTOR
IN PRIMARY HEALTH CARE

STIMULATING COMMUNITY RESPONSE

Abraham Joseph, M.D.

There is no doubt that the voluntary organizations have a leading role to play in expanding the concept of primary health care throughout the world. I think we, at Vellore, are very fortunate, because we have made the transition from curative services to primary health care. I hope to share some of our experiences with you, and to identify the processes through which the programs have been implemented.

Vellore Medical College was started by an American missionary, Dr. I. Carter. It has grown from a one room dispensary into one of the leading medical institutions in Southeast Asia. It also trains undergraduate, postgraduate, medical, nursing, and paramedical students. Comprehensive health care programs were offered both within the hospitals and to the surrounding urban and rural areas. However, despite these highly specialized curative services, the communities' health status remained unchanged. An early review revealed that the causes of sickness could not be limited to a single agent. Any definition of cause had to include biological, environmental, social, economic and cultural factors. In the early 1970s, the emphasis was shifted to a primary health care program, with a focus on community participation. The concept of community participation was alien to those who had been receiving free health services for years. Our problem was making the community aware of their potential resources, as well as each individual's role in improving his or her own welfare.

Health Workers Program. Until recently, health care at the village level was handled by a public health nurse. This had its advantages and disadvantages. There was rapid staff turnover and nurses were not consistently available to the community. There was also a lack of communication between the health team and the community. It was felt that some of these disadvantages could be overcome if community health workers were incorporated into the system.

The health workers program has encouraged active community participation. Every village program has a health committee which selects the health worker. This committee is also responsible for paying part of the health worker's salary and for supervising the work. The program provides for the training of only ten workers per year. More will be trained once the program is improved.

Community Development and Cooperation With Other Sectors: The Alma-Ata Conference has stressed the importance of integrating health with other development activities. The health sector alone cannot guarantee health

status. We must think in terms of total development. This is possible if the health team will work in close collaboration with other sectors.

In Vellore, we encouraged cooperation with other development agencies, especially the government agriculture, animal husbandry and social welfare departments. Our principal objective is to respond to community requests for improved income. As a result, cottage industries have grown rapidly in the last several years. Women in India, as in other developing countries, have few options for employment. The economic role of women is often neglected. We established women as income producers by setting up craft centers. Community participation was insured from the very beginning.

We now have seven centers making a variety of handicrafts. The women working in these centers contribute to a health insurance scheme. This insurance guarantees that the health of the whole family is cared for. Lack of proper marketing facilities has, unfortunately, hindered the expansion of these programs to other villages.

Our input in the field of agriculture is minimal. Loans are offered to small farmers who cannot afford to install electric pumps and irrigation wells. Farmers clubs have been organized in some villages to provide training programs for younger community members. We did not have the technical know-how to develop such programs so we invited the Agriculture Department to send in a team.

We help the chronically ill and handicapped villagers through sheep farming. At the end of the first year the beneficiaries are required to return half of their lambs. The National Bank is interested in the welfare of the handicapped, and our close contacts with the community enabled us to assist the Bank in the selection of deserving candidates. As a result, many families are now benefiting from this program.

The programs just discussed have helped to expand alternatives for income generation. Our objective is to help the community mobilize its resources and achieve its potential. We incorporated all groups--children, youth, women and men.

Hopefully, I have described ways through which the activist can stimulate social and economic change. In doing so, we fulfill yet another of the recommendations of the Alma-Ata Conference; namely, the intersectoral approach to primary health care. You may have already gathered that we work closely with the agriculture, animal husbandry, and social welfare departments of the government, not to mention the banks. We serve as catalysts for others and provide necessary manpower. Villagers can assume many of the positions required, but Vellore supervises and guides the personnel operating programs.

It is vital that the health system adequately support the primary health care program. We have been fortunate in creating strong links between the community health worker, the base hospital, and the referral hospital. The health worker is supervised by the public health nurse and social workers. Patients who cannot be tended at the village level report to the base hospital. Those patients needing more specialized care are transferred to the referral hospital.

The role of such specialized referral centers has come under severe criticism. It has also been suggested that voluntary organizations should not invest in such centers. I favor such investments. We, in the Community Health Department, have been able to achieve what we have because of the referral hospital. The community's perception of our competence has increased markedly because of our link with the larger hospital.

Training of Health Personnel. The Alma-Ata Conference further recommended that health personnel be trained in (or motivated toward) community service. The responsibility for structuring such programs rests with the medical institutions. We have made major curriculum changes. Students must excel not only in clinical diagnosis, but also community diagnosis. The doctors of tomorrow need to be able to participate effectively as members of a health team. Field practice is a necessity.

Major changes had to be made in the education programs at Vellore in order to accomplish these goals. In the first year of training, the students live in the village for three weeks. During this live-in experience they come face to face with the realities of rural life. They see firsthand the influence of social, economic and cultural factors on health.

Interaction with the village continues every year. Clinical skills are applied during each visit. The training students receive in the hospital pays off well in the community. Even though many volunteer organizations do not have facilities to train doctors and nurses, it should be possible for them to train community workers and health auxiliaries. At Vellore, we are fortunate that all health personnel can be trained in one institution. However, we do emphasize that training programs be implemented at the student's eventual place of work.

Our position as a private voluntary organization has allowed us to make innovations in primary health care delivery that would not otherwise have been possible under government sponsorship. Change has come slowly; it has been a gradual process. We, as voluntary organizations, have the ability to try out new things. This does not necessarily mean that we will achieve all of our objectives. Much still lies ahead. However, with the right attitude, we can hope to move ahead toward a better tomorrow.

THE ROLE OF THE PRIVATE SECTOR IN PRIMARY HEALTH CARE

FIELDING PILOT PROJECTS

J. Raymond Knighton

It would be superfluous for us to again seek yet another definition of primary health care. Rather, I am going to outline some of MAP's philosophy of health care programming. We, in MAP, agree that primary health care, per se, is the government's responsibility. We, as voluntary agencies, exist to be part of the health care delivery system within a given country. PVOs have a responsibility to demonstrate to the host government what can be accomplished in health care. In other words, to develop a pilot project and to analyze its potential for replication.

Governments have a hard time with broad programming. As PVOs, I think we can set up very small controllable projects that make such programming possible. MAP is doing this in the southern region of Sudan and in Bangladesh. PVOs also can train various types of primary health care workers for government programs. Furthermore, PVOs can undertake to educate the various community members.

One of the hardest jobs we find in the establishment of primary health care programs is educating the professional community. This is our number one difficulty. The curative trained national is probably the hardest individual to convince that there are alternatives to meeting health care needs. There are a few who have had the conversion experience, but not many. Surgeons are the easiest to convert. They get frustrated. Seriously, surgeons do very well in primary health care delivery services.

There is, in addition to education, the whole matter of creating training materials. This, too, can be done in a small project way. We found in Sudan there was nothing being done to train village midwives. The government just had not seen the potential.

We also find that, as PVOs, we are able to construct facilities for the government. In Sudan, MAP has a standard architectural design for a community health center. We just keep making duplicates in those places where the government requests us to build.

One of the easiest things PVOs can do is to provide the referral center for a primary health care system. This is not as easy as it might seem, because, again, there is a great deal of biased education in favor of the hospital or the major dispensary.

PVOs can further serve by augmenting the primary health care center with some special areas of concern, such as maternal and child health, tuberculosis, or leprosy. Finally, PVOs have a great responsibility to integrate health care with other developmental aspects of a community. All

are part of health. We, at MAP, find that it is impossible to go into a community and not become involved in nutrition, agriculture, water, and waste disposal. Then we get into education, particularly primary education for adults.

I want to conclude with a warning. PVOs include other than western based organizations. It is encouraging to note the number of very fine private and voluntary indigenous health care agencies. We should not duplicate such agency programs, but move in along side and say, "How can we help?" We need to help strengthen the local private and voluntary organizations, as they are the ones who are best equipped to carry out the primary health care functions so desperately needed.

III. FUNDING PVOs FOR
PRIMARY HEALTH CARE

FUNDING PVOs FOR PRIMARY HEALTH CARE

AN AID PERSPECTIVE

Thomas Fox

I have only been with the Agency for International Development (AID) for about six months. I do not consider myself to be an expert in international health, but I do know a great deal about the funding requirements of private and voluntary organizations. Therefore I will focus my remarks on the funding mechanisms available to PVOs.

AID has a partnership program with private and voluntary organizations. About one-tenth of AID's development assistance budget goes to private and voluntary organizations; they are a very significant component of our foreign aid program. Support has increased steadily over the last several years and it is projected to increase further in the next five or six years.

The origin of AID's renewed relationship with private and voluntary organizations dates back to 1973. At that time foreign assistance legislation was dramatically altered to reflect the United States' growing concern for the poorest of the developing countries. It was Congress' belief that our 1960s development assistance programs were not directly addressing the problems of low income people. These programs stopped short of significant alleviation. New Directions legislation, therefore, is the stimulus behind AID's vigorous support for private and voluntary organizations.

Prior to 1973, the relationship between AID and the PVOs had concentrated on Food for Peace programs, disaster relief, other sorts of relief programs, and a few grants. Grants were usually confined to population projects.

Private and voluntary organizations have a unique ability to reach the low income people in developing countries. PVOs have a humanitarian orientation; their concern for equity and for social justice leads them, philosophically, to insist that their resources reach the poorest of the poor. Furthermore, PVOs are not constrained by traditional government decision-making apparatus. Consequently, they are freer to work directly with community organizations and to effect change at a grass roots level. Freedom is what allows PVOs to be innovative in their work.

There continues to be within AID, and, indeed, within the PVO community, itself, some question as to whether or not PVO programs are actually the best way to access the poor. Evaluation data, carefully gathered by both the PVOs and by AID, have not proven that PVO programs are necessarily more successful in reaching low income people than are the larger bilateral or multilateral programs. However, I have indicated that AID's financial commitment to private and voluntary organizations is increasing.

In Fiscal Year 1978, \$141 million was given in grants and contracts. We project that about \$175 million will be authorized in Fiscal Year 1980. AID has increased its funding commitments steadily since 1970, with the most dramatic increases occurring in 1974 and 1975.

AID, basically, has two different mechanisms for the transfer of money to private and voluntary organizations. Both are governed principally, but not exclusively, by grant relationships. First, AID develops a program or an idea and awards a grant to a PVO to carry it out. Or, AID chooses to support a program that originates within the PVOs programming system, assuming, of course, that the private and voluntary organizations' program is compatible with AID's basic orientation.

There is a subtle distinction between an AID-originated program and an AID-supported program. Some tension, naturally, exists between AID and PVOs. Most PVOs prefer funding for the latter type of program.

AID's health priorities are in four areas: (1) tropical diseases; (2) health planning; (3) health services, especially environmental health, water and sanitation, and (4) low cost health delivery systems. PVOs are presumed to be most effective in promoting low cost health delivery systems and in mobilizing community efforts. PVOs are less likely to participate in the provision of sophisticated technology, that is large scale doctor programs or tropical disease research. The latter is an assumption, and not entirely substantiated by AID funding priorities. Nonetheless, it is a valid generalization.

Most of the current AID-supported PVO programs consist of low cost health delivery systems, water and sanitation projects, and nutrition and health education programs. There are a number of methods whereby a PVO could approach AID for funding. AID is continually seeking, on a competitive basis, contractors to carry out AID designed programs. The programs are advertised in the Commerce Business Daily. Requests for proposals (RFP) are circulated for bid every day. Private and voluntary organizations are free to bid on these requests for proposals, but few PVOs do. Most prefer to work with grants; some PVOs do not know that they qualify to work on a contract basis.

The second and most common funding method is operational program grants (OPGs). These grants are both project- and country-specific. They are awarded by AID mission directors in the field. AID mission directors can authorize grants up to \$500,000. OPGs minimize the time delays so characteristic of AID/Washington and are usually operational for three years or less. AID will finance up to 75 percent of the total program costs. The remaining 25 percent must come from other sources. Revenues may be provided from an in-country source, the PVOs own budget, foundations or corporations. There is no question, however, that the 25 percent balance is the responsibility of the PVO.

There is a wide range of programs available through the AID field missions. Included are water, sanitation and community health planning projects, well-digging programs, and nutrition and health education programs. To qualify for a grant, an organization needs a defined program, consistent with AID's priorities; a demonstrated ability to plan, administer and evaluate programs, and to register for and receive AID/PVO status.

Registration is a relatively simple, albeit time-consuming process. Information is required as to fiscal management capability, funding sources, governance structure, bylaws, and the activities of the Board of Directors. It is generally an objective series of documents that are exchanged; if accepted as a PVO, then the organization is eligible for OPGs and other grants.

Additional AID grants are available from Washington through the four regional bureaus, as well as the Development Support Bureau. The Offices of Health, Nutrition, and Population are particularly relevant to PVO interests. Finally, monies are available from the Office of Private and Voluntary Cooperation within the Bureau of Private and Development Cooperation. To date, no centrally funded grant has been authorized solely for health. Nonetheless, there are two possibilities for receiving centrally funded grants. First, there is the matching grant program. Matching grants are the newest category of AID/PVO funding. Only five such grants have been awarded thus far. However, the program has only been in operation for about a year, and it is expected that two grants for health-related projects will be authorized this fiscal year.

AID will pay no more than 50 percent of the total project costs under the matching grant program. This program is designed to assist those PVOs who are obviously capable of developing, implementing, and evaluating local projects. AID offers a relationship whereby the PVO is virtually free from AID oversight and management inquiry--as long as the PVO has demonstrated administrative and financial responsibilities.

The matching grants go to a somewhat elite corps of organizations. However, once the award is made, there is no question that an organization operates more freely than do other AID grantees. The approval process is more rigorous than other review processes. We are essentially judging the competence of a total organization; not simply a specific project. As I have indicated, though, once approval has been awarded, the PVO is free to manage the project as it sees fit.

AID has spent large sums of money in the last four to six years to help organizations to improve their design capabilities. As evaluation and implementation skills increase, so does organizational competence. If certain skill levels are achieved, then competency is assumed and PVOs are permitted to proceed freely. There is no question

that matching grant programs, that is centrally funded grants, are the wave of the future. Matching grants are clearly preferable to the institutional development grants of the mid-1970s.

Institutional development grants focus primarily on organizational capabilities. The grant is specifically designed to enhance an organization's ability to both evaluate and implement health programs. These grants are very rare, and Congress feels them to have little demonstrated value. Some exceptions could be made, but as yet, the criteria remains vague.

Exceptions could be justified if one of two conditions exist. First, the organization has a program that is unique. Unique, in this case, suggests either technical expertise not found elsewhere or demonstrated administrative experience. Finally, a development grant could be authorized if a PVO can prove that AID support would be time limited. A PVO must present irrefutable proof of private sector contributions to their program, thus confirming the program's financial viability after the first or second year. I do not encourage anyone to pursue this option; it is a long, tedious process. Matching grants, OPGs, and contracts are the most likely sources of AID support for PVO programs in health.

FUNDING PVOs FOR PRIMARY HEALTH CARE

MANAGEMENT'S ROLE

Michael Washburn

I have been both a staff member of and a consultant to many private voluntary organizations. My experience with these PVOs indicates that they are organizationally, not financially, poor. There are funds available for health projects, and there are donors willing to authorize the necessary expenditures. Unfortunately, though, not too many PVOs have the salesmanship to secure such funds.

Some organizations are more effective than others in tapping available resources. These PVOs are well organized, have strong internal controls, and a diversified financial base. In addition, these groups offer a clearly directed marketing strategy. The most common problems that PVOs encounter are as follows: (1) poor salesmanship; (2) lack of financial planning; (3) improper budgetary procedures, and (4) inadequate support staff.

In many cases, an organization's Board of Directors is made up of either academic or health professionals. These individuals do not, themselves, have the financial resources necessary to sustain the organization. Most Directors have limited contact with sources; that is, corporations, foundations or government, and are therefore reluctant to initiate requests. Often such professionals do not know the scope of the organization's work, and consequently, are unable to sell it to others. Individual Board members may have specific programmatic concerns of their own, but these concerns are more related to their professional life than to organization sponsored activities. While these individuals may be excellent technical advisers, they are not always the best fund-raisers.

Second, many executive officers are too busy to concentrate their efforts on fund-raising. Either the organization has not adequately designated fund-raising responsibilities, or the designate lacks sufficient interest in fund-raising, per se. Most officers relate to administration or program planning; fund-raising is alien to their daily routine.

A third problem is that too few organizations have diversified their funding base. Hence, these organizations become overly reliant on a single funding source. Thus, these groups are vulnerable to fluctuations in funding patterns. If, for example, the stock market declines or government policy shifts, then whole programs can be jeopardized. Multiple funding sources assure maximum flexibility.

Fourth, and perhaps most important, is an adequate cash flow. Without a proper accounting system and frequent cash-flow analyses, organizations risk financial shortfalls.

Fund-raising, in these situations, becomes governed by crisis management. Fund-raising must be accomplished in the context of long-range financial planning. Otherwise, it is nothing more than a "thumb in the dike."

Budgetary procedures must be learned by all organizations. Budgets serve a control function. They allow management to: (1) determine objectives; (2) take corrective action, and (3) evaluate management's performance. Most PVOs do not know how to properly compute project costs. If costs are underestimated, then PVOs are forced either to seek additional funding from the granting agency--which is frowned upon--or redirect monies from other projects in order to keep existing programs alive. Once an institution's financial integrity becomes impaired, many donors will shy away from authorizing grant monies, even if the project itself appears sound. A detailed accounting system, including administrative and accounting controls, is vital to fund-raising.

A fifth area of concern focuses on the support staff itself. In addition to a disinterested or overworked staff director, organizations need adequate backup personnel to assist in the orchestration of fund-raising efforts. Who, for example, will do the research or prepare a card file on Board connections with foundation or corporation executives and staff? Staffs should be able to spend time in foundation libraries investigating federal tax returns or reviewing annual reports.

Proposal writing requires a certain expertise. Non-technical personnel may produce vaguely worded scopes of work. At the same time, though, non-technical staff may be more attuned to the donor's specific interests and jargon. Consequently, the non-technical writer may be able to present a more persuasive case; he can address the issues based on a perceived level of understanding.

Many program staff do not understand their role in fund-raising. The organization is probably not set up to interpret data from the field, let alone determine project needs. Field accomplishments must be documented. The human element is what sells and such details can make a proposal much more persuasive.

Program staff must be held accountable for detailed financial planning, particularly short-term project costs. Staff experience should contribute to the development of new ideas and future priorities. Program and funding staff should not remain separate. Communication is critical. From time to time a fund-raiser will call a program officer and request a written proposal. Unless the purpose is specifically understood, the proposal will likely be created in a vacuum and possess limited potential for funding.

If communication does bog down and programs are created independently of each other, then staff competition will likely result. Such competition could lead to subtle staff

plays or arbitrary funding decisions. Morale problems will develop and program staff would refuse to participate in fund-raising.

Finally, organizations can attempt to undertake too much activity and lose their sense of purpose. An organization's uniqueness may be determined on the basis of technical competence in a given field, geographical preference or technological innovation. Very often, though, this uniqueness becomes obscured. Public relations efforts may not always highlight organizational strengths and promotional activities may dilute their impact in order to achieve mass appeal. This process can actually lead to a decline in revenue because the organization no longer stands above the competition; its leverage is lost. It is far more effective to target in on a few well-chosen funding sources than to write a proposal that will imply all things to all people. This selective criteria suggests that program staff will begin to demand a more effective corporate structure, as well as integrated fund-raising strategies.

Assess your organization internally. Ask questions. "Is this the kind of Board that can do fund raising? Are there any potential donors who sit on the Board? Do the Board and the staff work together on fund-raising projects? Do Board members accompany staff when making presentations? How often do the Board members go to meetings? Are individual Board members available for interviews with the press? Does the Board have a working knowledge of the organization's structure and purpose?" If the answer to these questions is no, then it is time to change the Board. Get new people on the Board who can afford to be more directly involved in fund-raising efforts.

Change can be traumatic. Change is difficult for any organization. Do not permit crises to dictate the course of events. Insist on reform now. Study the organizational structure and demand an effective accounting system; you can be certain that donors will.

The staff knows whether or not the organization is constantly running over budget. Do programs incur cost overruns? What is the organization's cash flow? Are there cash reserves? All are indicators of inadequate financial planning and can be turned around.

Most organizations are not willing to risk short-term cutbacks for long-term financial gains. It is feared that projects will suffer as a result. Too many organizations are unwilling to take the typical business approach, that is, to make capital investments in order to get the longer term payout. Non-profit organizations are reluctant to commit to such investments because of their lack of funds. However, unless one experiences a few lean years and commits to an investment strategy, the cycle of crisis management will never be broken and fund-raising will forever remain ad-hoc.

Every program officer ought to know what funding levels are required for the duration of their programs, and whether or not they will be expected to assist in the solicitation of those funds. Program staff should be made aware of informational requirements and, who, within the organization, will be responsible for utilizing the data.

Staff members should participate in the fund-raising process; writing a project proposal is very different from presenting an academic paper. The writing style is reduced to almost a journalistic level. Obviously, some theory has to be abstracted and applied. Detail is essential, but most funding agencies will have a limited understanding of it.

Dramatize the human element. Identify the target group and explain how these people will be benefited. Be aware of the uniqueness of the program's approach to solving a particular health problem and market it. Make a special claim on funding.

It is often helpful to bring in an outsider to assist in the internal review of an organization; someone who can help to focus on financial issues. It is often difficult, when you have been working long hours on the brink of financial disaster, to separate out which of the problems are the most pressing. The New Transcentury Foundation, under contract from AID, is available to provide technical assistance to organizations; they will evaluate Board development, Board-staff relations, staff structure, communications, and financial planning. New Transcentury has sponsored a number of workshops and conducted numerous individual consultations. For additional information as to the range of services available, contact Ms. Brenda Eddy, New Transcentury, Washington, D.C.

Management consultant organizations, like Kinsey and Company or Booz-Allen and Hamilton, do not have an in-depth understanding of non-profit organizations and may not be as effective in offering advice. However, a corporate approach could prove beneficial in assessing financial management. Those who concentrate only on fund-raising for non-profit organizations often lack management expertise. If outside assistance is sought, then look for those organizations with combined expertise in finance, management and program design. Do not hesitate to look for help.

FUNDING PVOs FOR PRIMARY HEALTH CARE

COMMENTARY

Patrick Kennedy

It is often said that only two things in life are certain: death and taxes. My association with the foundation community suggests one other certainty. No two foundations are alike. We are talking about a universe of almost 26,000 entities.

If foundations, themselves, are hard to get a handle on, the corporate grant makers are even more difficult. The Council on Foundations is in the process of researching multi-national contributions to health; but as yet, we have not been able to identify their scope of interest. At present, one must rely on annual reports. These reports, though, must be read very carefully as corporations tend to skip a line, a sentence, or a paragraph when it comes to reporting their grant-making activities.

**IV. PERSONNEL FOR PRIMARY HEALTH CARE:
RECRUITING, TRAINING, AND RETAINING**

PERSONNEL FOR PRIMARY HEALTH CARE:
RECRUITING, TRAINING, AND RETAINING

SELF-RELIANCE

Edward J. Ragan, M.D., M.P.H.

I was recruited by CARE in 1966 to work with CARE medical staff in Malaysia. I then left CARE to join the Canadian University Service Overseas (CUSO). We, at CUSO, have come to realize that recruitment has little to do with the survival of the organization; rather it relates to the tasks at hand. If our objective is to do what needs to be done, jobwise, then fund-raising and the public image necessarily take second place. However, if job satisfaction is achieved, our image will naturally emerge with a heightened vitality and programs will logically become bigger and more energized.

While CUSO, obviously, is concerned with the recruitment and selection of health workers, it is not particularly worried about retaining them within the organization. CUSO only emphasizes two-year contracts. Beyond that individuals are on their own. CUSO does seek a commitment from its recruits, but it is to a concept--international development; not to an organizational structure.

CUSO's recruitment process is primarily concerned with: (1) self-preparation; (2) continued education, and (3) responsibility. We, at CUSO, shy away from paternalism. CUSO seeks people who are self-reliant and able to look after themselves. Our method of recruitment is unique. CUSO has 75 committees throughout Canada that support the recruitment function. Local committees are responsible for initial recruitment. This is in addition to fund-raising and public education.

The educational component can sometimes work against the recruitment process. Often, public information decries Canadian development assistance overseas; it speaks to how we, as Canadians, contribute to mal-development. Such adverse publicity defeats our purpose. Some of the contradictions are directly related to CUSO's operational mandate. CUSO is a private, non-governmental organization, similar to the Peace Corps. Partial funding comes from the Canadian International Development Agency (CIDA). While 85 percent of CUSO's Canadian budget is authorized by the Canadian government, 50 percent of its total operating budget is provided by the developing countries. Hence, its partial autonomy.

CUSO volunteers are requested by host country personnel to work in already established job positions. Individual salaries are paid by the host, not CUSO. At present, CUSO has 60 health personnel, including doctors, nurses, lab technicians, nutritionists and dentists working in 40 developing countries. Forty more are expected to be placed between 1979 and 1981.

Recruitment for overseas positions begins at the local level. These committees conduct the initial interviews and, if additional screening is required, can seek advice from a health specialist in CUSO's Ottawa office. Job positions are advertised in local newspapers and professional journals.

There are several types of positions available, and the descriptions vary accordingly. Rarely does the description depict the fact. Job descriptions change with time. Consequently, CUSO speaks of job approximations.

Anyone who applies for an overseas position is expected to know something of development theory. Applicants must also know something of the area's living conditions. It is for this reason that the local committees sponsor educational programs to inform recruits of their anticipated responsibilities. Former overseas employees are invited to meet with the candidates and assist in their acclimation. If the candidates complete the instruction and still remain interested in a position, then the final selection process begins. This process includes requests for a detailed biography, personal and professional references, and a final statement of job skills.

The interview panel includes persons with overseas experience and professional skills similar to those of the applicant. The interview lasts for approximately one hour, and several development issues are explored. Interviewers seek mainly those persons with initiative, self-reliance, sensitivity, and appropriate skill levels. Personally, I look for common sense. There is no point considering a candidate who cannot relate to different cultural values.

The selection committee issues a statement of recommendation or non-recommendation. The candidate's evaluation is then scaled and the report is forwarded to Ottawa for further review.

Ottawa can seek additional information and often does so telephonically. The candidates are then matched with available openings. If a candidate appears suitable, his folder is sent to the country field-staff officer for a final opinion.

The field staff-officer is obligated to share the dossier with either the economic planning commission or the employer. CUSO prefers that the officer go directly to the employer. The candidate is notified once he or she has been determined mutually acceptable.

Final approval usually comes by telegram. Once Ottawa has received confirmation of the appointment, the candidate is notified and told to prepare for departure. Training begins with a pre-orientation workshop. This workshop is offered by the local committee and is very general in scope. A physician, for example, may be reminded of certain obstetrical procedures or briefed on tropical diseases. The

recruit is also given a bibliography, including materials on tropical medicine, maternal and child health, primary health care and nutrition.

The orientation program is continued in Ottawa. The course lasts about seven days, and the information is both site and skill specific. Primary health care is stressed, as are health delivery systems. Finally, CUSO begins its technology transfer training. Many physicians, nurses, lab technicians or the like, have never functioned as teachers. These individuals must be able to communicate their skills and witness their application at the local level.

Final training is offered en route. CUSO has a cooperative program available through the London Child Health Center. This program is under the direction of Dr. David Morley and provides individuals with the opportunity to seek specific courses of instruction.

Once the recruits are in-country, the CUSO field staff completes the employees' training. This orientation includes cultural considerations, politics and economics, and introduction to host country nationals. The training program sounds rather arduous, but that is because CUSO strives to identify those individuals who can work effectively in cross-cultural settings. CUSO is not concerned with promoting self-awareness. Such awareness will come with exposure.

CUSO employees must be self-starters. We offer very little logistical support, a bare minimum of material and no hand holding. At most, a health worker will be given a few thousand dollars to spend on health education.

At the conclusion of the two-year assignment, the employees are returned to Canada, and asked to remain in touch with the local committees. There are no formal job commitments, but it is hoped that these individuals will be available to consult with new applicants. CUSO also provides some assistance for job relocation, but mostly in the form of introductions to organizations like the International Development Research Center (IDRC), the Canadian International Development Agency (CIDA), or the World Bank.

Some former employees opt to work in Canada's developing areas, such as Northern Canada, but again, we do not promote retention. We support philosophical retention--to an ideology of equitable distribution. The bodies can move on; CUSO has too many staff members as it is. What we retain is a continuing commitment to the process of socio-economic development.

PERSONNEL FOR PRIMARY HEALTH CARE:
RECRUITING, TRAINING, AND RETAINING

A COMMUNITY AWARENESS STRATEGY

Phyllis Dobyms

I would like to begin with a quote from Ghandi: "All people in developing nations are always lost; the least, the lowest and the last." Save the Children recognizes the validity of Ghandi's remark, but we also believe that the poor hold within themselves the key to their own progress and advancement. This confidence is related to the agency's philosophy that development is the process of people taking charge of their own lives and that physically, socially, and economically deprived human beings are able to meet self-defined needs in a dignified fashion through their own efforts. Save the Children further realizes that growth and development of children, our primary purpose, is impossible when children are treated in isolation from their community.

Over the past five or ten years, Save the Children has shifted its focus from children directly to the community. This change is based on the belief that all development problems are cross-disciplinary and that the development process itself is a tangled web of inter- and under-related problems. These philosophical assumptions provide the underpinnings for a wide variety of programmatic activities. Our programs are designed to help local people develop the confidence and skills needed to tackle the problems they wish to confront within their own cultural context. Save the Children has field staffs in various countries who work closely with community members to plan, implement, and evaluate projects which will enable villagers to respond to locally established priorities. This process trains villagers to identify the linkages between developmental problems and to plan inter-related solutions.

People are the motor force propelling all change. The agency accordingly emphasizes human resource development. Save the Children has a methodology that it uses in those eighteen countries where it is working. Domestically, Save the Children has worked with American Indians, in Appalachia, the rural South, and inner cities. In almost all of these instances, we begin by organizing a village community committee; we begin at the grass roots. Once a community has been chosen, it is asked to select a representative community committee which includes both the rich and poor, men and women, young and old.

A field staff person, in this context, is called a field coordinator. Sometimes a team of people is required. It could be a field coordinator, a social development coordinator, agricultural or health specialists. All operate at the village level. In all instances we endeavor to hire local nationals, but occasionally an expatriate is sought to fill the country director's post.

Health and nutrition projects are offered in the context of integrated rural development programs. Save the Children tries to have, within the village development committee, a subcommittee on health. This subcommittee works together with country experts to describe their problems. These experts also help the committee decide what kinds of solutions they want, as well as the identification and selection of village health workers. Finally, the experts who remain at the village level supervise and work with village health workers. Save the Children's programs link with government health services at both the national and local levels, or wherever we can find government health services.

Although Save the Children can hire technical experts, it is the community that will identify change agents. Let me illustrate. A few years ago in Laos, an American drilling company drove a number of good wells for the benefit of villagers. The villagers were well aware of the advantages of having a constant source of good water and were quite happy to abandon their old water holes. However, three quarters of the wells were out of commission within two years. The villagers were unhappy about this but they did not know how to repair the pumps. The required repairs were not difficult, but some instruction was necessary to keep them active.

The well drillers had ignored the problem of maintenance, as well as that of the villagers' limited technical competence. Drillers worked with the headmen of each village, but these people had only limited influence and assumed very little responsibility for the wells.

In contrast, the wells drilled in Buddhist temple grounds were maintained and in good repair. Even the area around the wells had been kept clean and orderly. The Buddhist monks had the villagers' respect and were, thus, better able to recognize competent villagers than were the secular headmen. If all the wells had been put in the temple grounds, then there might have been fewer maintenance problems. A respectful attitude toward Buddhist monks, plus a willingness to cooperate with them, is traditional in most Southeast Asian countries. This knowledge, combined with technical improvement, could have spelled success. Technical improvement alone proved a failure.

Our community awareness strategy mandates that local people select their own change agents, or those persons who will assume the responsibility for change. Second, local villagers need to participate in both project design and implementation. Third, projects need to be grounded in the local culture.

Save the Children and the village community committee look at health problems together. We use a series of open-ended stories and visual aids in order to ascertain community beliefs about what is happening with regard to both child health and nutrition. Frequently this requires

walking around the village or holding community meetings in which women will participate. We need to assess the health and nutritional status of children in the area. However, by involving the villagers we are frequently able to communicate beyond just these two sectors. We look for answers that will take us beyond the stock reply; that kids die or there is no food.

Our strategy includes villagers from the beginning. We must have an initial commitment to both the project and the program; it has to become their program, because Save the Children is not going to have personnel in the village indefinitely. Unless we promote the participatory approach, the project will collapse as soon as we leave the village -- just as the well drillers left their village.

The community should select the village health workers. Unfortunately, the WHO guidelines produce a "wagging the dog" mentality. Too often, the training curriculum and materials that are available to village personnel require someone who is literate. Immediately, the tail is leading the dog. We try to find the person who can read and write and they may not be the most appropriate personnel.

Obviously the community must understand the nature of the job and the requisite skills required. Very frequently we find that villagers do not have a midwife or traditional health healer. We must find out whom they do use. In Honduras, we found that villagers relied on a non-professional who healed animals. Villagers assumed that he had a health interest and would be receptive to health training.

Preferably, we like to use people who are already part of the traditional health network. We avoid creating competitive situations; villagers should not be forced to choose between western-oriented health care and traditional cures. It is better to create practical western solutions in conjunction with traditional beliefs than to refute them. In Latin America, local people believe that a large number of diseases are related to hot and cold. Other diseases are thought to be related to contagions in bad air or odors. We consider these to be magical causes; similar to our evil eye, ghost fright, or evil spirits. However irrational the belief, it must be considered in any developing health strategy.

Certainly, training should be appropriate in terms of village health workers' experiential background, social and cultural contacts, and literacy level. If you rely on existing materials, then you quickly become hampered. Unless you are willing to put in your own time and effort to train village health workers, you will necessarily be limited to choosing literate people, and that may force a wrong turn in health care delivery.

To retain health care providers, we recommend the following:

1. Minimize job frustration.
2. Provide supervision and select supervisors with care.
3. Specify relationships and define the support structure.
4. Emphasize preventive care.
5. Maximize self-actualization.
6. Facilitate worker exchanges.

Obvious job-related frustrations should be identified and minimized. This assumes, of course, that you have the right personnel to begin with. Typical job-related frustrations include insufficient supplies, inadequate access to transportation, limited supervision, minimum community cooperation, and improper primary health care training. We have found that if workers are not given the necessary skills, then they lose credibility in the community. This is regardless of whether or not we are talking diagnostics or referral.

Preventive health care must be emphasized, including promotional materials. What kind of materials does the health worker need to promote community involvement, to help them recognize health problems, and to convince the community these problems can be solved? Creating solutions is a big stumbling block in the health field. Most villagers will say they need a clinic and a doctor. Rather than looking toward the end, villagers will rely on the means. A clinic is only one means for achieving improved health status. Immunization programs or maternal child health care, at some basic level, may prove to be more effective. Then the clinic that is two hours away might seem close enough. If the community can work through these steps, then there may be fewer buildings standing idle in rural areas.

Each village health worker should be taught to appreciate his or her own value and health workers should recognize that they are, indeed, health experts and skilled in the needs of their particular community. The health workers' views should be sought, and they should be given the maximum opportunity to exercise their creativity in organizing community campaigns with local leaders. In Indonesia we are currently running a series of three workshops. Each workshop runs a couple of weeks. We bring in province level community workers. These are all people from the village and clinic level. One individual may be a clinic health educator; another a clinic nurse volunteer. We work together to develop materials. Each will go home with a package of materials that he can use to promote village cohesiveness in health education. The workers may develop as many as 12 different approaches.

Supervisors should be chosen with care. They should not be people who will now look down on the village health workers because they are non-professionals. Instead, supervisors must demonstrate respect for the village health workers' skill and commitment. Supervisors must be trained to be effective back stops and to provide in-service support. PVOs should offer such training. This is an area that is extremely lacking right now.

Supervisors need to know more than the worker's immediate scope of work, disease incidence, and learning requirements. They must also be aware of their own personal and technical profile. A supervisor may be the hospital doctor or clinic nurse; whoever it is must be prepared to visit the village and observe technical accuracy. Supervisors must possess motivational skills in order to convince communities that Western-trained physicians are not the only answer to adequate health care delivery. We need good support systems and supervisory training.

Village health workers should not feel threatened by on-site supervision. As supervisors, physicians must learn to function as support personnel. When the physician comes, the village workers must know that they can share their concerns and disease-specific problems. Accurate diagnoses and treatment must be reinforced. Physicians cannot afford to be mystifyingly professional in these situations. Health workers need to feel rewarded.

Opportunities should be provided for village health workers to share their frustrations, problems and successes at monthly meetings. These meetings should promote group solidarity, identification with program objectives, and motivation. Village health workers recognize that their problems are not unique. This program has been extremely helpful in our Bangladesh project.

Village health workers should meet at each other's work sites. Visits by peers are powerful stimulants to those who take pride in accomplishment. Stipends to cover transportation will probably be necessary.

Team approaches should be encouraged. The team might include teachers, religious leaders or the head of the village development committee. It helps the village health worker's status within the community, enhances prestige, and provides local support systems.

Opportunities should be provided for village health workers to gain recognition for their work, both locally and regionally. Recognition ceremonies, certificates, and awards are always popular. Visits by dignitaries are extremely gratifying to individuals.

Selection of the village development committee is also important. These committees put in a lot of

time and work, and should be recognized. Incentives and rewards should again be provided. Generally, these rewards should be non-monetary. PVOs should not overpay doctors and village health workers; we do not want to compete with government services or other programs. We do not "raid" other organizations for personnel, nor do we pay salaries above that which the country pays. However, PVOs can provide incentives, because we do demand more work from them than does government service. Our principal incentive is additional training. I frequently include workers in training courses given in nearby countries or other locations.

Village health workers should be aware of how these programs relate to broader national strategies and priorities. Workers must realize that they are in the vanguard of nation-builders and understand their place in the national primary health care structure. Save the Children's programs do link into the national structure. Although we have never built a hospital, we do have village clinics in areas the government has yet to serve. In many instances, we will provide the personnel. Sometimes this does not work out and we have to provide our own personnel. More frequently, we negotiate a compromise. In Yemen, Save the Children established a pediatrics ward in the local "hospital," provided the government came up with the staff. Save the Children is scheduled to withdraw from the program within five years. Thus, Save the Children has few medical personnel. Rather, we have nutritionists and field workers, but the medical personnel is provided by the government.

Save the Children does practice community participation. Health programs must be community-specific and integrated into the clusters of market towns. Finally, these programs must be integrated into the existing health structure.

PERSONNEL FOR PRIMARY HEALTH CARE: RECRUITING, TRAINING, AND RETAINING

CARE: AN OVERVIEW

Donald Sanders

Years ago it was difficult to find a French-speaking public health specialist who had not only an academic degree, but also field experience and demonstrated language abilities. This is no longer true. Ex-Peace Corps volunteers, for example, have become interested in public health. Many of these volunteers have returned to North America and obtained a degree in public health. The availability of potential employees is definitely on the increase.

Job vacancies are usually advertised. Vacancies can be posted at conferences, announced on radio or solicited through the mail. Applications appear to be self-generating once an opening is known. Recent university graduates, those between jobs, people with field experience but no academic training, or husband and wife teams are the most likely to respond. In the last two years, CARE has received a number of applications from husband and wife teams. These teams present a unique problem to personnel officers -- problems that will be discussed further on.

Recruitment requires job descriptions. CARE requests that job descriptions be written by its overseas personnel; by those most familiar with project requirements. The complete job description includes: (1) the scope of the work; (2) travel requirements; (3) living conditions and medical facilities, and (4) schools.

Job descriptions must be written with flexibility. Projects can change and people sometimes end up too structured. Once overseas, the employees find it uncomfortable if the original scope of work prohibits change. Any good job will be a challenge. Individuals like to set their own objectives and should be allowed to do so. Creativity should be a selling point, not a constraint.

Most references are checked prior to an interview. Certainly the work experience is verified, as is education. Federal government regulations have reduced letters of recommendation to nothing more than confirmations of previous employment. Therefore, CARE recruiters prefer the telephone. That way, the interviewer is more likely to get off-the-cuff answers as to the applicant's ability.

Personal interviews are usually determined on the basis of preliminary telephone conversations. Every organization looks for a certain personality type. A telephone call will often decide initial interest. After all, only so much money is budgeted for interviews.

The budgetary requirements for recruitment vary from organization to organization. Individual salaries, fringe benefits and travel should be stated at the outset.

If these initial terms are mutually agreeable, then a personal interview can be scheduled. Logistically, such action may demand that hotel reservations, travel arrangements, and reimbursements be provided. Hence, some budget provisions must be made for recruitment.

CARE's interview process is a day long affair. A recruit may be interviewed by as many as five people. It is probable that the Director of Medicine and Health Recruitment, the Medical Advisor, the Medical Health Advisor, the regional Program Coordinator, the executive staff representative, and a personnel officer will all wish to personally review a candidate's qualifications. Interview time is limited to 30 or 40 minutes each. If more time is needed, then adjustments can be made later in the day. Recruiters look principally at a candidate's adaptability. Is he or shee flexible enough to acclimate to overseas living? Does the candidate seem to genuinely like people? And, the big question, or course, is, why does the individual want to work for CARE?

CARE does not pay high salaries. Therefore, there has to be some reason why a person would be interested in the job. Some come for the adventure. Some people are escaping a private reality and others are just gung ho. Motivation is a key variable.

After the interviews are completed, each person prepares a one or two paragraph summary of their interview. Recommendations do not have to be unanimous. If two CARE employees reject the applicant, but three vote positively, the recruit may still be hired. The differences are resolved in conference.

It is preferable for final applicants to go to CARE's country office. This is particularly appreciated if the position is a medical or public health assignment. Optimally, CARE should submit the documentation to the host country government or university for approval. Host personnel may reject a CARE nominee, despite the CARE selection process.

CARE does not offer formal training to recruits. Instead, CARE sponsors an orientation program. The program lasts for eight days, but it is not task-specific. The course seeks to present an overview of CARE, including fund-raising, financial planning, procurement, administration and CARE's personnel policies. Recruits, for example, must be able to read financial statements. Finally, CARE provides intensive language training of up to nine weeks.

Some medical and public health specialists are sent to various conferences and seminars, but these activities are geared more for exposure than instruction. Training is reserved for CARE national staff. In some countries, CARE has been successful in upgrading its staff; in other countries there has been no success at all. CARE keeps losing people.

For instance, the staff turnover in Bangladesh is very high. People leave for better jobs in Arab or African countries. Several of our best accountants have left for Nigeria.

Retaining personnel is a big problem for CARE, and it appears to be one for which there is no easy solution. Most people do not know how to manage people. I do not care whether it is CARE, business, or government; people just do not know how to handle other people in a working relationship. Organizations must have managers who can motivate, develop, discipline, regard and evaluate their personnel. Open communication must be encouraged if evaluations are to be meaningful to both employers and employees. A formal grievance policy may be necessary, particularly if communication has shut down. Finally, there is the question of how does a generalist evaluate a technical specialist? CARE would welcome ideas.

Unless a job description is accurately written, there is no criteria against which to measure an individual's performance. If CARE does not know why a person was hired, then it cannot know what the person is expected to accomplish. Job descriptions are a two-edged sword; if not prepared properly, they can cause grief for both the employer and the employee. Employees who do not have enough to do or who find that reality differs vastly from written proposals, will eventually cost your organization money.

The stress of overseas living can affect even the most dedicated employees. Work in a foreign country is not getting easier. People have a tendency to burn out after some years overseas. Fatigue, pressure from dependents, and living conditions, generally, all contribute to job decline. Husband and wife teams and working spouses pose particular to either study or seek employment in North America.

Unfortunately too many personnel policies succumb to overkill. Action oriented agencies opt for the quick impression. In-country candidates are passed over in favor of expatriates, or conversely, an organization's personnel manager yields to host country pressures. Program development, detailed information and constant program review are the key determinants of a successful personnel policy.

V. COORDINATION OF PRIVATE AND
INTERGOVERNMENTAL PLANNING

THE INTERACTION OF PRIVATE AND VOLUNTARY ORGANIZATIONS
AND THE WORLD HEALTH ORGANIZATION
IN RELATION TO
HEALTH FOR ALL BY THE YEAR 2000

John H. Bryant, M.D.

I. Health for All by the Year 2000: Responses from the
North and South

The first phases of the debate on Health for All by the Year 2000 drew reactions varying from fully supportive to outright scornful. An interesting contrast appeared in the ways people from the more developed countries and those from the less developed countries reacted to this goal of the World Health Organization (WHO). The interest from the more developed countries was mainly technical, often skeptical and even disdainful.

- What do you mean by health?
- What will you measure?
- We are hearing a lot of rhetoric and not much substance.
- And, in extreme situations, "I have had it up to here with Health for All."

Responses from less developed countries have been largely social and political in nature, often with a sense of drama, expressing a mood of hope and with no hesitation to speak rhetorically:

- It is the all in Health for All that is important.
- Equity in the distribution of health services should have priority over quality of health services.
- The idea of Health for All has touched a nerve center and the world has jumped.
- We have hungered for such a possibility and now it is before us.
- If it is to be only a dream, it is a dream worth having.

These comments not only illustrate some of the interesting differences in the ways people are responding to the idea of Health for All, but they also show that the idea of Health for All is being taken very seriously by the less developed countries. The question needs to be asked, nonetheless, "How seriously should Health for All be taken?" I shall argue that, yes indeed! It should be taken seriously. On that basis I shall discuss the relationship between private and voluntary organizations (PVOs) and WHO with respect to Health for All, and argue that the PVOs have a major role to play, but playing that role will require substantial changes in the ways they function.

II. Health for All: An Authentic Product of Contemporary History

Let me explain why the idea of Health for All must be seen as important. First, because the countries are dealing seriously with it. Alma-Ata took many by surprise. What began as merely another world conference captured the intense interest of many nations.

The first official statements of national policy after Alma-Ata were heard at the Executive Board of the World Health Organization in January 1979. There, in a dramatic response to questions from Dr. Mahler, Director-General of the World Health Organization, thirty nations, without exception voiced their commitment: China, India, Pakistan, the U.S.S.R., Mexico, Botswana, Burma, and others, including, of course, the United States.

The United States' position has two components. One is to support the Health for All movement, particularly as it relates to the poorest countries. The second is that Health for All applies to all nations and not only to the poorer nations. The United States is currently examining the implications for its domestic health policy of WHO's goal of Health for All by the Year 2000. There are two reasons for that. First, we have developing sectors in our own society. Second, new problems are continuously emerging as a consequence of over-development or mal-development, such as pollution, and the health problems associated with aging and adolescents in an affluent society.

At the World Health Assembly in May 1979, more than 140 countries expressed interest in Health for All, and a Resolution was passed unanimously which ratified the Declaration of Alma-Ata and established Health for All as having an over-riding priority for WHO. 1/

Another interesting passenger on what might be called the Health for All bandwagon is the World Bank, an organization given to neither romanticism nor rhetoric. At a major conference in Bellagio in April, 1979, Mr. McNamara made the Bank's position clear: it would lend in the health sector and Health for All would claim their majority interest.

Reasonable skeptics can argue that World Health Assembly resolutions and World Bank policies do not guarantee the validity and viability of a global program, particularly one as far reaching in social, political and technical terms as Health for All.

I will now take another approach, one that involves historical analysis, and suggest that Health for All is not merely an idea that has appeared on the scene as another serendipitous event, to persist or disappear according to how it strikes the fancies of people and nations; in short, a fad that has come and may soon go. I believe a much more

profound process is at work. Health for All has emerged out of a series of trends or ideas that have been evolving over the last two decades. Each trend or evolving idea reflects an area in which the world has been learning and changing, and they have converged to form the conceptual foundations for Health for All.

1. Changing ideas on the nature of development
 - a. Rejection of the trickle-down concept whereby large scale national investments are assumed to benefit the general population.
 - b. Increasing emphasis on social aspects of development, as through health and education.
 - c. The New International Economic Order, under which developing countries insist on a more equitable distribution of global resources, and reject social development, even though justified in terms of meeting basic human needs, as a substitute for economic development.
2. Increasing importance given to social justice and equity in the distribution of economic and social benefits, including health services.
3. Recognition of the central role of communities in development, including their participation, commitment, resources, ideas, creativity, and, imperatively, self-determination.
4. Appropriate technology, that is, recognition of the limitations and disadvantages of high technology and the importance of less complex, lower cost technology appropriate to local needs and capabilities.
5. Awareness of the distorting effects of an over emphasis on curative medicine, especially on hospital-based, specialty-oriented, technologically sophisticated care, and consequent emphasis on more balanced approaches to prevention and to lower cost, technologically simplified modes of medical care.
6. Growing recognition of the importance of alternatives to physicians and other health professionals, through expanded roles of nurses, increased use of auxiliaries in health centers and mobile teams, and to the use of community-based health workers, often as part-time volunteers.
7. The emergence of primary health care, emphasizing preventive, promotive and curative services available at or very close to communities in culturally acceptable patterns, and at locally affordable costs.

8. Accumulating evidence that primary health care works, that is, primary health care programs, under special circumstances, can reach total populations with health services that improve health at costs as low as \$1 to \$2 per person per year.
9. The importance of political will, that is, the widening acknowledgement that national and local decisions to extend primary health care to entire populations, with special attention to the social periphery, require firm commitments of political will from the relevant power structures if they are to be effective.
10. The trend, internationally, away from technical assistance, characterized by donor - recipient, patron - client relationships toward international health cooperation characterized by collaboration and partnerships, not only bilaterally between more-developed and less-developed countries, but also among the less developed countries and often in multilateral relationships.

Each of these evolving ideas reflects global learning. Old ideas, values and methods are found to be inadequate and give way to the new. The dynamics of historical change are unfolding as we watch.

I believe these ten ideas and trends (of course, there are others as well) have converged and coalesced to form the movement we know as Health for All by the Year 2000. If Halfdan Mahler had not identified that catch phrase in 1978, I believe it would have appeared anyway, probably not in those words but in some similar form, within a very few years.

Health for All has caught on and has been so widely accepted precisely because it encompasses and draws together the many strands of recent technical, political, social and ethical thinking and practice. Health for All is an authentic product of this historical evolution.

Through these comments, I have tried to make the case that Health for All is an important and viable movement for the purpose of discussing the interaction of WHO and the PVOs in relation to it. Before proceeding with that discussion, however, there is a large parenthetical comment that needs to be made about Health for All.

III. Health for All and the New International Economic Order

Just as we believe that health should be pursued independently from development more generally, the Health for All movement will not make much headway unless it finds its place in larger national and international development strategies.

A strong and searching debate is now under way about developing strategies under the rubric of the New International Economic Order. The disappointments of the developing countries in the failure of expected advances in economic development to take place and their resentment and often anger at what they consider to be overly protective positions of the more developed countries have led the developing countries to a formulation of the New International Economic Order, which calls for a more equitable distribution of world resources, particularly through more liberal trade arrangements.

Among the issues under debate are the relationships between economic and social development. As an illustration, the high priority given to meeting basic human needs by the more developed countries is received with skepticism by the less developed countries, who often see it as a smoke screen for the reluctance of the more affluent countries to take concrete steps to promote economic development and related political stability.

Thus, commitments to meeting basic human needs, including health, which might seem to the more developed countries to have unassailable humanitarian motives are sometimes viewed by less developed countries as having diminished moral authority. At the least, the terms of the New International Economic Order specify that social development is unacceptable without parallel economic development.

There is reason to worry that the debate over the New International Economic Order might deteriorate into two extreme positions: 2/

- a shallow view of economic development in which the concern is for investment and growth in aggregate national terms without concern for equity in the distribution of the benefits of development.

or, at the other extreme,

- an insistence that development should be defined in non-economic terms, that social justice and the meeting of basic human needs have over-riding priority in development strategies.

We can turn to health as a possible bridge between these extreme views: health can contribute, on the one hand, to development in the purely economic sense of increased productivity, and, on the other hand, to social justice and the meeting of basic human needs.

As we promote the idea of Health for All, we should not be blind to these issues, not only because of their social importance but also because of practical politics. Health for All will be achieved only to the extent that nations decide they want to achieve it, that they must achieve it. Such decisions will not be made alone in ministries of health, but in ministries of planning and in the

broad context of national development. Health is likely to receive a reasonable share of national commitment only if it has earned its place in national and international development strategies.

IV. The World Health Organization - Its Crucial Role in International Health Coordination

I will now return to the interaction of WHO and the PVOs and develop the argument that WHO and PVOs need one another, that neither side fully appreciates that, and that each should take some steps to engage and adapt to the other.

First, why do the PVOs need WHO? WHO is the single international organization with responsibility for coordinating multinational approaches to global health problems. In fulfilling those responsibilities, WHO is making impressive arrangements for involving member governments, other international organizations, and bilateral agencies in planning, financing, managing and evaluating global health programs. We are familiar with some of the examples: the smallpox program, the tropical disease research program, the expanded program on immunization. Another example is the management of research in WHO, the global and regional advisory committees on medical research. The ACMR's identify global and regional research problems, specify priorities and promote concerted action toward them.

As WHO comes to closer grips with its more general goal of Health for All by the Year 2000, it is clear that it is engaged in a program of unprecedented magnitude which will require entirely new mechanisms of organizational management. Two of these mechanisms should be mentioned now. One is a Health Development Advisory Council, which will bring worldwide expertise together, as persons rather than as representatives of member governments, to advise the Director-General on how the organization should proceed with its efforts to achieve Health for All by the Year 2000.

A second mechanism is a Coordinating Group on International Health Funding. In October, 1978, the World Health Organization convened an ad hoc meeting of donors--national bilateral agencies, and international agencies, including the World Bank, UNDP and OPEC, were there. The PVOs were not present, however; they had been forgotten. With respect to the meeting, it was clear to some of us that such ad hoc meetings would not meet the need for future coordination between WHO programs and the world donor community. We recommended that a permanent mechanism be set up, and this Coordinating Group on International Health Funding is the result.

The final plans for this group were put together just last month, and I noticed that the PVOs were not included again. Should they be? My queries at WHO about the PVOs drew such comments as: Who do you talk to when you want to talk to the PVOs? Each has its own objectives and agenda;

how can you bring them together to relate to a common objective, such as Health for All? Or, in the extreme situation: I'm sorry, but the PVOs aren't worth the time and trouble.

I made the case then, as I had tried to before, that the PVOs can be an extraordinary valuable resource to these global programs in terms of their experience, ideas, resources, and commitments. WHO apparently agreed and is making two positions on this coordinating group available for the PVOs.

Two important questions emerge. Why the slow and reluctant recognition of the PVOs, and how will the PVOs respond to this opportunity to serve on a global coordinating body for funding in relation to health? Before attempting to answer those questions, let me conclude these more general remarks about WHO.

WHO has the pivotal role in organizing and coordinating approaches to international health, particularly for Health for All. It has problems that might be expected of a very large bureaucracy dealing with complicated problems. Nonetheless, it is doing a good job. The leadership of the Director-General, Dr. Halfdan Mahler, is outstanding. It is widely accepted that WHO is one of the best, if not the best, organized and managed of the specialized agencies of the UN. Its commitment to social goals amount to more than rhetoric, and it retains a capability for developing technologically sound programs in pursuit of these social purposes. To the extent that we all share the goal of WHO for improving the health of the world's people, particularly those at the social and geographic periphery, we must acknowledge the importance of coordination among resources and programs--nationally and internationally, public and private. That role of international coordinator, convener and planner belongs to WHO.

V. PVOs - An Under-appreciated Resource

The PVOs bring at least two major contributions to international health: the value of their resources; and their understanding and experience with practical problems in the field, including their various approaches to them. The PVOs also have the burden of some disadvantages.

First, the resources of PVOs. Accurate data on the expenditures of private and voluntary organizations are exceedingly difficult to find, particularly when one tries to include the European private and voluntary organizations. Here are some rough and tentative figures. The private and voluntary organizations based in the United States, excluding the churches, spend about \$200 million a year on international health. Included in that figure would be about \$20 million from foundations and about \$2 million from the labor organizations. The expenditures of the European PVOs are probably well in excess of \$100 million a year. The church-related programs, Catholic and Protestant, in North America and Europe (I cannot separate those) contribute

about \$100 million dollars a year. Taken together the PVOs in North America and Europe are spending about a half billion dollars a year. 3/

Worldwide bilateral expenditure comes to a similar amount, a half billion per year. Multilateral expenditures of WHO, UNDP, the Banks, etc., also amount to about one-half billion dollars a year. 4/

The PVOs, then, contribute amounts that match those of the multilateral and bilateral organizations. In addition to contributions of these resources, there is no doubting the extensive experience of the PVOs in the field. They have practical experience in the distant parts of the field, often working where others are unwilling to work. They commit themselves for long periods of time, even decades, to the development of programs that cannot be expected to take root in two or three years. They often have a deep understanding of the culture and language of the people with whom they work. They reach the social periphery with low cost programs, often with much lower overhead costs than larger organizations can achieve. They develop non-government to non-government relationships that are valuable, particularly when government-to-government relationships are not going well.

They pioneer in areas that are picked up later by others: the use of community health workers; the development of primary care systems; integration of health and community development; disaster relief assistance; and appropriate technology, are a few examples.

An area of particular importance, often overlooked, has to do with indigenous PVOs. National churches (whose resources were not included in the figures above) contribute substantially to both national and international health programs. On a continental basis, church-related hospitals in Africa account for 20 percent of all hospital beds, and the proportion exceeds 50 percent in some countries. Local foundations, often cutting across lines of Christian and non-Christian faiths, integrate with other sectors of development.

Another example of indigenous grass roots development by private and voluntary organizations is in India. Over the last decade, the number of rural dispensaries has increased extensively from a few hundred to more than two thousand, even during a time of great financial constraint. How could this be? The number of Indian Roman Catholic sisters is growing substantially, and many of them are making their commitments to serve the people of India by working in these community-based rural dispensaries.

So, the private and voluntary organizations represent a vast resource of funds, people and experience that often cannot be matched by the larger organizations, such as WHO, the World Bank and the bilateral agencies.

But, there are problems with the PVOs as well, particularly when we consider how they might relate to this larger international picture of Health for All. One of those problems is coordination, which is a familiar problem judging from the multiplicity of coordinating mechanisms that already exist--fourteen major coordinating mechanisms were in North America and Europe at the last count, each coordinating a cluster of PVOs or an area of information. Nonetheless, the PVOs, here and abroad, remain highly dispersed and without coordinating mechanisms that could draw them together in collective action. They have no collective voice. The pluralism that is their strength, and within which resides the uniqueness and creativity that is so characteristic of PVOs, becomes a problem when joint planning and action are needed at national, regional or global levels.

The PVOs are often criticized, too, for what one might call their style of function. Familiar criticisms have to do with the ways in which they define their programs and priorities, and how these priorities are often used to ride roughshod over the priorities of recipient organizations or countries. The PVOs often push capital-intensive, high technology, short-term projects instead of providing long-term operational support for smaller, locally based, community related projects.

Less familiar, but still important criticisms of the foundations point to the lack of clear objectives; instead, their programs often simply follow historical patterns of giving. Susan Cole-King has shown in her studies of private and voluntary organizations in Europe (the observation applies in the U.S. as well) that there is rarely evaluation of donor functions, rarely a system of social accounting, whereby programs are judged in terms of their impact on specific social goals. Dr. Cole-King also noted that there is often a smugness on the part of PVO administrators, in that they know their programs are useful and see no need to declare objectives, much less evaluate the extent to which they are achieved. 5/

In brief, the PVOs appear to be a vast and important resource, but there are problems in achieving an effective coordination or engagement among them and between them and the larger process of bringing world resources to bear on global problems.

VI. Concluding Comments

I have argued that Health for All by the Year 2000 has the prospects of being a viable and lasting movement; that great importance is being given to it by virtually all the member governments of WHO; that WHO has the major planning and coordinating role for a global approach to Health for All; and that in developing new planning, coordinating and financing mechanisms, WHO appears to be reluctant or at least slow to recognize the importance of the PVOs.

WHO has indicated a willingness to include the PVOs, at least in its new Coordinating Group on International Health Funding. But, I believe WHO does not fully understand the PVOs and does not fully appreciate their importance. WHO at times lacks the flexibility for the fine tuning needed to adapt to the multiple possibilities that go with the private and voluntary organizations and the contributions they can make in this field. WHO needs help and urging to be more responsive.

I have also argued that the PVOs represent a vast and important resource to international health, including the Health for All movement, but they lack an effective coordinating mechanism and a collective voice that would facilitate their entering into a global planning and programming process.

In concluding, I return to the point that Health for All is an authentic, historical outcome of a series of evolutionary trends in the health field. In this connection, I believe that we in the international health field are at an historic crossroad.

The Health for All concept, especially the social, political, and technical requirements for achieving total coverage of populations, call for extensive and even radical changes from current approaches by national and international organizations. WHO clearly recognizes this and is pushing itself through a major transition in its structures and programs. The PVOs should recognize that they, too, are faced with an opportunity of major significance, namely to become full participants in this global effort to meet human needs. To do so will require, however, more effective coordination among themselves and more effective interaction with the international organizations and agencies.

1/ Thirty-Second World Health Assembly, May 7-25, 1979, WHA32.30, "Formulating strategies for health for all by the year 2000" pp. 27-29.

2/ John Galtung, The New International Economic Order and the Basic Need Approaches, "Compatibility, Contradiction, and/or Conflict?" Institut universitaire d'etudes du developement, Geneva. Goals, Processes and Indicators of Development Project, UN University unpublished paper.

3/ The figures for this paragraph are taken from the following sources: Foundation and labor union expenditures on international health activities - White House Report. "New Directions in International Health Cooperation," Spring 1978, p. 97 and 106.

European, American PVO and Church related expenditures: USAID, "United States Policy and Programs

on International Health as Related to Development Assistance." (Draft #2, unpublished), Office of Health, Development and Support Bureau, February 1978, pp. 53, 55.

4/ Ibid., pp. 52 and 53.

5/ Susan Cole-King, Health Sector Aid From Voluntary Agencies: The British Case Study, Institute of Development Studies, July 1976. Emmanuel de Kadt and Susan Cole-King, Dutch Health Aid Via Voluntary Agencies, IDS, March 1976.

VI. PRIMARY HEALTH CARE AND
A U.S. PERSPECTIVE

PRIMARY HEALTH CARE AND A U.S. PERSPECTIVE

Joseph M. Baldi

I. Primary Health Care: Who is Interested?

The U.S. Congress, in 1974, passed the Health Planning and Resources Development Act. Its first priority was to provide "primary care services for medically underserved populations, especially those that are located in rural or economically depressed areas."

The United States Public Health Service established the Rural Health Initiative, in 1975, and the Urban Health Initiative in 1976. Both are efforts to expand a nationwide system of community-based, primary health care to areas with serious health care problems. Over six million people have been targeted to receive these services.

Mexico, as well as other countries in this hemisphere, is concerned about providing health services to the rural and urban poor. These nations refer to their efforts as "extensión de cobertura de servicios primarios".

The Pan American Health Organization's U.S.-Mexico Border Health Association held a workshop on primary health care in Juarez, Mexico, December 12-13, 1977.

The World Health Organization sponsored a World Conference on Primary Health Care in Alma-Ata, the Soviet Union, in September 1978.

The National Council for International Health is sponsoring this conference, "Health for Humanity: The Private Sector in Primary Health Care."

II. Why Such Interest?

The principal reason why many world nations are interested in primary health care is their concern as to the effectiveness of existing health care systems; that is, the "traditional" approach toward health care. Former Canadian Minister of Health Marc Lalonde, in his book A New Perspective on the Health of Canadians - Nouvelle Prospective De La Santé Des Canadiens, has forced the world community to evaluate its health systems, the health professions, and its attitude toward health care. Lalonde's criticisms of traditional health care systems are being seriously reviewed by a growing number of professionals in the United States and in many other countries throughout the world. More and more people are asking: (1) Why are health care costs rising so sharply in the United States, Europe and Japan?, and (2) Should developing countries continue to allocate vast sums of money for the construction of large hospitals, research centers, or questionable purchases of costly equipment and technology?

The term "primary health care" refers to complex ideas or systems and is interpreted differently from country to country. For example, the U.S. Public Health Service/Health Services Administration has mandated that the following primary health care services be available:

- 1) diagnostic, treatment, consultative, referral and other (outpatient) services rendered by physicians, physician assistants, nurse practitioners, nurse clinicians, dentists, and other qualified dental personnel;
- 2) diagnostic laboratory and radiologic services;
- 3) emergency medical services;
- 4) preventive health services, including immunizations; prenatal and post-partum care; children's eye and ear examinations; voluntary family planning services; preventive dental services, and
- 5) transportation services as needed.

In addition to the aforementioned comprehensive services, the law also refers to "supplemental (primary care) services" that include:

- 1) home health;
- 2) extended care facility services;
- 3) mental health services;
- 4) rehabilitative services;
- 5) social services, and
- 6) health education, as well as several other services.

In the United States "primary health care" is applied in several contexts. First, there are the services authorized by the Public Health Service Act. Second, are those individuals who view primary care in categorical terms, such as screening, immunization campaigns, emergency care services, child clinics or health education. Although all primary care services are of individual value, the U.S. Public Health Service has sought recently to encourage health care as a total approach; one that includes self care and prevention.

It would be useful to cite the words of Dr. John S. Millis, Chancellor Emeritus of Case Western University, Cleveland, Ohio. Dr. Millis argues that the essence of effective primary health care is, "to 1) promote the availability of services to a broad spectrum of the population; 2) promote the dissemination of information and knowledge

to use these services widely, and 3) to encourage the people to use this knowledge on their own behalf." 1/

Many nations recognize that they must establish a strong primary care system in order to meet the basic health needs of the majority of their people. Most countries are aware that the large amounts of money spent on sophisticated secondary and tertiary care services will have to be redirected if primary care is to become more than an objective.

Health care systems in developing countries differ only slightly from those in the United States. Both experience disproportionate expenditures of health care resources (human and financial) on secondary and tertiary care; that is, the operations of large hospitals, medical and research centers, and the development or acquisition of expensive equipment and technology. This is as true of Brazil, Egypt, and Nigeria, as it is of Canada and the United States. Moreover, most of these resources go to large cities.

Not surprisingly, access is very difficult; almost impossible in small cities and rural areas. Those primary health care resources supplied to the rural areas are usually inadequate to meet the demand. Once established, the services become fragmented and difficult to coordinate. Thus, it becomes even less likely that the supply of primary health care services will catch up with the demand for them. Given the limited resources available for health care, we must strive for a reorientation of service priorities. Monies allocated for the construction of large hospitals or medical centers must be redirected toward primary health care, including the financing of recurrent costs.

III. Public Policy and Multinational Agency Commitments to Primary Care and the Impact on PVOs and Universities

Despite the fact that a disproportionate amount of funds is being allocated for secondary and tertiary care, the worldwide interest in primary health care problems has meant that more resources are now available for service delivery. The following U.S. Agency for International Development and Pan American Health Organization (PAHO) data are illustrative.

The total amount of USAID funds available for health programs has jumped sharply; from \$34.3 million in fiscal year 1965 to \$345.5 million in fiscal year 1979. The USAID proposed fiscal year 1980 budget for health programs, if appropriated, would total \$375.0 million, or \$29.5 million more than the previous fiscal year. Most of these funds will be awarded to PVOs and universities. Approximately 69 percent, or \$128 million, of the \$185 million USAID Office of Population FY79 budget will go to PVOs, universities, and consulting firms. The remaining \$57 million will go for bilateral assistance to developing nations.

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID) HEALTH,
NUTRITION, AND POPULATION PLANNING PROGRAM
(obligations and loan authorizations in millions of \$)

	<u>Health</u>	<u>Nutrition</u>	<u>Population</u>	<u>Total</u>
1965	32.4	-	1.9	34.3
1970	37.1	-	73.1	110.2
1973	42.9	3.1	121.7	167.7
1975	54.5	14.3	100.0	168.8
1979	130.0	30.5 (estimate includes loans)	185.0	345.5
1980 (proposed)	146.6	12.1	216.3	375.0

The Pan American Health Organization's (PAHO) health budget increased sharply from \$6.4 million in 1965 to \$106.8 million for 1980-81. The vast majority of PAHO funds are allocated to the national governments of member nations.

PAN AMERICAN HEALTH ORGANIZATION (PAHO) HEALTH PROGRAM
RESOURCES - 1965 THROUGH 1980-81
(in millions of \$)

	1965	1970	1975	1980-81 *
WHO regular funds	1.65	4.77	7.48	32.90
PAHO regular funds	4.49	8.85	15.44	61.77
Grants and contributions	0.28	3.09	2.08	12.12
Total	6.42	16.71	25.00	106.79

* proposed

The National Council's "Survey of Potential Conferees" has indicated that both PVOs and universities are concerned with the problems of sustained program funding. However, the large increases in USAID and PAHO health budgets suggest some improvement. It must be remembered, though, that as the budgets have increased so, too, has the number of PVOs and universities competing for these funds. Nonetheless, the USAID and PAHO proposed funding levels for fiscal years 1980 and 1981, if accepted, mean a continued, moderate increase in funds for primary care programs in developing countries.

IV. Observations and Recommendations for PVOs and Universities with Overseas Programs in Primary Care

I would like to make some observations that may be of help to organizations in addressing at least two of their major problems: (1) sustained project funding, and (2) coordination with host country government services.

Observations

- There are times when PVOs, U.S. universities, private foundations, Peace Corps and other foreign volunteer programs provide little to host countries. Such programs have a limited impact, even in those instances when service delivery is quite good. In a few cases, the work could have a major impact on the host country, either at the local, regional, or national level.
- Even health programs administered by large public sector organizations such as USAID and PAHO will in many cases have a limited impact on the host country.
- We know there are many obstacles to the establishment of successful development projects. These barriers include: (1) limited or severe fluctuations in funding; (2) lack of trained administrative, technical or professional staff; (3) cultural or language barriers, which may result in community indifference or religious or political opposition; (4) geographic, climatic or logistical problems; (5) poor project planning and conceptualization; (6) weak project administration, and (7) poor coordination with local or regional health programs.

All PVOs, universities and other organizations involved in the administration of primary care programs need to recognize major barriers to project implementation. Conversely, organizations should identify those key factors which contribute to project success. My own experience overseas indicates that the following condition applies: the degree of involvement of host country professionals, government officials and community in project planning, administration, and evaluation. Too frequently project efforts may be viewed as the "foreigner's project," even though the project is designed to provide services to the host country population. Even the best projects may receive lukewarm support if host country personnel are not actively involved.

Primary care projects administered by PVOs, private foundations, and universities should be coordinated with local, regional or national health programs. I suspect that PVO staff believes strongly in their project approach. Yet, at times, these people are unable to obtain support from local, regional or national health officials. Had the

project been developed, managed, and evaluated by host country nationals, or had local residents been named to community policy or advisory boards, then key host country residents, health professionals, and government officials might have shared some enthusiasm for the project and argued for its support. Enthusiastic host country support could result in a number of breakthroughs for PVOs. These would include: (1) funding for the project; (2) assignment of local or regional health professionals to complement project staff; (3) requests from local, regional, or national government officials for assistance in replicating successful health projects; (4) increased community acceptance and support, and (5) increased leverage with public or private funding sources based on project success.

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John S. Millis, Case Western University, Unpublished Paper presented at the Northeast Canadian-American Health Conference, Boston, Massachusetts, 1976.

VII. AN OVERVIEW OF CATHOLIC RELIEF SERVICES
EXPERIENCE IN MATERNAL AND CHILD HEALTH
PROGRAMS

AN OVERVIEW OF CATHOLIC RELIEF SERVICES
EXPERIENCE IN MATERNAL AND CHILD HEALTH PROGRAMS

Jean Gartlan

Catholic Relief Services (CRS) is concerned with health care. We have programs in each of the 65 countries in which CRS has offices. Our involvement, in all instances, is through local counterpart agencies, be they private or governmental. The largest single thrust, both in terms of the number of countries served and the number of people reached, is the provision of food and nutrition in maternal and child health (MCH) programs. These MCH programs provide for pre-natal and post-natal care; simple instruction for mothers in hygiene, nutrition and baby care; regular monitoring of the child's growth through the use of growth/weight charts, and supplementary feedings.

The centers are operated by indigenous agencies, that is churches or local councils, and are almost exclusively located in rural areas, small towns, or remote villages. In many cases, they are an integral part of a hospital or clinic facility. Catholic Relief Services provides scales, weight charts, guidance in the preparation of the instructional material for nutrition and hygiene classes; arranges for the distribution of food supplies, and provides regular staff visits for supervision of the food and nutrition programs.

The distribution of PL 480 Title II and other donated foods to children under five, as well as to pregnant and lactating mothers, guarantees valuable nutrition supplements. The availability of such foods also serves as an incentive for regular attendance at the centers. However, while the food supplements are obviously an important part of the program, the nutrition education classes are the mainstay. These classes focus on regular supplementary feedings, as well as the use of nutritious, locally available foods. The latter can serve as a means of providing the diet and health of the whole family.

The basic education message is as follows: when a mother registers her child in the program it must be made clear to her that she is making a commitment to feed her child "better," by applying what she is learning through the use of supplements or local foods. The mothers must understand the charts and examine them monthly in order to monitor their child's progress--or lack of it. This way, the mothers come to understand that good health is directly related to good feeding. A bulletin entitled Make My Children Grow was developed at an African regional conference in Accra, Ghana. It is a "how to" manual; particularly, "how to" instruct mothers in the use of local foods.

The program in the 18 countries of Sub-Saharan Africa was designed by Dr. Carlo Capone, CRS Regional Medical Director, Nairobi. It is estimated that approximately 675,900 children are seen at health centers each month. Since the attendance rate is certainly less than 100%, it can be assumed that the actual number of children attending, even

irregularly, is higher. Further outreach is demonstrated in terms of the number of mothers and other family members not registered at the centers, but nonetheless, affected by better hygiene or nutrition practices. The extent to which maternal and child health programs can impact the community varies according to the strength and effectiveness of each health center. A number of factors are involved: location, facilities, regularity of delivery of needed supplies and personnel. The health worker must possess not only knowledge and training, but also the ability to relate to and gain the trust of the mothers. Continuity is an important part of this trust, and it can be severely damaged if central authorities and administrators insist on frequent and arbitrary staff changes.

In two countries, we are assisting projects designed to extend existing service facilities into unserved areas. One project is a mobile health program in the Chiquitos vicarate of Bolivia. Santa Isabel Hospital in Chiquitos is the only institution of its kind in the vast vicarate--an area of approximately 195,000 square kilometers. The project seeks to establish a link between the health services of the hospital and the 100,000 people living in the 85 rural communities of the vicarate. This link is being forged through two mobile health teams operating from the hospital and through the ten government rural health offices. In order to stimulate the communities to participate in the improvement of their own health system, the program includes the recruitment and training of rural collaborators in each of the 85 communities.

An MCH/nutrition program is being developed as part of the project. It will begin with only a few communities at a time. When the mobile team visits a community, interviews with pregnant women and children under five are conducted separately from the general consultations; the women are introduced to a health program designed for them and their children. The program includes pre-natal and post-natal care, along with instruction in nutrition, hygiene and child care, and introduction of weight charts to monitor the child's growth. As in other MCH programs, PL 480 foods are used to demonstrate supplementary feeding of malnourished children. One important aspect of the program's promotion is the use of the vicarate radio station to prepare the people for visits from the mobile teams and to provide continuing, simple health education.

Support for the MCH program comes from the vicarate hospital; the Government of Bolivia's rural health offices; USAID, as well as from Catholic Relief Services. Support from the Bolivian government is essential. If the project is to be viable at the end of the three-year period, then the government will have to assume the recurrent costs.

The project director and, in a very real sense, its inspiration, is a nun-nurse who has been working in the area for 22 years. In fact, the project is merely a continuation of many of the things that she has been doing during these years. Based in San Ignacio, she has travelled constantly by car, bicycle, motorcycle or horse to the remote areas of the provinces bringing and promoting health services. It is

expected that the project will translate her isolated efforts into broad community involvement.

In the Northern Cameroon, the MCH project, assisted by a USAID grant, is adding education to a rural health program in two dioceses, Maroua-Mokolo and Yagoua. The project's fourteen dispensaries are the only functioning medical centers in these very large areas, and all of them serve vast numbers of people. Gobo, for example, serves 20,000 people in an area of 1,350 square kilometers.

For a health program to be effective, it must reach beyond the curative and preventive aspects and involve the villagers, themselves, in the improvement of hygienic conditions. Also, it must encourage the adoption of basic first aid measures in order to combat the onset of infection and disease. Health extension agents are being trained for this purpose. They are, generally, already on the dispensary staff and can assume the responsibility for promoting health education in a small number of villages in their area. Conditions vary, but in general the extension agents leave their dispensaries for one or two days each week to work in the villages under their supervision.

The goal of a health agent is to help organize a health "committee" in the village, comprised of five or six responsible and respected members of the community. These individuals may not necessarily be the most influential or politically powerful community members. Responsibility is given to this core group of villagers for creating a new awareness of health needs and for action to improve health conditions in the village, as a whole. Ideally, the extension agent serves as a catalyst; the health committee does the real work of organizing the villagers to think and act in new ways regarding health.

In the Northern Cameroons, the creation of fully-functioning health committees has proven to be a long, educative process. Thus, when the extension agent runs into too many obstacles in the creation of these committees, the emphasis is shifted to the training of village leaders--one or two interested persons who, although they cannot exert the influence of the whole committee, can nevertheless follow up on health education in the extension agent's absence. While this is a slow process, based as it is in one of the most isolated areas of the Cameroon, it can have a long-term effect not only on health conditions, generally, but it can also awaken people to their potential for self-reliance.

Catholic Relief Services' involvement in the Yemen Arab Republic is unique in that we are directly concerned with the administration of Al Olofy hospital, in Hodeidah. In 1962 the Yemen government asked CRS to provide staff for the newly built hospital. Although this request was outside our usual mode of operation, we complied for two reasons: 1) the obvious need, and (2) Yemen lacked trained manpower. Initial project support came from private donor funds.

As the hospital expanded, other groups, including medical teams from Russia, Bulgaria, and China, have joined

to staff the hospital. The CRS emphasis is not on in-service training. Support is provided by a USAID grant. The hospital has been designated as a government training hospital.

Immediately after the opening of Al Olofy, the hospital nutritionist began a program designed to reduce the high mortality rate of children under two. Child mortality was as high as 60% in some Hodeidah villages. The program, which literally introduces women to the concept of health, pregnancy and child-rearing, focuses on simple instruction in hygiene and nutrition, both during pregnancy and after birth. PL 480 foods have been used in supplementary feeding, but the concentration has been on the use of cheap, locally available foods--particularly the use of local porridge of cereals and legumes as a weaning food.

The second thrust of the nutrition program has been to train health-nutrition auxiliaries. Hopefully, this will enable the program to gain a firm foothold in the communities. The program began as a pilot project at Al Olofy and has been expanded to other areas of Yemen.

Program development has occurred in several ways. For example, the Sana'a unit, located in the Safia Model Health Center, has, itself, become a model of nutrition work and is widely visited by staffs of other MCH centers. The nutrition unit also cooperates with Radio Sana'a in recording health programs. Instruction in nutrition is given to student nurses at the WHO Nursing School. Perhaps the most significant step was the establishment of a mobile unit, in 1978, to serve remote communities in the north Tihama desert.

A team, comprised of the hospital nutritionist and two Yemini health/nutrition auxiliaries, began to go out for daily sessions with the women in the surrounding villages. A doctor and nurse from the hospital usually accompany the team. For most of the villages, it is their first contact with any form of health care.

This mobile unit program has become the basis of an expanded primary health care program in selected communities of the Tihamas. There are no basic primary health services available at present. The project will include the training of primary health care providers at Al Olofy Hospital. Local development boards will serve as a preliminary model for the entire region. Linkages with other voluntary agencies are planned, and UNICEF has agreed to provide technical transportation.

In Central America we have been closely involved in the formation and development of local community health service associations. In 1975 we, along with other voluntary agencies, helped fund the first Regional Encounter for Rural Health programs. This effort resulted in the formation of the Regional Committee for the Promotion of Rural Health Care. Its newsletter, El Informador, was published, until recently, in Guatemala by our Regional Medical and Nutritic Consultant, Dr. Frances Rothert.

Catholic Relief Services provided initial funding

the Association of Community Health Services (ASECSA) in Guatemala. By grouping health-related private voluntary agencies together, the Association hopes to provide educational services to its members as well as cost savings through systematic drug purchases. Extensive material on the Association is available, so I will merely refer to CRS's involvement in its founding.

We are also providing support for a community health movement in the Chiapas Highlands of Mexico. This project is a change from the traditional curative approach to health; it concentrates on the total physical, economic and social factors associated with health. This concept sees community health and medicine as part of the dynamic movement of social change. Treatment of parasitosis illustrates my point.

The Indian health promoters in the area know that parasites are water transmitted. When piped potable water is not available, most people opt to boil their drinking water. However, when men take their product to market they must walk long distances. Most cannot afford to take the bus or buy bottled soft drinks along the way. Since they must carry as much produce as possible, they cannot carry bottled water; hence, they are forced to drink from contaminated streams en route.

There are several reasons why the villagers are poor. They have been displaced from the best agricultural lands, and they are powerless to cope successfully with the non-Indian merchants who exploit them. Knowledge of parasitosis prevention is not enough in this case. Furthermore, real improvement requires the participation of the whole community. Latrines for only 20 percent of a community, for example, would probably have little effect on the elimination of the disease.

The facilitators of social change see community participation as the logical continuation of health programs, as well as a complement to the other processes of social change in the Chiapas Highlands. This realization was sparked by a three-day course/encounter for health personnel sponsored by the Diocese of San Cristobal de las Casas. Medicine was presented essentially as a social science. Disease etiology and community responsibility were stressed. Once grasped and accepted by the participants, this new concept of medicine and health became the basis of the movement. The methods for its promotion include facilitated inter-community contacts, specialized community health courses and specific technical counseling.

The effectiveness of this approach to health care has yet to be proven. To the extent that health care is perceived as part of an overall strategy for the support of grassroots organization, measurements of the improvement of health might not be the principal criteria for judging success. Nevertheless, if the approach is offered as an alternative to that of traditional curative medicine, which is considered to have failed, then the actual improvement of health must be a criterion of effectiveness.

This project is a good illustration of a principle we believe must be an essential part of all socio-economic projects--self-reliance. If health care projects are to be truly beneficial, they should lead to less dependency on outside resources or, at a minimum, to a more balanced inter-dependency between local and outside resources.

While in some programs this principle is more obvious than in others, it can be argued that all efforts which improve health are at least a start on the road to self-reliance. There can be no real improvement in people's lives if health is disregarded. There is probably no more important focus than to improve the human condition.

VIII. PRIMARY EYE CARE DELIVERY

PRIMARY EYE HEALTH CARE DELIVERY

John H. Costello

Blindness and eye disease are rapidly becoming recognized as among the world's most critical health problems. The World Health Organization estimates that the world's blind population has risen to over 42 million. This figure will likely double by the year 2000 unless measures are taken to prevent and treat blindness.

Forty two million is a staggering figure when one considers that the overwhelming majority of those currently or potentially afflicted are living in subsistence economies; wholly dependent on their labor for their existence.

Helen Keller International is the oldest United States organization concerned with the worldwide problems of blindness and eye disease. It was established in 1915 as the American Foundation for Overseas Blind. In 1977, our name was changed to honor Miss Keller. Helen Keller devoted many years of her life to serving our organization.

Our agency has provided continual assistance in the field of blindness for almost 65 years. In our early years we focused primarily on building institutions and supplying materials for the education and rehabilitation of the blind and visually handicapped. Now, however, the Helen Keller International directs its financial and manpower resources toward expanding the existing capacities of developing countries so that they can deal with the social and economic consequences of widespread eye disease and blindness.

In addition to stepped-up efforts to promote global concern about the extent to which blindness constitutes an obstacle to development, we have also instituted two major policy changes. In 1972, Helen Keller International expanded its activities to include, for the first time, prevention of blindness--now one of our organization's three major operational goals. Our objective is to control xerophthalmia--the leading cause of blindness in young children in the third world. We are now conducting prevention programs in Bangladesh, Haiti, Indonesia and Pakistan.

Our major prevention efforts have been concentrated in Indonesia. We are just now completing an important three-year research project to determine the etiology and distribution of this disease. The project is the result of cooperative effort between Helen Keller International, the Government of Indonesia and the Agency for International Development, with some input from the World Health Organization and UNICEF. The research findings are providing essential information that will enable us to implement a realistic, cost-effective response to xerophthalmia in Indonesia and elsewhere.

Preliminary study data indicate that, in Asia alone, as many as 250,000 children are blinded annually by xerophthalmia. Unfortunately, about one-half of these children will die. Helen Keller International and the Government of Indonesia are now developing a broad five-year disease prevention and treatment plan. This plan will include programmatic elements of food fortification and vitamin A capsule distribution, as well as health and nutrition education.

Helen Keller International's second major policy shift has been in favor of the "barefoot doctor" concept. We have turned from promoting the traditional approaches to meeting the needs of blind children and adults--that is, residential rehabilitation and educational facilities--to designing, implementing, and testing cost-effective, itinerant schemes aimed at delivering "basic skills for survival" to the rural blind. This requires the use of "barefoot field workers."

I have described this transition because it reflects our increased concern over the growing magnitude of the global problems of blindness. We must find innovative and realistic responses to the relevant social, economic and public health aspects of widespread eye disease and blindness. We recognize that our resources are few and that much more needs to be accomplished if there is to be any significant long-range impact on blindness.

There are four major categories of blindness: infectious diseases (namely trachoma); nutritional blindness; onchocerciasis, and cataract. Generally, the extent to which these diseases can be controlled depends on how well we can isolate their behavioral and environmental causes. It is imperative, then, that the development and implementation of primary eye health care--whether it addresses one or more of these causes of blindness--be in accord with the general principles of primary health care.

Primary eye care, therefore, should be shaped around the life patterns of the populations at risk; integrated into the national, regional or provincial health system, and designed to provide support at the periphery. Eye care programs should be fully integrated into community development projects, and should place maximum reliance on community resources. The local population should be actively involved in the programs' formulation and implementation.

Primary health workers should be trained to recognize the more serious eye conditions. These workers should be able to administer first aid treatment, make referrals, and request consultations. Treatment for minor eye conditions such as conjunctivitis, trachoma, superficial foreign bodies and trauma, as well as for xerophthalmia, must be made immediately available. Primary health care workers should also be provided with essential drugs such as topical sulfacetamide, topical tetracycline and other appropriate antibiotics, and with vitamin A capsules, eye shields and bandages.

The delivery of eye care at the primary level must, of course, be supported and reinforced at the secondary and tertiary levels. Because of the lack of ophthalmologists, the referral load from the primary level must--in most cases--be handled by full-time specialized ophthalmic assistants. These individuals, usually trained nurses, will require more extensive training in eye health, differential diagnosis, and minor lid surgery, such as trichiasis surgery.

Ophthalmic assistants should be available in those cases where the prevalence and incidence of specifically identified causes of blindness are excessive--as with cataract cases. Competence can be maintained if these individuals are permitted to perform these procedures on a regular basis. It is important to point out, however, that this capability can be developed only through long-term training and continued support and supervision of an ophthalmologist at the tertiary level.

These and other issues relating to the strategies and policies that must be employed in order to prevent and treat blindness were the subject of an important meeting in Asilomar, California last year. More than 40 experts in ophthalmology, public health, epidemiology and program planning took part in the discussions. My comments are a synopsis of the operational strategies set forward at Asilomar. My contribution will be published by WHO some time this summer.

It is clear that primary health care is the key to combatting eye disease. The multi-disciplinary approaches which must be designed and implemented challenge us to increased collaboration: those involved with blindness and those involved in community development, nutrition, maternal and child health, are but a few of the required participants. Such collaboration can lead to the development of essential managerial and technical structures; to deliver not only essential eye care services, but also other key health services.

IX. WHAT MAKES AN EFFECTIVE CHANGE AGENT?

WHAT MAKES AN EFFECTIVE CHANGE AGENT?

Everett M. Rogers

I want to talk with you about a particular kind of change agent. An administrator is a change agent in the sense that he is seeking to change the behavior of the people who work for him. My comments are confined to communication between the local health care provider and his client or patient. I want to summarize those factors which guarantee an effective health worker; this includes the entire range of health professionals.

There are three main factors that explain the relative effectiveness of change agents. They are accessibility, competence and empathy. Successful preventive health care requires continuous interaction between the provider and the patient. Consequently, preventive health has to be provided by someone who is accessible to the community and can spend a great deal of time with individual households.

Curative health care also suggests accessibility. The demand for such care cannot be regularized. The provider must be prepared to respond when illness or injury strikes. Therefore, availability, location, number and type of provider, are all factors determining quality curative care. The most effective investment, then, of scarce health resources is in the training of paraprofessionals. This is the case worldwide.

The cost of training one doctor is equivalent to that of 30 paraprofessionals. It is a very rough rule of thumb and varies from country to country. Paraprofessionals are not going to put medical doctors out of business. Obviously, one still needs a physician despite the presence of the 30 paraprofessionals. Someone has to be available to deal with the more difficult cases. We are merely extending physician outreach by introducing greater numbers of paraprofessionals into the health care system.

Cost computations prove rather conclusively why no country in Latin America, Asia, or elsewhere could provide adequate health care only through professionals. There is a fundamental difference between a hospital clinic which is open certain hours and a provider who lives in the community and is available day and night. This is why I am emphasizing a kind of health continuum similar to the three tier system in the Peoples Republic of China. This emphasis on paraprofessionals, however, introduces several nuances -- number and location of paraprofessionals and accessibility over time. These issues must be resolved if health care is to be provided to the rural poor. China has probably done a better job than most to solve these problems.

Our continuum is as follows: professionals, paraprofessionals and non-professionals. We should not forget that a great deal of health care is provided by non-professionals. Self-medication and self-curing are often attempted before our clients contact any non-professional

or professional. That is true in China and every other country.

There are many kinds of non-professionals. There are traditional birth attendants like those found in Thailand, Indonesia, India, or parts of Latin America. It is estimated that 80 percent of the babies born in the world, today, are delivered by traditional birth attendants. This fact can be ignored, as Americans tried to do in the Philippines in the 1930s, or it can be acknowledged by incorporating these attendants into the system. Traditional birth attendants are, in essence, non-professionals, but they can be given some training and utilized.

Access to a health provider is almost a prerequisite to a successful health care delivery system. If no health provider is available, then there can be no change agent. Access to health providers is the number one problem in almost every country in the world, and the lopsided ratios of clients to providers make it all the more discouraging.

The second factor is competence. Here, the consideration is perceived competence, not objective competence. Training is irrelevant except to the extent that it is perceived to be appropriate by the user.

Competence is two dimensional. Competence includes both technical and psychological considerations. Technical competence includes actual skills. For example, can health providers perform appendectomies? This question has been put to China's barefoot doctors. Do health providers understand that basic consumer measures differ? In many cases, the measures are determined on the basis of appearance. The criteria may be the type of equipment available or obviously visible; it may be the building in which the provider is located or the transportation required.

Psychological or safety competence is, in essence, the degree to which the provider is perceived by the client as looking out for his or her welfare. Safety competence implies trustworthiness; that the provider can be trusted to put the patient's welfare above that of his own.

Safety competence also rests in part on the degree of similarity between the provider and the client group. Generally speaking, the more similar the two groups are thought to be, the more competent the health provider seems. The more the change agents, that is health providers, have in common with their clients, the more effective they will be.

In China, barefoot doctors spend about one-third of their time farming. Since their clients are almost entirely farmers, their safety competence is greatly enhanced. Furthermore, they provide services at no cost to the consumer, so there can be no confusion as to the fee or reward structure.

Barefoot doctors are, indeed, perceived by their clients as being very homogeneous, and, hence, as trustworthy. Unfortunately, as accessibility and safety

competence increase, objective technical competence appears to decrease. Finally, health providers must be empathic. Empathy is the ability to put yourself in someone else's place. It is, of course, impossible for a provider and his client to be identical socio-economically. Education, income and language may differ. However, it is possible to be psychologically similar.

In training our medical students, though, we caution against too much empathy. Our motto is "empathy without sympathy." The idea of empathy is to think and view the world in the same way as the client. By so doing, the chances of affecting client behavior are greatly improved.

There are many kinds of empathy training which seek to make professionals aware of client lifestyles. The Director of the Bogota National Agricultural Extension Service asked me if I would design a two week training course for new extension workers. I recommended that the workers live with peasant families for two weeks. The Extension Service compromised with a week. The workers had some real war stories to tell. They described sleeping with rats running over their bodies. Some developed digestive troubles from the bad food. But, the workers learned to see the world through the peasants' eyes.

X. PROMOTING COMMUNITY PARTICIPATION
IN PRIMARY HEALTH CARE

PROMOTING COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

PAHO AND POLITICS

Lillian K. Gibbons, Dr. P.H.

The World Health Organization has defined five components of primary health care. These include: (1) community participation; (2) integration of traditional medicine into the formal medical-care system; (3) appropriate technology; (4) intersectoral approaches to development, and (5) levels of health care. The Pan American Health Organization (PAHO) has pursued this theme in its Ten Year Plan, 1972-82. The goals set forth in the plan include the extension of health care services to all areas, especially the rural and peri-urban areas. Primary health care, therefore, is vital to the Americas.

Those who know Latin America recognize the problems surrounding large cities; the "pueblos juvenes" or shanty towns, and the population density. It is estimated that by the year 2000, 80 percent of the world's population will live in such areas. Therefore, PAHO is concentrating its efforts on these people.

PAHO is undertaking several projects in the next couple of years related to both primary health care and community participation. Community participation implies many things to many people. Researchers are not really sure what motivates individuals to participate in health care delivery.

What are the factors associated with community participation? PAHO is launching research projects throughout the regions. Workshops will be convened to discuss community participation and to propose a methodology for its further study. The questions posed include:

1. What are the factors associated with community participation and successful health projects?
2. What factors contribute to the failures of community participation in health projects?

This project begins in July, in the Caribbean, with another workshop scheduled for Costa Rica. PAHO plans to involve educators and others in developing the methodology. Our first objective is to develop a skeletal methodology. Initially the community will be only indirectly involved through the health educators. Later, however, community members will be asked to respond more directly.

Several positive results are anticipated from the workshops. These include identification of community factors and organizational determinants, as well as an overview of project failures. Finally, each country will develop its own methodology.

PAHO's approach will be anthropological and include case studies. Once the data are returned to regional headquarters, a panel of experts will be convened to review it. This panel will likely include health educators, community development experts and others; each will be closely associated with evaluating the data and disseminating it.

PAHO is involved with two other projects for which community participation is a component. PAHO is arranging for site visits for various country nationals so that they may observe the more successful regional primary health care projects firsthand.

The project will begin with 10-12 representatives from the Andean Pact countries; it will be a traveling seminar. PAHO is particularly interested in project replication and, therefore, will emphasize each project's structure, process and outcome.

Second, PAHO is also currently seeking to relate community participation to health education. Most of the health educators that PAHO has assigned to the regions are there to promote community participation in health care. Unfortunately, some of the programs that health educators develop are too traditional. Health educators need to re-focus their efforts. Community development is not a re-socialization process. Rather a more traditional approach is required--one that looks at the community as it actually exists.

Finally, those involved in the community participation study must also be aware of the subject's political implications. In Latin America, the issue has become volatile. The "conscious-izing" of local villagers is becoming a tremendous political threat; or at least is perceived as a threat by some officials. How community participation is ultimately defined will be very important. Consequently, any study of community participation must include some political analysis.

PAHO is working with governments to develop a community participation component in their national health plans. Some governments are fearful that if people are encouraged to develop their full potential and to assume responsibility for their own health care, then they may later demand authority elsewhere. We must proceed rather cautiously with some countries. If governments become alienated, then access to the "grass roots" will be forever denied.

PVOs have a unique opportunity to assist in both the study and mobilization of community participation in primary health care. Most PVOs' operational structure leaves them relatively free from the kind of bureaucratic constraints that WHO or PAHO can impose on its field personnel. PAHO's mandate is given by governments; it is to governments that PAHO must respond. Therefore, it seems likely that PVOs, and not the larger organizations, will produce the more innovative results.

PROMOTING COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

EDUCATING CANADIANS

Genevieve Donovan

Before I begin I would like to clarify the definition of PVO. In the United States, PVO refers to a private voluntary organization. Canadians prefer the term NGO, non-governmental organization. Therefore, when I speak of NGOs I am, in essence, talking about PVOs.

Community development projects are high on CIDA's list of funding priorities. CIDA has a very reasonable budget for its overseas projects. Of the total monies spent on such projects, five percent is earmarked for public participation programs within Canada.

Like most agencies, CIDA is vulnerable to budget cuts. However, relative to other departments, the NGO office is holding even with the previous year's funding level. This is due in part to the quality of our educational or public participation programs. These funding levels are also the result of some very vocal NGOs. NGOs have proven themselves to be effective lobbyists; and they are not willing to sacrifice good programs.

The objective of the Canadian public participation program is really to gain support for our overseas projects. The Canadian program is also used as a means of promoting fund-raising. CIDA feels that if the people who are donating their money, either directly or indirectly, through their tax dollars know how these monies are being spent, then they will be more likely to support international development. Such educational programs are one way of increasing Canadian awareness of NGO activities abroad.

NGOs apply to CIDA for a share of development educational funds, the NGOs will match whatever amount is given finally. Often indigenous NGOs are invited to Canada to speak with local NGOs and to the Canadian public to explain their needs and in-country program activities. Small Canadian communities usually respond favorably to overseas visitors, especially when they are applauding Canadian cooperation. The public relations value of such encounters is immeasurable.

CIDA's public participation program includes Canadian universities. Students come to Canada from all over the world. These foreign students are invited into the public schools to get to know Canadians and inform them of third world problems. Some universities sponsor an International Week; it is a real celebration bash! The rapport that develops in each instance insures prolonged interest in development.

It is difficult to talk about development education solely in a health context. CIDA tries to facilitate discussions concerning all areas of development. Obviously, health and agriculture are high on CIDA's list of funding priorities.

Recently, CIDA invited Dr. Nita Barrow of the World Council of Churches to come to Canada and speak at five university campuses on international health and primary health care. Such meetings do not single-handedly alter public opinion. These encounters, however, do expose Canadians to the concept of primary health care and its relevance to developing country health schemes.

Some audiences do respond favorably to our message. CIDA estimates that at least one faculty member and student per campus has made a commitment to international health. Development education is working. Canadians cannot be expected to become enthused unless they first know the problems NGOs face in the field.

Recently CIDA was successful in enlisting the Canadian Home Economics Association in our public relations efforts. The NGO Division Director was invited to speak at their conference, as were several foreign students. One day of the conference agenda was devoted to international development. These women are mothers and teachers; their potential audience is unlimited. Through their involvement other Canadians are being informed and encouraged to support development activity.

There are numerous examples of CIDA's programmatic impact on the Canadian public. Canadian churches each year sponsor Ten Days for World Development. This activity coincides with Lent. It is a fund-raiser--CIDA matches half of all monies--and a time of decreased food consumption for Canadians. The churches stress that if Canadians consume less, then more is available for export to the world's poor.

CIDA is very interested in funding innovative public participation programs. One rather novel approach has been to fund appropriate education programs for journalists. Journalism students exposed to international development require a certain "sensitizing" so that they will know how to seek out culturally-relevant, unbiased information. International development is front-page news.

PROMOTING COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

COOPERATION IN GUATEMALA

Mary Hamlin de Zuniga

I'm very happy to be with you and to share our experiences in Guatemala. First of all, I would like to tell you a little bit about Guatemala. Guatemala is a very beautiful Central American republic of six and a half million people. It is roughly the size of the State of Michigan with beautiful mountains, volcanoes and volcanic lakes. About 45 percent of the population is Indian, and, between them, they speak 17 different languages.

Many of these people have no land. Two percent of the population control 80 percent of the land. The density of the population of Guatemala is such that most of the people live in the western highlands; an area bordering on Mexico. The Batan, or jungle area, has a low population density, but it is growing with colonization. The country's east coast is Caribbean in its attitude. We live in a very geographically divided country.

Sixty-six percent of the population is rural and, 64 of that 66 percent, live in villages of less than 2,000 people. Most of those villages have no public services; there is a minimum of rural electrification and very poor water systems. Water is a major problem and you can imagine the public health implications it suggests.

The life expectancy of a Guatemalan is about 60 years. If he or she is an Indian, his life expectancy is reduced to 45 years. Forty-three percent of the children die before they reach one year of age. What do they die of? Diarrheal diseases and protein-calorie malnutrition. Over three-quarters of Guatemalan children under five are malnourished. Half of these children have first degree malnutrition. People die of malnutrition because they have no land on which to grow their crops.

One-third of the population, mostly Indians, must travel to the south coast each year to earn additional income. One-third of the population is forced to migrate to the cotton, sugar and coffee fields because they cannot earn enough money from their land to feed themselves.

Throughout history, the Indian people have suffered. First, the Indians were conquered by the Spanish. Later, they were reconquered by others who came to use their land and exploit their labor. As I mentioned, the south is rich in crops, but they are export crops. Sugar cane is exported. Beef is exported to the United States and Europe; it is used to make dog food while Guatemalans go hungry.

People are dying from diarrheal diseases and deficiency diseases. Guatemalans are victims of all of the diseases of poverty.

About 20 years ago groups started coming to Guatemala to provide health services. However, primary health care was not popular then. Instead, people were establishing hospitals and health centers; there was very little effort made to train rural health workers.

About 16 years ago, Dr. Carol Behrhorst and the Maryknoll Sisters introduced the concept of health promoters at the community level. Training began immediately in both Chimaltenango and Huehuetenango. These health promoters soon became a threat to the established medical profession. The medical profession was unimpressed that doctors were training people with only second and third primary grade educations. As time went on, however, the government began to realize that these were the people who were actually providing rural health care in Guatemala.

I arrived in Guatemala in 1975 and was amazed to find so many groups working in health care. I had come from a very isolated part of Nicaragua and was working to build communication networks between the various health personnel. It was very hard work. Government and private organizations were at loggerheads.

I came to Guatemala with the hope of trying to develop improved communications between those people working in health in Central America. In 1975 we sponsored the first regional encounter for world health programs; we also established the Regional Committee for the Promotion of World Health. David Werner, of the Hesperian Foundation, and I have tried to keep the Committee going over the years. Working with the Committee has provided us with a unique opportunity to get to know many of the people who were working in health in Guatemala. It did not take us long to realize how much people wanted to get together; to share their mutual problems and learn new ideas. Yet no mechanism existed to facilitate such exchanges. People had friends who would go from one group to the other, but that proved to be a poor use of people's time. The few people who were doing the really tremendous jobs were constantly besieged with inquiring visitors.

In February 1976, Guatemala experienced a devastating earthquake. From then on, we were flooded with relief agencies. A lot of you may have arrived about that time. The numbers of people working in health were staggering. The Agency for International Development provided funds to the National Academy of Sciences to do a study of private sector involvement in health in Guatemala. Academy researchers discovered that there were over 150 programs in operation. About 45 of these programs involved primary care. Others included nutrition and nutrition feeding centers.

We became particularly concerned with those 45 agencies who were providing primary health care. Service was being provided through parochial and non-sectarian clinics of 100 beds or less, or small clinics operating on a two day schedule.

Those conducting the study gave me their findings on the premise that I would follow up with the agencies. Several of the agencies had expressed some grave concerns, and they did not want the study to become yet another file. Catholic Relief Services provided us with a small grant so that we could once again visit the agencies studied. People were impressed. We discovered that the majority of the rural health care in Guatemala was being provided for through the private agencies. Of those 10,000 villages of less than 1,000 people, only 350 of them had access to any government health service. Ninety percent of all the people who were working with the private voluntary agencies were health promoters. They were people from the villages who spoke the language and could relate well to their fellow-neighbor.

Nobody had ever realized the impact that private agencies were making on rural health. This fact was astounding considering the size of the Guatemalan national budget. Forty-five percent of all rural health care was being provided by the private voluntary health agencies.

From discussions, a plan emerged. We would try to unite, together, in a federation or an association. Our objectives were: (1) to build communication links; (2) to share our human and material resources, and (3) to seek solutions to the high cost of drugs.

Some people were nearing the conclusion that, unless they could buy medicines, their facilities would be forced to close. We were talking about groups that received large sums of money from the United States, Europe and Canada. We were also talking about very small clinics who would send representatives to laboratories in Guatemala City to buy drugs to take back to their communities. For these people it usually meant a lot of money, four or five days of wasted time and few purchases.

We established our commission. No other country in Central America, including Mexico, has the number of private voluntary agencies that Guatemala has. The commission met to discuss the legal implications first surrounding its incorporation. No other organization like this exists in all of Latin America. There is a very good reason why. Doctors do not want such organizations. Governments do not want us because they perceive us as a pressure group. We do not live in an African socialist state. We live under an extremely repressive dictatorship. We had to be clever in our method of organization. Otherwise, the government health services would never accept us.

I want to point out that, in Guatemala, government health services are very well established. These services are given a great deal of money to provide medical care through hospitals in large cities. Unfortunately, they do not extend themselves to rural areas.

We had many friends within the Ministry of Health. However, in July of last year, a new government was elected in Guatemala. Twenty-three salubristas, people with public health training, were fired. We had lost our friends and government policy had ordered public health services to once again build hospitals. Why? Why does the government want to build hospitals? Because there is money in building hospitals. There is precious little money in training rural health promoters. Thousands of government rural health promoters have been thrown out into the villages; they are without any supervision. Those of us with established programs are trying to incorporate the promoters into our projects so there will be some supervision and follow up. Unfortunately, we cannot cover all of the rural health promoters trained.

We are now an association, ASECSA. We act as a coordinating and a service agency. We have tried to combine the best of both structures so as to meet the objectives defined by association members. We have believed, from the very beginning, that community groups should participate in the determination of association goals. A general assembly founded the organization and elected its Board of Directors. The Board of Directors consists of five members. These people reflect the organizations, themselves. One young man is a biochemist who works with appropriate technologies in medicine. We have an Indian hospital administrator. There is also a nurse. We have a physician who works with a rural health and development program, as well as a North American nurse who has resided in Guatemala for the past 15 years. Finally, there is a rural health promoter on the Board. Each member has an alternate, and all volunteer to serve on commissions.

The commissions are responsible for the planning and implementation of services. There are three services: administrative, therapeutic and educational. The therapeutic service took a great deal of effort to plan. It has taken time to determine a list of essential drugs for rural Guatemala. We are dealing with people who have been exposed to a great deal of propaganda about medicine. What our village people consider to be essential drugs is not always what, maybe I, or some others, believe to be necessary. We are, though, itemizing the most useful medicines for application in rural Guatemala. I want to stress that service is very cost-effective. Our members have realized some genuine savings.

The same medicines bought in the same laboratory in the same quantities can have a difference of up to 117 percent in price. It depends on who you are, where you come from, how much business you do and with what laboratory. We buy in quantities. The companies are interested in what we are doing; they want to sell to us because they know that we have buyers. Thus, we have been able to save up to 117 percent on the cost of our drugs. As a result, we are able to sell the medicines at a very low price. Furthermore, we are

able to provide people with information on what the drug is, its side effects, the dosages, and to inform them of its relevance to a particular disease.

You cannot find that kind of information on any drug indication slip in Guatemala. In many cases, the indication slips given in Guatemala are not the same indication slips found in the United States. The drug companies are selling many dangerous drugs just to make money. Drugs that cannot be sold in the United States are on the market there. We are trying to help people to understand proper drug usage.

We also have a program specific to traditional medicine. Right now we are studying twenty of the most popular traditional medicines found in Guatemala today. Once analyzed by the Faculty of Pharmacy, these medicines will be available through our pharmacy as well.

Our educational service offers a two-pronged approach to learning. One approach is through the information center. The Center consists of a library, a resource facility and a book store. People can now buy books or materials at a low price for use in their programs. We have, now, in one place, most of the materials that have been written in Guatemala on health and health promotion. We also serve as the Latin American representative for David Werner's book Where There Is No Doctor, and we act as the distributors for Editorial-Pax Mexico; the group that does most of the English-Spanish translation of medical and paramedical texts.

We not only serve Guatemala with our information center, but also most of Latin America. The Center has movies, slides and other materials that people can take, use and return. We are making resources available to people who would never be able to buy them.

We also have a program of regional meetings. There we sit down with members and non-members in various areas of the country and work toward solutions to their specific problems. If they want a workshop on how to make simple visual aids, we will have a workshop on how to do so. This week, we are having the second meeting of representatives from government, INCAP, the Nutrition Institute in Guatemala, private organizations, artists, and others interested in the preparation of materials. We are attempting for the first time, to unify our criteria for teaching nutrition in the first year of life.

Everybody is teaching something on nutrition. But we have to be in the position of saying the same things to people. We are all supposed to be health experts, yet we all say different things. Consequently, we have been asked to more or less thrash out a consensus approach to nutrition education.

This all sounds very pretty, but do not underestimate the difficulty. Agency people are not used to working together. They have not always been willing to sit down and

discuss their problems. Some people are not yet ready to face the fact that one day all North Americans, all foreigners, may be forced to leave Guatemala. We do not want to teach dependency. There's too much dependency already. In health we want to work toward the day when our programs will be directed by Guatemalans; when Guatemalan health promoters are able to determine the content of the health programs in their areas. We have commissions of health promoters who run health promoter programs in the host state of Huehuetenango. Promoters make the decisions about what happens there. We want to share this expertise with other members.

I would just like to close by saying the effort that is being made by the people working in Guatemala; their willingness to come great distances to meetings, as well as give time and effort to the organizations is very gratifying. The response has been an open one. We are sure that in the next few years we will have established an association that no longer requires outside funding to survive. We hope to achieve self-sufficiency within five years. We are seeking ways to minimize our costs. We expect a lot of "buena voluntad". Buena voluntad translates as good will, and that is exactly what we have. We know that unless we can work together, we will never be able to protect ourselves from those situations which inevitably lead to the destruction of rural movements in Guatemala.

PROMOTING COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE HEALTH AND WELL-BEING

Sulochana Abraham, M.B.B.S., D.S.Q., M.D.

Existing health care systems in most parts of the world cater mainly to the needs of the urban elite. Thus the health needs of rural populations remain largely unmet. The magnitude of this problem suggests the need to develop a medical and health care program which would reach the vast majority of such populations. This program, to be successful, would require the cooperation of entire communities.

My remarks are based on the experience of the Community Health Department of the Christian Medical College, Vellore, South India. The Department caters to the health needs of a rural population of 30,000 persons as well as to those of an urban area of some 20,000 people. The College has been providing comprehensive health care for the past 23 years and primary health care, as defined by WHO, for the past five years. In 1977 a similar program was begun in an adjacent community. As a result the Rural Unit for Health and Social Affairs now serves approximately 80,000 people.

Community participation can be defined as the process by which individuals and families assume responsibility for their own health and welfare and develop the capacity to contribute to their own development and to that of the community. Through this process individuals are made aware of their own situation and of their potential for implementing change. Change occurs for the betterment of the community as a result of their own initiative and resources, not because of outside inducement.

It is unfortunate that people in rural areas have never been motivated to think for themselves. Rather, these people have been forced to become dependent on benefactors, obliged to accept solutions that have already been determined for them. This passive, non-questioning acceptance of their role is probably the result of voluntary organizations working among the needy, providing them with only material and monetary benefits. PVOs have made few attempts to better their attitude toward life.

Government programs are not without deficiencies either. We in the College have been guilty of some of these same faults. Realizing the pressing need for improving the health needs of the community around the hospital, we deemed it essential and appropriate to deliver health care to them at their doorsteps. It is little wonder that only 40 percent of the pregnant women had ante-natal care and that only 40 percent of the children had immunizations in spite of the untiring efforts of the health personnel. We worked under the misconception that what we felt was their dire need would also be the felt needs of the community. Efforts were made

to involve the community in implementing the program by talking to the leaders and women's groups. Even this was of no avail. On many an occasion the villagers would bring to our attention that food, water, and better income were their priorities and not ante-natal care, immunizations, and other preventive services. It was this constant dilemma that made us change our outlook and approach to health care.

The first major change in trying to involve the community was the attempt to utilize our own local resources. In India, as many as 80 percent of all babies are delivered by Dais or attendants. The doctor with his modern techniques, is regarded with suspicion by the village women. The villagers and the midwives share a common cultural identity with the patient and speak the same language. Consequently, the College sought to identify these midwives and trained them to provide better and more acceptable community service. A survey conducted three years after completion of the training revealed that only 15 percent of all deliveries were being handled by untrained women.

The experiment with midwives was gratifying; it proved to us that these women could do more than just deliver babies. Hence the community health workers program was initiated. The emphasis in this new program was given to community involvement in primary health care. This was a major step in involving the community. The community became responsible for selecting, supervising, and evaluating the activities of the health worker. Villagers are charged a small fee for the health worker's services. Since the community in a sense "owns" the program, there is built-in encouragement to seek its improvement and successful implementation.

In planning the health workers program, we have tried to follow closely the guidelines set forth in the 26th issue of Contact. Axiom 2 states, "Design for health planning will not take root if it is designed for the people instead of by them." Axiom 3 states, "Provision of health care is more acceptable to the people if it is brought by persons selected by the community, out of the community, and who remain an integrated part of the community throughout their training and work."

Selection of the Villages

The College's program was not imposed on any community. The programs were explained at a large village gathering and those who wished to have the program were welcomed, provided they were willing to participate fully and to locate many of the resources. Villages which showed an inclination then proceeded to nominate and select their own health committee, which consisted of a chairman, a secretary, and a treasurer. Committee membership varied from seven to thirteen individuals. Care was taken to insure that every section of the community was represented, including women.

The health committee is responsible for planning and implementing the program. The health team serves as resource

persons or observers. Too often past health teams have imposed their ideas on the community, and this has been the reason for failure of many of our health programs. The role of the health team should be to sensitize the committee members. The health committee and the health team are required to meet once a month. Occasionally health committees from different villages meet together to discuss their experiences and limitations. The health committee plays an important part in supporting and encouraging the health worker.

Selection of the Worker

Guidelines helped the committee choose its health workers. These guidelines specified that the health worker should be female, between the ages of 25 and 45, preferably married, and with at least a minimum of formal education. It was interesting to note that despite these guidelines, two of the twelve villages selected unmarried, illiterate women. The unmarried women, however, soon proved their worth. One has proven to be one of our most dilligent health workers. What we assumed would be the ideal criteria were proven incorrect.

It was thought that meetings should be held once every month. Actually it is difficult to arrange a meeting once in two months. The health workers program is the community's responsibility, and it is up to the committee to guide the worker in solving problems. The villagers' main interest is usually to change the socio-economic status of the community. Consequently, the department embarked on programs which would help to improve this status. Cottage industries and tailoring units were started for women. Every effort was taken to insure community responsibility in this project. The department helped to provide the sewing machines, but the trainer's salary was paid mostly by the women. The community provided the workplace and paid to put up sheds and secure raw materials.

A good example of community participation is our Dairy Project. The State Government had a Dairy Development Corporation which was trying to form societies in villages. Members of the society sold the milk to the community, who in turn supplied the cooperative market. This ensured that co-op members were getting more money than if they sold their milk to the private vendors.

To make the community aware of the program, members of the Dairy Cooperative and the State Bank were invited to address the community. The leaders, realizing the co-op's importance, made an active effort to enroll members into the society. However, when it came to the milk supply, the cattle owners faced threats from the private milk vendors who had loaned money to many of them on the condition that milk would be supplied to them. The private milk vendors made an obvious profit on this deal. The co-op proved to be a threat to their thriving business, and the cattlemen were not in a position to repay the loan. The cattle owners,

through their representatives, approached the Community Health Department to raise the money to repay the loan. Meanwhile, the milk vendors continued to threaten co-op members. The villagers stood together and were able to overcome their problems. A society which could provide barely 25 litres of milk now was able to distribute 100 litres per day.

The village of Veppenpet, with its population of 1500, is yet another success story. The medical students who visited the village weekly realized the implications of social factors on health. The students had already created a rapport with the villagers. With the welfare of the villagers at heart, the students took it upon themselves to help the villagers improve their economic status. After considering the limitations, they offered to teach the village girls the art of macrame. The members of the village got together and selected a bright young girl to go an institution to learn this new art. She traveled ten miles each day and paid her own way. After several weeks she had mastered the art and could now impart her knowledge to others. Over twenty-five girls had enrolled in her class. A committee was formed which included two women from the craft center. A shed was erected, thanks to a small contribution from the College, and in no time the craft center was in full swing. The committee met monthly to discuss their progress. Instead of redistributing the center's profits among its members, the committee decided to utilize these funds differently. One of the leaders had a centrally located irrigation well; however, he did not have the money to install an electric pump. The committee agreed to loan him the money, to be paid back with interest, on the condition that he also provide water to irrigate the lands surrounding his own. Within a month the barren land was cultivated.

The leaders, with the help of the enthusiastic craft girls, helped to organize immunization programs. Ninety percent of the children were immunized; this was accomplished with very little input from the health team. The craft center is entirely managed and supervised by the village; the College only helps to market the products.

Mothers clubs have been formed in all our villages. These clubs meet with the health team once a month at a convenient time. These gatherings provide an educational encounter for the mothers. It was as a result of these meetings that the mothers requested that tailoring classes be started. In order to generally broaden the members' outlook and provide incentives for improvement, tours were arranged to places of historical importance as well as to other craft centers. These experiences have helped make the women more aware of their own capabilities and more able also to make group decisions when necessary.

Youth clubs have been formed in all of the villages and they likewise contribute to immunization and other health programs. Sporting meets are held yearly for village youth.

This encourages participation and also provides an opportunity for them to meet young people from other villages. The youth are also utilized in drama and skits which are part of the educational process.

From these experiences it is clear that community participation demands flexibility. Voluntary organizations must be prepared to accept suggestions made by the community and to make the community's priorities the project's concern. Health should be viewed through the community's, rather than through the professional's, eye.

Ours has not been a total success story. We have had many pitfalls, disappointments and frustrations. On many occasions the health team has had to retrace its steps. Immunization programs planned in minute detail have met with poor attendance. Such instances have dampened our spirits. However, we realize that it is a slow process, and we need to work patiently to grapple with community problems.

I would like to conclude with a Chinese poem which conveys the concept of community participation:

"Go to the people,
Live among them,
Learn from them,
Love them.
Start with what they know.
Build on what they have.

But of the best leaders,
When their task is accomplished,
Their work is done,
The people all remark,
'We have done it ourselves.'"

- Old Chinese poem.

XI. CASE STUDIES

COMMUNITY HEALTH CARE DELIVERY -
THE CHALLENGE TO MISSION HOSPITALS:
REPORT FROM HAITI

Jean A. Morehead and Jack J. Fransen

Mission and private sector hospitals in developing countries are facing an unprecedented challenge. These hospitals are finding themselves at the advancing edge of a movement whose purpose is to question a number of very basic, long standing tenets associated with health care delivery. This movement is in response to the repetitious, relentless call of the world's poor; human beings caught in the ever tightening grip of rampant population growth, social and economic inequalities, and malnutrition of the body, mind and spirit. We are confronted, daily, with the stark reality that our current disease-care delivery system is simply not adequate. This is especially true if our ultimate goal is positive health for a community or a country. To paraphrase the words of Dr. Carroll Behrhorst of Guatemala: to attempt to eradicate disease by curing the sick is to "try to empty the Atlantic Ocean with a teaspoon. It made the toiler feel active and useful, and caused everyone to exclaim, 'My, what a beautiful teaspoon!'"¹/ The lasting impact is negligible.

These concepts seem so obvious and simple. Yet many mission and humanitarian organizations involved in health programs in developing countries persevere in following old paths. These groups equate progress with multiplying teaspoons! I would like to comment briefly on the future direction health care is likely to take, and to express my feeling that mission and private sector hospitals possess the leadership potential necessary to sustain these new trends.

Those of us in the field of public health and development are laboring under a number of false illusions. The constitution of the World Health Organization, in 1948, defined health as "the state of complete physical, mental and social well-being, not merely the absence of disease or infirmity." We persist, however, in calling the system, as currently structured within the developing countries (and in the United States), the "health-care delivery system." Need I comment further that everything about the present system is disease oriented?

Would not a system of "health care," among other things, be one in which the training institutions set about to train professionals to help themselves to stay healthy? If this were the case, then such topics as prevention, health education, and community organization would no longer be considered soft electives. Health professionals would no longer be rewarded on an ascending ladder of elitism; each rung dealing with more exquisite and rare pathologies. The financial and power base within the system would be forced to move outside of the diagnostic

and treatment institutions and take up residency where the action really should be, namely, in the community. Good health, like good education, would more likely become a right than a privilege. The community health care professional would no longer be considered a mere "paramedical." Instead the doctor or nurse would be the "para-health worker." This shift in hierarchy would identify the physician's adjunctive position, rather than allow him a primary role. The community health care worker, then, would assume responsibility for keeping the community healthy.

These are not facetious comments. I am convinced that primary health care, if it is to be effective at all, is going to demand a radical redefinition of "good health." Mission and humanitarian organizations serving in developing countries should be among the first to understand the broader meaning of health. Viewing man in his entirety is part and parcel of most of their service programs. These organizations are, therefore, in a pivotal position to help advance a system which would address some of the wider problems of health care delivery.

The majority of mission and private sector health facilities in developing countries are located where the vast numbers of unhealthy live, that is, in rural areas. The facilities usually have been in their locations for a substantial length of time. Their stability is derived from a commitment to the local people. Many of the administrators and staff have a knowledge of and working relationship with the local political infrastructure. Personnel are usually conversant in local dialects and have observed key change agents. Hopefully, too, they have identified some of the felt needs of the communities in which they live. It has been said that hospitals in developing countries are the greatest untapped resource available to a country's health care system. 2/ As a public health consultant to a number of church-related agencies, I must agree. The potential for multiplying a community's knowledge of health is there, within the walls of the hospital. The question is how to get this knowledge into the hands of the community itself.

What, then, are the key barriers blocking these community-based health programs? Most members of hospital governing boards are expatriates; many are overly oriented toward treatment programs. It is becoming increasingly difficult to finance, staff, and maintain these high-technology treatment centers at levels acceptable to such boards. Most are not willing to contemplate the addition of new innovative community programs. It is argued that these programs will multiply costs and pull staff away from their "primary duties." Staff members, themselves, are reluctant to accept new roles which emphasize areas of preventive health care. Their educational background has inadequately prepared them to deal effectively with issues such as community involvement and development, health education, and group dynamics. The

medical staff is hesitant to become involved, as they see it, in the non-health needs of the community.

There are no familiar measurement indices for determining success. The affirmation of a job well done may be years in coming. All of these facts feed the desire to maintain the status quo. Yet the situation is not without hope! Innovators do exist within the system. The Doctors Arole, Directors of the Jamkhed Project in India, are outstanding examples. The Aroles began with the felt needs of communities and proceeded from there. They saw themselves as trainers of community health workers and adjusted their curative time accordingly. Revenues from curative services helped to finance the preventive services. ^{3/} At the time of my visit 3½ years ago, the program's goal of becoming self-supporting was close to being achieved.

I want, now, to move from the general to the specific and focus on one organization's attempt to follow the trends I have just been outlining. Grace Children's Hospital in Port-au-Prince, Haiti, was established eleven years ago as a private sector hospital to treat children with tuberculosis. Its founders were directed toward the establishment of a T.B. treatment facility only after discussions with a number of mission and government health officials. These health professionals emphasized the outstanding need for this type of facility; over 85 percent of the adult population would test positive to a tuberculin skin test.

From 1967 to 1975 the hospital maintained approximately 200 inpatient beds. The average stay, per person, was one year. After discharge, patients usually continued on drugs for an additional year. A program evaluation took place in 1974-75. The result was a shift in emphasis from inpatient to outpatient treatment. Not everyone on our Board of Directors agreed with the new outreach program. However, it was to the Board's credit that they allowed the expanded outpatient clinic to come into existence. It now services over 4,000 patient visits a month.

The T.B. consultant who evaluated our program has written that "at least two-thirds and probably more of the patient population would have no need for hospitalization provided that adequate ambulatory drug treatment were available. For these children the hospital is in fact serving primarily a custodial function." ^{4/} I might add that this finding is not confined merely to hospitals serving T.B. patients. Dr. Helen Gideon, in 1973, carried out an analysis of eight generalized mission hospitals in six Indian states. Her findings suggested that "48% of inpatients would probably not have needed to come to the hospital if they had been treated or advised earlier by a paramedical worker." ^{5/}

As difficult as it is for me to admit, I realize that in making the shift to the large ambulatory clinic we are still just multiplying the teaspoons. We were treating far more patients, but the critical preventive aspect had yet to be addressed. In the latter part of 1975, International Child Care, the foundation which supports Grace Children's Hospital, began a project of BCG vaccination for children from 0 - 20 years old. This mass immunization project utilized dermajets. Teams of Haitians were trained to do the advance work of contacting local chefs de sections. Their duties included public information meetings, organizing the crowds on vaccination days, supervising the record keeping, issuing patient cards, and administering the vaccinations. Auxiliaries were also trained to give the newborns their vaccination by syringe. Over a million children nationwide have been vaccinated against T.B. in the three years.

Per patient costs for these three programs differ widely. An average hospital stay of 4½ months costs approximately \$652.00 per child. This compares to \$27 per child in the outpatient clinic. Our mass vaccination program costs \$1.15 per child.

Once the vaccination program was put into effect, it became necessary to develop some system for maintaining vaccinations of the newborns. Initially, teams would return to previously vaccinated areas in order to inoculate newborns, but the expense per infant proved too prohibitive. We then began to ask that small mission and government clinics carry out the outreach program. This attempt was equally unsuccessful, as most of these clinics were outreach oriented, and, hence, poorly equipped to deal with the community. The Program Director wrote, "Many of the small mission clinics are understaffed and overcrowded, often treating ailments as presented by patients rather than engaging in preventive programs, vaccination and education." 6/

In 1978 the program began to recruit rural health agents. This was done partly out of frustration. These health agents were men and women chosen from the community in which they were expected to work. They were chosen for their intelligence, motivation, capability and dependability. The health agents were given a short apprenticeship on a vaccination team. If their work habits and attitudes appeared favorable, then they were sent to Grace Children's Hospital for further training with the Department of T.B. Control. Basic training included general hygiene, nutrition, first aid, and simple diagnostics. When the health agents returned to their villages they were expected to monitor the treatment of T.B. patients, to put their training into practice, and to promote better water supplies, latrines and housing. The hospital, in cooperation with the Department of T.B. Control, will train approximately 80 new community workers this year. This will be the basis for a pilot project of T.B. case finding, treatment and control.

I wish that I could report to you that our program had begun from the bottom up; that we had first come to Haiti and established our goals by determining the felt-needs of the community; that we are able to finance our preventive work from our curative services, or that communities, themselves, had financial control and responsibility for the health agents. This is not yet the case. We are aware of all of these shortcomings, and we are most cognizant that our goal must be to build a system which can eventually be taken over and integrated into the government health infrastructure. We have added preventive care to curative services. Our vision for the future is to press on so that one day we can say that we are truly delivering health care.

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- 1/ Carroll Behrhorst, Health by the People, ed. by Kenneth Newell (Geneva: World Health Organization, 1975), p.31.
 - 2/ Rufino L. Macagba, "The Changing Role of Hospitals in Developing Countries" (Manila: VII International Hospital Federation Regional Conference) November, 1978.
 - 3/ Mabelle and Rajanikant Arole, Health by the People, ed. by Kenneth Newell (Geneva: World Health Organization, 1975), p.15.
 - 4/ Thomas M. Daniel, Report on the Child Care Foundation and Tuberculosis Control in Haiti (Cleveland: Case Western Reserve University School of Medicine, September 1974), p.15.
 - 5/ Helen Gideon, "How Much of a Hospital's Work could be Done by Paramedical Workers?" Contact No.17, (October 1973), p.9.
 - 6/ Henry D. Kroop, Personal Communication, April 1979, p.13.

CASE STUDIES

THE HOSPITAL AS CHANGE AGENT: A REPORT FROM ZAIRE

L. Arden Almquist, M.D.

Mission and church-related hospitals in third world countries often enjoy a long history of credibility. Reputations are won through constant quality service, despite repeated episodes of political and economic chaos. The thesis of this paper is that such hospitals may now capitalize on their reputations and become effective change agents. Admittedly, in most third world nations, governments have assumed full responsibility for national development, including development of the health sector. Governments have over extended themselves, particularly in the rural areas, and many health needs go unserved. There is a role for the PVO-related hospital of solid reputation to act at the community level. Well-designed programs have access to funds from foundations, from philanthropic and religious agencies, and even from governments disillusioned with the results of large scale aid programs. Money can be found for those programs showing significant indigenous support and a strong element of self-help.

I wish to illustrate this thesis with a description of five hospital programs in Zaire. All have occurred within the past decade, or earlier, and have moved from a traditional emphasis on curative medicine to become agents of change. It is not possible, in the limited time afforded me, to offer detailed statistical proof of the soundness of this thesis. However, I am prepared to attempt to validate it. There are other hospitals in Zaire, but, again for lack of time, I include only the following:

1. Bulape: a 100-bed Protestant hospital located in the Mweka Zone of the West Kasai region. Its expatriate relationship is British.
2. Bwamanda: a 150-bed Catholic hospital in the Ubangi sub-region of the Equator. The expatriate relationships are Swiss and Belgian.
3. IME Kimpese: a 400-bed ecumenical Protestant hospital in lower Zaire, between Matadi and Kinshasa. Its expatriate relationships are American, British and Swedish.
4. IMELOKO: a 155-bed government hospital in the Businga zone of the Mongala sub-region of the Equator. This hospital is managed by a Zairean philanthropic PVO in association with the Paul Carlson Medical Program of Chicago.
5. Vanga: a 200-bed Protestant hospital on the Kwilu river in the region of Eandundu. The expatriate relationships are American and Canadian.

Each possesses unique features. I will concentrate, though, on their commonality since what emerges, in my opinion, is a replicable model.

All of the hospitals serve populations ranging from 20,000 to 200,000 persons. Each focuses on the delivery of primary health care through a comprehensive, integrated community health program. The shared elements are:

- A. Base hospital of 100 to 400 beds.
- B. Satellite health centers established on self-help principles; variable in number (up to 25); serving 4,000 - 15,000 people in a radius of 10 - 15 kilometers and staffed by two to seven persons.
- C. Mobile teams, one to five in number and staffed by two to six persons, travelling by foot, bicycle, motorcycle, 4-wheel-drive vehicles, truck, or single engine plane.
- D. Community health programs:
 - a) Pre-school consultation (under-five clinics)
 - b) Pre-natal consultations.
 - c) Family planning ("desirable births" in Zaire).
 - d) Nutrition programs.
 - e) Training programs.
 - f) Tuberculosis/leprosy control.
 - g) Immunization campaigns.
 - h) Sanitation/hygiene instruction.
- E. In addition, one or more of the following may be a further component at one or more of the centers named:
 - a) Primary school health program.
 - b) Eradication of intestinal worms/latrine construction.
 - c) Goiter/cretin control.
 - d) Agricultural development.
 - e) Development of appropriate intermediate technology.
 - f) Adult literacy program.
 - g) Bible classes and/or evangelism.

There may be more than one base hospital in a single complex of integrated community services as in the case of Vanga-Sala/Busala and Kimpese-Sona Bata. The base hospitals offer: (1) essential curative services tailored to the community; (2) public health services and preventive medicine, as described above; (3) nutrition services; (4) specialty services, reflecting needs peculiar to the larger areas served; (5) research in medical problems specific to the area, such as leprosy, schistosomiasis, buruli ulcer in Kimpese or endemic goiter/cretinism in Bulape; and (6)

training programs for nurse auxiliaries, medical assistants, midwives, health advocates and preceptors. Some of the centers offer several training programs.

The resident nurse practitioners in the satellite health centers are capable of diagnosing and treating 90 percent of the patients seen. They refer difficult problems to the base hospital, perform minor surgery, and, unless a midwife is present, handle normal deliveries. The nurse practitioner is also responsible for the public health and preventive medicine programs of the villages served. This includes case-finding and ambulatory treatment of tuberculosis and leprosy, under-fives, pre-natal, family planning, and immunization clinics. Mobile teams assist the local nurse practitioner in these and other programs. Such programs may incorporate sanitation, eradication of worms, control of water sources, and the forming of local health committees.

Time does not permit describing each program in detail. Most are self-explanatory. Immunization, for example, may include polio, DPT, measles, BCG, and smallpox. However, I prefer to focus on the uniqueness of each program.

Bulape, for example, carried out a goiter survey in 1976. This was followed by a program of iodized oil injections as part of its pre-existing community health program. Pharoah, and others, have reported that, in goiter endemicia, women with the most abnormal T4, T3, and TSH levels show a higher frequency of spontaneous abortions, stillbirths, and cretins.^{2/} The Bulape survey showed a 28.5 percent prevalence rate for endemic goiter. These findings certainly justified an attack by the community health team. Dr. Brown writes "perhaps the most important element in administering the goiter control program lies in the pre-existing community health project. The mobile team is already functioning in the villages. Team members routinely give injections to large groups of people and lecture on nutrition and other health topics. A firm rapport is already established between village people and Bulape health workers. The goiter surveys and iodine injections are rightly regarded as a routine part of a broader community health service." ^{3/}

Bwamanda, again on the basis of a broad community health program, has successfully introduced soy beans into the diet, thus enriching the local "fuku" (manioc mush) with an acceptable protein. This mix was developed through persistent experimentation, particularly a soy bean milk for undernourished infants. At the same time, raising soy beans for the nearby Comingem vegetable oil and soap factory at Gemena has improved the standard of living for the local farm populace.

Kimpese has a deserved reputation as a rehabilitation center. This center is unique in West Central Africa, as its community health efforts are rooted in self-help. As a center for the care of Angolan refugees, Kimpese's nutrition

programs evolved quite naturally. The nearby CEDECO project, an imaginative program of agricultural development, is a Kimpese spin-off--an instance, in short, of the hospital functioning as change agent. CEDECO, for example, makes plows, cultivators, corn-shellors, coffee-hullers, and cotton gins from simple materials such as wood. These implements can be replicated by skilled craftsmen in any part of Zaire.

Dr. Dan Fountain of Vanga has produced a superb 255-page manual of diagnosis and treatment for use by nurse auxiliaries and others. Entitled How to Build Health, it focuses directly on the delivery of primary health care. Vanga has been uniquely successful in ascaris eradication campaigns. Ascaris campaigns have been linked to latrine construction and village sanitation, including control and amelioration of the village water source. Ascaris eradication is highly significant. "It has been estimated that perhaps one thousand million people...harbor roundworms. Many pediatricians, and others, have a feeling that this parasite is contributing substantially to ill health and to growth retardation in tropical children...Stephenson et al. have shown that ascaris suum in malnourished pigs adversely affects nitrogen balance and also results in pathological changes in the small intestine...Stephenson and Latham have found that ascaris infected Kenya preschool age children grow significantly after being dewormed. 4/

The IMELOKO hospital was built by the Belgians as a leprosarium from a land concession of 2,320 hectares or 5,600 acres. Located in a mixed savannah/forest 40 km from the urban center of Businga, it lay unused until March 20, 1968. Dr. Wallace Thornbloom, veteran Covenant missionary, opened its doors at a time when the expatriate missions were surrendering their charters to the indigenous churches. Instead, IMELOKO secured a charter as a philanthropic PVO. Its Board of Directors, six Zaireans and one expatriate, were mandated to manage the hospital and its programs.

The hospital opened with a public health bias. It operates as a primary care center providing general services. IMELOKO has sired seven satellite primary care centers--all on a self-help basis. In five of the seven instances, the local community has built the center, including a dispensary and resident nurse's house. One group of villages, Bojarawa, added a 20 km road. Another, Ngakpo, built an airstrip in the rain forest; it was their only means to secure a resident nurse or visits from the mobile teams. On two occasions, long-abandoned government dispensaries were taken over.

A specially constructed mobile unit was fielded from the outset. Staffed by a driver-mechanic, doctor, nurse-midwife, and nurse aide-lab technician, the team sought to establish a data base among primary school children. No up-to-date facts on endemic diseases were available to the team. Dr. Theodora Johnson and her team, twice, toured the entire Ubangi/Mongala sub-region, living in the villages for weeks at a time, examining children, interviewing mothers, and

treating problems presented them. Dr. Johnson reported her findings on 18,000 children at an international conference on mobile clinics held in Yugoslavia, and her invaluable collection of basic health information is now at the University of Brussels for transfer to a computerized record.

The certified staff consists of:

- three physicians: an American internist, Dr. Roger Moxon, of Grand Rapids, Michigan; a Zairean generalist, Dr. Masukiti; a Zairean/American preceptor, and a visiting specialist, Dr. Waldo Newberg, a San Francisco surgeon.
- one expatriate R.N./midwife/anesthetist, Jody LeVahn.
- three Zairean R.N.s: Ganakomba Ashemba, hospital administrator, trained at Kimpese, Vanga, and Rennes, France; Ngobo Bidobe, surgery and family planning, trained at Kimpese, Karawa, and Mama Yemo, Kinshasa Loma, anesthetist, trained at Kimpese and Mama Yemo, not yet returned.
- eight auxiliaries at the hospital. One is specially trained as a laboratory and X-ray technician.
- seven other auxiliaries, who staff the satellite primary care centers.
- one midwife, Babese Motemo, wife of the hospital administrator, trained in midwifery at Karawa and in family planning at Dakar and Rennes, France.
- one expatriate builder/engineer, Robert Bergstrom, with nurse/wife, Erma.
- one Zairean electrician, Ngendu Aboli, trained in Brussels.
- two agriculturists; one expatriate, Richard Newberg, and one Zairean, Penze Fatigbe, trained at Nsele, President Mobutu's farm near Kinshasa.
- one expatriate nutritionist, Jim Thomas.
- several driver/mechanics, masons, carpenters, painters, etc.

IMELOKO has been able to function as a change agent because it has had the good fortune to have a land grant which has permitted it to move naturally from nutrition to agriculture and the development of appropriate intermediate technologies. It has combined basic community health efforts with farming to raise the standard of living of a number of people. A second bit of good fortune is the relative nearness (80 km) of the Karawa hospital, an excellent curative center with schools for auxiliaries and mid-

wives. Karawa also has a trade school and shop geared to offering technological help to the region.

Let me illustrate my thesis with a description of the cattle/fish pond/soy bean/rice/water supply set ups. Together they constitute an exciting ecological model.

A cattle program was launched in 1974 with help from OXFAM, USAID, and the Peace Corps. The construction of six fish ponds was made possible by a gift from World Vision. These ponds are fed from the overflow of a water system built by the Belgians. Spring water is captured and pumped to the reservoir which supplies the hospital and staff dwellings. One fish pond is large enough to be used for recreational purposes; it is deep enough, at the dam, to permit the construction of a water wheel. The fish are vegetarian Tilapia, which reach pan size in 6 months, when given daily feedings of papaya and manioc leaves and weekly feedings of hammer mill sweepings (corn, manioc, soy beans). Finally, the overflow from the water wheel feeds a series of rice paddies. Dry rice is indigenous to the area, but yields are low.

The cattle herd now numbers over 200. This is despite an extension program and the twice-monthly butchering of beef for hospital patients and staff. The manure fertilizes gardens, winged bean and soy bean fields, as well as the fish ponds (for algae production). The cattle are local Dhama/Dahomey-Guinea; they are resistant to sleeping sickness. Fifteen area farmers have started their own herds from Loko stock. Three have built their own fish ponds. One individual, inspired by the water wheel built at Karawa by Bob Thornbloom to serve that hospital, is building a water wheel at the base of a waterfall in his own village. The water wheel will act as a small generator for electricity and will power a hammer mill for grinding corn and manioc, and a coffee huller. This action will triple the return on his coffee when he sells it. Appropriate intermediate technology! The hospital as change agent!

There are other programs (milking goats, rabbits, and the like) and instances of appropriate intermediate technology (a charcoal-burning autoclave, a mobile saw mill). I could name a score of individuals who have taken what they have learned at or from IMELOKO to launch themselves in agribusiness or crafts. Individuals like Zebanza, a Loko carpenter who now, on his own, makes doors, windows, furniture, and truck bodies. Zebanza earns a fine living and is a credit to his family and village.

Research into endemic and epidemic diseases has been an integral part of the IMELOKO's total approach to primary health care. In 1968 the Armed Forces Institute of Pathology used IMELOKO as its base in studying the buruli ulcer in Zaire. Institute personnel returned in 1977 for an in-depth study of onchocerciasis. Onchocerciasis affects 40,000,000 of the earth's population and has blinded half a million. IMELOKO staff has collaborated with the University

of Brussels, IRSAC (Zairean national research agency), and the Karawa hospital to study endemic goiter/cretinism and its treatment. Again, during the epidemic of Ebola hemorrhagic fever, a fever which killed over 300 people in Zaire and the Sudan, IMELOKO supplied a mobile team for case finding.

What does restructuring the hospital potentially accomplish?

1. It can lower mortality and morbidity rates, especially among children.
2. It improves nutrition, with all that that implies.
3. It resolves the curative/preventive medicine priorities dilemma and inculcates wholistic relationships among diverse services, that is medicine, agriculture, church, government and education.
4. It can raise people's living standards.
5. It can liberate people long paternalized from depending on others and restore their dignity and initiative.
6. It strengthens the laypersons of the church so that they assume responsibility for financing the church's programs, including the construction of buildings. Hopefully, this will free the church from the dominance by expatriate agencies.

The hospital is a change agent whether it knows it or not; whether it chooses to be or not. Dr. Van Leeuwen has stated this incisively: "The cure of sick bodies makes a backward village community absolutely dependent on the resources of modern medical science, which are among the greatest achievements of our secularized world; it brings down the death rate and upsets the traditional stability of social life; it creates fresh needs and fresh wants; it lays the village open to a money economy and the world market--the sole agencies through which a 'cured body' can go on providing itself with the means of enjoying in the future the same standard, or, if possible, even a better standard of physical security." 8/

The challenge for those who deliver primary health care is whether to play the role of ostrich or of partner in the process. I am suggesting we opt for partnership; to help the community-oriented but under-equipped societies retain their integrity. We must reject the disruptive and unusable elements of the Western bio-medical technological model while at the same time, accept, absorb and adopt useful elements. We can provide better health and a better life for the poorest of the poor.

- 1/ IMELOKO, for example, has received assistance from agencies as diverse as the Irwin Young Foundation, the Kresge Foundation, the Public Welfare Foundation, the Pathfinder Fund, World Vision International, OXFAM of England, SIMAVI and ICCO of Holland, Bread for the World of Germany, USAID, the Government of Zaire and the World Bank.
- 2/ "Fetal Hypothyroidism and Maternal Thyroid Status in Severe Endemic Goiter," Journal of Clinical Endocrinology and Metabolism, Volume 47, No. 2, p.359,
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- 3/ R. Brown, D. Venzon and T. Manchester, "The Control of Endemic Goiter by Iodized Oil in a Community Health Programme," Royal Society of Tropical Medicine and Hygiene, Volume 72, No. 3, 1978, p. 275.
- 4/ M.C. Lathem, "Strategies to Control Infection in Malnourished Populations -- Holistic Approach or Narrowly Targeted Interventions?" American Journal of Clinical Nutrition, Volume 31 (December, 1978), p. 2298.
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- 6/ op. cit., Journal of Clinical Endocrinology and Metabolism.
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 "Isolation and Partial Characteriation of a New Virus Causing Acute Haemorrhagic Fever in Zaire," Lancet, March 12, 1977, 569-571.
- 8/ Arend Van Leeuwen, Christianity in World History, (London: Edinburgh House Press, 1964), p. 429.

CASE STUDIES

PRIVATE VOLUNTARY AGENCIES

TANZANIA

Janet F.A. Craven, M.D.
Justina Simon

To a Tanzanian, voluntary agency refers mainly to the Tanzanian church; not to foreign agencies, but to those Tanzanian churches delivering health services to the people. I am sure that you all know about Tanzania; it has become quite topical. Julius Nyerere is our President. He provides great leadership, and is attractive to the Christians in our nation. The country is committed to primary health care and primary rural development.

Administratively, Tanzania has 97 districts and 20 regions. The country is a million square kilometers and has 17 million people. Ninety percent of the population live in rural villages. It is very sparsely populated, perhaps 18 people per square kilometer. Half of those people are under 15 years of age and only half a million of them have jobs. Annual salaries average \$1,000 per year.

In 1967, the Arusha Declaration spelled out the concept of rural development. In 1972, authority was transferred from the ministry to the regions. Each region is divided into several districts. The medical officers in the districts advise on health programs. This occurs regardless of whether the programs are sponsored by the district hospitals, rural health centers, dispensaries or village health posts. Village governments are created at the community level to deal with health. The lines of responsibility are sometimes blurred, but initiative rests with the local health committees. The third Five Year Development Plan is firmly committed to helping the people where they are. Health objectives include strengthened infrastructure, limited hospital expansion, prevention of communicable diseases, and the appropriate training of a suitable staff.

The health status of the country is poor. Infant mortality is relatively high. Life expectancy is 47 years. This compares to 35 years in 1961. Twenty to twenty-five percent of the vulnerable population experience some degree of malnutrition. This is particularly obvious in the case of measles. The children who get measles become extremely ill; many die. Primary health care would prevent 40-45 percent of hospital and out-patient deaths due to measles.

The voluntary agencies participating in health are mainly church-related. We do receive some assistance from Catholic Relief Services, OXFAM, Save The Children, World Neighbors and many agencies I will not take time to mention. In fact, we have a cancer control program sponsored by Howard University. However, I want to concentrate mainly on voluntary agencies operated by the Tanzanian churches themselves. There are ten major denominations running health

services, as well as four smaller groups. Together, they run 65 hospitals. These hospitals began as dispensaries. In fact, they began as back door medicine. There are 400 dispensaries all combined and this comprises 35-40 percent of the total available medical services in the country.

Policy decisions, at least since 1972, have been made by the Christian Medical Board of Tanzania. The evolutionary history of this Board is quite interesting. Prior to 1947, there existed a body, of sorts, of non-Catholic doctors who met under the guise of Mission Medical Committees. However, in 1947, Catholic physicians were permitted to join the committees. The result was the formation of a single Mission Medical Committee; this Committee met yearly.

In 1961, the Mission Medical Committee changed its name to the Tanzanian Christian Medical Association. It is a professional medical association and membership is extended to doctors and health administrators. Nurses and others are elected to membership. The Association's limited membership presents something of a problem. Doctors and a few qualified administrators do not adequately represent the medical services offered to the communities. Furthermore, it was felt that this group of expatriates could not make policy to the exclusion of African Christian church leaders. So, in 1972, after much negotiation, the Tanzanian Christian Medical Association was restructured, and, from it, the Christian Medical Board of Tanzania emerged.

The Board is very interesting. In fact, it is unique. The Board takes in four members of the Catholic Conference, four members of the CCT Christian Council and four members of the medical profession. It meets twice yearly and has its main office in Dar. We have a small secretariat, two office staff, a messenger and a doctor. The Board is not a big coordinating body; most of the coordination we read about is the result of spontaneous action.

There is a long history of cooperation between the voluntary agencies and the government that dates back to pre-independence days. The Ministry of Health established a Medical Advisory Committee in the 1950s to oversee grants and aid. Grants were conditionally given to hospitals. Money was given on a pro-rata basis for the training of nurses, medical aides and medical assistants. The Committee met twice yearly and debate was heated. We had some good fights. Perhaps it was the sense of competition.

Government grants have been going to the hospitals and training schools for at least 20 years. The voluntary agencies do a lot of training of nurses, midwives and some laboratory technicians. Eye course training is done in cooperation with the government at designated district hospitals. In addition, 15 of the 65 district hospitals in Tanzania are operated by church staff. Although fully

funded by the government, these hospitals function in the absence of government personnel. Policy thrust remains similar throughout.

The government and the Tanzania Episcopal Conference (TEC), as well as the CCT Christian Council, are equally committed to rural development. Instead of building hospitals and schools, priority has been given to poultry, fishing nets, farm implements, grinding mills and all the things, like water, that make life more bearable. Village level projects are developed within the churches; the church acts as both catalyst and funding agency.

Maternal and child health (MCH) care projects are developing, principally, at the district level. The number of mobile units required has been drastically reduced. Shinyanga district, for example, has been divided into three sections. The sections are independently supervised and each offers maternal and child health programs. There are 48 fully staffed dispensaries in all, with additional training programs underway. This type of MCH project development is spontaneous--on the spot. It is taking place in other areas, too. Development has occurred because the government decided to have primary health care specialists available to mothers and children.

There is no question that infant mortality is high. So the church cooperation began in 1975. The churches joined the maternal and child health programs principally to see that mothers received good ante-natal care. The churches also promoted vaccination programs for mothers and children under five. Finally, nutrition education was offered to expectant mothers and under fives.

The dispensaries provide excellent potential for program coordination. Unfortunately most dispensary personnel are not adequately trained to carry out MCH programs. Week long seminars have been given to the staffs, but the training received has been insufficient for the task at hand. To compensate, the CCT and TEC now provide for on the spot training. We use what we call the parent hospital, one hospital which serves or supervises surrounding dispensaries as the training site. There may be 15 or 20 persons involved, but only one who is active in maternal and child health care will come to the parent hospital for instruction. Each individual receives a week's training while working in the hospital, itself. They are encouraged to bring along any problems which their dispensaries face. More than just theoretical training is required.

Additional training is provided for maternal and child health aides. The aides' training continues for two years. It begins upon completion of seven years primary education. The aides spend nine months in the field and are enrolled in the hospital school for the remainder of their training. These schools were built with assistance from AID.

The Ministry has been slow to participate in training programs. Initially, the government gave little thought to the role of voluntary agency personnel. Now we are playing catch up. We, in the agencies, are trying to save the situation by sharing our knowledge and equipment with the government. We are giving to dispensaries regardless of denomination or affiliation.

Our consultations include both government and church MCH personnel. We meet often to discuss our program objectives and to encourage villagers to come forward with questions. We are striving to work for the good of all village people.

We wanted to conclude by outlining those factors which have made the Tanzanian government so open to co-operation. There is a very strong atmosphere of family or African socialism in Tanzania. It is the feeling that all people are brothers; there is nothing more important than people. Our people share a common language, Swahili. We do not depend on English. There is common schooling; often it is church schooling. Finally, there are clear party and government directives which are easily adhered to. Furthermore, there is a well-defined government and administrative hierarchy that reaches right down to the village level.

In the churches, nowadays, there is a great deal of inter-communion and fellowship. The emphasis is very much on Christian input. Somehow, to be a Christian seems preferable to being a national. The value is in pooled resources. Land, money and personnel are all shared. We hope that by so doing, we can avoid duplication. As Christians, we are beginning to think that we make a better impression on the rest of the world, particularly government, if we do not duplicate project efforts. If we do show a united front, then as Our Lord said, "we love each other and the world."

There is a great enjoyment in meeting people from the other side. It is not surprising to find that we very often have the same ideas. We find it most enriching to cross over to government and other denominations only to find out that they have similar outlooks and fears.

The only future for really expensive services is to have them fully integrated through some national platform. There are problems. There is feeling and a knowledge that eventually a lot of these big programs will become government controlled, or at least government-run. However, we have a very benevolent government in Tanzania, so we are not experiencing too much government domination. The government has a distinctive policy, yes, but the church has endorsed it. There is a long history of cooperation to be proud of.

**XII. ORAL REHYDRATION THERAPY: AN APPROPRIATE
TECHNOLOGY FOR PRIMARY HEALTH CARE**

ORAL REHYDRATION THERAPY, AN APPROPRIATE TECHNOLOGY
FOR PRIMARY HEALTH CARE

Robert P. Juni, VMD, MPH

Diarrheal diseases are presently recognized as a major health problem; particularly in those countries that can least afford the cost of a cure. Recent strategies for reducing the damaging effects of diarrhea include use of simple glucose-electrolyte solution to counteract fluid deficits arising from stool losses. A survey of a dozen Latin American countries indicates that problems have arisen in the design and production of logistical support. The appropriateness of oral rehydration therapy at the primary health care level is discussed herein with particular reference to the problems of adapting the technology to community and family subgroups. Integration of national programs of oral rehydration therapy into primary health care systems is a logical consequence of non-governmental, organizational activity.

1. The Health Problem

Acute diarrheal diseases have been identified as a major health problem world-wide. These diseases retard the growth of young children and impair the quality of life of those suffering from their debilitating effects. It is a major killer of the poor.

The World Health Organization has given diarrheal diseases the highest priority in developing countries. There can be no doubt as to the extent or complexity of the diseases. Yet, despite the lack of factual information on the effects of diarrheal episodes on human health and development, some reasonable assessment is possible:

a. Diarrhea is the major single cause of death in children below five years of age.

b. Diarrhea exacts significant catabolic losses because of a reduced capacity for nutrient absorption; a toll that is equal to an actual physical shortage of food in those areas where malnutrition is endemic.

c. Diarrhea affects the growth and development of children by repeatedly interfering with their regular alimentation. In some instances, the feeding schedule of growing children is reduced almost monthly, and the appetite diminishes over a number of days resulting in a decreased caloric intake.

d. More than a third of the beds in children's wards are given over to cases of diarrhea requiring expensive antibiotics and intravenous fluids.

e. Diarrhea claims frequent interruptions in normal body functions, affecting a wide variety of human and social endeavors--tourism, for example.

2. A Primary Health Care Strategy

While many health programs tend to focus on major illnesses and preventable diseases, a more realistic assessment may emphasize the deleterious effects of this ailment on small children; particularly where national policy has identified primary health care as a priority. No one denies that the problem of diarrheal diseases can be reduced through improved community sanitation, increased water and food supplies or personal hygiene. However, the required changes in life style are drastic, and the benefits are slow to accrue. Thus, it is widely believed that a strategy of oral rehydration and nutritional maintenance can produce a greater impact on the control of diarrheal diseases. Oral rehydration and nutritional maintenance offer a perfect opportunity to apply newly discovered scientific techniques to the solution of a major health problem. In brief, oral rehydration therapy is both an effective and appropriate strategy for primary health care programs. The principles of oral rehydration are not difficult to grasp. With some enabling action at the national level, the community can participate in the program's implementation.

The fact that oral rehydration therapy has not been more widely adapted to primary health care programs suggests that perhaps its application has not been adequately understood by health professionals. Its potential has gone largely unrecognized. Experience gained so far may promote better understanding of oral rehydration. Hopefully, increased experimentation will enable it to be applied at the community level.

The basic elements of the strategy can be summarized as follows:

a. Most acute diarrheal diseases have a similar pathophysiological effect, even though the main bacterial or viral agents operate through different mechanisms. There is a net loss of water and electrolytes. This loss leads to decreased blood volume, shock, potassium deficiency, and acidosis.

b. Progressive dehydration is the immediate cause of the mortality associated with diarrhea, and it can be counteracted by replenishing stool losses.

c. The anorexia and vomiting that accompany diarrhea adversely affect the nutritional status of small children by adding to the slowness of recovery and encouraging susceptibility to repeated episodes.

d. In general, acute diarrheal disease is self-limiting; chemotherapy has not proven to be effective in treating it, except in shortening the course of the illness or, in some cases, its transmissibility.

e. Glucose can enhance the transport of sodium across the gut wall with the consequent replacement of fluids and

other electrolytes, thus avoiding those deficits which represent the greatest danger to the patient.

f. Oral fluid therapy prevents and treats dehydration rather than stopping the diarrhea. Furthermore, it allows supportive dietary intake to continue. The success of this approach can be measured by the decreased requirement for intravenous fluids.

g. Oral rehydration fluid has been found to be satisfactory regardless of the causative agent or patient's age. It can be used to correct fairly advanced dehydration, as well as to maintain proper fluid balance through use of the body's homeostatic machinery.

The presently recommended composition per liter of final solution is: Dextrose, 111 millimoles; Sodium, 90 mEq; Potassium, 20 mEq; and Bicarbonate, 30 milliEquivalents. The programs require the ready availability of these glucose-electrolyte packages in mixed form. Front-line health workers and mothers can administer the therapy on-site. A child with watery stools merely drinks this solution to maintain adequate hydration. If a fluid deficit has already occurred prior to the administering of the solution, greater effort must be made to restore fluid balance and to assure proper kidney function. Nutritional intake of bland food should be resumed as soon as possible to avoid greater nutritional deprivation. Other antibiotics or anti-diarrheal drugs are not recommended.

Although this strategy is simple, its execution is more complicated. Some degree of technical expertise is required for implementation. Also, improved supply support techniques are needed if oral rehydration therapy is to be administered whenever and wherever diarrhea occurs. Ideally, these two objectives are but two halves of a circular pie. First, improvement in logistical support must take form as strategies are defined. Second, more effective operational tactics should become possible as innovative methods of supply are devised.

3. Logistical Considerations

While several clinical trials and demonstration clinics are now seeking additional data on the effectiveness of oral rehydration in treating diarrhea cases, there has not been a corresponding increase in the availability of supplies. A cheap, readily accessible source of glucose and electrolytes is needed if oral rehydration solution is to be made available to communities or individual homes on a continuing basis. A program must be developed to organize national support for a community-level primary health care scheme; this includes logistics.

Most of the pilot projects and clinical trials conducted so far have used prepared packets of oral rehydration powder provided by UNICEF. The recommended formula is available commercially. Over the past three years, UNICEF has let

contracts for the production of these special packets. However, countries now prefer to purchase their own supplies.

Rural health practitioners advocate taking the fluid by mouth. Promoters use common household foodstuffs to make up the solutions; broths, teas, and wheys of varying composition to replace fluids and avoid dehydration. Home use is encouraged in nearly all instances. The beneficial effects of oral rehydration are becoming sufficiently obvious; it is now being recommended for clinical as well as domiciliary use. Obviously, the logistical considerations necessary to popularize a household remedy are quite different from those required to support a community level primary health care program.

The Pan American Health Organization has arranged to study the logistical implications of implementing oral rehydration therapy on a national scale. PAHO is assessing also the local production capabilities for the glucose-electrolyte mixture. The problems of adapting sound scientific technology to local conditions are many. Frequently, problems have arisen because of a lack of fixed policy, or because steps are being taken without regard to similar actions elsewhere. There are many operational problems that have to be resolved as well, but they will require additional pilot studies or operational research.

Analysis of the logistical problems associated with oral rehydration therapy gives some guidance to those who wish to help. More specifically, non-governmental organizations should become more aware of the nature of existing administrative problems, and contribute effectively to their resolution. At least, they can avoid others' mistakes in promoting implementation.

Oral fluid therapy requires changes in several policy areas. While assistance in promoting greater understanding of oral rehydration therapy may be beneficial on the national level, it can be extremely sensitive when brought to the communities. How can continued availability of the basic chemicals be assured? Such assurance would mandate some form of national commitment to support oral rehydration in the clinical management of acute diarrhea, as part of a broader program of primary health care. Economic decisions may influence, to some degree, both the availability and uniformity of the local stocks used in the mixture. Adaptation of scientific knowledge of intestinal absorption and secretion, particularly the restoration of electrolyte balance, should not remain confined by past customs and patterns of food distribution. One possibility is to market oral rehydration as a drug. It can, then, compete more effectively with other antidiarrheal drugs, antibiotics, and intravenous fluids.

Once a decision has been made to supply oral rehydration powder in the form of a registered drug item, a number of questions arise: (1) the choice of manufacturing the item through a government agency or a commercial enterprise; (2) specifications for the ingredients, including

local availability of supply, and (3) marketing and educational strategies. Standardization is key; yet it is problem plagued.

Implementation of the therapy will most likely happen in conjunction with other primary health care programs. To ignore a small, but strong health-related activity would be anti-developmental. However, to rely on a primitive, languishing national scheme may weaken the viability of an oral rehydration program. The wisest choice for collaboration may evolve by its own accord.

4. Program Implementation

During a joint WHO/UNICEF Consultation on the National Production, Packaging, and Distribution of Oral Rehydration Salts held earlier this year in Bangkok, representatives from countries of all regions reported on the status of their national program and on the operational difficulties encountered. An analysis of the discussions supports my original contention: The greatest difficulty remains the introduction of oral fluid maintenance at the family and community level. The present image of clinical efficiency in intravenous infusion contradicts the simpler use of the mouth.

Confidence in oral rehydration has not been fostered by cottage artisans who purport to adapt oral rehydration to primitive cultures. Sugar and salt solutions have been used for combatting dehydration for quite a while. The results have been particularly good in communities where poor baby care practices contribute to fluid deficits, misconceptions of sickness and remedies that discourage proper feeding and water balance. Deaths from dehydrating diarrhea can be prevented by the administration of glucose and electrolytes in specific concentrations; intravenous therapy would be the logical alternative. As the composition of the rehydration solution deviates from optimal clinical conditions, the absorption of water becomes less efficient and intravenous therapy becomes mandatory. However, the strategy of glucose-enhanced sodium absorption has advantages which merit its promotion in the management of acute diarrhea. The task for primary health care is to guarantee the accessibility of oral rehydration therapy and to educate individuals and communities as to its proper use.

Innovative approaches to promoting oral rehydration therapy and nutritional maintenance require additional experimentation and logistical adjustments. The challenges to non-governmental organizations are obvious.

XIII. PROGRAM PARTICIPANTS

PROGRAM PARTICIPANTS

- Abraham, Sulochana, M.D., Rural Health Center, Vellore, India.
- Almquist, L. Arden, M.D., World Relief Commission of the National Association of Evangelicals and Paul Carlson Medical Program, Kansas City, Missouri.
- Arole, Rajanikant, M.D., Director, Jankhed Project, India.
- Baldi, Joseph M., U.S. Public Health Service, Rockville, Maryland.
- Bryant, John H., M.D., Deputy Assistant Secretary for International Health, Department of Health, Education and Welfare, Rockville, Maryland.
- Costello, John, Helen Keller International, New York, New York.
- Craven, Janet F. A., M.D., Secretary, Christian Medical Board of Tanzania, Dar es Salaam, Tanzania.
- Cronk, C. Robert, Executive Director, Project Concern, San Diego, California.
- Dobyns, Phyllis, Director, Overseas Operations, Save the Children Federation, Inc., Westport, Connecticut.
- Donovan, Genevieve, Program Manager, Canadian International Development Agency, Ottawa, Canada.
- Fox, Thomas, Director, Office of Private and Voluntary Cooperation, Agency for International Development, Washington, D.C.
- Fransen, Jack J., International Child Care (USA), Inc., Toledo, Ohio.
- Garltan, Jean, Women's Organizations Coordinator, Catholic Relief Service, New York, New York.
- Gibbons, Lillian K., Dr. P.H., Regional Advisor - Primary Care, Pan American Health Organization, Washington, D.C.
- Goffio, Frank L., Past Executive Director, CARE, New York, New York.
- Joseph, Abraham, M.D., Christian Medical College, Vellore, India.

Juni, Robert P., Consultant, Washington, D.C.

Kennedy, Patrick, Council on Foundations, Washington, D.C.

Knighton, J. Raymond, President, MAP International, Wheaton, Illinois.

Macagba, Rufino L., Jr., M.D., Associate Director, Health Care Delivery Services, World Vision Relief Organization, Los Angeles, California.

Morehead, Jean E., International Child Care (USA), Inc., Toledo, Ohio.

Nute, William, Jr., M.D., New York City Department of Public Health, New York, New York.

Ragan, Edward J., M.D., M.P.H., Consultant, Canadian University Service Overseas, Ottawa, Canada.

Rogers, Everett M., Ph.D., Department of Communications, Stanford University, Stanford, California.

Sanders, Donald, Director, Overseas Operations, CARE, New York, New York.

Wallace, Ned, M.D., Chairman, National Council for International Health, Washington, D.C.

Washburn, Michael, President, Michael Washburn Associates, New York, New York.

Zuniga, Mary Hamlin de, Public Health Advisor, Chimaltenango, Guatemala.

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NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

The National Council for International Health was established in 1971 to facilitate communication and cooperation among the many groups in this country, both public and private, involved in U.S. international health activities in developing countries. The Council is made up of both organizational and individual members and is currently developing a number of activities designed to encourage more effective use of U.S. health services for improvement of international programs in the third world. These include:

- A comprehensive directory of U.S.-based agencies involved in international health;
- A consultant and technical assistance directory to serve the needs of private and voluntary organizations;
- Training workshops on areas of special interest (i.e., oral rehydration, sanitation);
- 1980 International Health Conference on the theme "International Health: Measuring Progress" (June 11-13, 1980, Washington, D.C.);
- A regular newsletter, plus publication of the proceedings of the annual international health conference.

Other services currently being developed by NCIH for the U.S. PVOs include a job clearinghouse to meet the needs of the organizational members of NCIH as well as of individuals seeking new employment opportunities, and an international health publication center which would be a single focal point for those seeking publications in different topical areas of international health.

Individuals or organizations seeking information about NCIH activities or about membership in the Council should contact

National Council for International Health
2121 Virginia Avenue, N.W. - Suite 303
Washington, D.C. 20037
(202) 338-1142

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George Washington University
Medical Center

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Pan American Health Organization

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University of Michigan

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World Education

Dr. Rufino L. Macagba
World Vision Relief Organization

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League for International Food Education

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Department of HEW

Dr. John H. Bryant
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Dr. Martin S. Wolfe

Official Canadian Observers

Canadian International Development Agency

Dr. C.W.L. Jeanes

Canadian Medical Association

Dr. John S. Bennett