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**W**orld  
**F**ederation of  
**P**ublic  
**H**ealth  
**A**ssociations

Report on

Third International Congress



# WFPHA NEWS

World Federation of Public Health Associations

## Member Associations:

Asociación de Salud Pública de Argentina  
Australian Public Health Association  
Association Belge d'Hygiène et de  
Médecine Sociale  
Sociedade Brasileira de Hygiene  
Canadian Public Health Association  
Sociedad Chilena de Salubridad  
Asociación Costarricense de Médicos  
Especialistas en Salud Pública  
Sociedad Cubana de Administración  
de Salud  
Fiji Branch of the South Pacific Public  
Health Association  
Société Française d'Hygiène de Médecine  
Sociale et de Génie Sanitaire  
Gesellschaft Allgemeine und Kommunale  
Arzte der DDR (Dem. Rep. Germany)  
Bundesverband der Ärzte des  
Öffentlichen Gesundheitsdienstes e.V. der  
BRD (Fed. Rep. Germany)  
Asociación Médica de Salud Pública de  
Guatemala  
Commission Médicale Chrétienne d'Haïti  
Hungarian Society for Public Health  
Indian Public Health Association  
Iranian Public Health Association  
Israel Public Health Association  
Associazione Italiana per l'Igiene e la  
Sanità Pubblica  
Japan Public Health Association  
Korean Public Health Association  
Lebanese Public Health Association  
Sociedad Mexicana de Salud Pública  
New Zealand Branch of the Royal Society  
of Health  
Society of Health of Nigeria  
Public Health Association of Pakistan  
Philippine Public Health Association  
Sudanese Society of Preventive and  
Social Medicine  
National Association of Public Health  
Inspectors of Trinidad and Tobago  
The Royal Society of Health (U.K.)  
American Public Health Association  
(U.S.)  
Sociedad Venezolana de Salud Pública

## CONFERENCE REPORT

WFPHA Third International Congress

"Primary Health Care: World Strategy"

Partially supported by Contract AID/DSPE-C-0053

Submitted by:

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Secretary*

## CONTENTS

- 1.0 Background
- 2.0 Sources of Financial Support
- 3.0 Objectives
- 4.0 Delegates
- 5.0 Program
- 6.0 Recommendations of the Congress
- 7.0 Evaluation of the Congress
- 8.0 Post Congress Publications

### Appendices

- 1. Program
- 2. Field Visits
- 3. Partial List of Foreign Delegates
- 4. Texts of Keynote Addresses
- 5. Texts of Selected Overview Session Presentations
- 6. Texts of Illustrative Examples of Workshop Presentations
- 7. Sample Evaluation Form and Results of Tabulation

## 1.0 Background

The World Federation of Public Health Associations (WFPHA) held its third triennial congress during February 23-26, 1981, in Calcutta, India. The meeting was hosted by the Indian Public Health Association (IPHA) during its 25th annual meeting and was cosponsored by UNICEF and WHO. The theme of "Primary Health Care: World Strategy" provided a unique opportunity for health workers from government, the private sector, and international organizations to exchange views and examine plans and progress in implementing primary health care as the means to reaching the worldwide goal of "Health for All by the Year 2000."

The WFPHA has a membership of 32 national public health associations from both developing and industrialized countries. The IPHA, one of the Federation's founding members, was selected from among several offerors to host the meeting; the two previous triennial Congresses were hosted by the Public Health Association of the Federal Republic of Germany (Bonn, 1975) and the Canadian Public Health Association (Halifax, 1978).

The WFPHA was founded in 1967 as a way for national public health associations to join efforts to strengthen the public health professions and to improve personal and community health throughout the world. The initial group of 7 members has grown to 32, with 4 additional public health associations expected to apply for membership at this year's annual meeting in May. Criteria for membership are that the potential member group be concerned with public health generally as distinct from single disciplines; have status as a non-governmental organization; and be recognized as the national public health association of the country of origin. Annual dues assessment is based on the national membership of each member association.

The headquarters of the WFPHA are in Geneva; the annual meeting is held there each May at the time of the World Health Assembly of the World Health Organization. Business in Geneva is transacted through the office of the Honorary Secretary-Treasurer. Since inception of the WFPHA, the American Public Health Association (APHA) has served as the group's secretariat. The Executive Secretary has traditionally been a member of the APHA International Health Programs staff.

## 2.0 Sources of Financial Support

Sources of funding for the Congress were as follows:

WHO & UNICEF: As a recognized non-governmental organization in official relations status with both the World Health Organization and the United Nations Children's Fund, the WFPHA provides an ideal mechanism through which member groups can collaborate with international organizations in areas of mutual interest. In this instance, both WHO and UNICEF cosponsored the Congress, providing funding for participation from both headquarters and the various regional offices and contributing to direct Congress costs. WHO regional offices that contributed directly to Congress costs or that sponsored participants were the Pan American Health Organization, the Eastern Mediterranean Regional Office, the African Regional Office, the South East Asia Regional Office, and the Western Pacific Regional Office.

US Agency for International Development: Through a contract with the American Public Health Association (AID DSPE-C-0053, "Accelerated Delivery Systems Support"), USAID calls on APHA to hold "one conference per year in collaboration with other donors and designed to help the health leadership in developing countries plan and extend national primary health care programs." A sum of \$21,346 AID/APHA contract funds were expended on the Congress to support the participation of nationals from developing countries as program participants, conference planning activities by APHA staff, and to help finance a number of direct conference costs.

In addition, several US AID missions financed travel for their staff and/or host country counterparts to attend the Congress.

American Public Health Association: APHA supported the Congress through its annual dues to the WFPHA.

US Department of Health and Human Services: The Office of International Affairs of the Health Resources Administration awarded the WFPHA an \$87,000 grant for the Congress. These funds were used in part to support the travel and per diem of 25 U.S. delegates, including that of 7 APHA staff and APHA leadership. The APHA delegation was headed by Dr. William H. McBeath, APHA Executive Director, and Stanley Matek, President-Elect of APHA. HRA funds were also used to support direct Congress costs.

Government of West Bengal: The government of West Bengal, the state in which Calcutta is located, provided support directly to the Indian Public Health Association for the Congress.

Indian Council of Medical Research: The ICMR likewise supported the Congress directly through the IPHA. A 1981 joint publication of the ICMR and the Indian Council of Social Science Research entitled Health for All: An Alternative Strategy was distributed to all Congress participants in their background documentation.

All-India Institute of Hygiene and Public Health: As the seat of the Indian Public Health Association, the AIIHPH lent its facilities and staff in the great amount of preparatory work necessary for the Congress. The Organizing Committee was made up of IPHA members of the Institute; special note should be made of the Scientific Sub-committee, which reviewed all manuscripts and prepared the volume of abstracts.

### 3.0 Objectives

The objectives of the Congress were threefold:

- to foster the exchange of experiences in implementing primary health care programs, particularly on the inter-regional level;
- to identify common problems and constraints and to learn of solutions that have been successful in overcoming them;
- to carry forth the challenge embodied in the Declaration of Alma-Ata by supporting programs aimed at achieving "Health for All by the Year 2000."

The Congress was dedicated to the memory of Dr. John B. Grant, Director of the All-India Institute of Hygiene and Public Health during 1939-1945, who pioneered many of the principles supporting the primary health care movement today. Present on his behalf were his widow, Denise Grant, and his son, James Grant, Executive Director of UNICEF.

### 4.0 Delegates

Over 700 delegates from some 50 countries attended

the meeting. Of these approximately one third were from outside India. Countries represented included Angola, Australia, Bangladesh, Brazil, People's Republic of China, Canada, Ethiopia, Egypt, Gambia, Indonesia, Japan, Jordan, Korea, Kuwait, Laos, Lebanon, Lesotho, Liberia, Mexico, Mozambique, Nepal, Niger, Nigeria, Pakistan, Philippines, Sri Lanka, Sudan, Sweden, Tanzania, U.K., U.S., U.S.S.R., West Germany, Yemen. The Congress was successful in attracting, at minimal cost to AID, a number of senior level people from the Ministries of Health of developing countries, thus helping to meet the APHA contractual commitment for the conference to help the health leadership in developing countries plan and extend national primary health care programs.

There was a balance among delegates from government, private groups, and international organizations. In addition to the member associations of the WFPHA, groups sending representatives included the World Health Organization, the United Nations Children's Fund, the U.S. Agency for International Development, the Danish International Development Agency, Medicus Mundi, Africare, Project HOPE, the United Nations Fund for Population Activities, the U.S. Department of Health and Human Services, the Inter-American Development Bank, and the World Bank.

## 5.0 Program

The program was designed to foster the objectives through a mixture of plenary sessions and technical workshops. These keynote addresses were delivered by James Grant, Executive Director of UNICEF, and Dr. David Tejada de Rivero, Assistant Director General of WHO. The session was chaired by Dr. John LeSar, of USAID Delhi, the ranking AID representative at the meeting. Mr. Grant was introduced by Dr. William McBeath, Executive Director of APHA.

### 5.1 Keynote Addresses

In his keynote address, designated as the Second Hugh Leavell Lecture, Mr. Grant warned that as long as goals for improving health remain merely the interest of Ministries of Health, those goals are undoubtedly doomed to failure. "It is only possible to overcome the worst aspects of absolute poverty if alternative strategies are devised in virtually every major field," he stated. We in the front line of the primary health care movement must

6

work to advance national will to devise and implement strategies for social growth. The first step is to convince the global community that human progress is as important as economic progress. National decision-makers must be shown that growth as indicated by reduction in infant mortality or increase in life expectancy is as or more important than growth in gross national product.

"We desperately need a series of examples to illustrate how investments in health can bring dramatic returns on the development front.....Recent history shows that progress often comes when it is people-led, when people are ahead of government," Mr. Grant added. Consequently, we who are interested in improving health must lead the cause by contributing to the will and by facilitating progress.

Dr. Tejada analyzed the concept of primary health care and the role of WHO as a coordinating authority and technical resource. In his view, the complex nature of health problems has in some circles led to an oversimplification of what primary health care means, while in other circles an over-conceptualization has occurred. In practice primary health care calls for the "development of a set of health activities that should correspond to health needs of the people, to the resources available, and to the constraints existing at national or community levels."

Primary health care in its fullest sense encompasses much more than the eight components enumerated in the Declaration of Alma-Ata, according to Dr. Tejada. The challenge is not to make a package of the eight components, but to initiate some primary health care activities while trying to fulfill such necessary ingredients as political commitment, transference of responsibility in delivery of health services, use of appropriate technology, multi-sectoral coordination, community participation, and a supportive referral system.

The full texts of Mr. Grant's and Dr. Tejada's addresses are contained in Appendix 4.

## 5.2 Overview Session

Day two began with a morning plenary session in which primary health care leaders gave an overview of the issues at hand. The five sub-themes covered were developing national plans of action, implementation of field

programs, manpower planning and training, special demonstration and research projects, and community participation.

Because of unavoidable last minute changes from the printed program for the Overview Session, the actual list of program participants and their topics is given here.

Session 201 "Overview Session"

Tuesday, February 24, 1981, 9:00-1:00  
Oberoi Grand Hotel Ball Room

Chairman: Dr. John Evans, Chief, Health,  
Nutrition, and Population,  
The World Bank

Rapporteur: Dr. George Silver, Yale  
University School of Medicine

Developing National Plans of Action

Dr. Samir Banoub, Kuwait, "Comprehensive  
National Planning to Assure Integration of Primary Care,"  
on behalf of Dr. Al-Awadi, Minister of Health of Kuwait

Dr. Carl Taylor, Johns Hopkins University School  
of Public Health, U.S., "Planning for Implementation"

Dr. Samir Banoub, Director, Office for National  
Health Planning, Ministry of Health of Kuwait, "Converting  
National Policies and Commitments into An Implemented Plan  
of Action"

Discussion: Abraham Drobny, Inter-American  
Development Bank

Implementation of Field Programs

Dr. A.A. Rozov, Ministry of Health, U.S.S.R.,  
"The Role of Primary Health Care in the National Health  
System of the U.S.S.R."

N.N. Vohra, Ministry of Health, India,  
"Critical Aspects of Implementation"

Manpower Planning and Training

Dr. Timothy Baker, Johns Hopkins University School of Public Health, U.S., "Health Manpower for Primary Health Care -- A Framework for Planning"

Dr. Pien Chiowanich, Lampang Health Development Project, Thailand, "Training of Rural Community Paraphysicians and Volunteer Primary Health Care Workers: A Partnership for Effective Rural Health Care"

Special Demonstration and Research Projects

Dr. Sushila Nayar, Kasturba Health Society, India, "School Teachers as Community Health Volunteers"

Dr. David Morley, Institute of Child Health, U.K., "Health Care for All Children by 2000 A.D."

Community Participation

Leel Gunasekera, Director of Social Services, Sri Lanka, "Keynote Speech on Community Participation"

Dr. Hunponu Wusu, University of Lagos, Nigeria, "Community Participation in Nigeria"

The session was devoted to consideration of recurrent themes in primary health care. What are the obstacles? What are the simplest and most effective pathways to accomplishment? What successful efforts can be noted?

Dr. Banoub (Kuwait) and Dr. Taylor (USA) addressed the problems of constraints and obstacles with some emphasis on intermediate goals. Resource constraints are serious and the world situation is such that we cannot expect major budget increases in the near future. Health programs do not seem to have high priority and certain bureaucratic rigidities obstruct needed change and collaborative efforts. We must learn to use existing resources better.

We must develop stronger intersectoral cooperative efforts. In this connection, it is plain that high level policy decisions are better adapted to intersectoral liaison, and that such decisions can be relayed through agencies.

Programs that facilitate synergistic approaches, such as social and economic development and health resource development are most desirable. Planning priorities should reflect those decisions. Planning and management capabilities must be developed to ensure maximum effectiveness of programs in action.

Funding priorities should go to elements the community does not want to pay for. Communities have shown themselves willing to pay for buildings, food needs, and curative medicines. We have tried to get the community to pay for unpopular things like salaries. In China, for example, the government funds secondary and tertiary hospitals; communes and production teams fund primary health care.

In calculating resource potential, the traditional aspects and resources of health care must not be overlooked.

Drs. Drobny, Pien, Baker, and Rozov addressed themselves to implementation with rather more emphasis on manpower, but including organizational elements as well. First of all, it is clear that implementation will require a matrix of health workers with different costs and benefits. Obviously, to the extent possible, a shift is favored toward less skilled front line workers. However, the costs of supervision and some quality concerns dictate careful analysis and not rigid dogma in decisions on types and distributions of health workers.

There is an interdependence of frontline health workers and physicians. They need to function as a team. For doctors to be educated to understand and accept the team role, changes in curriculum and training will be necessary.

Continuing education is a sine qua non for all health workers -- as the situation changes, they must be prepared to change with it.

While productivity is a key element in maximum deployment of resources, quality is an essential element in both "care" and "cure." Patient satisfaction is an element that cannot be overlooked.

Health programs cannot exist in a vacuum, and programs for reasonably adequate nutrition, education,

and employment must be pursued concurrently with health program development. This means also education and health system orientation in other sections for eventual joint activity.

Women are a powerful resource that cannot be neglected in human resource considerations. They must be protected, efficiently used and given equal opportunities in health services. With education, training and investment mothers can do more than health workers in saving children's lives.

Mr. Vohra spoke eloquently to planners and implementers alike regarding several aspects of the problem. He pointed out that the existing structures of the health services have to be dealt with; we do not start with a clean slate. Education of clients has to accompany education of health care workers to ensure that all seek the same goals.

Planning and management, a number of speakers emphasized, must be strengthened at every level: top, bottom and in between. There need be no single planning mode -- creative tension is desirable. Let's have top-to-bottom and bottom-to-top channels open simultaneously.

It should be brought home that management of primary health care is not easier, but more complex than institutional management, and training should be so structured. At the same time, primary health care managers must be given flexibility and freedom to innovate; division of authority is extremely important. There will be more involvement, more expression of initiative, and probably more prompt and effective implementation. Accountability must be emphasized, however, so that services are seen to reach people.

While planning is best achieved in the multi-sectoral mode at the top, at the community level the multisectoral viewpoint will best be achieved if the impetus comes from below. Government implementation is better done by a particular section since bureaucracies are difficult to change.

There was a useful suggestion for a high level commission for social development on an equal footing with the Commission on Economic Development. Separate national commissions (e.g., primary health care, population, nutrition, women, etc.) should be avoided as counterproductive.

Every speaker emphasized the need to develop greatly community involvement and participation. It is extremely important to create active pursuit of health objectives by citizens themselves. They should not be passive, dependent recipients of services. Moreover, such dependency fosters imprecise and sometimes irrelevant program planning and uncaring service provision. A primary health care program needs the advice and guidance of the community to carry out its mission. Community members are key providers. As Dr. Nayar pointed out how school teachers helped to improve children's nutrition, Dr. Morley pointed out that older children have a great influence because they spend so much time with younger children and should be used in services ("CHILD-to-child"). In some instances evidence was given, as Dr. Hunponu Wusu did, of community control of primary health care, in which the situation was much better for students to learn and patients to receive care. There was mention of self help, better understanding and use of services. Dr. Gunasekera emphasized involving citizens' spiritual and traditional values as well as professional concerns in a primary health care center. This offered more satisfying results and increased citizen interest and participation.

Many speakers, including one from the floor, emphasized the importance of investment in female literacy and income earning which together may do a great deal toward improving the health of children.

Dr. Evans concluded with a crisp summary:

- Help for the primary health care program must come from outside as well as inside the health field.
- Improvement of health for children waits upon improvement of the status of women.
- Planning should be both to-to-bottom and bottom-to-top.
- The present balance of resources distributions is incorrect, and it should be changed at the front line.

The complete texts of the papers of Drs. Banoub, Taylor, Baker, Pien, Morley, and Gunasekera are contained in Appendix 5.

### 5.3 Workshops

The plenary sessions were followed by two sets of concurrent workshops -- one set on Tuesday afternoon, and one set on Wednesday morning. Participants were therefore able to choose two workshops on different sub-themes or two workshops on the same sub-theme. In addition, a special session sixth workshop was held on Wednesday morning to allow for the presentation of a few papers that had inadvertently been left out of the final program.

### 5.4 Concluding Sessions

Plenary sessions resumed after the morning workshops. WHO representatives presented the plans and progress of their area in a session on regional strategies; this session also contained presentations on the roles of voluntary organization and professional organizations.

In the concluding session, an hour of open discussion was followed by remarks by Dr. David Morley, Dr. Hunponu Wusu, and a congress summary delivered by Dr. Banu Coyaji on behalf of a steering committee made up of representative Congress delegates. The summary contained a series of recommendations for further implementation of primary health care.

The last order of business was a vote of thanks from Dr. Yousif Osman, Vice-President of the WFPHA.

The complete program as distributed to participants is contained in Appendix 1. Also included is the program for the special session workshop.

The final day of the Congress offered a choice of field trips to health facilities in and around Calcutta. The list of sites is contained in Appendix 2.

### 6.0 Recommendations of the Congress

A steering committee formulated a series of eleven conclusions/recommendations emanating from the deliberations of the Congress. These were presented to all participants by Dr. Banu Coyaji during the concluding session.

In her closing comments, Dr. Coyaji remarked that "one striking point that has emerged is the commitment

of all of us assembled here from fifty countries to the fulfillment of the goal of Alma-Ata -- Health for All by the Year 2000."

She noted, however, that this will remain a slogan unless there is a total revolution in the delivery of health care:

"This cannot be achieved by minor reforms, expansion of systems as they exist today. We have to move away from outdated, counterproductive, personalized, hospital-oriented health care with its super-specialization, sophistication, skyrocketing costs, and mystification, which has given excellent service to five percent of the people, mediocre service to another fifteen percent, and practically no service to eighty percent of our people.

Primary health care should be the cornerstone of health services, and the community should be involved at all stages, from planning, training, implementation, and funding. Why are we not ready to hand over funding to the community?....They who are the consumers of health care should no longer be at the periphery, but at the heart of the system.... Services do not reach the people, but begin with the people and are located in their midst.

The message to them should be: Your health is in your hands -- the quintessence of the community health approach. 'Health for All' depends above all on three important things. Most important of all, the will to do it--nothing can be done without it; the extent to which it is possible to reduce poverty, to achieve social and distributive justice, and to spread education; and the extent to which it is possible to organize the poor and underprivileged to fight for their basic rights.

If we the people rededicate ourselves to the realization of these goals, we will be able to keep our destiny by the year 2000."

## Congress Recommendations for the Further Implementation of Primary Health Care

### 1. Reaffirmation

Two and one half years have passed since the goal of "Health for All by the Year 2000" was officially declared by the signatories of the Declaration of Alma-Ata. As we have taken initial steps to meet that goal, our conviction that it can be achieved stands firm. Today we reaffirm that goal as well as the recommendations of the Declaration of Alma-Ata.

We also welcome the United Nations General Assembly action in December 1980 that included "Health for All by the Year 2000" and the promotion of primary health care as part of the New International Development Strategy for the 1980s and beyond.

### 2. Achievements

The emphasis on primary health care has raised the consciousness of policy-makers and has achieved a landmark shift in public thinking so that the universal availability of health care has become an accepted goal. In the spirit of Alma-Ata, a wide range of actions have been initiated. In particular, the health system is searching for new working relationships with communities and is beginning to collaborate with other development sectors.

### 3. Fulfillment of Commitments

The next few years will be critical as directions are set for the twenty-year journey we have begun. The time has come for governments to fulfill the commitments they made at Alma-Ata and in adopting the UN New International Development Strategy. The process of developing national and regional strategies has been initiated and will continue to evolve. We now need carefully structured implementation plans defining targets and timing and assigning direct responsibilities.

### 4. Synergism

For universal primary health care to become a reality, the community role must be central, with national policy specifically designed to promote self-reliance. The health services should stimulate and support a process

by which communities and families become primarily responsible for the planning, implementation, and monitoring of actions to promote health. In this process, communities and families will also contribute substantial resources to the improvement of their health. Decision-making about health should begin with the people rather than treating the public as consumers who become increasingly dependent as services become more sophisticated and expensive. Synergistic national and community planning can result in programs that are economically feasible, culturally and politically viable, and based on appropriate technology.

#### 5. Role of Private Groups

Such private groups as professional associations and voluntary organizations can be especially influential by carrying out three functions: to help create and maintain the political commitment and public motivation that is required for implementation; to pioneer new approaches through special projects; and to help shape the values that determine the day to day work of all health workers and, through them, of society generally. Involvement of these groups stimulates a greater sense of caring in the community. As with community participation, government services should include private organizations in planning and decision-making.

#### 6. Exchange of Experiences

An immediate need is to provide more opportunities for exchange of experiences among those involved in field activities in primary health care. Many forms of information exchange must be used. Health institutions should play a leading role in this regard since field workers often do not have the time to analyze and report the results of their work.

#### 7. Urgency for Research

Greatly increased support should be provided for health services research that leads directly into a process of implementation. Health services research can provide direct means of applying the results of biomedical research and resolve the growing problems in organization, management, and funding of health care. Special support is needed to extend rapidly the development of expertise in health services research. Field projects covering populations large enough to test and demonstrate all components of an effective primary health care system are needed.

Progressive incorporation of new approaches and methods should be based on adaptation, extension, and training that builds on the considerable successes in current projects.

8. Evaluation and Monitoring

Better evaluation and monitoring must become a continuing process so that substantive learning from experience occurs. New approaches are needed for systematic surveillance and feedback, using indicators that not only measure inputs, but also outcomes as shown by impact on health status.

9. Concomitant Steps

Measures to improve the socioeconomic status of communities must occur concomitantly with health services development. In particular, increasing opportunities of women through access to education, income, and participation in decision-making will lead to health improvements. Additionally, specific preventive measures for common diseases, prenatal care, better nutrition of children and women, encouragement of breastfeeding, and better living conditions should be part of a major and concerted effort to reach these, the most vulnerable of all groups.

10. Framework for Implementation

The practical process of implementation requires immediate attention to providing a new framework of management including supervision, logistics, referral, evaluation, and surveillance. A fundamental need is reallocation of roles among the various categories of health personnel, community representatives and family members, with appropriate training at each level. Rationalization is required of the use of drugs and technology with specific new control measures such as are provided by the new WHO/UNICEF code on infant feeding.

11. Resource Realignment

Underlying all these recommendations is the absolute necessity for more financial support. International funding should be mobilized to contribute to and fit in with national plans. Health for all will require substantial resources from all levels of participation -- local, national, and international. A realignment of world priorities will help make a better quality of life for the world's people a feasible goal.

## 7.0 Evaluation of the Congress

### 7.1 Tabulation of Participant Questionnaires

A printed evaluation questionnaire was distributed to Congress participants during the first series of workshop sessions. Delegates were asked to fill the forms out after their last session of attendance and leave them in the registration area. To date some 150 completed questionnaires have been received.

Tabulation to date shows that the two subjects of greatest interest to participants were community participation and manpower planning and training.

Dr. David Morley's presentation on "Health for All Children by the Year 2000" was rated most often among the five best presentations. Following, in descending order, were James Grant's keynote address, Carl Taylor's talk on "Planning for Implementation," Mya Tu's presentation on the South East Asia Regional Strategy for Health for All, and Dr. Samir Banoub's presentation "Converting National Policies and Commitments into an Implemented Plan of Action." Texts of most of these presentations are contained in Appendices 4 and 5.

It should be noted that since the plenary sessions did not compete with others for attendance, it is virtually assured that the most frequently listed as the best presentations would be from among those in plenary sessions. When tabulating results from workshop sessions separately, presentations most frequently listed were those of Kalyan Bagchi (Bangladesh) "Nutrition in Primary Health Care," N.H. Antia (India) "Problems in Primary Health Care and a Strategy for Action," and Dr. Richard Smith (U.S.) "Primary Health Care: Diarrhetic or Reality? -- Practical Considerations from Field Experiences." Copies of Dr. Smith's presentation and of another well received paper, that of Dr. Raymond Isely, are contained in Appendix 6 as illustrative examples of workshop presentations.

Other results of the tabulation follow.

- Over half (77) of participants polled found the meeting of direct value to their work; 63 found it stimulating, but not of direct value; 2 found it not relevant.

- An overwhelming number (104) found the most valuable part of the meeting was hearing about new ideas and sharing experiences.
- Concerning program, one half of the suggestions favored more discussion, one eighth more plenary sessions, another eighth more presentations of papers in workshop sessions, and one quarter found the balance of the three appropriate.
- 116 respondents found the Congress documentation that was provided to all participants useful; 25 answered no to this question.
- Concerning logistics, overall organization was rated good, transportation good to fair, facilities good (excellent ranked second), and cultural events and meals were both rated excellent to good.
- Rating the Congress overall, 63 participants said the meeting met their expectations quite a bit, 44 said it met them somewhat, and 15 found the meeting exceeded their expectations; 20 participants said the Congress only met their expectations minimally.
- Two thirds of those polled reported that the Congress was successful in acquainting them with some innovative approaches. When asked to specify, the following were listed:
  - distance learning programs
  - design of child-sized latrines
  - training women in maintenance of hand pumps
  - use of teachers for community health work
  - the various possible levels of community participation
  - insights into health planning
  - the Sarvodaya "awakening of all" concept in Sri Lanka
  - teaching preparation of rehydration fluid

- developing visual aids for community education and participation
- use of analytical teaching methods in lieu of traditional didactic teaching
- insights into training community health workers
- value of motivational factors in improving health
- insights into manpower planning
- program for delivering health care services to nomads

Several of these innovations are described in the April 1981 issue of the APHA quarterly newsletter Salubritas.

A copy of the evaluation form and totals of the tabulation are contained in Appendix 7.

## 7.2 Preliminary Assessment

The Third International Congress of the World Federation of Public Health Associations set a new landmark for non-governmental international public health gatherings.

- Collaboration from many groups, both governmental and non-governmental, led to a successful meeting.
- A forum was provided for formal and informal exchange of experiences across national and regional lines among representatives of government, the private sector, and international organizations.
- The conference was marked by exceptional attendance, both in total numbers and in balance of representation among the various components of the health sector and among the various levels of health practitioners, including service deliverers, program managers, national planners, educators, representatives of international coordinating bodies, donors, and internationally prominent spokesmen for the health for all movement.

- Participants profited from a variety and balance of presentations focusing on theory and practice, planning and implementation.
- Participants benefited from the opportunity to observe public health problems and their attempted solutions in India.
- The meeting was a source of motivation and renewed challenge for participants to continue their work in implementing primary health care.

The strain on facilities brought about by the impressive attendance and an overly laden program that did not leave ample time for discussion were conference weaknesses that should be corrected at the next Congress.

#### 8.0 Post Congress Publications

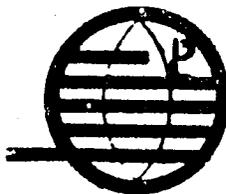
Three publications related to the Congress will be available to the public in the coming months.

In honor of Dr. John B. Grant and the Congress, the Johns Hopkins University Press has published a special edition of his collected writings, Health Care for the Community, as edited by Conrad Seipp. The volume was out of print before this republication. Congress delegates from developing countries were able to purchase the book at a subsidized rate, thanks to an AID/HHS subvention. The volume is now available at the special rate of US\$8.50 from the American Public Health Association and the National Council for International Health. List price is \$12.50.

The WFPHA is preparing a specialized publication on the Congress that will include the full text of keynote presentations, summaries and excerpts of particularly valuable presentations, recommendations of the Congress, an index of program presenters and their topics, photographs, and a list of delegates. One goal of this publication is to make the content and conclusions of the Calcutta Congress known to decision makers who were not present at the meeting and who may not be specialized in the health field.

Thirdly, preliminary plans of the Indian Public Health Association call for publication of the full Congress proceedings later this year.

**THIRD INTERNATIONAL CONGRESS OF  
WORLD FEDERATION OF  
PUBLIC HEALTH  
ASSOCIATIONS**



# **PROGRAMME**

**TWENTYFIFTH  
ANNUAL CONGRESS OF  
INDIAN PUBLIC HEALTH  
ASSOCIATION  
AND  
ELEVENTH NATIONAL  
CONFERENCE OF INDIAN  
ASSOCIATION OF PREVENTIVE AND SOCIAL MEDICINE**



**Calcutta, India**

**February, 23-26, 1981**

22

**THIRD INTERNATIONAL CONGRESS OF WORLD FEDERATION OF  
PUBLIC HEALTH ASSOCIATIONS  
TWENTYFIFTH ANNUAL CONFERENCE OF  
INDIAN PUBLIC HEALTH ASSOCIATION  
AND  
ELEVENTH NATIONAL CONFERENCE OF INDIAN ASSOCIATION OF  
PREVENTIVE AND SOCIAL MEDICINE, CALCUTTA, INDIA**

**P R O G R A M M E**

<b>Hours</b>	<b>Monday, 23-2-1981</b>
0800 to 0845	Registration
0930 to 1100	Inaugural Function Place : Rabindra Sadan
1100 to 1130	Tea/Coffee Break
1130 to 1215	<b>DHANWANTARI ORATION</b> <i>Chairman : D. N. Chakraborty (India)</i>  <i>Y. L. Vasudeva (India)</i>  Community Involvement and Community Participation in Health Care Delivery and end of line Health Care Delivery
1300 to 1400	Lunch
1400 to 1645 101	<b>KEYNOTE SESSION (Plenary I)</b> Place : Oberoi Grand Hotel (Ball Room)  <i>Chairman : J. Lesar (U.S.A.)</i> <i>Keynote Address : Second H. R. Leavell Lecture</i> <i>Introduced by: William McBeath, APHA Executive Director</i> <i>James Grant, Executive Director, UNICEF</i> <i>Keynote Address : David Tejada de Rivero,</i> <i>Assistant Director-General, WHO</i>
1830 onwards	Dinner

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(In the following pages figures within parentheses indicate Abstract numbers)

**Tuesday, 24-2-1981**

**Hours**

- 0900 to 1300 201 OVERVIEW SESSION (Plenary II)**  
Place : Oberoi Grand Hotel (Ball Room)  
*Chairman* : John Evans, Chief, Health, Nutrition and Population,  
World Bank, New York  
*Rapporteur* : George Silver (U.S.A.)
- 0900 to 0905** Opening Remarks by the Chairman
- 0905 to 0945** **DEVELOPING NATIONAL PLANS OF ACTION**
- 0905 to 0920** Samir Banoub (Kuwait)  
Primary Health Care : Converting National Policies and commitments into an Implemented Plan of Action (P 1)
- 0920 to 0935** John S. Bryant (U.S.A.) *Oliver Taylor*
- 0935 to 0945** **DISCUSSION** : Barkat Narain (India)  
Interdependence of Health and Welfare Programmes (P 2)  
Abraham Drobny (Inter American Development Bank)
- 0945 to 1025** **IMPLEMENTATION OF FIELD PROGRAMMES**
- 0945 to 1000** O. V. Grinina and A. R. Rozov's (U.S.S.R.)  
Primary Health Care in the National Health Services of the Soviet Union
- 1000 to 1015** N. N. Vohra (India)
- 1015 to 1025** **DISCUSSION**
- 1025 to 1105** **MANPOWER PLANNING AND TRAINING**
- 1025 to 1040** Plen Chiowanich (Thailand)
- 1040 to 1055** Carl Taylor (U.S.A.)
- 1055 to 1105** **DISCUSSION** : Timothy Baker (U.S.A.)
- 1105 to 1130** Tea Break
- 1130 to 1210** **SPECIAL DEMONSTRATION AND RESEARCH PROJECTS**
- 1130 to 1145** Sushila Nayar, B. K. Mahajan, P. N. Rao, Darshan Singh and M. D. Gupte (India)  
School Teachers as Community Health Volunteers (113)
- 1145 to 1200** David Morley (England)  
Health Care for all children by 2000 A.D. (P 3)

**Hours**

1200 to 1210	DISCUSSION
1210 to 1250	COMMUNITY PARTICIPATION
1210 to 1225	A. T. Ariyaratne and Luel Gunasikara (Sri Lanka)
1225 to 1240	O. Ransome-Kuti and A. Bamisaiye (Nigeria) The Progressive Involvement of the Community in Primary Health Care : A Plan from Lagos (Nigeria) (P 4)
1240 to 1250	DISCUSSION
1250 to 1300	Concluding Remarks by the Chairman
1300 to 1400	Lunch

**Tuesday, 24-2-1981**

**202-206 : Scientific Session I**

1415 to 1715 hrs Concurrent Sessions on Sub-Themes.

Participants select a Scientific Session of their choice. In each Scientific Session seven authors from different places will present their topics for 15 minutes each. This would be followed by exchange of information.

**202 DEVELOPING NATIONAL PLANS OF ACTION**

Place : Oberoi Grand Hotel (Ball Room)

*Chairman* : Dr. Alli (Nigeria)

*Rapporteur* : M. B. Bodram (Canada)

**Hours**

1415 to 1420	Introductory Remarks by the Chairman
1420 to 1435	R. A. Smith (U.S.A.) Primary Health Care—Diarrhoeotic or Reality ? —Practical Considerations from Field Experiences (1)
1435 to 1450	N. H. Antia (India) Problems in Primary Health Care and a Strategy for Action (2)
1450 to 1505	Rama Ram, L. C. Gupta and A. K. Ram (India) Present Situation of Primary Health Care in the different countries (3)
1505 to 1520	O. O. Hunponu Wusu (Nigeria) Strategies of Primary Prevention for Public Health Personnel in the Delivery of Primary Health Care in Nigeria (4)

**Hours :**

- 1520 to 1535     **Mary Ann Micka (Sudan)**  
Sudan's Plan for Primary Health Care among Nomads (5)
- 1535 to 1555     **Tea/Coffee Break**
- 1555 to 1610     **Younghat Ryu and Sung Woo Lee (Korea)**  
Country Statement on Primary Health Care in Korea (6)
- 1610 to 1625     **A Basu and P. Sen (Canada)**  
Programme for Primary Health Care in Nursing (7)
- 1625 to 1705     **DISCUSSION**  
Invited Discussants :  
K. K. Datta, R. S. Sharma and C. K. Rao (India) (8)  
A. K. Sannoh (Gambia)  
George Varky (India)  
M. Ibrahim Soni (India) (9)  
Ajit Mehta (India) (10)  
B. G. Sahasrabudhe (India) (11)

**O P E N**

- 1705 to 1715     **Concluding Remarks by the Chairman**
- 1900 to 2030     **Visit to Exhibition at Maidan**
- 2030 onwards     **Dinner by WFPHA**

**Tuesday, 24-2-1981**

**202-206 : Scientific Session I**

**1415 to 1715 hrs Concurrent Sessions on Sub-Themes**

**203 IMPLEMENTATION OF FIELD PROGRAMMES**

**Place : Viceroy Room**

**Chairman : Yousif Osman, (Sudan)**

**Rapporteur : Jeremiah Norris (U.S.A.)**

- 1415 to 1420     **Introductory Remarks by the Chairman**
- 1420 to 1435     **Pien Chlowanich, John Rogosch and Ronald Wilson (Thailand)**

**A System of Evaluation and Management Information for Integrated Rural Health Care : The Lampang Project Experience (21)**

## Hours

- 1435 to 1450 Gyan Sagar (India)  
Management Approach to Integrated Rural Development (22)
- 1450 to 1505 N. T. Borotho (Lesotho)
- 1505 to 1520 E. Daniel and H. Palti (India)  
Evaluation of Anemia Control Programme for Infants and under two years children in a West Jerusalem Community (23)
- 1520 to 1535 A. A. Contractor (India)  
Primary Health Care—World Strategy—Implementation of Field Programme (24)
- 1535 to 1555 Tea/Coffee Break
- 1555 to 1610 B. N. Tandon (India)  
ICDS Approach—Its Relevance to Primary Health Care (25)
- 1610 to 1625 Asish Bose (India)  
Logistical support for Implementation of Primary Health Care Programme (26)
- 1625 to 1705 DISCUSSION  
Invited Discussants :  
D. Rama Rao (India) (27)  
S. K. Sharma (India) (28)  
A. K. Govila and S. Sapra (India) (29)  
Deoki Nandan, V. P. Shrotriya and S. P. Agnihotri (India) (30)  
K. K. Datta, R. S. Sharma, R. K. Misra, V. K. Kaushik and M. Datta (India) (31)  
Prema Bali (India)
- O P E N
- 1705 to 1715 Concluding Remarks by the Chairman
- 1900 to 2030 Visit to Exhibition at Maiden
- 2030 onwards Dinner by WFPHA

**Tuesday, 24-2-1967**

**202-206 : Scientific Session I**

**1415 to 1715 hrs Concurrent Sessions on Sub-Themes**

**204 MANPOWER PLANNING AND TRAINING**

**Place : Burdwan Room**

**Chairman : N.R.E. Fondall (U.K.)**

**Rapporteur : Abebe Engdasaw (Ethiopia)**

**Hours :**

- 1415 to 1420**      **Introductory Remarks by the Chairman**
- 1420 to 1435**      **B. Ghosh (India)**  
**A Methodology for Projection of requirements and Supply of Specialists in Health Sciences (41)**
- 1435 to 1450**      **Pien Chiowanich, Choomnoom Promkutkeo, Ronald Wilson and John Rogosch (Thailand)**  
**Training of Rural Community Paraphysicians and Volunteer Primary Health Care Workers : A Partnership for Effective Rural Health Care (42)**
- 1450 to 1505**      **Eugene Boostrom (U.S.A.)**  
**Appropriate Technical Co-operation for National PHC Programs : Use of Prototype Materials in Training and Management (43)**
- 1505 to 1520**      **A. L. Saha (Nigeria)**  
**Growth of Primary Health Care Services in Nigeria (44)**
- 1520 to 1535**      **J. D. Alter and Satya P. Sangal (U.S.A.)**  
**Maldistribution of Physicians in India and the United States (45)**
- 1535 to 1555**      **Tea/Coffee Break**
- 1555 to 1610**      **D. Banerjee (India)**  
**Training of Public Health Workers (46)**
- 1610 to 1625**      **P. K. Khan (India)**  
**Total Health Care during Female Sterilization (47)**

**Hours**

**1625 to 1705**      **DISCUSSION**  
Invited Discussants :  
Timothy Baker (U.S.A.)  
Mustaq Chaudhury (Pakistan)  
Abdallah Baltaji (Lebanon)  
G. P. Sen and P. N. Khanna (India) (48)  
Sova Sen (India) (49)

**O P E N**

**1705 to 1715**      Concluding Remarks by the Chairman  
**1900 to 2030**      Visit to Exhibition at Maidan  
**2030 onwards**      Dinner by WFPHA

**Tuesday, 24-2-1981**

**202-206 : Scientific Session I**

**1415 to 1715 hrs Concurrent Sessions on Sub-Themes**

**205 SPECIAL DEMONSTRATION AND RESEARCH PROJECTS**

Place : Regal Room

*Chairman* : Abdol Rahaman Kobbashi (Sudan)

*Rapporteur* : John B. Wyon (U.S.A.)

**1415 to 1420**      Introductory Remarks by the Chairman  
**1420 to 1435**      Kamal Islam (Bangladesh)  
Gonoshasthya Kendra—Savar Project (58)  
**1435 to 1450**      Uthaiwon Nutcharas (Thailand)  
Lampang Project—A Research Project in Primary Health Care (59)  
**1450 to 1505**      Esmond J. Garrett, Kiran Kumar Alla and K. L. Standard  
(West Indies)  
Approaches to Primary Health Care in the Caribbean (60)  
**1505 to 1520**      K. S. Sanjivi and M. A. Ramaswamy (India)  
Mini Health Centre Project (61)

## Hours

- 1520 to 1535 K. K. Chaudhury (India)  
Medic Scheme in Arunachal Pradesh (66)
- 1535 to 1555 Tea/Coffee Break
- 1555 to 1610 Banu J. Coyaji (India)  
Vadu Budruk Rural Health Project (62)
- 1610 to 1625 Krishan Lal and J. K. Sharma (India)  
Rehbar-I-Sehat, Scheme in Jammu and Kashmir State (63)
- 1625 to 1705 **DISCUSSION**  
Invited Discussants :  
Gladys Hardy (U.S.A.)  
R. D. Bansal, V. K. Gandotra and S. P. Suri (India) (64)  
B. C. Ghosal (India) (65)  
V. Rahamathullah and C. R. Ramachandran (India) (67)
- O P E N**
- 1705 to 1715 Concluding Remarks by the Chairman
- 1900 to 2030 Visit to Exhibition at Maidan
- 2030 onwards Dinner by WFPHA

**Tuesday 24-2-1981**

### **202-206 : Scientific Session I**

1415 to 1715 hrs Concurrent Sessions on Sub-Themes

#### **206 COMMUNITY PARTICIPATION**

Place : Pre-function Room

*Chairman* : Francisco Sangane (Mozambique)

*Rapporteur* : Dobhanom Muangman (Thailand)

1415 to 1420 Introductory Remarks by the Chairman

1420 to 1435 Vimala Charles (India)

Community Development—An Entry Point in Community Participation (78)

1435 to 1450 Mary P. Johnston (Indonesia)

Community Participation in Primary Health Care Programme (79)

**Hours**

- 1450 to 1505     **Mary Annel (Guatemala)**  
Rural Health Promoters' Project
- 1505 to 1520     **Susan B. Rifkin (Hong Kong)**  
Attitude About Community Participation in Community Health  
Programme (81)
- 1520 to 1535     **Raymond Isoloy (U.S.A.)**
- 1535 to 1555     **Tea/Coffee Break**
- 1555 to 1610     **N. S. Deodhar, P. C. Sen and A. Rahman (India)**  
Singer Shows the Way—An Experiment on Community  
Participation (82)
- 1610 to 1625     **D. Banerjee (India)**  
Community and Health Services (83)
- 1625 to 1705     **DISCUSSION**  
Invited Discussants :
- U. N. Jajoo (India)  
H. N. Mathur (India) (85)  
S. K. Sharma (India) (86)  
Pramila Subramaniam and Saroj S. Jha (India) (87)  
J. S. Gill and Monica Sharma (India) (88)  
S. K. Roy, B. B. Mukhopadhyay, M. M. Ganguly and  
R. Das (India) (89)

**O P E N**

- 1705 to 1715     **Concluding Remarks by the Chairman**
- 1900 to 2030     **Visit to Exhibition at Maldan**
- 2030 onwards     **Dinner by WFPHA**

**Wednesday, 25-2-1981**

**301-305 : Scientific Session II**

**0900 to 1100 hrs Concurrent Sessions on Five Sub-Themes**

Participants select a Scientific Session of their choice. In each Scientific Session five authors from different places will present their topics for 15 minutes each. This would be followed by exchange of information.

**301 DEVELOPING NATIONAL PLANS OF ACTION**

Place : Ball Room

*Chairman* : M. El-Shabrawy (Egypt)

*Rapporteur* : A. K. M. Kafiluddin (Bangladesh)

- 0900 to 0905     **Introductory Remarks by the Chairman**

**Hours**

- 0905 to 0920 P. R. Dutt (India)  
Environment and its Control for Health—Action Plan (12)
- 0920 to 0935 P. K. Chatterjee and V. Venugopalan (India)  
International Drinking Water Supply and Sanitation Decade,  
1981-1990 (13)
- 0935 to 0950 P. G. Adyalkar (India)  
Water Scarcity and Ground Water Resources in India—Supply of  
Water to All by the Year 1990 A.D. (14)
- 0950 to 1005 Kalyan Bagchi (Bangladesh)  
Nutrition in Primary Health Care (15)
- 1005 to 1020 B. C. Ghosal (India)  
Role of Health Education in the context of Primary Health Care  
—Health for All by 2000 A.D. (16)
- 1020 to 1050 DISCUSSION  
Invited Discussants :  
P. V. Manjramkar and Usha Shaha (India) (17)  
A. K. Chakraborty and K. K. Chowdhury (India) (18)  
B. B. Biswas (India) (19)  
V. K. Gandotra and R. D. Bansal (India) (20)  
J. S. Bali (India)

**OPEN**

- 1050 to 1100 Concluding Remarks by the Chairman
- 1100 to 1115 Tea/Coffee Break

**Wednesday 25-2-1981****301-305 : Scientific Session II**

0900 to 1100 hrs Concurrent Sessions on Sub-Themes

**302 IMPLEMENTATION OF FIELD PROGRAMMES**

Place : Viceroy Room

*Chairman* : Abdul Sattar Yusuf (Maldives)*Rapporteur* : Yasuhiro Kanonaga (Japan)

0900 to 0905 Introductory Remarks by the Chairman

0905 to 0920 K. N. Udupa (India)

Role of Indian Medicine in Primary Health Care (32)

**Hours**

- 0920 to 0935      **Sudha Kaul (India)**  
**Primary Health Care—Its Role in the Prevention and Management of Cerebral Palsy (33)**
- 0935 to 0950      **M. K. Sudarshan and V. M. Gupta (India)**  
**A Study into Logistics of Medicines under the Community Health Volunteers Scheme in a Primary Health Centre (34)**
- 0950 to 1005      **M. Saran and R. N. Srivastava (India)**  
**Delivery of Primary Health Care through Community Health Volunteers—An Evaluation Study (35)**
- 1005 to 1020      **S. C. Saxena, R. Chandra, B. C. Srivastava, S. L. Bagga and V. Bhushan (India)**  
**A Study of Performance of Community Health Workers (Volunteers) in the Area of Community Development Block of Lucknow District (36)**
- 1020 to 1050      **DISCUSSION**  
**Invited Discussants :**  
**Nirmala Murthy (India)**  
**S. D. Gaur and S. C. Mahapatra (India) (37)**  
**A. P. Kulkarni and P. V. Salho (India) (38)**  
**J. Chakraborty and B. R. Roy (India) (39)**  
**J. S. Mathur, R. K. Gupta and Bhakt Prakash (India) (40)**
- O P E N**
- 1050 to 1100      **Concluding Remarks by the Chairman**
- 1100 to 1115      **Tea/Coffee Break**

**Wednesday, 25-2-1981**

**301-305 : Scientific Session II**

**0900 to 1100 hrs Concurrent Sessions on Sub-Themes**

**303 MANPOWER PLANNING AND TRAINING**

**Place : Burdwan Room — 3**

**Chairman : Lydia Novak (U.S.S.R.)**

**Rapporteur : Louiso Benecko (Y.A.R.)**

**0900 to 0905      Introductory Remarks by the Chairman**

**0905 to 0920      S. M. Marwah (India)**

**Multidisciplinary Integrated Training Methodologies for Personnel of Health Delivery Systems (50)**

## Hours

- 0920 to 0935 J. S. Mathur, S. C. Gupta and Gopal Krishna (India)  
Manpower Utilization in Multipurpose Functioning of Primary Health Centres (51)
- 0935 to 0950 K. C. Patnaik and P. N. Khanna (India)  
Veterinarians in Manpower Planning for Health Services (52)
- 0950 to 1005 Abraham Joseph, S. Bhattacharji, Jaya Prakash Mulijil, S. Job Jayakaran and S. Suriya (India)  
Utilization of Village Level Workers (53)
- 1005 to 1020 Mary Ann Micka (Sudan)  
An Innovative Teacher Training Unit in Sudan (54)
- 1020 to 1050 DISCUSSION  
Invited Discussants :  
A. V. Sangamnorkar and Vikash Gaidhani (India) (55)  
K. Vijayaraghavan D. Hanumantha Rao and M. C. Swaminathan (India) (56)  
Y. N. Mathur, D. Hanumantha Rao, J. G. Sastry, N. P. Rao, K. V. R. Sarma and M. C. Swaminathan (India) (57)
- O P E N**
- 1050 to 1100 Concluding Remarks by the Chairman
- 1100 to 1115 Tea/Coffee Break

**Wednesday, 25-2-1981**

### 301-305 : Scientific Session II

- 0900 to 1100 hrs Concurrent Sessions on Sub-Themes
- 304 SPECIAL DEMONSTRATION AND RESEARCH PROJECTS**

Place : Regal Room

Chairman : R. Abisudjak (Indonesia)

Rapporteur : M. Page (Malawi)

- 0900 to 0905 Introductory Remarks by the Chairman
- 0905 to 0920 A. N. Arumugam, N. Shantharam and Y. Chandrashekar (India)  
Health Care by Innovation (68)

## Hours

- 0920 to 0935 S. Thomas, B. Cowan, H. N. S. Grewal (India)  
Reaching the Unreached through the State Health System in Punjab (69)
- 0935 to 0950 I. U. Dudani, T. P. Jain and B. L. Tamboli (India)  
Expected load of Medical Care for Paramedical Workers at Rural Health and Training Centre, Naila, Jaipur (70)
- 0950 to 1005 Ancilla Tragler (India)  
A Comprehensive Community Health Project in Slums in Bombay (71)
- 1005 to 1020 E. B. Sundaram (India)  
Linkage Between Health Services and Integrated Development in a Rural Area—Nauyhit Integrated Rural Project for Health Development (72)
- 1020 to 1050 DISCUSSION  
Invited Discussants :  
A. K. Govila and P. N. Shrivastava (India) (73)  
L. G. Chinchkhedkar (India) (74)  
V. K. Shrivastava, R. Chandra and B. C. Shrivastava (India) (75)  
S. Darshan, J. S. Neki and D. Mohan (India) (76)  
L. G. Gupta, S. R. Gupta and A. K. Govila (India) (77)  
R. K. Chandra (U.S.A.)

## O P E N

- 1050 to 1100 Concluding Remarks by the Chairman  
1100 to 1115 Tea/Coffee Break

Wednesday, 25-2-1981

## 301-305 : Scientific Session II

0900 to 1100 hrs Concurrent Sessions on Sub-Themes

### 305 COMMUNITY PARTICIPATION

Place : Prefunction Room

*Chairman* : A. Drobny (Inter-American Development Bank)

*Rapporteur* : Ahmad Sayed (Afghanistan)

0900 to 0905 Introductory Remarks by the Chairman

0905 to 0920 Y. P. Rudrappe (India)

Community Participation (90)

0920 to 0935 Sr. Sara Kaithathara (India)

Community Participation in Primary Health Care (91)

**Hours**

- 0935 to 0950      **S. P. Mukhopadhyay (India)**  
Resources in Health Educational Activities in affecting Community Participation (92)
- 0950 to 1005      **P. V. Sathe and N. S. Deodhar (India)**  
Development of Visual Aids for Community Education and Participation (93)
- 1005 to 1020      **P. C. Samantaray (India)**  
Medicines for Millions—The Formidable Challenge the Community has to accept (94)
- 1020 to 1050      **DISCUSSION**  
Invited Discussants :  
~~Anita-Mackey (Kenya)~~  
~~Sanoussi Konate (Mali)~~  
Abdulwahab Makki (Yemen)  
Okusanya (Nigeria)  
S. X. Charles (India) (95)  
Mrinalini Pathak, Y. A. Kotkar and R. D. Mazumdar (India) (96)

**O P E N**

- 1050 to 1100      **Concluding Remarks by the Chairman**
- 1100 to 1115      **Tea/Coffee Break**

**Wednesday, 25-2-1981**

**306—Plenary Session III**

**Place : Ball Room**

**REGIONAL STRATEGIES OF HEALTH FOR ALL**

**Chairman : D. Tejada de-Rivero**

**Rapporteur : D. M. Fernando (Sri Lanka)**

- 1120 to 1130      **African Region**  
S. H. Siwale
- 1130 to 1140      **Eastern Mediterranean Region**  
M. A. Choudhuri
- 1140 to 1150      **South East Asia Region**  
Mya Tin
- 1150 to 1200      **Western Pacific Region**  
D. P. Piyaratne

**Hours**

- 1200 to 1210      **ROLE OF VOLUNTARY ORGANIZATIONS**  
                         **S. C. Soal (84)**
- 1210 to 1220      **ROLE OF PROFESSIONAL ORGANIZATIONS**  
                         **S. Kossler**
- 1200 to 1300      **DISCUSSION**

**Wednesday, 25-2-1981**

**307 : Plenary Session IV**

**Place : Ball Room**

1400 to 1445

**DAS GUPTA MEMORIAL ORATION**

2.00 - 2.45

*Chairman* : P. L. Tauli (Brazil)

A. P. Ray (India)

Some thoughts of Phasic Development in Health Programme

1445 to 1700

**CONCLUDING SESSION**

*Chairman* : Kripa Narain  
Secretary, Health and Family Welfare, Govt. of India,  
New Delhi.

*Rapporteur* : S. Izutsu (U.S.A.)

1445 to 1450

Introductory Remarks by the Chairman

1450 to 1605

Sub-Theme Summation by the Rapporteurs

The five Rapporteurs will present their reports

1605 to 1620

Tea/Coffee Break

1620 to 1640

Congress Review

1640 to 1655

Concluding Remarks by the Chairman

1655 to 1710

Vote of Thanks

1730 to 1830

Reception by the Governor, West Bengal

1830 to 2000

Cultural Programme

6.30 - 8.00 pm

Musical Instruments of India—Rabindra Sadan

2000 .

Dinner (Subscription)

35

**ADDENDUM**  
**SESSION CO-CHAIRMAN**

<b>SCIENTIFIC SESSION NO.</b>	<b>SUB-THEME</b>	<b>CO-CHAIRMAN</b>
202	Developing National Plans of Action	J. Romain (Haiti)
203	Implementation of Field Programmes	A. Rozov (U.S.S.R.)
204	Manpower Planning & Training	H. Ohlin (Sweden)
205	Special Demonstration & Research Projects	T. M. Khadir (Jordan)
206	Community Participation	M. Mandara (Tanzania)
301	Developing National Plans of Action	A. Böhm (West Germany)
302	Implementation of Field Programmes	I. Pathmanathan (Malaysia)
303	Manpower Planning & Training	P. Prince (Australia)
304	Special Demonstration & Research Projects	K. Niija (Mali)
305	Community Participation	M. Tu (Burma)
306	Regional Strategies	K. Du Pung (China)
307	Concluding Session	A. Gazzaz (Saudi Arabia)

SUPPLEMENT TO PROGRAM

Wednesday, 25-2-1981

Scientific Session II

0900 to 1100 hrs. Concurrent Sessions on Five Sub-themes

Participants select a Scientific Session of their choice. In each Scientific Session authors from different places will present their topics for 15 minutes each. This will be followed by exchange of information.

308 Special Session

Place: Prince's Room

Chairman: N.R.E. Fendall (U.K.)

Rapporteur: Susan Rifkin (Hong Kong)

0900 to 0910

Introductory Remarks by Chairman

0910 to 0930

Moussa J. Idi (Niger)

Developing a National Plan of Action for Primary Health Care Delivery in the Republic of Niger

0930 to 0950

Ahmed I. Gomaa (Egypt)

Strengthening a Rural Health Services Delivery Project in the Arab Republic of Egypt

0950 to 1010

Warren L. Berggren (U.S.)

Implementation of Primary Health Care: Supervision, Information, and Evaluation

1010 to 1020

A. Bamisaiye and O. Ransome-Kuti (Nigeria)

The Progressive Involvement of the Community in Primary Health Care: A Plan from Lagos, Nigeria

1020 to 1100

Discussion

**THIRD INTERNATIONAL  
CONGRESS OF THE WORLD  
FEDERATION OF PUBLIC  
HEALTH ASSOCIATIONS**

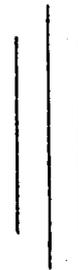
**&**

**25th ANNUAL CONFERENCE  
OF THE INDIAN PUBLIC  
HEALTH ASSOCIATION**

**&**

**11th NATIONAL CONFERENCE  
OF I.A.P.S.M.**

**FIELD VISIT PROGRAMME**



**CALCUTTA**

**February 23-26, 1981**

**ITINERARY OF FIELD VISITS ON 26 FEBRUARY, 198'**

Place of Visit	Appx. distance	Departure from Calcutta		Return journey		Lunch/Liaison Officer
		Place	Time AM	Dep. from field	Arr. Calcutta	
I CINI Complex — Child in Need Inst., Joka. To contact Dr. S. N. Chowdhury, <i>Director</i>	20 km	Grand Hotel	8-15	11-45 AM	12-30 PM	<i>Lunch:</i> No arrangements <i>Liaison Officer:</i> Dr. H. Saha
II SINGUR Complex — P. S. Singur Dist. Hooghly. To contact Dr. A. Rahman, <i>Officer-in-Charge</i>	45 km	a) Grand Hotel b) AIHHPH	7-30 8-00	11-45 AM	1-15 PM	<i>Lunch:</i> No arrangements <i>Liaison Officer:</i> Mr. A. K. Adhya
III NIMPITH Complex — PO Nimpith Ashram Dist. 24-Parganas. To contact a) Swami Buddhananda, <i>Secretary</i> b) Dr. D. K. Ghorui, <i>MO in-Charge,</i> PHC, Nimpith	65 km	Grand Hotel	8-00	2-30 PM	5-00 PM	<i>Lunch:</i> Indian style at cost and on advance intimation. <i>Liaison Officer:</i> Dr. S. N. Choudhury
IV KALYANI Complex — Kalyani, Dist. Nadia To contact Dr. (Mrs.) Gayatri Ghose, <i>Principal,</i> Health & Family Welfare Trg. Cen., Kalyani.	60 km	Grand Hotel	8-30	3-00 PM	5-30 PM	<i>Lunch:</i> Indian style at cost and on advance intimation. <i>Liaison Officer:</i> Dr. R. Garai

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4. Texts of Keynote Addresses

Second Hugh R. Leavell Lecture

"Health for All by 2000: Sincere Commitment  
or Empty Rhetoric?"

Delivered by James Grant

Executive Director

United Nations Children's Fund

Session 101

Monday, February 23, 1981

WFPHA Third International Congress

Calcutta, India

NOT OFFICIAL

**D R A F T**

FOR EDITORIAL REVIEW ONLY

79

Thank you very much, Dr. Deodhar. Mr. Chairman, Dr. McBeath, distinguished delegates to this meeting.

I feel a great sense of warmth and belonging as I stand here. I feel it in part because Hugh Leavell, in whose name this lecture is being given, was a close friend of my father's. They were colleagues who worked together. The last time I saw Hugh Leavell was here in Calcutta. They were two men pursuing parallel courses at a time when they were relatively in the wilderness, and if I may say so, particularly in the United States.

I'm also pleased to be here with the All-India Institute as the host. The Institute was not only a place where my father worked, learned a great deal, and developed warm friends that lasted throughout his life, it was also a place I visited during World War II, and it was the center from which the blood came to my combat unit in Burma during World War II, as a result of the activities of the center here. So my ties here are really many indeed.

It is particularly appropriate that we are discussing here "Health for All by the Year 2000." This was what my father was committed to -- health for all. He was also committed to the concept of health for all in our time, and that's really what we're talking about today.

We gather here in the first months of a new decade in which the United Nations General Assembly has proclaimed "Health for All by the Year 2000" as a target for the world community. The question before us really is, however, is this a sincere commitment or is this just one more of the many pieces of rhetoric -- a cruel hoax -- such as we have so often seen before. The World Food Conference in 1974 proclaimed that in ten years we would do away with hunger; we are now getting close to ten years and nowhere near that goal. As we look at the question of how attainable health for all is in our time, let us start by looking at what the facts are today. What are our starting points?

On its thirty-fourth birthday last December, UNICEF issued its first annual State of the World's Children assessment. In it were a series of conclusions from which I shall quote. First, "of the 122 million children born last year," it says in December 1980, "children born in the International Year of the Child, one in every ten is now dead." In India this means that some two and a half million children born in the International Year of the Child were dead a year later. It means that some 35,000 small children die each day, nearly 10,000 of them in India. They die very silently. We know how silently when we realize that the Italian earthquake that commanded the headlines of the world brought 5000 tragic deaths. But that same day 35,000 small children around the world died without notice. They were largely from weak families, poor families, and they were the weakest and the poorest of those parents.

81

The second quote is that "on present trends, the number of people who live and die without adequate incomes, food, water, health care, or education, is likely to increase." There are today, for example, roughly one billion illiterates. If current trends continue by the year 2000, there will be one a half billion illiterates, a 50 percent increase. However, on the positive side it is worth noting that while the absolute numbers grow, percentages have been going down -- of those who are illiterate, hungry, in ill-health. Thus, we see in India, as compared with the time when my father came here, a death rate that has been halved from some thirty to fifteen in a period of about forty years and a life expectancy that has increased by two thirds from some 31 to 51 years during this period.

The third quote from this assessment is that "the message of the past three decades is not that the problem of world poverty has been or is being solved, but that it can be solved." We know the problems of poverty around the world, but we also know that some low income countries with nearly half of the population of the developing world have achieved remarkable progress in overcoming the worst aspects of absolute poverty. These include countries under all kinds of systems -- People's Republic of China, South Korea, Taiwan, Sri Lanka, and Kerala, India, are illustrations of remarkable progress at very low incomes.

Fourth, the assessment states, "Specifically the targets for a new future have been realistically set by the New International Development Strategy, at reducing infant mortality

in all countries to 50 or less (as compared to 132 per 1000 births for low income countries today), increasing life expectancy to 60 or more, as compared to 49 for low income countries today, enrolling all children in primary schools, and eradicating mass illiteracy by the year 2000," as compared to 80 percent illiteracy for the low income countries today.

Now these are ambitious goals indeed. They call for, by the year 2000, all low income countries' achieving higher life expectancy than the very best in the world in 1920. It means that to achieve these goals over the next twenty years, most low income countries will need to achieve two to four times the rate of progress of that in the past twenty years in closing the gaps of illiteracy, life expectancy, and infant mortality. And, I must say, that with the storm signs of global stagflation continuing to at least the first half of the 80's, the economic prospects look very dark indeed.

The first conclusion of the State of the World's Children 1980 was that "although idealistic in the context of past experiences, these goals are realistic in the sense that the principal obstacle standing in the way of this realization is the will and the commitment to achieve them." But, and these are the critical questions, is it realistic to believe sufficient will and commitment can be developed to achieve these historical unprecedented goals? If so, how much of it depends upon us, those of us in this room and our colleagues?

I suggest three propositions. First, that we in this room and our like-minded colleagues can contribute significantly to increasing the national will that is essential. Secondly, we

83

can contribute significantly to making progress less difficult and less costly, thereby reducing the amount of will required. Third, and the final proposition here, is that unless we and others like us do both, "health for all" will be largely a cruel hoax on the poor in the world.

It might be useful to discuss, when we try to assess how likely this is, the evolution of "health for all." The real genesis of "health for all" probably came in the 1920's, when people such as Dr. Grant, Hugh Leavell, C.C. Chen of China, and others first began to pioneer primary health care techniques and the concept that you must involve the community, use auxiliaries, and develop alternative strategies in order to evolve a nationally replicable pattern. These techniques were further defined at the All-India Institute here, at Singur, by the Bore Commission, still considered a landmark report today. It was then 1977 when WHO first suggested the goal of "Health for All by the Year 2000." It was in the fall of 1978 that WHO and UNICEF agreed at Alma-Ata that primary health care was the means to achieve this set of goals.

The question still rises, how likely is it to be achieved? I would say that as long as these sets of goals remain just the goals of Ministries of Health, they are undoubtedly doomed to failure. It must go much further. Fortunately, a parallel evolution has been going along with "health for all" during the last decade. The landmark for this occurred in the mid-70's, when several years of growing conviction that growth alone was not going to reach the people, that the growth of "trickle-down" was not enough. And it was in 1975 that a series of benchmark

84

conferences heralded a new emerging consensus that it was possible to overcome the worst aspects of absolute poverty in this century if alternative strategies were devised in virtually every major field. The ILO World Employment Basic Needs Conference in 1975 was the first of these. The second was the report by Timbergen and a group of fellow consultants called Reshaping the International Order, and the third was Mr. McNamara's landmark address to the World Bank in 1975. All of this culminated last fall in the United Nations General Assembly with the New International Development Strategy for the 80's and beyond, which as introduced by the chairman of the preparatory committee, the Ambassador Niaz Naik of Pakistan, with these words:

"An important new feature of the present strategy is that it conceives of development as an integral process, and the objectives of social and human development have been accorded a new emphasis. This is in fact the most significant result of the negotiations on the strategy....The strategy thus contains specific goals and objectives relating to the elimination of hunger, universal primary education, primary health care for all, and a sharp reduction in infant mortality by the end of the century. In particular, the role of development of women has been fully recognized."

This was a landmark indeed, because it integrated fully for the first time the social goal with the economic goal. This still leaves us with the question, "How 'do-able' is this by the Year 2000?" If so, what is required of us, of the low income countries, of the high income countries, of the middle income countries?

85

I think if we look at the central problem, it's quite clear that there are two basic underlying stresses. One is the stress that is associated with poverty, which leads to malnutrition, and the second, that associated with gross underdevelopment of basic services available to people who are poor. The two tend to go hand in hand.

Low income and lack of access to basic services is largely a structural problem. In 1976-77, the largest study ever undertaken on the world food and nutrition situation was done by the U.S. National Academy of Sciences. At the very end, when the report was finalized and issued to the public, the chairman said, "Doubling food production next year on present patterns would not materially change the status of the great majority who are hungry and malnourished today." This is another way of saying that structural problems underly much of the stress we are seeking to cope with.

This is illustrated in my own country, the United States, where we have a very interesting phenomenon. Washington, D.C., which is the highest income major political unit in the United States, with the highest per capita expenditure on medical care, both public and private, has had in the mid-70' the lowest life expectancy in the United States and the highest infant mortality in the United States. A great contrast indeed.

You see some of the structural problems here in India, where a situation of having large grain crops -- 28.5 million pounds -- has not changed dramatically the percentage of people who are hungry and malnourished. One sees contrast between

86

that and the state of Kerala, which though one of the low income states, has the highest life expectancy as well as the lowest infant mortality in India. All of these point to an underlying set of structural problems. It all means that alternative approaches are required if the problems are going to be coped with, and this has been the subject in the past year of a series of major studies. One of them that to me has made a major contribution is the World Bank's World Development Report 1980, which deals extensively with this subject. Our own State of the World's Children 1980 deals with this topic, and the report Health for All: An Alternative Strategy, put out by the Indian Council of Medical Research is another major 1980 contribution to thinking through this problem.

Now, as one looks at the world scene and the problems of ill health and poverty, I think one can say that there are two somewhat separate groups of poverty and ill-health problems. One is on a vertical axis in which one finds the great mass of poverty in the low income countries, a significant group in the middle income countries -- in northeast Brazil, in northern Nigeria -- and then still significant pockets in countries such as the United States and in parts of Europe. Roughly a billion people are in that category (table A).

	Population <sup>1</sup> (millions)			Per Capita Income (in constant 1975 U.S. \$)				Physical Quality of Life Index <sup>2</sup>			
	1975 Total	Absolute Poor	Under- nourished	2000 Total	1975	1985	2000	1950's (approx)	1970's	2000	
Low Income Countries (LIC: \$300-per capita)	1,300	700-800	400-640	2,250- 2,100	100	150	170- 195	220- 330	15	40	56
Middle Income Countries (MIC: \$300+ p.c.)	800	150-200	80-120	1,350- 1,050	450	950	1,130- 1,330	1,450- 2,200	54	67	73
High Income Countries (HIC: \$2,000+ p.c.)	700	35-70	20-35	850	2,600	5,800	7,000- 8,300	9,000- 14,000	90	95	97

<sup>1</sup> Includes centrally planned economies

<sup>2</sup> Physical quality of life index. Life expectancy, infant mortality, and literacy figures are each rated on an index of 0-100. Higher PQLI figures for 2000 are targeted on halving the disparities between those of the most advanced countries and the current level for each category of countries; the lesser figures assume roughly a continuation of past trends.

A second side of the poverty problem can be looked at in terms of countries, and then it becomes very clear that some three quarters of those in absolute poverty are in a group of extremely low income countries -- countries with an income that is only a fraction of that of the middle income countries and for which the problem becomes obviously much more difficult to cope with.

Looking back on the lessons of the past few decades, what reason for hope do we have? What we see is that two keys have been required where real progress has been made. First has been national will. Second, particularly in low income countries, has been the development of far more relevant knowledge, alternative strategies for approaching the problem. When one looks at the issue of national will, how is it much easier to deal with the national will problem of high income countries? The poor are only small minorities. It doesn't require vast proportions of the income to relate

to that problem. And we see this in the United States, where in the mid-60's for the first time there was a really serious effort to attack the problem of those at the absolute poverty level. Within a ten-year period, that number was reduced from more than forty million people below the poverty line to well under twenty million below the poverty line.

But to emphasize once again how much of a structural problem this is, I refer you to a table that compares Puerto Rico with Washington D.C. (table B).

Table B

1970	P.C. GNP (\$)	Inf. Mort.	Life Exp.	PQLI	1950 DRR
Wash., D.C.	7,350	29	67	88	0.6
Puerto Rico	2,300	24	74	91	9.0

Source:

The table shows that Washington, D.C., which has three times the per capita income of Puerto Rico, has a lower life expectancy rate and a higher infant mortality rate than Puerto Rico, which is a much poorer state. And that Puerto Rico, which twenty years ago, thirty years ago was way behind Washington, D.C., has now passed it. And when one asks why, it becomes very clear that the central distinguishing characteristic of Washington, the lack of progress in Washington, D.C. is that until very recently it has been the one part of the United States without political participation. There has been no voter franchise. There has been no reason why the powers that be in Washington, D.C., when allocating the country's health resources need address them to the very poor. Whereas

in a highly competitive democratic situation, it is a major political imperative to see that certain basic services reach the poor. They vote. They don't vote until very recently in Washington, D.C.

Turning to the middle income countries, what one sees is great income disparities, a high thirty or forty per cent that is in great poverty. On the other hand, I think we know that in the next twenty years one can be fairly optimistic about most of these countries and their progress on the health/income side. Their incomes are rising fast. If you look at Latin America, by the end of this century per capita income in Latin America will have passed that of Western Europe in 1960. Now, this doesn't mean there won't be serious internal structural dislocations and turmoil. The real question is how much turmoil? We are seeing it today in Central America, in El Salvador, in Guatemala, we saw it a year ago in Nicaragua, as this pressure for change between the capital and the country-side has brought actual revolution. But looking toward the end of the century, I think one can be reasonably confident that these societies will have resources to address their problems.

The really difficult problem comes when we look at the low income countries, and here it's far more difficult because of the absolute poverty. It's noteworthy that in India today the per capita income in real terms is roughly one half that of the U.S. in 1776, the time of the American Revolution. If India were successful to the fullest of its dreams by the year 2000, its per capita income in real terms will be roughly equal to

that of the United States in 1776, of the U.K. in 1776. And at that moment per capita income in India will still be only one third the level of middle income countries today. This illustrates the seriousness and the difficulty of this set of problems in the low income countries.

The question then arises, how can we advance national will, how can we find easier alternative strategies that make progress easier to accomplish and therefore require less national will -- in the low income countries, in the middle income countries, and in the high income countries?

I will outline seven requirements. Three are requirements particularly relevant to us here today. The first point is that with respect to national will, it is imperative that the international, the global community accept the concept of human progress as being as important as the concept of economic progress. Today the world community talks in terms of GNP growth rates. A country is doing very well if it has a three or four per cent per capita economic growth rate. We don't get the same kind of accolades if a country manages to reduce its infant mortality rate dramatically or increase its life expectancy considerably. So really one of the first tasks is to advance the acceptance of human progress being as or more important than economic progress.

Under this same point, it becomes important to think of human progress in time frame terms. We're not talking about human progress fifty years from now or seventy-five years from now: we must be able to talk about human progress in the 80's.

GNP growth rates are talked about as 3 per cent a year, 4 per cent a year, 5 per cent a year: we need to talk about increasing life expectancy, decreasing infant mortality in the same terms.

Also related is the need to convince the national decision makers that investing in people, investing in children is good for economic growth.

Now, on these three counts I think we have seen good progress in the last five years. The New International Development Strategy, Alma-Ata, Health for All -- these are all contributing to a new standard of measuring progress and setting time goals.

A great contribution was made by the World Bank's Development Report for 1980 that came out this past summer. (tables C,D,and E) Coming from the Bank for the first time was a major set of documented conclusions that investment in social progress contributed significantly to economic growth if measured over a long enough time frame. The Bank documented it most clearly on the education front, but the findings are equally applicable on the primary health care front.

Three tables bring this out. The World Bank notes (table C) that investment in primary school education in a low income, low literacy country over a period of twenty years will bring an average return of 27 per cent a year, significantly higher than most economic investments can be expected to bring.

Table C

Rates of return to education

(percent)

Country group	Primary	Secondary	Higher	Number of Countries
All developing countries	24.2	15.4	12.3	30
Low income/adult literacy rate under 50 percent	27.3	17.2	12.1	11
Middle income/adult literacy rate over 50 percent	22.2	14.3	12.4	19
Developed countries		10.0	9.1	14

Source: Development Report for 1980,  
World Bank

It is also noteworthy that they found that investment in primary education in a low income country will bring twice the rate of return that investment in university education will bring.

A double set of conclusions here is applicable across the board: 1) investment in primary health care, in primary education, can be very good economics indeed, and 2) investment at the primary levels, as distinguished from the university or hospital level, will be significantly more productive in terms of economic growth.

Table D indicates that if the average developing country were to shift one per cent of its GNP from investment in physical facilities to investment on the social side, at the end of twenty years that country would witness significantly more economic growth than if the investment had been in physical facilities.

Table D

Consequences of switching 1 percent  
of GNP from physical investment to  
primary schooling

	Income per person	Adult literacy rate
Initial situation	\$640	55%
	(outcome without the switch=1.00)	
Outcome 7 years later	0.99	1.00
Outcome 20 years later	1.00	1.11

Source: Development Report for 1980,  
World Bank

Table E sets out the proposition, that if progress is combined on several fronts at the same time, they develop a synergistic effect. Thus, if a farmer is educated but does not have access to credit, to other inputs, this will increase his productivity by roughly six percent a year. On the other hand, if along with education, the farmer has access to credit and other inputs, his productivity increases by some twelve per cent a year, the synergistic result from investment.

Table E

Farmer Education and farmer productivity	
Study	Estimated percentage increase in annual farm output due to four years of primary education rather than none
With complementary inputs*	
Brazil (Garibaldi), 1970	18.4
Brazil (Raunda), 1969	4.0
Brazil (Taquari), 1970	22.1
Brazil (Vicose), 1969	9.3
Colombia (Chinchina), 1969	-0.8
Colombia (Espinal), 1969	24.4
Kenya, 1971-72	6.9
Malaysia, 1973	20.4
Nepal (wheat), 1968-69	20.4
South Korea, 1973	9.1
Taiwan (banana, and pineapple) 1964-66	15.5
Taiwan (rice), 1964-66	2.3
Average (unweighted)	12.6
Without complementary inputs	
Brazil (Candalaria), 1970	10.3
Brazil (Conceicao de Castelo), 1969	-3.6
Brazil (Guarani), 1970	6.0
Brazil (Paracatu), 1969	-7.2
Colombia (Malaya), 1969	12.4
Colombia (Moniquiva), 1969	12.5
Greece, 1963	25.9
Average (unweighted)	3.1
No information on availability of complementary inputs	
Average of eight studies (unweighted)	6.3

\*Improved seeds, irrigation, transport to markets and so on.

Source: Development Report for 1980, World Bank

The returns from investment in health facilities is an area which we in the health field need to document much more. I think it's noteworthy that if you take a small example, the eradication of smallpox, the United States invested some fifty million dollars in the worldwide effort to eradicate smallpox. In one year after the eradication was complete, the United States had a saving of more than a hundred and fifty million dollars, three times its fifty million dollar investment worldwide in the 70's for smallpox eradication. It has been able to do away with immunizations, quarantine facilities and an array of other things.

We desperately need to get a series of examples that illustrate how investments in health can provide a dramatic payoff on the development front.

Point two in the group of seven requirements is that we need vastly increased knowledge of two types. We need vastly increased knowledge on the social science side on more effective forms of distribution, and we need far more research on the hard science side on technologies that are more appropriate for the poor.

It's quite clear that on the distribution side, we need in virtually every field, including medicine, to find alternative approaches that result in carrying the medical dollar, the education dollar, the nutrition dollar much further than is the practice today. We also need to find out what the payoffs are in integrating health and education and other progress together to get a synergistic result. This of course is very much the subject of primary health care. In other words, primary health care is a major effort to arrive at community participation, people participation, use of auxiliaries, at the same time integrated with progress on the education front, the nutrition front, and other fronts parallel with that progress on the health services front.

It is very clear that the world is making a very modest investment indeed in research on the problems of the poor. I think one can safely say that in health and agriculture less than one percent of the world's research project expenditures today

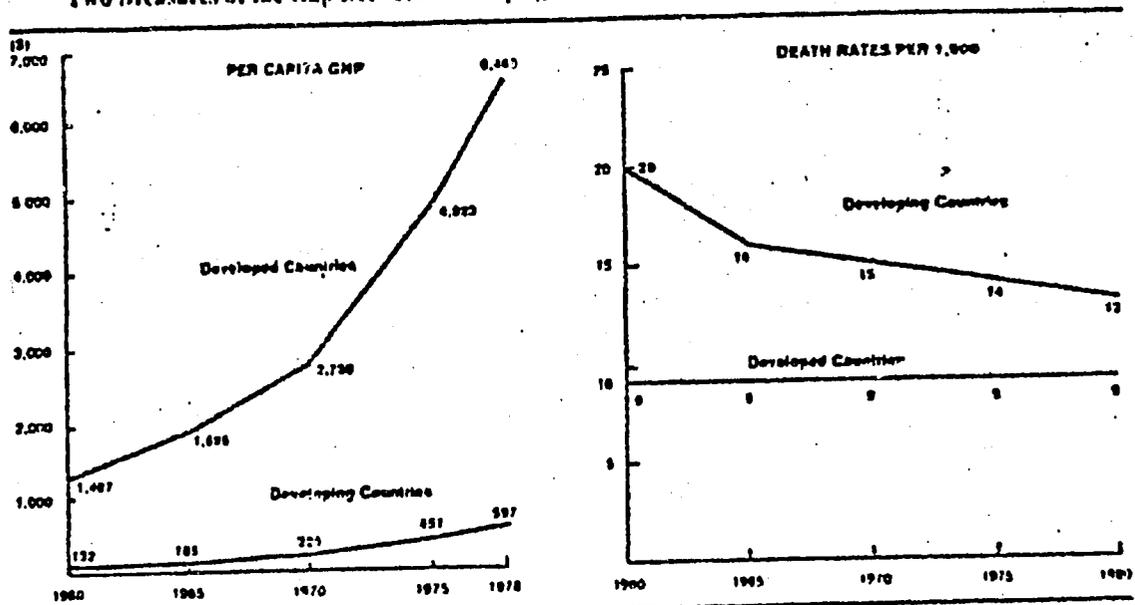
have primary application to the problems of the world's poorest billion people. We have vast sums available for cancer research, heart research, but very little for schistosomiasis, the great infectious diseases, river blindness, malaria. This clearly is an area requiring a major shift. Equally we need far greater dissemination of the results of what we have found. I attach to this statement (Appendix 1) some twenty postulates that John Grant laid out, mostly as he was living here some thirty odd years ago. These represent probably ninety per cent of the collective wisdom we have today about how to tackle health problems that encompass the poor majority of society. But we have been unable to get these accepted and documented in such a way that they are actually applied.

The third requirement is how to get better means of measuring progress in human beings. The focus, as I indicated earlier, has been progress as measured in economic terms. In human terms we have tended to focus on how many dead or how many doctors -- not on end results. It's clear that if we focus on end results, then we can really tell whether or not people are progressing. For example, the world has recently launched worldwide water decade. The underlying theory of this water decade is that it will result in much greater health. We are now finding in most rural areas that bringing clean water to the surface alone cannot have a significant impact on child mortality and child morbidity. But we derive a sense of satisfaction from measuring in terms of number of wells drilled or number of villages provided with a safe water supply. But if we look to the underlying yardstick

of infant mortality and morbidity, we are seeing that this rather major investment in most countries, in most areas, is not bringing anything like the returns we think it ought to.

Table F indicates that if one looks at progress in terms of death rates, one can see that in the last thirty years there has been significant progress at the very time use of per capita GNP indicates that the gap has been widening greatly.

Two Measures of the Gap Between Developing and Developed Countries, 1960-1978



SOURCES: Per Capita GNP figures for 1960, 1965, 1970, and 1975 are from *World Development and Social Progress 1978* p. 24, and 1978 per capita GNP figures are from the same source. Table A.4; death rate figures are from U.N. *Statistical Yearbook Demographic Indicators*.

The three postulates I have just put forward are relevant to all of us in this room. We have a major capacity to convince governments that they ought to think in terms of people progress as the real task of whether progress is being made. Secondly, we in this room have a major capacity to advance and to promote research on more effective poor-focused systems, alternative strategies that do work and that are successful in involving

community participation, use of auxiliaries and paraprofessionals. We in this room also have a capacity to develop and insist on the development of better yardsticks for measuring progress of primary vital statistics.

We need to talk about four other basic requirements at the same time. The first is that there does need to be increased concessional resource transfer from the rich countries to the low income countries in particular. An increased transfer of some twelve to twenty billion dollars a year would be a minute percentage of the world's six trillion dollar gross total product, and would provide the foreign exchange resources for a successful worldwide effort aimed at the year 2000. Secondly, it's very clear that the industrial countries need to allow greater access to the markets for manufactured products of the low income countries if the low income countries are going to be able to achieve economic progress. Third, there is a major need to convince the high income countries that their prosperity is increasingly dependent upon the prosperity and growth of the low income countries.

I won't go into these three, but it's very clear that these need to go along with progress on the other front if we are going to succeed with "Health for All by the Year 2000."

I close on the final point by saying we need initiative from major new sources if there is to be a break from the pattern of the past. I would say that the New International Development Strategy represents one of the many that will be required. But clearly there does need to be a real consistent

push before present patterns will change.

Let me conclude on the note that, first, the world community has rhetorically accepted "Health for All" for all people by the year 2000 to a degree that most people would have found unbelievable five years ago. Five years ago very few people would have believed that you could get the international community to accept these kinds of goals, that we would have achieved the type of progress embodied in Alma Ata and in the New International Development Strategy. It is very clear that if we are to convert these rhetorical goals into reality, the next three or four years will be vital. If the next three or four years do not witness major progress on these goals, then we will have missed the opportunity for our time.

Now there are pessimists who say these goals are impossible to achieve in the 80's and the 90's. They say the world is far less organized now than it was twenty years ago. This is a far more pluralistic world: we are moving into a global recession.

The optimists reply that progress frequently comes at times of great difficulty, and progress frequently comes when it is people-led. Certainly in India when you think of your national liberation in the late 40's, it was because people were ahead of government insisting on change. The Civil Rights movement in the United States was people pressure ahead of government. UNICEF has just been involved in the salvation of a nation that was on the verge of entering a holocaust -- Kampuchea. This again was a case where governments were really not prepared to respond until there were such massive public opinion pressures

that it became bad politics not to respond and good politics to respond. We mounted the greatest relief effort since the end of World War II for that country and brought it back from the edge of disaster.

It was just last month that the World Health Executive Board passed an infant formula code that was jointly developed by WHO and UNICEF, and I would venture to say that that code would never have come to be if it were not for private groups that were out ahead of government forcing the case.

I am saying here that the key to progress is the willingness of people to say that past situations are unacceptable. The concept that 35,000 small children are dying everyday is unacceptable when we have the means to avoid it. I would say that success in this goal of health for all by the year 2000 depends on our contribution in two ways. One way is to do everything possible to increase the national will that puts this subject high on the agenda. The second way is through our contribution to research, our learning from the projects we are undertaking. We must document that it is possible to make major progress at a fraction of the cost that governments and politicians had thought necessary before, and that the benefits, economically and politically, are far greater than realized before.

The stakes are high indeed. If this set of goals articulated at Alma-Ata and by the New International Development Strategy is achieved, it means that by the year 2000 some five million fewer small children will be dying every year and some ten to twenty

million fewer children will be born every year than the United Nations now projects for the year 2000. Is there a more worthy cause for us to be dedicated to?

Thank you.

## Appendix I

### GRANT'S PRINCIPLES AND CHANGE\*

1. The use made of medical knowledge and the efficiency of health protection depend chiefly upon social organization.
2. A vertical medical system cannot stand by itself unless it is integrated with other social activities in a joint horizontal attack upon the problem of social reconstruction.
3. Organization implies reliance upon tested practicable methods and training institutions designed to meet local needs.
4. Socioeconomic progress depends chiefly upon actual demonstration of feasibility and worth.
5. Demonstrations, to be successful, must make use of technical methods which are scientifically efficient and economically practicable.
6. Demonstration units must take into consideration the economic practicability of extending them to the nation as a whole. This implies that the principle of self-help be adopted, as no Asian country can as yet afford to make full use of available technical knowledge through tax funds alone. Among the most essential elements of self-help is the development of technical consciousness at the village community level. Generally speaking, universities are most qualified to undertake demonstration projects.
7. The immediate social problem is to overtake the lag between modern knowledge and its use in the setting of a community. The single outstanding and basic cause of this lag in the health field is the lack of scientific investigation of methods to apply the results of the growing body of scientific knowledge to society. As the principal instruments for generation, utilization and application of new knowledge are the universities, these institutions must be held primarily responsible for the failure to develop effective and scientifically based community health care.
8. Investigation requires a suitable organization to determine the most effective and economical methods of applying the results of basic research to the maintenance of health and the cure of disease through organized community effort. This implies that the investigative organization must control its own experimental community in the same manner that teaching hospitals are available for research in clinical medicine.

9. Public Health administration is effective in proportion to its adherence to the following seven principles: a) social services are interdependent; b) health maintenance can be achieved only if the consumers of services themselves are technically aware and practice the knowledge which they possess; c) the administration of special functions (e.g., health, agriculture, education, etc.) should be undertaken only by one governing body; d) compromise between theory and practicability is necessary in social progress; e) administrative procedure must be based upon sound economic consideration and practicable financial budgeting; f) success depends upon the extent of self-participation, directly or indirectly, by the citizen; g) methodology must be developed inductively through controlled experimental communities administered by personnel who are trained in methods that are scientifically derived.
10. For planning to be effective it must build up from the local unit of organization to the central administration rather than be superimposed from the centre on the periphery.
11. The eventual goal of all administration is to achieve as much decentralization of services as is compatible with efficiency. A major factor in this undertaking is the development of community technical consciousness of health needs among the consumers of the community. This can best be achieved when the health services are established as an integral part of community development designed to raise the welfare level of local inhabitants in all fields through self-help which can look to the technical agencies of government for guidance and support.
12. It is necessary to attempt to clarify the impact which financial investment in health care has upon social, economic and political development in general.
13. A demonstration project, if not conducted at an appropriate financial and technical level and if the mechanism for duplicating or expanding upon it is not readily forthcoming, can be a hindrance in terms of further development.
14. For a community project to succeed the community unit chosen for demonstration must conform to an already existing political unit of the country in question.
15. The first principle of administration is that when a function is to be undertaken by government for the welfare of its people, this function should be discharged by a single agency.... The greatest single obstacle to health progress in many countries is the establishment of social insurance which permits the security agency to establish its own institutions for the provision of health care.
16. The efficient distribution of health care services requires that they be coordinated within a given region in a systematic pattern. The regional system should provide for, among

other things, continuing education, and periodic evaluation of the system itself.

17. A regionalized area should contain a population large enough to be self-contained in supporting the provision of all branches of health care facilities. This requires a population of between 250,000 and 500,000. This level is needed to render efficient service and supervision and to support the costs of service personnel. Coordination is effected by establishing a two-way flow of professional and administrative services between the peripheral units and the base, which preferably should be a teaching medical center.
18. Sound planning of medical education is essential; for it is only through the systematic and continuous application and coordination of the techniques and principles of administration, the available resources, the staff and the services, with a view to establishing their distribution, effectiveness and cost. The principal aim of research is the dissemination and utilization of these findings to improve the administrative and technical practices of health care.
20. The successful development of health care services, as a social service, requires a suitable national atmosphere and an appropriate economic system with equitable distribution. The prerequisites are satisfactory land tenure and laws, and legislation prohibiting the flight of capital.
21. A teaching hospital should be intimately linked and integrated with an adjacent community field practice area, for teaching purposes, and to provide integration and continuity of care. In addition, this enables the teaching hospital to undertake an epidemiological assessment of its role in the care of at least that proportion of its patients admitted from the practice area and of the practice population as a whole.

These simply stated, highly original, and profoundly important precepts and concepts are a measure of the man. Neither before John Grant nor after him has the need for scientifically proven principles as the basis of community health care been so convincingly argued, and their characteristics so comprehensively described. In fact, these stand alone, unmodified and unreplaced, as a timeless monument to the man and his work.

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\*Reproduced from the Future of Academic Community Medicine in Developing Countries. Willoughby Lathem, M.D., editor. The Rockefeller Foundation 1979. Selected list of principles formulated in the period 1921-1959, which was taken from Seipp, C. (Ed.): Health care for the Community, Selected Papers of Dr. John B. Grant. Johns Hopkins Press, 1963.

PRIMARY HEALTH CARE - WORLD STRATEGY\*

It was a wise decision to select the subject "Primary Health Care - World Strategy" as the theme for this Third International Congress of the World Federation of Public Health Associations being held jointly with the Silver Jubilee celebration of the Indian Public Health Association. Nineteen eighty-one is, in fact, the year in which an initial global strategy for the attainment of the social goal of Health for All by the Year 2000 will be decided upon by the Thirty-fourth World Health Assembly. As you all know, the International Conference on Primary Health Care, held in Alma Ata in 1978, stated that primary health care is the key to attaining this social goal.

The Alma Ata Conference, jointly sponsored and organised by the World Health Organization and the United Nations Children's Fund, was the culmination of a preparatory process. This had entailed, among other activities, a large number of national, regional and international conferences, seminars, workshops, study groups and other meetings. The Conference on Primary Health Care in Industrialized Nations, held in New York in December 1977, made it abundantly clear that the primary health care concept and approach is not relevant only to developing countries. The International Congress of Non-governmental Organizations on Primary Health Care, held in Halifax, Canada, in May 1978, underlined the important role of non-governmental organizations in implementing primary health care.

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\*Presented by Dr D. Tejada-de-Rivero, Assistant Director-General, World Health Organization, Geneva, at the Keynote Session of the Third International Congress of the World Federation of Public Health Associations and the Twenty-fifth Annual Conference of the Indian Public Health Association, Calcutta, 23-26 February 1981.

The Declaration and the Recommendations of the Alma Ata Conference were, therefore, a point of synthesis or crystallization of many experiences undergone in many different countries. They were also the result of a process of participation that culminated in the collective commitment of governments, United Nations organizations, specialised agencies and non-governmental organizations. This means that although most of the conceptual aspects of the primary health care approach already existed before Alma Ata, it was at that meeting that a comprehensive and coherent conceptual framework took shape.

In May 1979, the Thirty-second World Health Assembly endorsed the Declaration and Recommendations of the Alma Ata Conference and considered that "in accordance with the basic policy of adapting international activities to the real needs of countries, strategies and plans of action for attaining health for all by the year 2000 should be formulated first and foremost by the countries themselves, and that the regional and global strategies formulated on the basis of these national strategies, as well as on the basis of the strategies of regional groups formed by countries for practical reasons, should promote and facilitate accelerated development of primary health care in the Member States of WHO, as well as the attraction of substantial and continuing additional international resources for these purposes". If the term "primary health care" is well known, what is less well known is the authority of the World Health Assembly, what the World Health Organization is and why this whole process has been launched through it.

Many factors contribute to distort the real meaning of WHO: The wrong identification of WHO with its secretariat composed of international staff located in Geneva, in the six regional offices or in the countries. The fact that WHO is one of the so-called "specialised agencies of the United Nations" also induces incorrect generalisations. The technical reports of its Expert Committees and other scientific groups create an impression that WHO is simply a highly scientific body whose sole function is to summarize the state of the art in very specialised technical health issues and, accordingly, to give highly specialised advice to countries. In this respect there still are some few who hold the opinion that WHO should confine its activities precisely to those functions.

Dr. Halfdan Mahler has repeatedly stated that WHO is a co-operative of countries (or, in the language of the WHO Constitution, a co-operative of "Member States"). WHO's Constitution opens with the following words:

"The States parties to the Constitution declare ..."

and after having stated the principles on which the Organization will base its functions and activities it says: "Accepting these principles and for the purpose of co-operation among themselves and with others to protect the health of all people, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization ...". Therefore, the co-operative character of WHO has existed from its inception. Thus, it follows, that the World Health Organization IS its Member States - that is to say, countries of the world acting collectively through global and regional mechanisms and acting individually in the

implementation of their collective decisions. The World Health Assembly is the highest policy-making body of WHO and decides the policies of the Organization. And because WHO is a co-operative of equals, at the World Health Assembly all countries - regardless of size or wealth - have an equal vote in the policy-making process.

The World Health Organization has two fundamental constitutional functions : to be the directing and co-ordinating authority on international health work and to provide its Member States with technical cooperation. Both functions are mutually supportive. The directing and co-ordinating function permits the Member States to decide collectively on the health goals, policies and programmes they desire and to act collectively and individually to attain them. In this way "international health work" begins in the countries and ends in the countries. On the other hand, technical co-operation in WHO terms implies a true partnership between the countries themselves, through the proper use of their Organization, including its secretariat. Therefore, WHO is not at all a supra-national entity to which countries may come to request assistance on a donor-recipient basis.

WHO has not only a technical role but also a social one; however, it should be quite clear that WHO's technical role is in no way diminished by its social role. WHO's social role is characterised by its humanitarian efforts to promote social justice in health matters, particularly through a more equitable distribution of health resources among and within countries. Dr Mahler has stated in a report that "The Organization's socio-political role therefore has to be interpreted in the sense of

supporting national action aimed at inducing change for the better in health situations through collective definition by Member States of health goals, the adoption of principles for realizing them, and the promotion of the reforms in the health and related socio-economic sectors that will enable the goals to be attained. In other words, this role implies promoting action for health, and not merely indicating how such action might be carried out."

It is in this context that we have to see any world strategy on primary health care. It is also in this context that it is easier to understand the true meaning of the concept of primary health care.

There is no doubt that the impact of Alma Ata was much greater than had been foreseen when the Conference was first proposed. This has contributed to the wide acceptance of the term "primary health care", despite its limitations in expressing the full conceptual content behind it. However, this wide acceptance includes faithful true believers, eager to impose the concept as an infallible and unchangeable truth, opportunists ready to benefit from its popularity - jumping on the bandwagon with their own old, discrete programmes, and cynics waiting silently for the time when the "fashion will be over" or implementation of the concept will have been proved impossible. In any case, the term "primary health care" is well known. It has become common, and with such fashionable technical and colloquial use comes the tendency to oversimplify its real meaning. This is a universal tendency, especially when we deal with social problems. In today's fast-changing and conflicting world the social problems and the approaches to face them are, indeed, becoming

more and more complex and "ill-defined". Their complexity is well understood although frequently forgotten. What is not clear to many is their "ill-definition" : I will try to explain my point:

Think of an ordinary, simple clock compared with a satellite destined for outer space and composed of highly sophisticated precision mechanisms, many of them computerised and full of controls. In terms of complexity there is an obvious difference, but in terms of "definition" both are "well-defined". Each part of the clock and each part of the satellite has a pre-set and regulated behaviour in terms of movement, actions and/or reactions. Each part has been conceived for a pre-defined purpose and functions accordingly. In short, each element of those systems has been conceived for a well-defined role in relation to the whole.

On the other hand, social problems are indeed as complex as the most sophisticated satellite but their components have no regulated behaviour but rather tend to have their own and sometimes erratic pattern of existence which does not necessarily relate to the whole system. Furthermore, their relationships with other components of the "system" in terms of actions and reactions vary widely and are often unpredictable. One of the elements of the complexity and "ill-definition" of a social problem is man's behaviour, conditioned by cultural and moral values, knowledge and experience, temperament and personality, ambitions and complexes, transitional moods, etc. Empathy, the struggle for power, social and organizational pressures, and overall cultural and social contexts and circumstances play significant roles in any social problem. Even the new mathematical developments for dealing theoretically

111

with social problems, as for example the games theory, are not able to give us more than possibilities and probabilities - freely sprinkled with the words "if" and "provided that". Thus, one can begin to understand that the natural human tendency when facing complex and "ill-defined" problems is escapism through a process of oversimplification. This would appear to be what is happening at the moment with regard to primary health care.

For some, primary health care is identified only with the community health workers recruited from a poor, rural locality, given some training and trying to do their best with an over-simplified or primitive health technology. For others, primary health care is a new name for the expansion in coverage of the old basic health services, disease oriented, curative and where the providers still decide what is to be delivered and the people are still just passive recipients. Even for some of those who are familiar with Alma Ata, primary health care is simply a question of how to combine the activities known as the "eight components" included in point VII of the Declaration of Alma Ata. Yet again, in some minds, primary health care is simply a parallel and even vertical health care system, independent from the conventional and expensive health system provided mainly for the affluent few in the capital city and main urban areas of a country. Thus primary health care becomes a second- or third-rate service for poor and rural areas. These erroneous oversimplifications hide not only the true concept and significance of primary health care but its very origin and the factual reasons for its emergence as an urgently needed and feasible approach in facing up to the health problems of today.

The health situation in the world is summarized in the Joint Report of the Director-General of WHO and the Executive Director of UNICEF, presented to and unanimously endorsed by the Alma Ata Conference. I should like to quote some pertinent paragraphs from it:

"There is widespread disenchantment with health care throughout the world. The reasons are not difficult to discern. Better health could be achieved with the technical knowledge available. Unfortunately, in most countries this knowledge is not being put to the best advantage for the greatest number. Health resources are allocated mainly to sophisticated medical institutions in urban areas. Quite apart from the dubious social premise on which this is based, the concentration of complex and costly technology on limited segments of the population does not even have the advantage of improving health. Indeed, the improvement of health is being equated with the provision of medical care dispensed by growing numbers of specialists, using narrow medical technologies for the benefit of the privileged few. People have become cases without personalities, and contact has been lost between those providing medical care and those receiving it."

"At the same time, disadvantaged groups throughout the world have no access to any permanent form of health care. These groups probably total four-fifths of the world's population, living mainly in rural areas and urban slums. In some countries, even though health facilities are located within easy reach, inability to pay or cultural taboos put them out of bounds."

"To complicate matters, health systems are all too often being devised outside the mainstream of social and economic development. These systems frequently restrict themselves to medical care, although industrialization and deliberate alteration of the environment are creating health problems whose proper control lies far beyond the scope of medical care."

"Thus, most conventional health care systems are becoming increasingly complex and costly and have doubtful social relevance. They have been distorted by the dictates of medical technology and by the misguided efforts of a medical industry providing medical consumer goods to society. Even some of the most affluent countries have come to realise the disparity between the high care costs and low health benefits of these systems. Obviously it is out of the question for the developing countries to continue importing them. Other approaches have to be sought."

More than two years have passed since the Alma Ata Conference, and there is no point in trying to develop further the conceptual aspects of primary health care. The lack of knowledge and/or understanding of its real meaning and implications does not pre-suppose a lack of conceptualization. Another form of escapism, while facing concrete social problems, is their over-conceptualization. In many ways, we have reached a limit in intellectual contributions for the conceptualization of primary health care. Actually, the main problem is just how - given the existing peculiarities and different contexts and situations - primary health care is to be implemented in each country as part of a self-sustaining process of health development and as the main element of the national strategy that could make possible the achievement of the social goal of Health for All by the Year 2000.

However, there are many constraints which need to be analysed objectively in each particular country situation if we really want to take the first step in bridging the gap between concept and practice.

Some of the constraints are internal to the health system (and internal to the health workers' minds) and are most likely to come to light as soon as the first concrete steps are taken towards re-orienting the health system to the primary health care approach. Let us mention some of them.

We have been used to see health services systems working on the basis of almost independent and unco-ordinated activities. Some of them are related to specific age groups of the population, others in function of specific diseases, or based on the technology used for control of diseases.

At the same time, health services systems have been developed from the point of view of the providers of health care, with an almost total disregard for the real needs of the people to be served.

Despite a genuine acceptance of the concept of primary health care, health workers are too used to dealing with their own specific technical areas and to working within institutional and administrative systems which require them to show tangible and immediate results. Consequently, we find <sup>now</sup> health specialists trying to "adapt" their own specialized field as a part of primary health care. This produces a collection of independent activities which, whilst differing from the traditional lines and "adapted" to the primary health care concept, is a poor substitute for the real thing. The real thing involves the development of a set of health activities that should correspond to the

health needs of the people, to the resources available and to the constraints existing at national or community levels. In this respect, certain practices of health programme managers - both in countries and at the international level - are becoming sadly familiar. Some feel driven to succeed in their actual, isolated responsibilities and are too impatient to wait for the materialization of a comprehensive primary health care approach. Others may be willing and ready to use any initial primary health care measure as long as it provides a convenient tool or vehicle for the advancement of the particular programmes they favour. Nowadays, it seems to be difficult to discover any activity which is not "an integral part of" or "in the spirit of" or "related to" or at least "linked to" primary health care.

The primary health care concept makes it possible to develop a comprehensive and systematic approach to health services. All possible health activities are closely inter-related. Priorities among the different components are defined in relation to the needs of the populations. Supportive and complementary actions from other sectors have to be considered. The interaction within the different levels of the health services system is oriented to the needs of the people to be served. However, there is little practical experience, and even less imagination as regards putting this comprehensiveness into practice. The normal and simplistic tendency would be to try to implement everything simultaneously - which is impossible.

In planning, programming and implementing health activities we are used to dealing with certain classical health resources. For example, certain types of professional and auxiliary personnel are accepted without discussion as "unchangeable facts of life". Our training efforts, both in terms of content and of method, have been conditioned by the pre-existence of such classical resources, and the one has permanently consolidated the other.

Policy-makers, technicians and administrators in the health sector are too used to working almost exclusively with technical tools. Just as one example related to the need for national strategies and plans of action, the existing planning and programming methodologies, managerial processes and other administrative mechanisms are sometimes too logical and rational. They appear almost to have been built up from the point of view of mechanics or physics for they take no account of the very real fact that social problems are complex and ill-defined. They are, furthermore, based on the implicit assumption that the political and economic contexts are permanently stable and that there is a complete absence of social and political conflicts. Thus, in practice, we find that the users actually become the slaves of their tools, under the illusion that social problems and groups are to be treated as mechanical objects, like parts of a clock. Furthermore, the very concept of strategy is misunderstood. Thus, a strategy for health for all and primary health care should be much more than a formal and logically organized document with a definition of objectives, setting of priorities, identification and quantification of targets, selection of indicators, description of

117

approaches, enumeration of actions. The WHO Executive Board recognised this when, in its document "Formulating strategies for health for all by the year 2000" it stated very explicitly:

"The strategies should incorporate the systematic identification and use of suitable entry points for fostering health development, ways of ensuring the involvement of other sectors bearing on health, the range of political, social, economic, managerial and technical factors, as well as obstacles and constraints and ways of dealing with them.

... It is part of the national strategy to identify and make use of all favourable conditions and factors, as well as to recognize constraints and identify existing and potential obstacles that could impede the attainment of national goals. The ways of dealing with the above will depend on their nature."

We are used to working with formal structures, manuals and organigrams, forgetting the fact that any social system is composed of many informal parallel structures functioning simultaneously in different and contradictory ways. Technical or moral authority; political power and pressures; social, economic and/or familiar interests and influences; inter-personal empathies, sympathies and antipathies; and even emotional and sentimental links are always present, making the formal structure only an ideal term of reference because in practice it never exists and it never works as presented in the organigrams. Another fact that is too often forgotten is that these informal parallel and superimposed functioning and living structures are, in many cases, infiltrations or reflections within the health system of much broader systems, including

those coming from beyond the national context. This fact, occurring as it always does, even within the "status quo", becomes all the more grave when a process of real change is necessary. The Joint Report of the Director-General of WHO and the Executive Director of UNICEF, already mentioned, states:

"It can be seen that the proper application of primary health care will have far-reaching consequences, not only throughout the health sector but also for other social and economic sectors at the community level. Moreover, it will greatly influence community organization in general. Resistance to such change is only to be expected; for instance, attempts to ensure a more equitable distribution of health resources could well meet with resistance from political and professional pressure groups, and the use of appropriate technology may arouse the opposition of the medical industries."

To try to introduce changes, plan and programme actions and institute procedures in a vacuum whilst assuming an absence of constraints, obstacles and even active opposition is, of course, relatively simple. The self-satisfaction of technicians working out guidelines and methodologies in precisely this way is as real as is the plethora of national health plans and programmes which are taking up space on library shelves without being implemented.

On the other hand, the demand for simple and easy proposals for dealing with complex and difficult problems is a reality. "Minimum packages of primary health care activities" are insistently requested, for example, by politicians, high-level technocrats, local health administrators and now, mostly by funding institutions, as the overall

solution for putting primary health care into practice. These "minimum packages" are also supposed to take the form of universal models or recipes that can be applied, with perhaps some minor changes, in any country or in any situation. This point is directly linked with yet another constraint. Fast becoming an increasing danger is the fact that despite the consensus on the conceptual total framework of primary health care, officials at country level as well as in international organizations are over-emphasizing or taking into consideration only the so-called "eight components" in a way that is almost obsessive. It is true that emphasis was given in Alma Ata to the inclusion of at least certain activities in order to avoid the distortion of primary health care into a second- or third-class health care service for the poor and rural areas. However, certain requirements in the development of primary health care are far more important. Let us enumerate them very briefly:

- Political commitment and the will to bring about the reforms that are essential, translated into political decisions taken by the government as a whole and at all levels. A real process of reorientation of the health system and a clear re-allocation of resources are the best indicators of the political commitment;
- A progressive process of transference of responsibilities in the delivery of health services from the highly specialised professionals on the one extreme to the individuals within the family on the other;

- The review of the technology used at all levels of the health services system and the development of an appropriate technology which is scientifically sound, acceptable to those who will apply it and to those for whom it is to be employed, capable of being adapted and further developed if necessary, and financially viable today in the country and within the local communities;
- Multi-sectoral co-ordination, workable at least both at the national level for the formulation of compatible policies and at the community level for concrete actions;
- Community participation at all levels, for the definition of problems, setting of priorities, supervising and controlling the health activities, etc.; and
- The need for a supportive ~~and~~ referral system that will make it possible for any person to reach any level of the health services system.

The problem is not, then, how to make a package of the "eight components" but how to initiate some primary health care activities whilst trying to fulfil, at least as the initiation of a long-term process, all the requirements just mentioned.

To close the gap between theory and practice in implementing primary health care is not a simple endeavour. However, each day we glean more experience that shows that it is not impossible. At the present time, with less than 20 years to go to the year 2000 we have no alternative but to act. In countries and directly in the field. It has already

121



National public health associations are clear examples of non-governmental national organizations which must be involved and should play a very important and active role. They may, and should, exercise a leading role.

The importance of international support for primary health care was also underlined by the Alma Ata Conference. One recommendation referred to the need for countries to share and exchange information, experience and expertise as part of technical cooperation among countries, and particularly among developing countries. Another recommendation similarly emphasized the role of international organizations, multi-lateral and bilateral agencies, non-governmental organizations, funding agencies and other partners in international health. It was recognized that in order to promote and sustain primary health care and overcome obstacles in the way of its implementation there was a need for strong and co-ordinated international solidarity and support, but with the full understanding that the co-ordination of any external international support must be undertaken by the countries themselves in a spirit of self-reliance and self-determination. Countries individually have to be the masters in their own houses in relation to external support. Countries also exercise this co-ordination collectively through their World Health Organization. This is the basis for the whole world-wide effort of formulating strategies for health for all that started immediately after Alma Ata.

123

International non-governmental organizations have, therefore, an important role in support of this international action. This would mean among other responsibilities, the support of corresponding national non-governmental organizations and facilitating the exchange of experiences, information, expertise, etc. This is our challenge and we have to face it. It is not just an opportunity but, in looking at the world today, a moral duty.

**5. Texts of Selected Overview Session Presentations**

Introductory Paper to  
The Third International Congress of the  
World Health Federation of  
Public Health Associations on "Primary Care",  
Calcutta 23 - 26 February 1981

COMPREHENSIVE NATIONAL PLANNING  
TO ASSURE INTEGRATION OF PRIMARY CARE

By  
Dr A. Al-Awadi\*

**Best Available Document**

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\* M.D., M.P.H., Minister of Public Health, KUWAIT

## Introduction

Primary health care is considered as a major tool to achieve and maintain an acceptable level of health. It is the only solution to assure equitable provision of essential services, physically close to the community, quickly responsive to its needs, and directed to the advantage to the least favored. During the second half of this century or even before, extensive efforts were done to develop and strengthen primary health care. Eminent public health workers like Dr John Grant started this constructive effort on primary care in this country, others continued the task until it was crowned by the historical declaration of the Alma-Ata Conference on Primary Health Care, in September 1978.

This declaration, widely accepted by the International Community, presents the real challenge for us as public health workers. It lays the foundation for our future activities since much is left to be done to achieve the global goal of "Health for All by the Year 2000". The main challenges are: what type of health do we hope to achieve by the year 2000? why particularly this date? by whom and how it is to be achieved.

### Scope of Primary Health Care:

Before Alma-Ata, we were mainly concerned with what is known as "basic health care" which includes maternal and child health, family planning, immunization, prevention and control of communicable diseases and treatment of common diseases and injuries.

It was always clear to health professionals that the real determinants of health are not in their hands. This was the rationale for extending the scope of primary care in Alma-Ata to include health related activities such as health education, safe water supply, nutrition and basic sanitation. The new extended scope was even left open for countries, to add to it, activities required to achieve and maintain good health for its citizens. To me, education is a major activity since a causal association always exists between health and the educational status of the

community. Moreover, social and economic development are major determinants of health, especially in less developed countries and in rural communities. Thus, it is a one-package deal necessitating the establishment and implementation of an over-all socio-economic plan including health in order to achieve health for all.

#### Environmental Control:

Urbanization and industrialization are desirable goals for socio-economic development plans in most of the developing countries. Primary health care should address environmental control as a major activity early enough before emergence of environmental problems.

#### Why "The Year 2000":

This date is not too far from now, yet the international community can use it as a dead-line rather than a defined target date. Health for all must be the today goal, upgrading the level of health to reach the best achievable one to all citizens in all countries by the year "2000". WHO, was aware of that when it declared the next decade as the "water decade" and to implement the extended program of immunization, as well as other constructive activities. The "year 2000" can only be used as a reasonable horizon to promote long-range planning activities in countries, and then moving through a rolling horizon of twenty-years period.

#### Primary Health Care in Developed Countries:

The joint report of the Director of WHO and the Executive Director of UNICEF to the Alma-Ata Conference, stated clearly that the report concentrates on the needs of developing countries in particular, since for them, it is a burning necessity. This is a completely rational priority, yet, if we intend to achieve "Health for All", then we should consider seriously what is to be done to develop primary care in developed countries and/or in urban communities. These communities are usually over-supplied by specialized health manpower, by sophisticated institutions and teaching hospitals. Yet, the financial accessibility for all individuals to basic health

needs can never be assured. In developed countries, with a wide range of specialized health professionals, the individual fails to identify a defined entry to the health care system. There is always the danger that services provided are neither person-centered nor continuous, and usually people served are obliged to "shop" for services in a disintegrated manner. The problem is more and more confronted by inhabitants of urban slums in big cities, where housing and basic sanitation are inappropriate, and the financial barrier is a major constraint for their accessibility to adequate care.

### Conclusion:

Primary health care is the major tool to achieve and maintain an acceptable standard of health. The scope and concept of primary care as declared by the Alma-Ata Conference on Primary Care is the basic foundation for future work and activities. Health-related activities as nutrition, health education, safe water supply, nutrition, and basic sanitation are major activities for promoting health.

The community, health professionals, economists and decision-makers should consider the following:

- Planning for an over-all socio-economic development rather than planning for health services. This should at least include education, economic development, and environmental control.
- The year 2000 should be considered as the dead-line to achieve health for all. It is the reasonable horizon to stimulate long-range planning, to continue on a rolling horizon.
- Primary health care, is as well a right for developed countries and/or urban communities. Plans should be established and implemented to assure for these communities proper accessibility, person centered care, a unified entry to the health system, as well as comprehensive services.

## Calcutta Speech

### Planning for Implementation

In this home territory of one of the greatest spirits of this century, Rabi dranath Tagore, I quote his statement which expressed the theme presented in Jim Grant's eloquent speech yesterday.

"Most of us who try to deal with the problem of poverty think only of a more intensive effort of production. We forget that it brings about a greater exhaustion of materials as well as of humanity. It gives to the few excessive opportunities for profit at the cost of the many. It is food which nourishes, not money, it is fullness of life which makes one happy, not fullness of purse. Multiplying material wealth alone intensifies the inequality between those who have and those who have not, and it inflicts so deep a wound on the social system that the whole body eventually bleeds to death."

It is also a great temptation to quote John Grant because he wrote so well about what we are still trying to implement. Rather than quoting John Grant, I am trying to arrange for you to read his marvelously up-to-date writing. A volume of his collected papers edited by Conrad Seipp went out of print some 10 years ago. With considerable difficulty I have been able to arrange a reprinting especially for this conference; 250 copies were subsidized by the U.S. Government and shipped to India. They are now in Delhi airport customs but should be here before you go home. Only for delegates from India and developing countries we have arranged that you can get a copy for Rs 20 at a desk outside this hall when they arrive.

Yesterday David Tejada clearly presented the need that was evident after Alma Ata for countries to prepare National Plans of Action. He tells me

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130

that about 100 countries have now prepared national strategy documents defining policies and directions in moving toward health for all by the year 2000. On the last day of this meeting the WHO regions will present reports synthesizing the regional strategies.

All of this effort will mean nothing unless we take the next steps to define implementation in plans of action. At Johns Hopkins over the past 14 years our Program for Senior Health Planners has progressively shifted to what we now call "Planning for Implementation." Within the 20-year frame of the strategy documents we now need pragmatic and focussed five-year cyclic plans and yearly revisions to move incrementally to implementation.

Having been born in India and having spent half my life living and working in the villages, I will now focus on India, and I will take the liberty of being blunt. The ICSSR-ICMR\* Ramalingaswami report will contribute little unless there is an effective planning for implementation process now established. Publicity is creating public consensus and the isolated criticisms are mostly defensive reactions of doctors. Implementation will be facilitated by the following seven steps:

1. From decision makers we need openly stated commitment and political will for action. The honorable Chief Minister's pledge yesterday is a start.
2. Planning and evaluation units need to be greatly strengthened at central and state levels. India has always done well in standing on the one leg of planning by committee. The other leg needs to be strengthened of having a staff of full time planners working on the implementation process.

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3. The greatest problems in implementation tend to be straightforward management issues. I will give only one example. The government health systems are usually paralyzed by a lack of drugs. At the same time an uncontrolled flood of drugs pours into the villages through private channels. Our studies showed that in the Punjab and Karnataka 70 percent of the drugs used by traditional practitioners are the most powerful available pharmaceuticals-- not harmless "jari-barties." Background documents for the ICSSR-ICMR report showed that with present trends there will, by 2000, be as much money spent on privately paid for drugs as in the total government health budget. We incapacitate peripheral workers by giving them only a few harmless and relatively ineffective drugs with a year's supply being used up in a few weeks, while in the private sector the flow of penicillin and chloromycetin is unchecked.

In the sessions that follow discussions will focus on numerous other management issues such as supportive supervision, role reallocation in the health team, and referral.

4. A particular challenge in the Alma Ata definition of primary health care is to do something practical about intersectoral cooperation. As with community participation the slogan is accepted in rhetoric because we know we could not agree on what it means. So far we have tried mainly to manipulate the other sectors into doing our work

rather than finding synergistic ways of working together. If we impose on the busy village school teacher, who will produce the educated next generation which our data show is a powerful determinant of health?

In addition to education there are three sectors which overlap with health so much that we are constantly speaking of integration. Population, nutrition, and control of water and other environmental factors also overlap in the work of other ministries. We have been recommending supra-ministerial commissions to try to get coordination.

I have come to believe that the first need is to separate policy from implementation. The commissions could be important in setting policy, but then they should delegate implementation to appropriate ministries. The time has come also to recognize that a cabinet can only accommodate one inter-ministerial commission. Rather than separate commissions for population, nutrition, and water, a single commission for social development could cover all three areas.

5. Another challenge to implementation from Alma Ata is community participation. Vasudeva's comprehensive oration yesterday masterfully defined the issues. I consider this to be the most challenging subject before us for an intensive health services research effort. It is time for us to step outside of our professional egocentrism and stop taking over the people's right of decision about their health.

We create dependency rather than self-reliance. The health system should increase the capacity of the community and of individuals to solve their own health problems. Rather than waiting passively, the health system should work with the community to design and apply appropriate interventions.

For largely political purposes governments and international donors have consistently insisted on doing for the people what the people would most like to do for themselves. I will mention three things for which there is existing demand and for which everyone wants to get credit. The best example is that of putting up buildings which provide a visible landmark that something has been done. Village people take great pride in providing facilities even when they are desperately poor. There is nothing that brings a community together more than putting up a building that will fit with their culture and needs. Secondly, they can work out ways of meeting their food needs except in temporary emergencies. Third, around the world people are eager to pay for curative medicines, and they do because then they know the drugs are more likely to be good. We must make provisions for regular supply at reasonable cost with some provision of essential medication for the poorest. But there we would need to get politicians to stop going around promising free medical care. These are the three most expensive components of primary health care and the people would be glad to

pick up these costs. Our problem has been that we have tried to get communities to pay for what they don't want to pay for, such as salaries, while the government gets credit for paying for what is in greatest demand. Abel Wolman, who helped greatly with the Calcutta masterplan, has always said that "any planner is a fool to pay for anything that anyone else will pay for." Anyone who says primary health care is too expensive to implement is nearly assuming that the health system will pay for everything, and this is fundamentally wrong.

6. A direct and effective way of implementing PHC is to move progressively and deliberately from projects to general implementation. The ICMR conference last April showed that since Narangwal there are now almost a hundred good field projects around India--of which more than 30 were reported at that meeting. It was clear that a critical mass of experience has been created infiltrating general services around. Anything we know how to do should be moved directly into implementation. The disillusion with projects is largely because nothing has been done to ensure a flow of problems from the health system to the project and a feedback of solutions back to the system. John Grant, at Ting Hsien from PUMC and Singur from the All-India Institute have pioneered the idea that every educational institution should have a field practice area just as they have a teaching hospital. I can remember him talking about universities as the "academic arm" of health services.

Some of the reasons for projects are: 1) when an approach is known to work generally but there is need for local adaptation; 2) when judgment about whether to proceed with implementation is strongly influenced by cost: financial in cost effectiveness terms; management cost in availability of manpower, supervision; logistical needs in meeting the problems of scale in general implementation. Potential harm from a new intervention has to be evaluated. This can be either iatrogenic complications or more often political acceptability and cultural blocks. Many good interventions have produced massive backlash when imposed too abruptly on people. As agricultural extension has clearly shown demonstration projects produce a natural diffusion of social change when personal initiative is required. In India the potential is especially great if the longstanding recommendation could be implemented of having effective field practice areas both for health services research and for community-side teaching just as hospitals provide bedside teaching.

7. Underlying everything I have been saying is the fundamental issue that we need to improve the quality of care and caring. The greatest problem in official systems is not so much quantitative as qualitative as indicated by lack of concern and service motivation. This cannot be imposed or dictated. Repeatedly, an experience that was especially gratifying to me at Narangwal was, in the constant flow of visitors from the government services, when someone, whether a

high official or a neighboring ANM, would shake their heads when leaving and say, "The greatest thing I have learned is that I can do what I have been doing differently." We should not be embarrassed about the Narangwal spirit or the Jamkhed spirit in projects. Complaints that this quality of caring interfering with replicability are totally irrelevant. We should deliberately enhance the quality of caring in projects and learn how to promote a contagion because the only way we will ever get these qualities to permeate the health system is by learning how to use projects better.

Ghandhi said:

"Medical relief as part of village work or social service-- has appeared to me to be the laziest form of service and often even mischievous. It works mischief when the patient is expected to do nothing save swallow the drug given to him. He is none the wiser for having received the medicine. If anything he is worse off than before. The knowledge that he can get for nothing, or for a trifle, a pill or a potion that will correct certain irregularities will tempt him to repeat them. The fact that he gets such aid free of charge will undermine his self respect which should disdain to receive anything for nothing.

There is another type of medical relief which is a boon. It is given by those who know the nature of diseases, who will tell the patients why they have their particular complaints and will also tell them how to avoid them. Such discriminating relief is an education in hygiene, teaching people how to observe cleanliness and to gain health. But such service is rare."

(Ghandhi Village Swaraj Narajwa 1962 p. 198-199)

The problem is not only with health workers. My increasing concern in community participation is that just turning decisions over to community leaders may not lead to health for all. Community leaders may have become the elite because they are the greatest exploiters. The health system may have

137

to develop mechanisms so that they don't monopolize services. The greatest health problems are among the poorest, and dramatic improvement can come only by concentration on improving their conditions. At Narangwal we showed that 30-50 percent decreases in death rates, reduction in fertility, dramatically greater average height, weight and psychomotor scores in study villages as compared with controls occurred only because we preferentially reached those in greatest need.

Two things were necessary. First, village leaders learned that it was in their own best interests to ensure equity. A variety of community incentive approaches based on indices of coverage need local testing. Second is a new approach to surveillance. Individual surveillance is illustrated by the nutrition growth chart. Community surveillance has been developed by epidemiologists to give warning of outbreaks of infections such as influenza or of famines. A third use is to follow a specific high priority activity such as eligible couples lists for family planning. I propose an even more important use for the health-for-all goal which is surveillance for equity. Surveillance of groups in special need should lead to affirmative action to redress discrimination not for emotional reasons but for pragmatic health justifications.

A new definition of equity came out of the Narangwal research. Equal access may be good enough in affluent countries. Cultural barriers and shame may make the poor hesitate to come to model facilities, and this requires a public health outreach. We learned that to achieve equity we

had to shift from input to output indicators. Inputs suited to the needs of the poorest must be increased preferentially to reduce disparities in income.

Finally I quote again from Tagore who saw clearly the need for starting a process of rural development; in a few villages and progressively expanding to the whole country:

"If we could free even one village from the shackles of helplessness and ignorance, an ideal for the whole of India would be established. Let a few villages be rebuilt and I shall say they are my India."

Jai Hind.

201

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PRIMARY HEALTH CARE: CONVERTING NATIONAL  
POLICIES AND COMMITMENTS INTO AN IMPLEMENTED PLAN OF ACTIONS

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## C O N T E N T S

	<u>Page</u>
Summary	1
1. Introduction	2
2. Plan Preparation	2
2.1 The National Health Planning Process	2
2.2 Stages of Planning	4
2.3 Who are the Planners?	4
2.4 Common Problems in the Planning Process:	5
2.4.1 Excessive Information Requirement	5
2.4.2 The Lack of Economic Justification of Health Programs	6
2.4.3 Limiting the Scope of Country Health Planning to Medical Care Services	6
3. Decision-Making on the Proposed Plan of Actions	7
3.1 Resource Allocation between the Health Sector and other Sectors	7
3.2 Resource Allocation within the Health Sector	11
3.3 Geographical Resource Allocation	11
4. The Rôle of International Agencies	11
References	13
Annex I	
Annex II	

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141

## S U M M A R Y

Most countries are committed politically through its national declarations to provide adequate health and primary health care to all its citizens. This paper discusses why these policies and commitments occasionally fail to be converted into action plans.

The first common difficulty is encountered in the plan preparation itself, where a comprehensive national long planning process may be lacking or inefficient. Those who prepare the plans may be professionally trained planners, health administrators, academicians and senior clinicians, or expatriate consultants. Neither of these can do the planning but a carefully selected mix is the appropriate planning group. Excessive gathering of unnecessary data is a common feature. Usually health plans are not economically justified as a profitable investment in health in order to gain the support of politicians and economists.

Decision making on resource allocation for health and primary care is always in favor of sectors other than health and/or of the medical care other than primary care. In developing countries the most important cause is economic erosion due to local wars and political unrest. Health professionals and politicians usually are in favor of prestigious medical care monuments accumulated in urban areas.

The paper discusses some proposals for planners and international agencies concerned with health to overcome these difficulties.

1. Introduction.

In most countries, there are declared policies in its constitutions or national declarations assuring that health is a right for every citizen. Moreover, primary health care is being more and more emphasized since the Alma Ata declaration in September 1978, and after raising the global goal of "Health for All by the Year 2000". This should be converted into an implemented plan of actions assuring equitable provision of primary health care services, where its scope is extended to include nutrition, safe water supply and basic sanitation, other than the basic health services.

There is a wide gap between the declared policies and the actual implemented action. It is more recognized in less developed countries due to a variety of constraints. These are mainly: limited resources to fulfil ambitious goals, inadequate or nonexisting long-range comprehensive planning, and inappropriate decision making for resource allocation between the health sector and other sectors, and/or within the health sector itself.

2. Plan Preparation

2.1 The National Health Planning Process:

Three stages of increasing complexity of planning can be distinguished in mixed economy countries, there are: a project by project approach, integrated public investment planning, and comprehensive planning. The latter should be developed gradually passing by the first two stages since comprehensive planning is a complicated pragmatic process that should evolve gradually (Waterson, 1965).

## 2.2 Stages of Planning:

Although planning is a unique activity in every country, yet commonly agreed upon stages can be identified. Taylor (1976) outlined the following stages for planning:

1. Planning the planning and developing the planning competence.
2. Statement of policies and broad goals.
3. Data gathering, including demographic, epidemiologic, economic, services utilization, and availability and projection of facilities and manpower resources.
4. Priority statement of health problems.
5. Plan outline with statement of major alternative proposals.
6. Development of the detailed plans and programs with targets and standards.
7. Implementation as a part of the health planning process.
8. Continuing evaluation specifically for follow-up of plan implementation and as a tool for plan revision and updating to assure a continuous planning process.

Annex I. presents a model of PERT chart used for the planning process to prepare Kuwait's national health plan.

## 2.3 Who are the Planners?

Planners vary from one country to the other, and throughout the stages of planning in the same country. They may be professionally trained planners, top health administrators, senior clinicians and academicians, expatriate consultants, or rarely community representatives.

Classically, certain characteristics are to be considered in developing a rational comprehensive national health plan. These are agreed upon by the WHO Expert Committees on National Health Planning, Geneva (1967), Reinke et al (1972), Hilleboe et al (1972), Levey and Loomba (1973), Schaefer (1974) and Abel Smith et al (1978), these are:

- There should be a high political support to the plan and the existence of the will to plan.
- Necessary machinery activity and capacity are required to be available within the Ministry of Health for health planning; for coordination with the overall socio-economic planning at the top level, and for ensuring the co-operation of the public and professional organizations participating in the planning process and gaining their acceptance and support.
- It should be built on local needs and demands, through valid information system and applying modern techniques of operational research and systems analysis to measure objectives, targets and effectiveness, and describing the community in a defined demographic, socio-economic political, cultural and health characteristics.
- Health planning is a continuous dynamic process that should start by planning the plan, getting the plan accepted and continuous evaluation of the plan through implementation.
- Planning implies standards which become the bases of the corresponding control system.
- The plan should fulfil basic elements of "good" health care including proper accessibility, continuity, quality efficiency and effectiveness (Banoub, 1979).

The professionally trained planners, though are the most legible to do the technical procedures, yet, if left alone, they may resort to sophisticated procedures in an idealistic attitude of "professionalism" or "plannism" that may render health planning a difficult process and prohibit contribution of other categories. Top health administrators on the other hand, may consider planning as a part of their prestigious administrative responsibility rather than being a technical skill. Academicians and senior clinicians by nature, and due to their traditional medical education, may only recognize ultraspecialties and medical care monuments as the main features of modern health care, ignoring first of all primary care and the promotive-preventive services. Many developing countries experienced beautiful documents of health plans prepared by expatriate consultants lying on shelves or in drawers which were never implemented, simply because they were irrelevant, unreasonable, or sometimes because of being too intellectual. Much is being mentioned regarding community involvement, yet the role of community representatives is usually resisted or denied by professionals especially in developing countries.

Therefore, effective planning can only be achieved by choosing planners as a carefully defined mix of all the above mentioned categories, defining a specific role for each group within the organization of the comprehensive health planning team. The balance between these roles is the determinant of success for plan preparation.

## 2.4 Common Problems in the Planning Process:

### 2.4.1 Excessive Information Requirement:

Planners, in an attempt to idealism, may require an exhaustive list of information. Sometimes the lack or unreliability of the existing data are an excuse for not to plan. It is a common practice that much effort and resources are spent in the stage of data gathering to collect information that will never be used. Since the planning process is subject to con-

tinuing updating and remodelling, the decision must be that the initial plan should rely on the existing information, and inevitably by using assumptions or small surveys to cover gaps in the existing data. Occasionally informed experts or community leaders, through group process techniques as the Delbecq or Delphi methods may be quite adequate for problem identification and priority setting.

#### 2.4.2 The Lack of Economic Justification of Health Programs:

Unless country health programs are presented in an economically justified way they will never be accepted or supported by high politicians and decision makers. Expenditure on health should always be expressed as a profitable investment to be appealing to economists. Primary health care should be recognized as the major tool to add productive years of life to the community through prevention and control of morbidity, mortality and disability caused by the major health problems. In developing countries, where underemployment and/or over-population are common features, this concept may not be convincing. Primary health care then can be economically justified as a tool to economize the demand and utilization of secondary and tertiary care facilities which are the most expensive parts of health services with the least yield in terms of health. It was possible in Kuwait to identify three major priority projects to be implemented, only by presenting the years lost to the society due to infectious diseases of infancy and early childhood, motor vehicle accidents, and hypertension and ischemic heart diseases (Annex II).

#### 2.4.3 Limiting the Scope of Country Health Planning to Medical Care Services:

Although we are always talking about health as "a state physical, mental and social well-being", yet most of

the health plans are medical care-oriented or even hospital-oriented. This is a common feature of all country plans especially the developed ones. It can be due to the fact that the broad concept of health determinants is not in the hands of health professionals, who are used to plan alone. Inter-sectoral and over-all socio-economic plans are usually economic-oriented, while health plans are medical care-oriented, with a major gap and lack of integration between economists and health planners.

### 3. Decision-Making on the Proposed Plan of Actions

#### 3.1 Resource Allocation between the Health Sector and other Sectors:

The percapita G.N.P. differentiates countries of the world into rich, less rich, poor and very poor countries. Variation is very wide ranging from less than 100 U.S. dollars to more than 15,000 US dollars percapita per year. What is more striking, is that those countries with higher G.N.P. percapita spend higher proportions on health either in terms of G.N.P. proportions or governmental expenditures (Table I). This makes the absolute monetary value on financial resource allocation to health minimal in more poor countries (Table II).

TABLE I. Health Expenditures in Selected Countries

Country	Year	Percapita G.N.P. (US \$)	Health Expenditure as % of total central government expenditure	Public Health expenditure as % of G.N.P.
Ethiopia	1976	100	4.5	0.9
Nepal	1976	120	6.7	0.8
India	1976	150	2.7	1.2
Pakistan	1976	170	1.8	0.6
Sudan	1976	290	1.6	0.9
Thailand	1976	380	4.3	0.7
Mexico	1976	1,090	4.2	0.7
Iran	1976	1,930	3.3	1.5
Italy	1976	3,050	16.8	5.7
United Kingdom	1976	4,020	12.9	5.2
France	1975	6,550	15.1	5.6
Denmark	1974	7,450	6.8	6.7
United States	1976	7,890	9.7	3.3
Switzerland	1976	8,880	10.1	3.5
Kuwait	1977	15,480	5.9	1.6

Source: -WHO, Sixth report on the World Health Situation part I, 1980.  
-World Bank, Health, Sector Policy Paper (1980).

TABLE II. Government Health Expenditures Per Capita in  
Developing Countries, 1976

GNP per capita	Total Number of Countries	Health Expenditures					
		\$1 or less	\$2 to \$3	\$4 to \$5	\$6 to \$10	\$11 to \$20	above \$20
		Number of Countries					
Less than \$150	15	11	4	0	0	0	0
\$150 to \$299	22	7	10	4	1	0	0
\$300 to \$599	19	1	5	2	9	2	0
\$600 to \$999	16	3	1	0	6	6	0
\$1,000 to \$1,500	14	0	0	2	3	6	3
T O T A L	86	22	20	8	19	14	3

Source: World Bank, Health, Sector Policy Paper, 1980

One of the main causes of the relatively low proportion of G.N.P. spent on health in less developed countries could be the inevitable choice of expenditure on defense, weapons, and wars.

As international public health workers, we can not ignore the impact of wars and political unrest on health in developing countries. These countries are the most who suffer from local wars and political unrest in the last thirty years since World War II. Local and regional wars are waxing and waning in developing countries so that one can conclude that "Health for All by the Year 2000" can never be achieved unless "Piece for ALL", can be accomplished. Table III presents military expenditures in selected countries. Declared expenditures can be far less than real expenditures. It can be noticed that wars in these countries are causing the following:

- If data are available on war casualties in terms of mortality and disability, it may indicate that local wars are one of the most serious epidemics in the world.
- It erodes the minimal rate of economical development.
- It encroaches on socio-economic developmental programs including health.
- It diminishes the active labor force including health manpower deviating a sizeable proportion of it to the armed forces and its support services.
- It is the cause of major health and social problems associated with mass human movement of refugees in different parts of the world.
- It is a major cause of mental stress and insecurity in the affected countries.

As an example, one of the most important activities of primary care as outlined by Alma-Ata declaration is the adequate supply of safe water. Accordingly, the United

Nations Mar del Plata Conference in Argentina, announced the water decade 80-1990. noticing that 78% of rural population and 23% of urban population in the world has no access to safe water. "To attain this goal the international community must raise over US \$ 6,000 millions every year: a vast sum - yet less than the developed world paid out in military expenditure every fortnight last year" (WHO, 1980).

TABLE III. Military Expenditures in Selected Countries

Country	Year	Total in US \$ millions	As Percentage of Central Government Expenditures	As percentage of G.N.P.
Ethiopia	1980	84	27	2.9
India	1979	4,406	26.9	3.9
Mexico	1979	519	2.1	0.7
Iran	1979	3,974	11.4	17.4
Iraq	1979	2,328	30.1	10.9
United Kingdom	1980	24,448	10.7	4.9
United States	1980	142,700	23.3	5.2
U.S.S.R.	1975	124,000	-	13
Switzerland	1980	1,832	18.9	1.9

Source: Annual report of the International Institute of Strategic Studies in London, 1980/1981.

### 3.2 Resource Allocation within the Health Sector:

Primary health care is obviously considered as the most effective approach for obtaining health on an equitable base. Yet still the decision is taken favoring institutional care of patients which is consuming about 70% or more of health expenditures in both developed and developing countries. "The bulk of limited government outlays for health go towards maintaining expensive, well equipped hospitals manned by highly trained personnel concentrated in urban centers" (World Bank 1980).

In other words, primary health care including promotive and preventive care are the least favored among health services. This long standing pattern requires a lot of efforts in order to be changed, by health professionals, medical educators and top decision makers. Health planners should always take the initiative to rationalize this concept in health plans they prepare.

### 3.3 Geographical Resource Allocation:

The discrepancy can be noticed in facilities and manpower distribution between urban and rural communities in both developed and developing countries. This results from preferences of both decision makers and health professionals. The formers react mostly to urban population needs, who are politically more powerful, and the latter prefer urban areas for social and financial reasons. Health plans should favor rural communities, promoting their positive participation in service planning in order to change the political preference. Primary health workers should be chosen, and preferably trained and maintained in the community.

## 4. The Role of International Agencies

A major role of these agencies can contribute to converting the declared policies into plans of actions. Perhaps WHO role is constructive through stimulating "the formulation of strategies for Health

for All by the Year 2000". It is a model, yet much has to be done in this aspect.

The whole UN Agencies with its limited resources can never contribute to service provision or effective financial support of programs. There should be a coordinated effort between these agencies avoiding gaps and overlaps.

Their major role collectively can be guided by the fact that "if you give a man a fish he will eat for one day, while if you teach him how to fish he will eat everyday". Thus a coordinated effort should focus on the following:

- Peace settlement through the international community and the United Nations.
- Technical assistance to countries to develop its planning capacities, and to formulate its national health plans.
- Interchange of experience and information especially in-between developing countries.
- Research in the field of primary health care delivery, including developing indicators and evaluative techniques.
- Training of health manpower especially of senior planners, trainers and primary health care workers.

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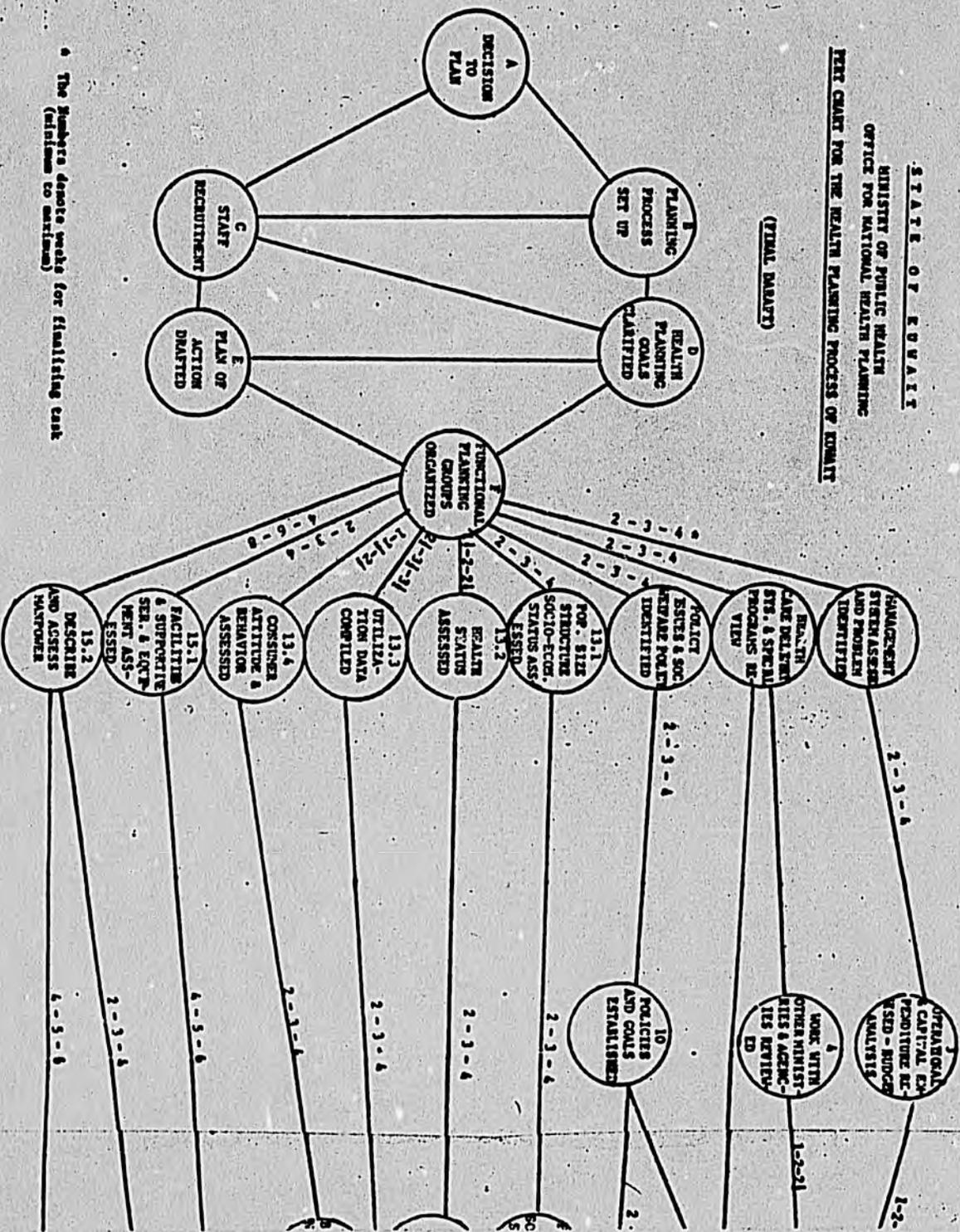
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STATE OF EGWAIT  
 MINISTRY OF PUBLIC HEALTH  
 OFFICE FOR NATIONAL HEALTH PLANNING  
 FERT CHART FOR THE HEALTH PLANNING PROCESS OF KENYA

(FINAL DRAFT)



\* The Numbers denote weeks for finalising each (minimum to maximum)



A N N E X II.

Estimated Years Lost to Society in Kuwait\* due to Mortality and Morbidity of Leading Diseases in 1978

<u>Cause of Morbidity and Mortality</u>	<u>Years Lost</u>
Enteritis	12,518.8
Pneumonia	10,462.9
Upper respiratory infections	9,855.4
Motor vehicle accidents	9,510.7
Perinatal diseases	8,585.9
Congenital anomalies	6,560.3
Ischemic heart disease	6,163.6
Infectious hepatitis	6,130.7
Deliveries	6,039.9
Neoplasms	5,867.2
Hypertension	5,379.4
Other intestinal diseases	5,350.2
Other injuries	4,841.9
Immunizeable diseases	3,972.4
Skin diseases	3,731.5
Uro-genital diseases	3,643.5
Other infectious diseases	3,627.1
Ear diseases	3,095.2
Other heart and circulatory diseases	2,823.2
Eye diseases	2,602.8
Bronchitis, asthma, emphysema	2,375.3
Neurologic disease and epilepsy	2,212.7
Musculoskeletal and connective tissue disease	2,059.2
Liver cirrhosis	1,232.8
Tuberculosis	1,143.3
Mental diseases	1,013.7
Rheumatic fever	1,006.8
Blood and blood forming diseases	912.3
Appendicitis, hernia, obstruction	546.9
Other respiratory diseases	449.0
Diabetes	403.0

Total population in 1978 = 1,205,205

Cause of Morbidity & Mortality (cont'd)

Years Lost

Female reproductive system diseases  
Complications of pregnancy  
Other endocrine diseases

183.7  
123.9  
74.2

Source: Ministry of Public Health, Office for National Health Planning, Kuwait "Health for All in Kuwait by the Year 2000", 1980.

# HEALTH MANPOWER FOR PRIMARY HEALTH CARE - A FRAMEWORK FOR PLANNING

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## SUMMARY

The three elements of health manpower planning are described and a matrix describing health workers by income and type of practice are presented as aids to clarifying the process of planning for health manpower to meet primary health care needs.

## INTRODUCTION

Primary health care has many definitions ranging from the two page definition of the U.S. National Academy of Sciences, Institute of Medicine <sup>(1)</sup>, to the recent eleven page article on "An Empirical Definition of 'Primary Care' " in the Journal of Community Medicine <sup>(2)</sup>, to the WHO Alma Ata declaration <sup>(3)</sup>. For purposes of this presentation, however, we will assume that primary care includes the point of first contact, is not restricted to medical care but includes preventive health services, and is to be made available to both rural and urban populations.

Primary health care planning, to be appropriate, must be placed in the context of secondary and tertiary care resources in the area for which one is planning. It is not appropriate to attempt planning for health manpower for primary care without considering the complementary needs for secondary and tertiary health care manpower. To be sure, there are great differences in the type of work required for these different levels of care, but some primary care manpower is drawn from essentially the same pool of doctors, nurses, assistant nurses as secondary and tertiary care manpower.

## ELEMENTS OF MANPOWER PLANNING

The three basic elements of health manpower planning are DEMAND, SUPPLY and PRODUCTIVITY. They are related as shown in the diagram following.

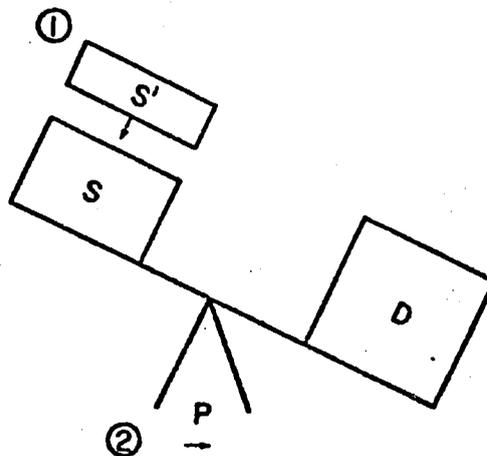


Fig. 1 Supply-demand balance on the fulcrum of productivity. (4)

Demand is usually considered as effective economic demand, either by individuals on a private payment basis or by tax payers through their government system. There are, of course, limits to the amount of funds that are available in either of these systems. The amount of funds are an important, realistic planning constraint. It is not enough to say that we will provide "health services to all" without considering the expenses of these to the nation's government or to the individuals of a nation on a private paying basis. Of course, the extent of demand depends, to a large extent, on the price for individual services. We will return to this point later. Demand is demand for services, not for individual health professionals.

Supply of health manpower refers to individuals, usually in terms of full-time equivalents (FTE). (i.e., 2 half-time workers equal one full-time equivalent.) This concept of full time equivalents is essential for planning purposes, particularly when some of the health workers are not available on a full-time basis.

161

Productivity is the fulcrum for the balance of supply and demand.

Productivity is usually described as the number of services provided per unit of time per health worker. In a very simple example, we can assume that a community of 100,000 people will have a need for 2 to 3,000 complete series of immunizations per year. (Birth rate 20-35; estimate of size of cohort requiring immunizations each year.) If the effective price of immunizations is close to 0 for the individual (i.e. the community decides to provide immunizations free of charge to individuals), the demand may approximate the need. If an "immunizer" has a productivity of approximately 4,000 immunizations per year, the supply of immunizers required is from .25 to .5 full-time equivalent (FTE) "immunizers" for the community.

Of course, real life planning is not this simple. One deals with teams of workers and mixes of services. When one discusses the mix of health manpower on the various teams serving the needs of the people for primary care, it is readily apparent that the price (salary) of the types of workers will determine how much of the need for services can be converted into effective economic demand. This leads us to the next section which deals with the matrix of levels of health workers and types of service.

#### MANPOWER PLANNING MATRIX

See Table I following.

**TABLE I**  
**HEALTH WORKERS BY INCOME AND TYPE OF PRACTICE (5)**

	<i>High income, long education (12 years basic + 6-13 years professional)</i>	<i>Medium income, medium education (10-12 years basic + 2-5 years professional)</i>	<i>Low income, short education (6-12 years basic + 0-2 years professional)</i>
<i>Type of practice</i>			
Unsupervised independent general clinical practice	Physician (GP)	Assistant medical officer, licentiate, <i>behdar</i> , health officer (Gondar), <i>feldsher</i> , nurse	Dresser
Hospital or group practice	GP and specialist: e.g. surgeon, pathologist, radiologist, psychiatrist, orthopaedist	Nurses—general duty and specialist, surgical technician, laboratory technician, X-ray technician, physical therapist, etc. <sup>a</sup>	Nurses' aide, practical nurse, dresser, laboratory assistant
Antenatal, delivery, and postnatal care	Physician-obstetrician	Midwife	Auxiliary midwife, <i>dai</i>
Drug compounding and dispensing	Pharmacologist	Pharmacist	Dispenser, compounder
Mental health	Psychiatrist	Psychiatric nurse, psychiatric technician	Psychiatric aide
Dental practice	Dentist	Dental hygienist	Dental aide
Public health	Health officer (M.D.)	Health visitor, public health nurse, health educator	Home health aide, etc.
Environmental sanitation	Sanitary engineer	Sanitarian	Malaria assistant, sanitary inspector, etc.
Average cost of training: X		0.3-0.5X	0.1-0.2X
Average earnings per year: Y*		0.2-0.5Y	0.1-0.2Y

\* Including consideration of private practice as well as government salary.

Table I classifies health workers by length of training, income and the type of practice. It does not indicate professional or subprofessional levels, as professionals are in both high- and medium-income groups. Specific work function was specifically omitted, as there are wide overlaps in function among the three groups. Another parameter that has not been included in Table I is supervision. In most cases, there will be supervision within groups as well as

across professional lines. For example, the chief nurse or supervisor will assume responsibility for most supervision of field nurses, while the physician will also give orders to field nurses for patients under his direct responsibility. Some middle-income health workers have responsibilities within a health system far greater than some high-income professionals in private practice.

A point that should be emphasized is the vast difference in scope of responsibility between independent duty, generalist paramedicals and paramedicals who work with the benefit of supervision.

Although the generalizations in Table I may not be completely applicable to every country, the system has overall applicability to most countries.

Major economies can be realized as functions are transferred from high-salary to low-salary workers, because the main costs in the health industry are for services rather than goods. This principle is based on the assumption that productivity does not decrease at the same rates as salary.

Examples from dentistry show the magnitude of increases in productivity that may be expected from use of auxiliaries and aides. An American Dental Association survey showed that each additional full-time auxiliary working with a practicing dentist increased the dentist's productivity by approximately 30 per cent<sup>(6,7)</sup>. A U.S. Navy study showed that each middle-level dental technician could boost the productivity of a dentist well over 50 per cent<sup>(8)</sup>.

There are limits to this principle; otherwise, we would have the janitor performing all primary care functions. Downward delegation of functions is limited by (1) quality of care expressed as end-results of services, (2) acceptability to consumers, and (3) perhaps most important, acceptability to the professionals who set standards for

164

care. Physicians in developing countries often state that nothing but physician care is good enough for their people, when, in point of fact, only a small portion of the people have the benefit of any modern medical services at all.

CONCLUSION

Affordable, appropriately trained and supervised, acceptable, and efficiently used health manpower are the most important element of planning for primary health care. This article presents fundamental concepts useful in health manpower planning for primary health care.

165

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**TRAINING COMMUNITY  
PARAPHYSICIANS AND VILLAGE  
HEALTH VOLUNTEERS IN THAILAND :  
A PARTNERSHIP FOR EFFECTIVE  
RURAL HEALTH CARE**

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**COMMUNITY PARAPHYSICIANS**  
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**IN THAILAND:**  
**A PARTNERSHIP FOR EFFECTIVE**  
**RURAL HEALTH CARE**

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The Lampang Project in Thailand is one of several approaches the Ministry of Public Health has fostered to deal more effectively with observed inadequacies. The innovations and modifications of the existing provincial health system that constitute the Project's key features include:

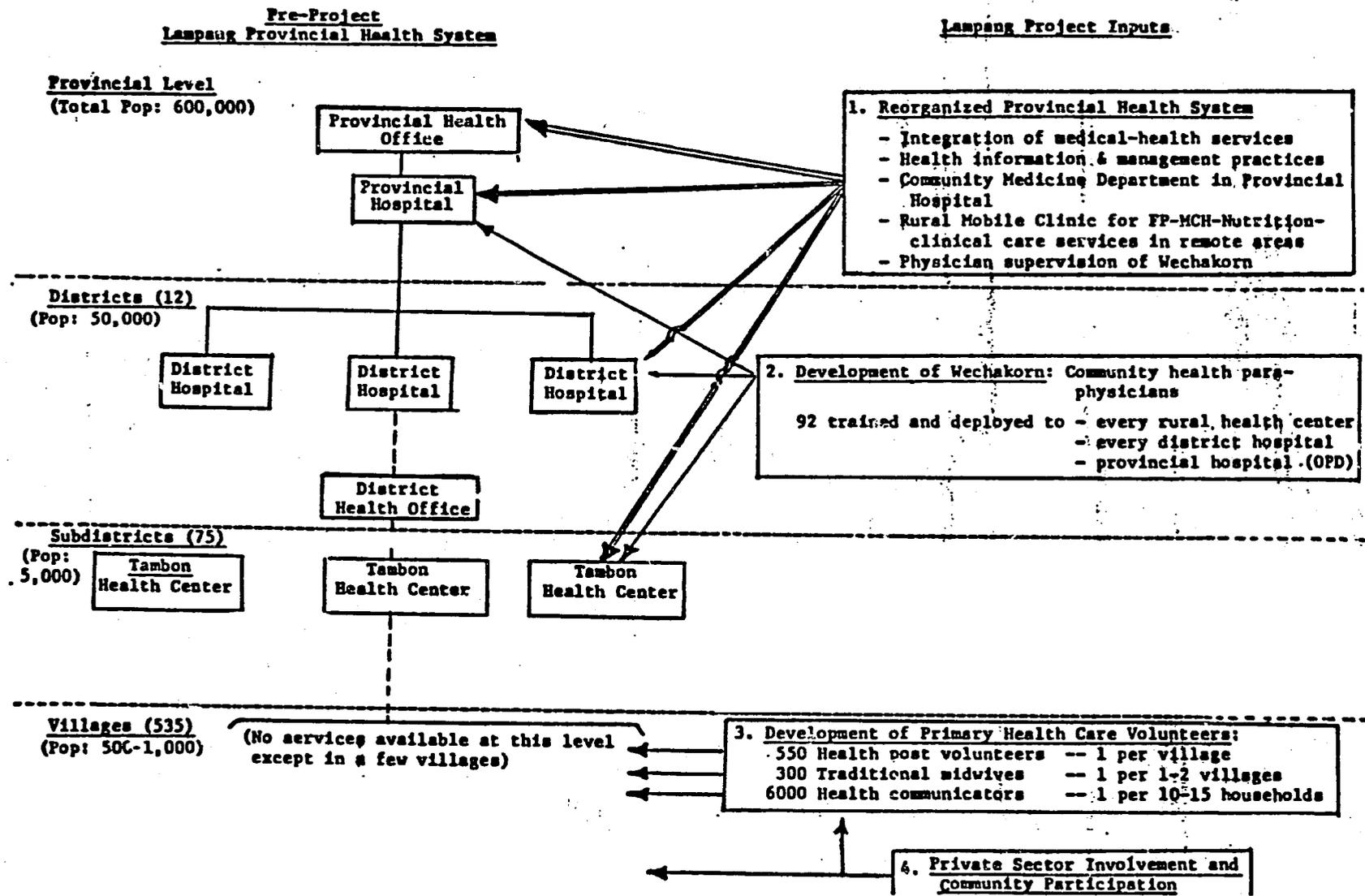
1. Reorganization and strengthening of the provincial health service infrastructure by:
  - a. Integrating the curative, disease prevention, and health promotion services by coordinating and administering them under a single provincial health administration;
  - b. Establishing a Department of Community Health within the Provincial Hospital; and
  - c. Improving management and supervisory practices, in part by developing a practical management information system.
2. Development of community health paraphysicians (wechakorn) to overcome the lack of skilled curative services available at the periphery. Ninety-two wechakorn, recruited from among nurses, midwives, sanitarians, and nurse aides have been

trained for one year in the provincial and district hospitals, after which the majority return to assignments in subdistrict health centers.

3. Deployment of three types of community health volunteers in every village of the province. At least one "health post volunteer" (HPV) and, where available, one "traditional birth attendant" (TBA) have been trained for each of the province's 545 villages, making basic primary health care services and nonprescription drugs accessible to every villager in the province. To assist the health post volunteers, groups of "health communicators" (HC) are also trained, one for every ten families, to provide a network of advice, referral, and health information in every household. By 1979, 650 health post volunteers, 350 traditional birth attendants, and almost 6,000 health communicators have been trained.
4. Stimulating community and private sector involvement. This is a major emphasis in the development process. Community support has been actively sought through the formation of "Village Health Committees," whose function is to select the volunteers and to provide local support to them once the volunteers are in place. Efforts have also been made at the local level to involve private organizations and health care providers (such as druggists, private clinics, Rotary and Lions Clubs) and others with important roles in village health care and development.

Figure 1 provides a summary picture of how the new inputs of the Lampang Project have modified and supplemented the previously existing provincial health system with a view to enlarging and improving rural health services.

**FIGURE 1: LAMPANG PROVINCIAL HEALTH SYSTEM AND THE INPUTS OF THE LAMPANG HEALTH DEVELOPMENT PROJECT**



170

2013

Two of the major thrusts of training in the Lampang Project have been program for developing community health paraprofessionals, called wechakorn and three groups of village level primary health care volunteers.

#### 1. COMMUNITY HEALTH PARAPROFESSIONAL (WECHAKORN)

A major effort has been devoted to training wechakorn because of their strategic importance to the entire Project. Their basic role is: (a) to greatly expand the availability of both curative and preventive/promotive health services in rural areas; (b) to reduce the burden on medical doctors in the district and provincial hospitals of handling simpler cases so that they can concentrate on more serious and complicated ones; and (c) to be the principal link between the village health volunteers and committees and the higher echelons of the expanded health care system.

Wechakorn candidates have already had a certain amount of training and experience in the health field, usually as sanitarians, nurses, nurse-aids or midwives. The wechakorn's training is designed to equip him/her to take a strong leadership role among the health center team, and to establish a relationship with the village health volunteers that is crucial to providing effective health care coverage in the area. After completion of the one-year training course, the wechakorn is able to:

1. provide medical care for patients suffering from common illness and injuries by using available resources under the physician's overall responsibility;
2. recognize cases that are beyond his capability, refer patients, and consult physicians as necessary;

3. supervise the health center team members;
4. administer the health subcenter or assist in clinical and administrative work in the district hospital; and
5. promote and guide community health development programs.

The training approach used for wechakorn is problem-oriented and the methods are competency-based. The methods of training wechakorn were adapted from the MEDEX model, which originated in the United States during the late 1960s. The short one-year duration requires that theoretical and classroom material be minimized and practical clinical experience be maximized. Emphasis is on "learning by doing".

The training and deployment of wechakorn has been one of the most outstanding features of the Lampang Project and is a major factor in the increasing utilization of health services at the periphery of the health care system. Fourteen wechakorn from remote rural health centers were trained for six weeks and are now delivering primary dental care services, in addition to medical and other health services which they now deliver. In many parts of Lampang, wechakorn have assumed a role of leadership and technical guidance to health post volunteers and other health workers in providing and coordinating local health programs, such as nutritional surveillance, operating child nutrition centers, and conducting family planning programs, including promotion of vasectomy in areas scheduled to be visited by the provincial hospital's rural mobile clinic.

### Development of Instructional Materials

Identification of training requirements followed a logical process. The first step was to identify and define the local health problems. This was done by conducting an analysis of health service records from all levels of service units in the Province. After the first groups of health post volunteers were deployed, analysis of their records gave further evidence of the preponderant health problems at the village level. Community Health and Nutrition Surveys of the Project, and other health surveys were examined to help identify key health and medical problem areas. The second important approach was to analyze the job descriptions, tasks, and performance of existing health workers at health units where wechakorn would be deployed. The third step was to define the new role of the wechakorn at each of the service units where they would be deployed, and then to determine the exact job description for wechakorn. Once the health problems of the communities and the job description for wechakorn are determined, the basis is established for development of the curriculum that will be used in the training of wechakorn.

Instructional materials and instructional process for wechakorn training were based on the MEDEX approach. Instructional materials were developed along the lines of the Medex training modules that were evolving at the time the Project began in 1974. Once the wechakorn roles and job descriptions were determined, the training objectives, learning experiences, testing and evaluation were developed in the context of a competency-based training approach. Key personnel development staff of the Project were sent to the University of Hawaii, the University of Washington, and the MEDEX/Micronesia Training Program in Truk, Micronesia, to become familiar with the MEDEX approach. Later, consultants from the Health Manpower Development (MEDEX) Staff of the University of Hawaii worked with training staff in Lampang to assist in

developing format and content of training materials and to advise on training and evaluation methods.

Preceptors from the Lampang Provincial Hospital and district hospitals, and instructors from Chiang Mai University Medical School and the Lampang Provincial Hospital were repeatedly oriented to understand and accept the wechakorn role and the competency-based training approach. Before the training began, the instructors and preceptors were asked to develop some 24 training modules for wechakorn training. Content outlines for the clinical training modules were done by Provincial Hospital staff, and the detailed writing of the training modules were done largely by staff of the Lampang Project and the University of Chiang Mai School of Medicine. Audiovisual materials of common local problems were collected or developed for each module. Each module had lists of specific required skills. Lesson plans and a trainee's log book were also developed for use in training.

#### Selection of Wechakorn Candidates for Training

Candidates for training were selected from existing government health workers of three major types -- nurses, midwives, and junior health workers or sanitation workers. Practical nurses with at least two years experience in the health field could also qualify. They were not over 40 years of age and had a good recommendation and performance record. Recognizing the importance that the first group of wechakorn should be well-qualified and able to create the imagery needed for acceptance by both health professionals and consumers, the candidates for the first training group were proposed by their immediate superiors (eg. district health officers) and were then interviewed by the provincial health supervisors to select those who were the most outstanding and experienced. For selection of the second and third groups, the candidates took an oral and written examination, and those with the highest scores were selected. Although this method identified the most

alert and intelligent candidates, it some times created a shortage of personnel when more than one candidate were selected from the same service unit.

#### Profile of a Typical Trainee

The "typical" profile of wechakorn in Lampang is of two types: (1) a midwife in her early twenties, and (2) a junior health worker in his late twenties. Both have several years field experience in government health services before entering the wechakorn training program. In most cases, they are deployed to the same or nearby area in which they worked before wechakorn training. They are generally hard workers and are well-motivated. They enjoy providing both curative services and health promotion and disease prevention services, and they work closely with the health post volunteers in the villages of their areas.

While their health centers are not fully equipped or supplied, the numbers of patients seen at their health centers has increased from about 5 per day to about 40 per day. With wechakorn now serving all health centers and district hospitals in Lampang, overall utilization of medical and health services has increased tremendously and service coverage of the population most in need--women and children--has increased to satisfactory levels. Wechakorn have been well accepted by both their co-workers and their communities. Some have been given special training in primary dental care to meet a major public dental health need, and they are performing well in this new role. The most active and best performing wechakorn have been given awards as one incentive. The vast numbers of international and Thai visitors to the Lampang Project have provided an incentive for those who receive these visitors. But one existing problem is that they cannot be administratively promoted.

#### Training Program Design and Methods.

The total length of training was 12 months which included 4 months (16 weeks) of intensive didactic training and 8 months (36 weeks)

of preceptorship rotations. The didactic phase is done first with the class together as a group for the entire four months. The eight-month preceptorship phase is divided into an initial phase of 29 weeks for clinical rotations among the various departments of the hospital, including night duty. Working under close supervision of hospital physician preceptors, trainees learned to take histories, examine patients, diagnose problems, and prescribe proper treatment. Protocols guided the learning process for wechakorn by providing simplified decision chains which systematically present the steps in dealing with a patient presenting with a given problem or set of problems. In addition to the 29 weeks of hospital rotations, wechakorn spent four weeks working in rural health centers, one week for community health resource planning, and another two weeks on electives.

The overall training content is arranged, as follows:

1. Core Skills:

1.1 History taking and medical terminology	30 hours
1.2 Physical examination, anatomy and physiology	60 hours
1.3 Laboratory examination	30 hours
1.4 Use of formulary	6 hours
1.5 Introduction to comprehensive health care	6 hours
1.6 How to use protocol	6 hours

2. General Clinics:

2.1 Skin problems	30 hours
2.2 Ear, Eye, Nose and Throat problems	30 hours
2.3 Chest problems	30 hours
2.4 Abdominal problems	30 hours
2.5 Genito-Urinary/Kidney, Ureter, Bladder problems	30 hours
2.6 Diarrhea/Vomiting/Dehydration	12 hours
2.7 General problems	30 hours

3. <u>Emergencies</u>	84 hours
4. <u>Maternal and Child Health</u>	
4.1 Maternal and Child Care	
4.2 Family Planning	
5. <u>Community Health and Field Supervision</u>	
5.1 Nutritional problems	30 hours
5.2 Prevention	30 hours
5.3 Vital Statistics	18 hours
5.4 Community Health Education	18 hours
5.5 Supervision	12 hours

In the classroom or didactic phase of training, each module was presented consecutively in a logical sequence. The modules comprised a series of discrete learning units, each with a pre-test and post-test for each learning objective. The modules are problem-oriented and employ decision chain protocols for ease of learning and later reference. Training methods included lectures, integrated teaching and case presentations, supported by audiovisual materials such as films, slides and, to a less degree, videotape.

In the preceptorship phase, wechakorn trainees rotated every three weeks to the various clinical departments of the Provincial Hospital and the district hospitals. In addition to experience gained with the various preceptors in various departments during the daytime, trainees also served night duty with physicians in the emergency room of the Provincial Hospital. Following the preceptorship phase in the hospital, trainees spent a period of four or five weeks at the rural health centers.

The function of trainers varies according to the phase and content of training. In the classroom or didactic phase, teaching staff give lectures, demonstrations, clinical presentations, and use other appropriate

methods for imparting essential knowledge and to begin skills development. In the preceptorship phase, trainers provide demonstrations of clinical problems, re-check patients seen by trainees, discuss the problem and treatment, and provide immediate feedback to the trainee on his performance, recording their proficiency in their log books...Each required skill is first demonstrated, and later observed by the trainer and recorded so that the trainee's progress can be reviewed. Punctuality, responsibility, and human relations data are also recorded and reported. Interesting topics and case presentations are discussed in conferences held weekly at both Provincial and district hospitals.

## 2. PRIMARY HEALTH CARE NETWORK

Extending into every village is a network of village primary health care volunteers health post volunteers, health communicators and traditional midwives. The Lampang Project trained 901 health post volunteers, 352 traditional midwives, and 5,636 village health communicators for the provision of primary health care services at the village level to over 600,000 rural residents of the 592 villages, 75 subdistricts, and 12 districts of Lampang Province. On average, there are 1-2 health post volunteers and about 9-10 health communicators per village, with 1 traditional midwife serving two villages. The ratio of each type of community health volunteer to population covered, on average, would be about the following:

1 health post volunteer	:	700 villagers
1 traditional midwife	:	1,700 villagers
1 health communicator	:	110 villagers

### A. VILLAGE HEALTH (POST) VOLUNTEERS (HPV, VHV)

The planned role and expected activity of the health post volunteer are summarized as follows:

- (1) to provide simple first-aid and illness care, using safe "household" medicines, provided by the government, for such conditions as fever (includes anti-malarial medicines, cough, gastroenteritis, diarrhea, headache, conjunctivitis, ear infection, intestinal worms and parasites, common skin diseases, minor accidents, minor burns, bites and stings, fainting, nosebleeds, and water accidents;
- (2) to provide medicines for some chronic conditions, such as tuberculosis and leprosy;
- (3) to provide health promotion and disease prevention information concerning maternal and child health, family planning, nutrition, and sanitation;
- (4) to support community nutritional surveillance and to promote and support nutrition care for affected families;
- (5) to provide family planning information and condoms and birth control pill resupplies (under the supervision of the wechakorn);
- (6) to recognize serious illness cases and refer them to the appropriate health facility, usually the local health center (for examination and treatment by wechakorn);
- (7) to support and supervise the work of health communicators in his village;

- (8) to record health post activities in the health post log, including contacts with health communicators and village health activities, and to record births deaths and migration of local residents; and,
- (9) to help coordinate government health activities in his area, and to promote and motivate villagers to undertake local health activities.

Health post volunteers have been trained by local health personnel, other government officials, and training staff of the Lampang Project's Division of Personnel Development. The training was conducted over a two-week period in the local area, usually at a temple or school, for groups of twenty or thirty trainees. Training methods include lectures, demonstrations and some audiovisuals. The training curriculum is summarized, as follows:

- (1) Introduction to the government health system and orientation to the Lampang Project strategy.
- (2) Orientation to the role of village health post volunteer, in relation to the roles of other community health volunteers (health communicators & traditional midwives) and to health center wechakorn and other government health workers.
- (3) Cooperative arrangement of health post volunteers, child nutrition center attendants, and village health committees.
- (4) Human relations
- (5) Provision and collection of health information in the village

- (6) How to conduct community health and nutrition surveys
- (7) Nutrition
- (8) Sanitation
- (9) Family Planning
- (10) Maternal and Child Health
- (11) Primary medical care for URI, gastroenteritis, diarrhea, headache, intestinal worms and parasites, bites and stings, bleeding, water accidents, trauma, fever (including malaria), eye and ear infections, and skin diseases
- (12) Use of household medicines
- (13) Recognition of serious illnesses and injuries, and referrals to health center (and follow-up)
- (14) Distribution of resupplies of medicines for tuberculosis and leprosy
- (15) Recognition and referral of some communicable diseases
- (16) Health education, with particular reference to MCH, FP, nutrition and sanitation
- (17) Recording and reporting deaths, births, and migration of villagers
- (18) Oral hygiene
- (19) Community water supply and sanitation programs
- (20) Community development programs
- (21) Supervision of village health communicators
- (22) Taking blood smears for malaria examinations
- (23) Health information, communication, record-keeping

Upon completion of training, HPV's return to their village and establish a small area in their home which serves as a consultation area when neighbors come for help. This consultation area usually has a bed for patients to be examined and treated by the HPV. It also has a small medicine cabinet to store simple non-prescription medicines which the HPV sells to his patients. Some of the more successful volunteers see as many as two hundred patients each month. The medicines provided by the HPV, are sold as inexpensively as possible, but with an allowance for a small profit -- which is the only monetary incentive allocated to the volunteers.

After treating the patient, the HPV enters a record of patient contacts in his daily log. This record assists the local health worker to supervise the HPV by seeing whether the latter has given the proper treatment for the diagnosed ailment. In addition, the log allows the health worker to know which health problems are most prevalent in the community, as well as which of the HPV's supplies must be replaced. By helping his neighbors in times of need, the HPV establishes his credibility which will facilitate the introduction of preventive and promotive health care in his community.

Two programs which benefit from the services of the HPVs were those related to family planning and nutrition surveillance. The volunteers help extend family planning services, to fellow villagers, by discussing the advantages of small families, spacing, and the usefulness of sterilization for those individuals who have decided that they do not want any additional children. Initially, HPVs suggest that interested neighbors visit the nearest local health facility to discuss an appropriate family planning method; but HPVs are supplied with condoms and oral pills, and provide follow-up services for their community.

The Community Health Department of the Lampang Provincial Hospital, with assistance from the Family Planning Division and the Lampang Project, began a rural Mobile Vasectomy Clinic program designed to help reduce the high fertility of the province. In the first nine months of operation, more than eight hundred individuals received vasectomy service. To a large extent, the success of this program can be directly attributed to the efforts of the HPVs. Before the mobile clinic actually arrives in their community, volunteers meet with local health workers and health communications personnel of the Lampang Project to promote this activity. The volunteers were informed about the advantages of this procedure, as well as the nature of the vasectomy operation. They could then go out into their communities and intelligently discuss with their neighbors the benefits of vasectomy. This direct interpersonal communication between volunteers and friends and relatives is one of the most effective forms of motivation in Thailand. The motivation activities, of the volunteers, have been so successful that a number of communities have already requested that the Mobile Vasectomy Clinic return to their area.

The Nutrition Surveillance Program is also benefitted from the efforts of the HPV. After conducting community health and nutrition survey, the widespread problem of malnutrition, primarily PCM, became apparent. In Hang Chat District, over forty percent of the surveyed children demonstrated undernutrition, PCM or other nutritional deficiencies. If this figure is applied to the entire province, approximately thirty thousand children in Lampang are undernourished. This is a staggering figure when one considers all the resources, especially manpower, needed to ameliorate such a problem.

By utilizing the large corps of health post volunteers, the provincial health care delivery system has the capacity to operate a nutrition surveillance program. In some areas, health post volunteers have gradually taken on greater responsibilities in this project. To

insure that they contribute to the nutritional surveillance monitoring system, the provincial health organization initiated a refresher nutrition education program. Local health workers met with health post volunteers to discuss the nutritional problems in their communities. Volunteers were then trained to weigh all pre-school children in their village using a simple, accurate, but inexpensive market scale. The results of these examinations are subsequently recorded on a "Road to Health" type growth chart (developed by Lampang Project personnel) to determine the child's nutritional status. With support from the local health workers, the health post volunteers followed the progress of second and third degree malnourished children. This was accomplished by health post volunteers' helping to distribute food supplements and educate families to choose locally-available nutritious foods for their children. The use of health post volunteers has not only increased the villagers' awareness of this problem, it has also demonstrated that volunteers in cooperation with responsive government health workers are capable of establishing an effective nutritional surveillance program, using minimal outside resources.

In some areas, however, the surveillance and nutrition improvement program could not be adequately maintained because of inadequate supervision, support and/or coordination from government health workers. As designed, the system still relied primarily on inputs from government health services ---and, without the essential government health service inputs, the program's impetus waned. In areas where wechakorn and other health workers are well-motivated, supervised and supported, nutrition surveillance and service provision through village health post volunteers can be effectively maintained.

In an effort to help ameliorate the malnutrition problem through increased production of locally available foods, agricultural extension training for health post volunteers was planned and conducted by staff from the Lampang Project, the local agricultural extension office, and the

regional community development office. The program aimed at providing health post volunteers with additional skills needed to improve local agriculture, education and community development activities. Health post volunteers were trained in basic agricultural methods needed for developing local demonstration gardens at schools, temples, health posts, or other community centers; poultry and pig raising projects; and similar activities to improve the availability and accessibility of basic foodstuffs for local consumption and/or for generating more income. A total of forty health post volunteers were trained in this pilot project.

#### B. VILLAGE HEALTH COMMUNICATORS

Health Communicators are the second type of village volunteer developed by the Lampang Project. One health communicator is chosen for about 10-15 households, making a total of about 10-15 communicators for each village. Their role is to promote the services of the local health post volunteer and the subdistric health center. They also receive and disseminate health information among the households assigned to them, under the overall supervision of the health post volunteer.

The health communicator candidates are selected by the village committee and sent in groups of 50-75 to a training center near their home.

Teaching is done through small group discussions and lectures, supplemented with handouts, posters, models, and slides.

The health communicators are generally younger than the health post volunteers and thus tend to be more transient in their services. However, because of lack of clarity of their contribution, the impact of their attrition or service performance has not been observed.

While the project had originally set a target of 6,100 health communicators, based on the ratio of one health communicator per 10 households, this target was revised and the ratio was changed to one health communicator per 15 households. The health communicators have been found only marginally useful, particularly when adequate supervision and support for health post volunteers has not been adequate. At the same time, health communicators have been productively utilized during health promotion programs and other local activities, such as in helping to organize fellow villagers for nutritional surveillance and mobile health and vasectomy services.

Some project and provincial health personnel feel that the role of the village health committee could be expanded and more local health activities organized by the village health committees if more attention were given to training and providing technical guidance to village health committees. Indeed, village health committee members could, themselves, act as "health communicators", working closely with the village health post volunteer and with local health workers.

#### C. TRADITIONAL BIRTH ATTENDANTS (OR "GRANNY" MIDWIVES)

Traditional birth attendants, or "granny" midwives -- almost all women -- still deliver a majority of the children born in rural areas and attend to pre- and post-natal care. Because they are usually older and closely involved in family affairs, they have great influence in the village. Traditional midwives are selected in every village where one is present if they are not over 60 years of age. In some areas that are well served by government health facilities, the number of traditional midwives has been decreasing, with the result that only one midwife could be identified and recruited to serve two villages. The traditional midwives are trained in groups of about 25 at the Lamang Regional Midwifery School for a period of two weeks. During the course of the training, which is carried out by Project and Midwifery School staff,

the trainees learned to:

1. give advice to mothers and children in using health services from local facilities;
2. detect abnormal pregnancies and refer them to health centers or to the district or provincial hospital;
3. assist normal deliveries using aseptic techniques;
4. advise mothers and children about good nutrition;
5. give minor medical care using household medicines;
6. encourage villagers to practice family planning; and
7. report births to the health post volunteer or village headman.

Since the traditional midwives are usually illiterate, the midwifery school training has been adapted to their special needs. The general content is presented in an informal setting by demonstrations and observations, and by lectures making use of role playing, models, pictures, movies and slides. The trainers are all local women who speak the local dialect.

Traditional midwives are entitled to free medical care at the local health center, district, and provincial hospital. They are normally supervised by the government midwives in the subdistrict health centers and receive refresher training once a year.

Table 1

Summary Profile of Community Health Volunteers Developed in Lampung

Method \ Category	Health Communicator	Health Post Volunteer	Traditional Birth Attendant
1. Main job	Provide health information	Give primary health care	Perform normal delivery and assist M
2. Background	Limited age, local inhabitant, village committee member	Local literate inhabitant	Practicing TBA
3. Selection	Sociometry, village committee	Village committee	Local health official
4. Training	2 Days (12 hrs.) School or temple in village	10 Days (60 hrs.) District hospital	10 Days (56 hrs.) School of midwifery
- Time			
- Place			
- Curriculum			
MCH	8%	4%	69%
Nutrition	16%	4%	9%
F.P.	8%	4%	9%
Preventive & Promotive	33%	12%	9%
Supportive	35%	11%	4%
Treatment	-	65%	-
- Trainer	Local health officials	District hospital staff	Provincial and midwifery school staff
Special Training	-	Agriculture	-
5. Deployment	1 for 10-15 households	1-2 for each village	Almost 1 in every village
6. Logistics			
- Supervision	By HPV and local health officials Village committee	By local health officials -Village committee, local health officials & district coordinator	By local health officials Local health officials
- Support		- Rotating fund for medicines -FP pills and supplies	Pills and supplies
- Incentive	Free medical care	Free medical care	Free medical care
<b>Total Trained</b>	<b>5,636</b>	<b>901</b>	<b>352</b>
<b>Provider:Population Ratio</b>	<b>1:110</b>	<b>1:700</b>	<b>1:1,700</b>

## EXPERIENCE AND LESSONS LEARNED

### A. WECHAKORN

Although wechakorn and primary health workers have been deployed only a few years, it is already evident that the utilization of government health services, particularly at the health centers and district hospitals where wechakorn are assigned, have increased markedly in contrast to the Project's control areas. Preliminary review of data suggests that there is now a reversal of the former trend of increasing reliance on hospital-based provision of curative services to more appropriate provision of medical and health services at the periphery, away from the overcrowded hospitals. Consumer satisfaction with government health services in general -- and with wechakorn in particular -- is very high. It is primarily because of the development of wechakorn and village-based primary health care workers that Lampang has been able to increase coverage from some 20% at the beginning of the Project to about 70-80% at the present time.

1. Support for wechakorn in the district and provincial hospitals has presented only minimal problems since the wechakorn work in close proximity to their physician supervisors and can consult with them and receive in-service training regularly. However, for wechakorn located in the more distant sub-district health centers, technical support is a crucial need and often a difficulty. In districts that have physicians at the district hospital, clinical conferences are held when the health center workers come to the district for the monthly staff meeting. It has been less feasible for the district hospital physicians to travel around to the sub-district health centers to provide on-the-job supervision and instruction, in part because of demands on them at the district hospital and also because the district hospital has no officially-defined role in supervising sub-district health center activities. There has been a clear need -- and an expressed

request from the wechakorn themselves -- for individualized, extended technical supervision at their work sites, but this has been difficult to arrange on a regular basis.

2. Supplies and equipment needed by the wechakorn at their health centers was a problem for the first group of wechakorn because, as former midwives and sanitarians, they had not been authorized to order antibiotics, for example, or to insert IUDs. Although there had been an orientation for provincial senior staff concerning the role of wechakorn, when the first group completed its training there was still some confusion about what they were authorized to do. For example, a few provincial staff members questioned supplying the wechakorn at the health centers with a new lines of drugs and equipment. This problem has, for the most part, been resolved as a result of continued discussion and clear demonstration of competence by the wechakorn.

3. The provision of regular, periodic supervision, however, has been a problem because of the overload of routine administrative work and the extensive time and travel required to provide optimal levels of supervision. Therefore, the administrative and technical supervision and support of wechakorn and village health post volunteers is still not considered to be satisfactory. The plan was for the wechakorn to provide supervision to each village health post volunteer in his area (usually about 10-15 village health post volunteers in the area served by a health center) at least twice per month. But the demand on the time of wechakorn for provision of curative care at the health center precludes the possibility for such an extensive field supervision schedule. The original plan was for technical supervision of wechakorn to be conducted monthly, but the district hospital physician and the district health supervisor are generally too busy to make visits this often.

The provision of adequate levels of supplies and new equipment needed for wechakorn in health centers became a problem when the first wechakorn were deployed. And the supply problem increased as the demand for services increased with increasing numbers of trained wechakorn deployed and with increasing utilization of health center services. The consumption of supplies increases at a more rapid rate than that of the increase in service contacts, particularly when integrated medical and health services are offered. If the support and supply line problem is not solved early, the result will be lowered morale and performance among the new health workers, followed by consumer dissatisfaction.

#### B. VILLAGE HEALTH VOLUNTEERS

Health post volunteers have made a clear contribution to oral contraceptive distribution, helping to lighten the burden on rural health centers and making villager acceptance more convenient. They have provided simple curative care to large numbers of their fellow villagers. Volunteers have consistently referred about 10% of their medical care contacts to other health facilities, which is a positive achievement in bringing seriously ill villagers to appropriate levels of treatment. Providing curative care is considered by many health leaders to be a requisite to building credibility in the village. But curative care has a limited impact, and should not be viewed as an end in itself. If it can be used to help establish the volunteer's credibility in the village, then it can lead to volunteer involvement in other important activities crucial to the health of the villager: nutrition and oral rehydration, water supply and sanitation, immunizations. The health post volunteer network has been established, and has made notable achievements in one or two important areas. But its full potential for serving the health needs of the village and improving the health of its population have not yet been fully utilized.

1. The two-week training course for health post volunteers seems adequate to provide the basic skills needed to begin their work. A period longer than this would probably be beyond the time active household and community members could be available. But it is also clear that two weeks is not enough to make a volunteer an effective primary health care workers. Besides basic pre-service training, the volunteer must have supplies and materials required for his work at hand on completing training. There has often been a lag period before the volunteers have been properly equipped, delaying volunteer's initial activities and undermining motivation. Moreover, volunteers need continual follow-up education, regular technical and administrative support, and consistent supply deliveries from the government health care system. Experience has shown clearly that to enable our volunteers to perform effectively, there is a need for continual and meaningful support from the peripheral health workers.

2. There may be, perhaps, too much emphasis on curative care; because it is generally what villagers demand. It is no doubt important to have some simple curative care skills as a means of establishing credibility, and they may lighten the load on health centers for minor ailments. But focus on clinical care has somewhat sidetracked the needed emphasis on prevention of problems more directly related to health status. We need to narrow our focus to three or four selected program areas that have high potential for impact on health in the community. In Lampang, this might be nutrition, immunizations, sanitation, and family planning. Ideally, the training should be competency-based, that is, the volunteers in training should actually be given practice in doing the tasks that will be required to carry out these programs in the community. For example, if they were to take part in a nutrition surveillance program, they should actually have practice in weighing children, recording the weights, and practice in mixing and introducing oral rehydration solutions, making some preliminary identification of children with problems. This

means that the training activities are not only in the classroom, but there should also be community exercises, so that, in the end, the volunteer acquires skills in which he has confidence, which may stimulate him to take more initiative in developing activities in the community. This is, admittedly, an ideal situation. To accomplish this means that each volunteer training group must be small (10-15 trainees) and much of the training would be carried out at the tambol (sub-district) level.

3. Links with Peripheral Health Workers. Assuming we can redirect volunteers' work towards activities that may have a direct impact on health, we must emphasize that volunteers cannot work alone. Intensified efforts in immunization, nutrition surveillance, sanitation, and family planning all require close cooperation and support from the government peripheral health care workers and their district and provincial supervisors. The volunteers can help to identify problems and can stimulate community interest in dealing with them, but the government health care system must be prepared to provide the technical support and deal with the demands generated by the community health activities. This is important bridge to gap. If our peripheral health workers accept the importance of the role of the primary health care volunteers, and if they make an effort to support and provide continuing education to the village volunteers, it will be important factor in reinforcing volunteer performance and insuring long-term continuity. We must cement the link between the periphery of government health care system and the village-based primary health care system.

Although it seems perfectly clear to most of us, who are outside of the day-to-day life at rural health centers, that primary health care is probably the only way to dramatically expand health care coverage of the rural population, not everyone at the service operational level recognizes this. To many health workers, who may already be over-worked, training, supplying and supporting rural primary health care

volunteers are only added burdens. They may not realize how much the volunteers can help them to serve the majority of the rural population.

4. Management. The adoption of primary health care in Thailand has caused the government to put a village health volunteer network into operation. This network, involving thousands of volunteers, adds a huge burden of management to the provincial-level health care system, generating demands for supplies, drugs, and technical, and administrative support.

The notion of self-reliance is integral to primary health care. The aim is to make our underserved population realize there is much they can do to help themselves, and train them how to do it. Primary health care can be mistakenly viewed as an independent, self-supporting system that will relieve some of the burden on the government health care services. But to achieve the full potential of primary health care requires new responsibilities and intensified effort on the part of the government health services. Stimulation of community interest and support, training the volunteers, keeping them supplied, supporting them technically and backstopping their community health activities are minimal requirements to provide a structure in which primary health care can fulfill its potential.

#### CONCLUDING COMMENT

If "health for all" is to become a reality, it will be generated from a partnership between primary health care workers at the village level and peripheral health workers of the government health care system. In Lampang, this partnership occurs at the crucial link between the village health post volunteers and the wechakorn. But systems of supervision, support, technical guidance and continuing education are needed by both the wechakorn and village health post volunteers. Beyond this, open communication and frequent encouragement are essential.

194

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**Third International Congress of the WFPHA and  
25th Annual Conference of the IPHA, Calcutta (India)**

**February 23-26, 1981**

**Special Demonstration and Research Projects in  
Primary Health Care**

**David Morley**

**Professor of Tropical Child Health  
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196

## Summary

Enormous problems arise in providing primary child care in the developing countries of the world. Not only are resources limited but they are also unjustly distributed. Doctor-centred and largely curative urban-based programmes are inappropriate. Soon there may be as many village health workers as there are primary school teachers. There is a need to find and develop programmes in which workers representing different disciplines but with similar objectives can work closely together.

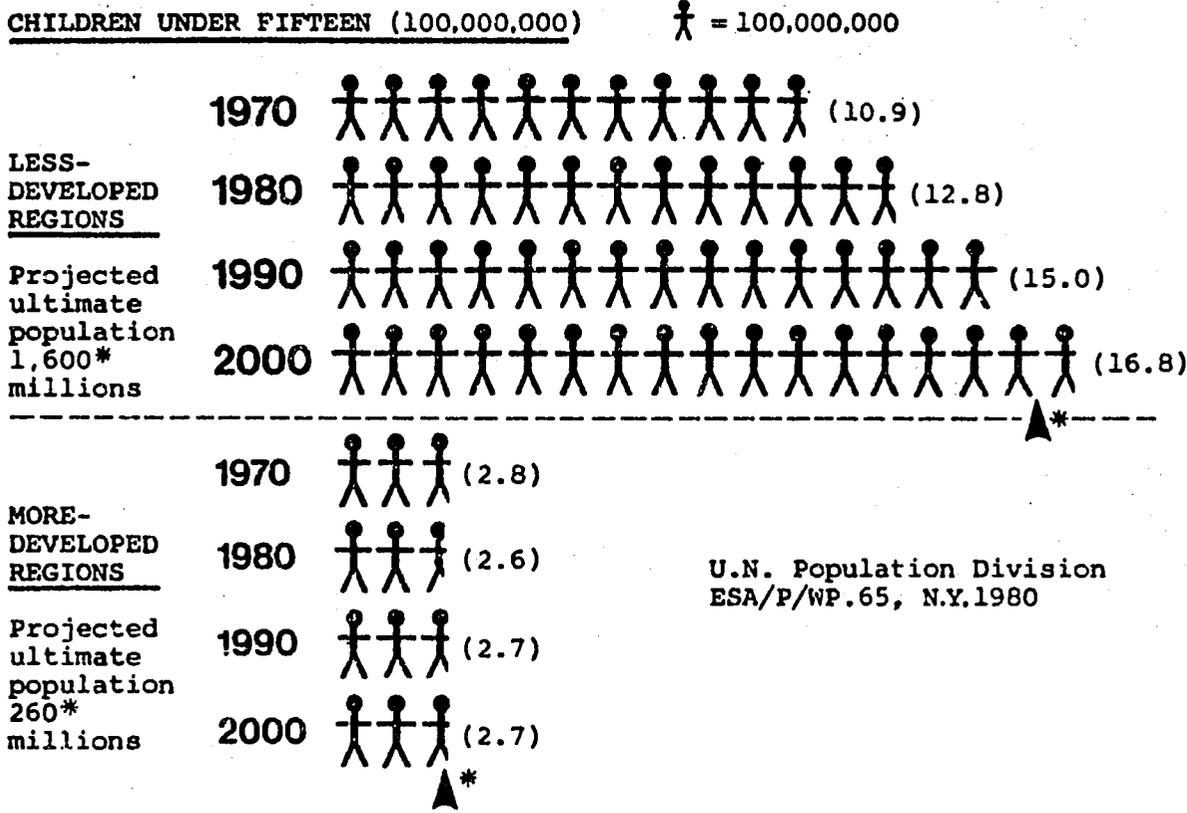
Improved nutrition will involve an increased consumption of staples. Locally ground and home cooked staples produce an excessively bulky diet for small children. Fortunately the energy density of the child's food may be significantly increased by addition of locally produced edible oils and fats. The health worker will need to work closely with the agricultural extension officer if these oils or fats are to be readily available.

Appropriate primary health care will depend on a change in direction of the whole health system. As neither universities nor ministries of health are commonly agents of change some other force is required. With help from those in education a new drive towards appropriate methods of child care may be provided by a distance learning programme targeted at the ongoing education of health worker teams in rural and slum areas.

## Size of the Problem

The number of children in our world between now, the end of the century and an ultimate projection is given in figure 1. The rapid increase in the world's child population will be concentrated between now and the end of the century. At the present time, three quarters of these children live in rural areas and up to the end of the century the number in rural areas will be increasing, although not as rapidly as in the urban areas of developing countries. Between 1975 and the end of the century the population of children in the cities and slums of our world will treble. (Fig. 2)

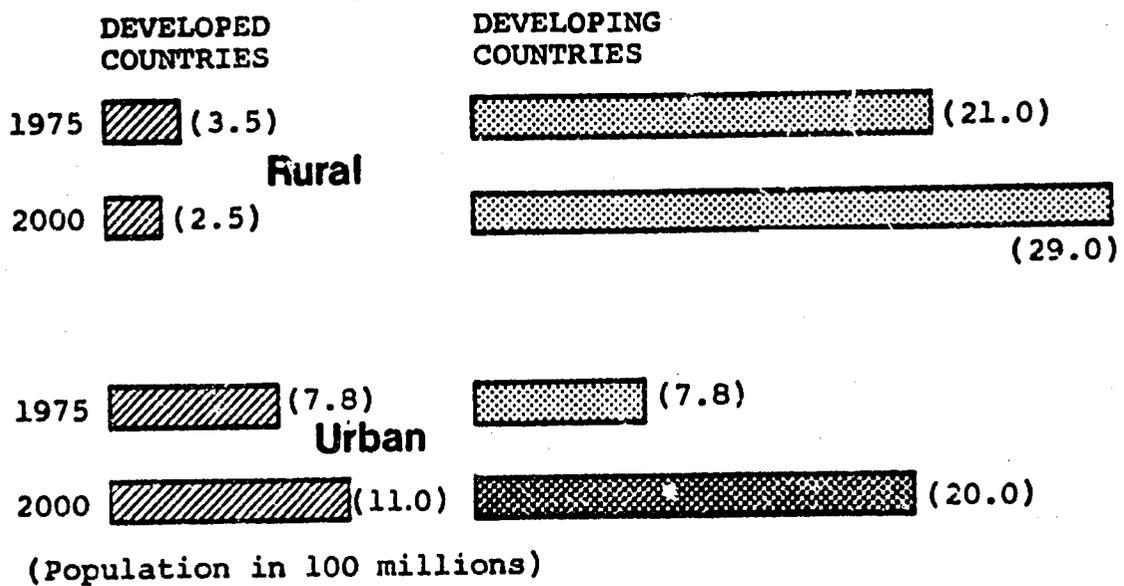
India currently has 275 million children. By the end of the century this will have reached 335 million. India spends between 10-20 Rupees per head on health care in most states. However, this figure is almost meaningless as was shown by the Mangudkar Maharashtra State Commission in Bombay. Although Maharashtra is one of the states spending more per head on health care than most states, these resources were absorbed by the cities and no more than the equivalent of US 2 cents per head per year was spent on the rural population (figure 3). Although the analysis shown in figure 3 was made for 1976 it is unlikely that there has been much redistribution. At a time of inflation, when resources are diminishing, health care investment may be cut back in rural areas rather than in the cities. The politicians will do their utmost to protect their interests and those of the urban-based doctors.



**Figure 1**

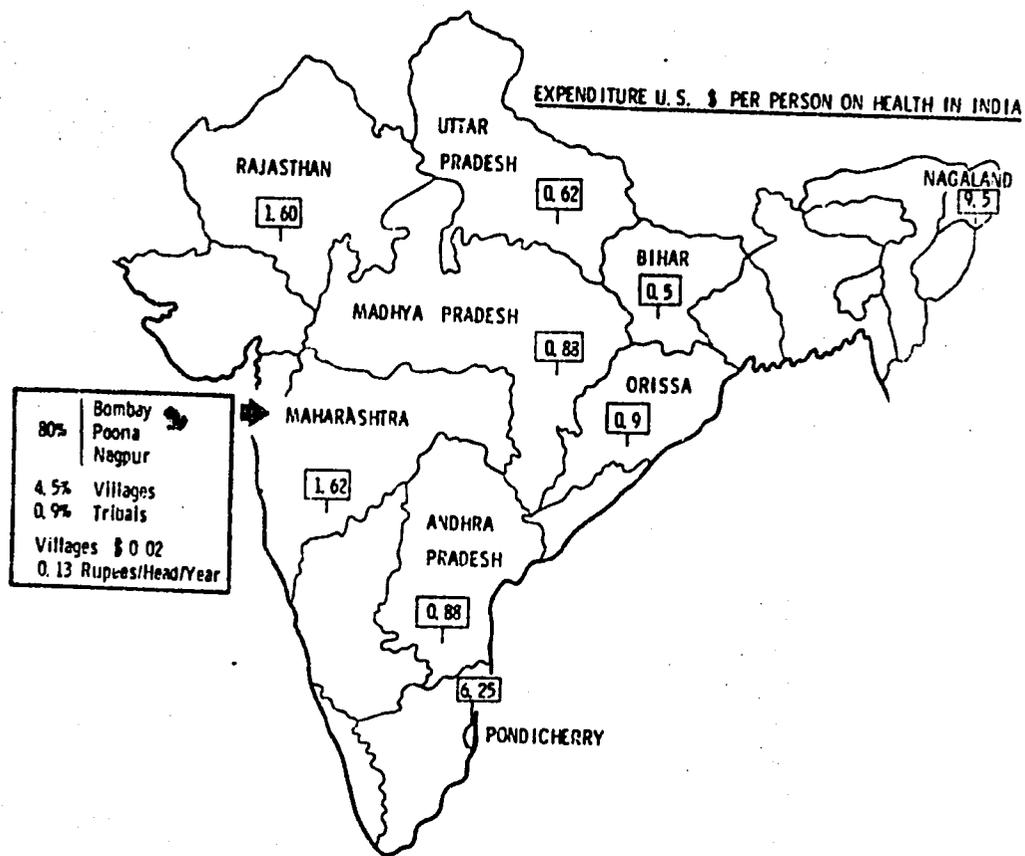
Increase in the population of children in our world is expected to be slowing down by the turn of the century and will have reached the ultimate projected number. For this reason the next two decades' provision of even basic services for the rapidly growing numbers of children will be a tremendous task.

**WORLD GROWTH OF RURAL AND URBAN POPULATIONS (1975 - 2000)**  
 (W.H.O. '80. 6, Rep. on World Health Situation, p.234)



**Figure 2**

The number of children living in rural areas will continue to increase till the end of the century. The dramatic increase will occur in the cities and particularly the shanty towns - there the population will have increased three fold in the last quarter of this century.



**Figure 3.**

In 1976 between US.\$0.50 and \$1.50 was spent per head on health care in India. However, the Mangudker Maharashtra State Commission showed that only 4½% or \$0.02 was spent in rural areas where most of the children live.

201

The pattern of health services in developing countries remains similar to those in Europe and North America. As a result the resources allocated to child care are <sup>also</sup> similar to those for a Europe in which children make up less than a quarter of the population and not 40% as in developing countries. This maldistribution is unfortunate as, in terms of 'cost benefit', expenditure on immunisation and other measures taken in Under Fives Clinics are among the most effective health expenditures. The pattern of need in the developing countries is very different. In the second year of life each child living in a village of a developing country is likely to have 5-10 times as many illnesses compared with the well-nourished children living in the highly sanitary and salubrious environment of Europe.

#### Working with Primary Education

The primary school is to be found in almost every village. In spite of many shortcomings and a lack of resources, the school and its teacher are highly respected. Within the next two decades each village will receive help from perhaps as many village health workers as there are school teachers. Much of the community health workers' functions will be not too dissimilar from those of the teacher. The village health worker will provide health education in better nutrition, managing diarrhoea, preventing diseases through immunisation as well as treating a few common conditions such as pneumonia and skin infections.

For example, in her training she may have been taught how to make a salt and sugar solution using a block of wood she (or he) prepared herself (figure 4). She will see that such simple measures are widely distributed in the village and all the women will be familiar with their use. Similarly, she will have learnt to assess the nutrition of children between the ages of one and four. She will achieve this using her finger and thumb, <sup>round their mid-upper arm</sup> and attempt to develop this as a means of 'greeting' to small children in the village.

In spite of the teacher and the primary school being highly respected, those intent on rural development will not be happy with the present objectives of the curriculum and the hopes of parents, teachers and schoolchildren. This is to instruct children so that they can achieve the next step on the education ladder into the secondary school. Whatever else may be achieved, this step up the educational ladder is likely to be a step away from the village and involvement in improved agriculture and a broader based village economy.

For this reason, those health workers who are prepared to seek out senior colleagues in education may find that they are interested in efforts to alter the curriculum so that it will have a greater health and development content. A specific example of such a development and its wide acceptance has been the CHILD-to-child programme. For thousands of years older children have been caring for their baby brothers and sisters. Only in 1979 with the Year of the Child was this capitalised to create a programme so that these older children can be taught how to care for and stimulate the young children who may be in their care for so much of the day (figure 5).

203

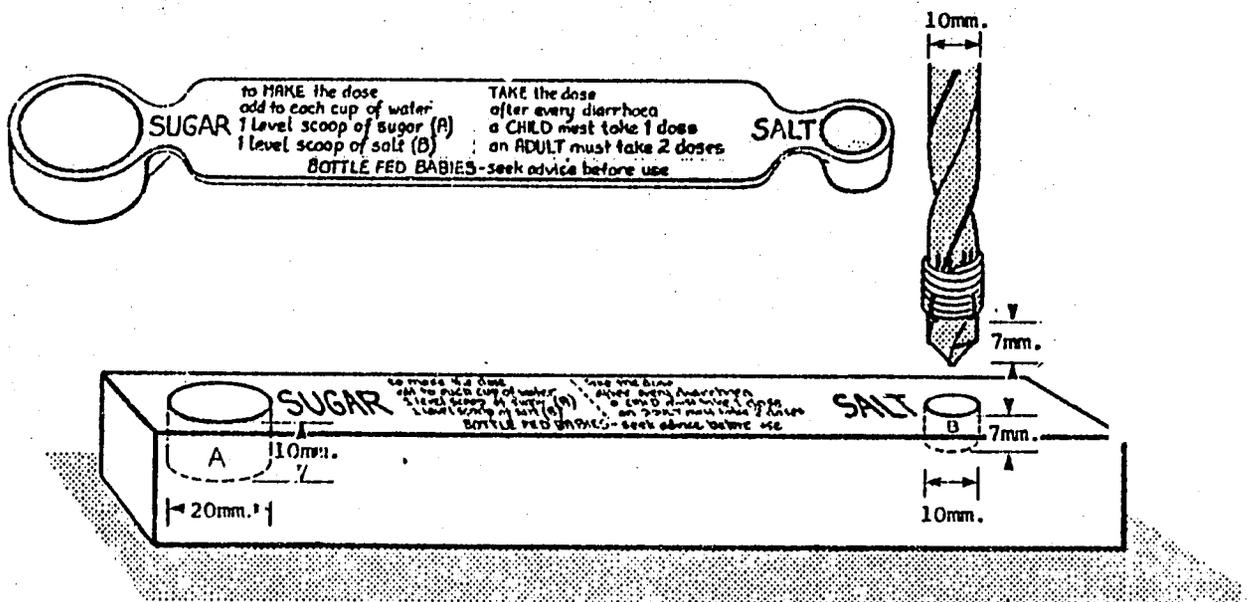
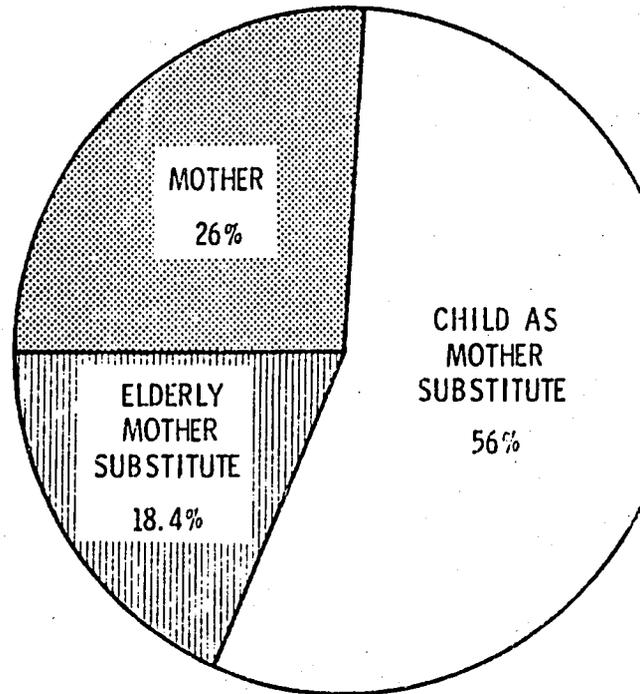


Figure 4.

A block of wood in which holes have been drilled for the appropriate quantities of sugar and salt. The instructions as to how to use this may be written on the wood in the local language by school children. The two-ended plastic spoon can be used to check the size of the holes. A sample spoon is available from TALC\*

204



WHO PROVIDES CHILD CARE ?

Figure 5

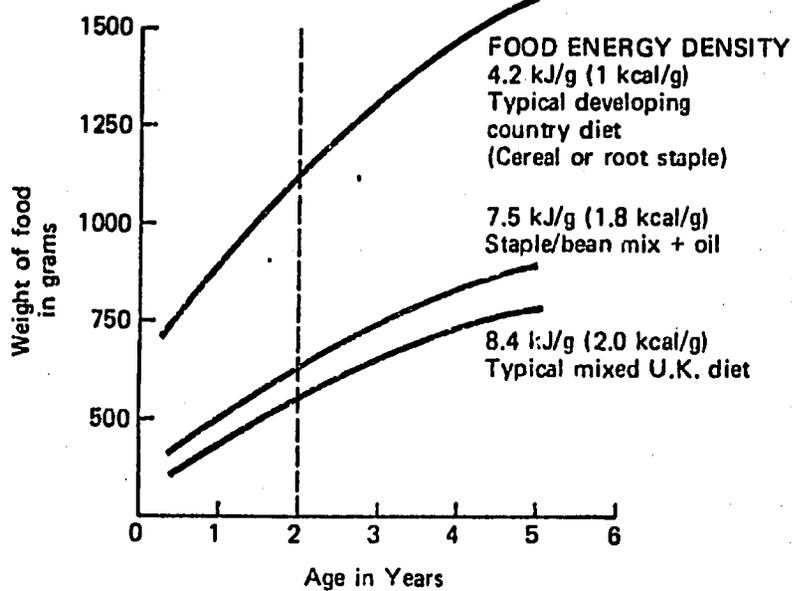
Figures from Shah show that in one area of rural Maharashtra more than half the children are cared for by older children.

## Working with Agriculture

For more than twenty years a deficit of protein has been accepted as the priority problem in child under-nutrition in developing countries. In the last ten years there has been a shift of emphasis to the even greater deficit of energy as the priority problem for most young children. The reason for this limitation is largely one of high water content and sheer bulk of food fed to infants and young children. If the bulk of the child's <sup>diet</sup> can be reduced by increasing the energy density of the food, then both the energy and the protein deficit would be made good. Emphasis has now shifted to increasing the oil intake along with the mainly cereal diet together with a quarter of the volume in some form of legumes together with a green leaf as a source of vitamin A. (Figure 6)

Unfortunately, a recent small study of articles in newsletters circulating amongst village health workers indicated that the editors and writers still placed emphasis on persuading mothers to increase their child's protein intake. This is an indication that appropriate teaching is still not reaching the mothers of less privileged children to whom giving advice about more protein is almost irrelevant.

## FOOD INTAKES IN RELATION TO ENERGY DENSITY



**Figure 6**

The large bulk of cereals that a small child has to eat is a major limitation of adequate food intake. Addition of edible oils has a dramatic effect in reducing the weight (bulk) of food required.

## Appropriate Net of Ideas at Village Level

There are now many excellent and well tried ideas on providing appropriate health care which circulate through the international information net. Perhaps too little emphasis is taken in developing the individual who has a hand in both the local net and the international net of ideas. To overcome this, TALC\* over the last year has developed a service by which the names of those interested will be distributed to the editors of free newsletters. The newsletter has many advantages. It is short, usually easy to read and can be widely distributed in large numbers at limited cost. Some, such as "Salubritas" and "Contact", may have distributions approaching 20,000, and are available in a number of languages. Such newsletters have a great potential if only they can be brought to those who are in contact with <sup>and can develop</sup> a local network of ideas.

### Comprehensive health care for all by 2000

Attempts, however, will be needed to change the knowledge, attitude and behaviour of senior health professionals. With almost no exceptions, the health care establishments in our world are driving along the straight and broad road to provide more expensive curative services available to a fraction of the urban population.

\* TALC is short for The Foundation for Teaching Aids at Low Cost, Institute of Child Health, 30 Guilford Street, London WC1N 1EH. It is a charity run by a group of housewives distributing 12,000 books and a third of a million transparencies each year. A list of what is available can be sent on request.

Figure 7

Efforts of the World Health Organisation and other international bodies to achieve a more appropriate distribution of services with emphasis on promotive and preventive care are unlikely to meet much success until the health establishment changes course. Such a change of course is not a "U turn" but rather a firm hold on the steering wheel.

- 2 -

Over the last decades hundreds of commissions and conferences have suggested and come up with "radical" changes in the curriculum for doctors and other workers being trained in "disease palaces". Progress is miserably slow. Nor can we hope that most ministries of health will make any dramatic change as they are buffeted from one emergency situation to another. Neither university nor ministry of health are change agents.

An alternative is needed. This should fill if possible an existing void so as not to compete or challenge other institutions. With limited resources it should give encouragement, support and ideas to those few who provide services to rural areas and slum populations. The void to be filled is the ongoing education of these health workers. In most countries a young doctor can train to be a surgeon, obstetrician or paediatrician. If he is to remain a general duties officer in spite of being an essential member of the health team, he can hope for little ongoing education. Perhaps even more serious, he will find little encouragement or assistance in providing further education for the health team with whom he works.

Just as in medicine, there have been many advances in the last decade, the same applies in education and one area particularly appropriate is in distance learning. There are many examples of such programmes in America and Europe. The one best known to the author is the Open University of the UK which has some 90,000 students working in their own homes.

In developing countries, a distance learning programme is required headed up by an educationalist as the problems involved are more in education than in health. The small distance learning team would include a young and enthusiastic doctor, nurse, medical assistant and artist. They would prepare material for those in more isolated units in rural areas to take up as a regular study programme. At first the teaching would be didactic, perhaps on why measles is severe and how to manage dehydration. As the training progressed the staff of the rural units would be asked to study their own situation, what they achieved, which groups of the population they served, and more important, failed to serve. In time they would be encouraged through this training programme to involve their community in bringing forward additional resources so that the health team could integrate with the community in providing appropriate health care. Such a programme would not be easy and <sup>at first</sup> only a small minority of rural health units would achieve success. However, those are the units to which medical students and others would be directed so that they could learn for the first time how a well-led health unit with limited government resources but co-opting resources from the community could bring about a revolution in the health of the people. There is evidence that this can be done in populations of around 70,000 (Gwatkin et al, 1980). This knowledge now needs to be used for the good of all the under-privileged children in our world.

THIRD INTERNATIONAL CONGRESS OF THE WORLD FEDERATION  
OF PUBLIC HEALTH ASSOCIATIONS IN GENEVA AND THE TWENTY  
FIFTH ANNUAL CONFERENCE OF THE INDIAN PUBLIC HEALTH  
ASSOCIATION CALCUTTA - FEBRUARY 23 - 26, 1981.

KEYNOTE SPEECH COMMUNITY PARTICIPATION

BY .. LEBEL GUNASEKERA

SARVODAYA EXECUTIVE OFFICIAL AND DIRECTOR OF SOCIAL SERVICES

SRI LANKA.

(1) It is my great pleasure to represent here Mr. A.T. Ariyaratne President of Lanka Jatika Sarvodaya Sharamadana Sangamaya to whom you had kindly extended an invitation to grace this occasion and deliver a key note speech on Community participation while communicating his own work in this field. Since Mr. Ariyaratne was unable to be present due to another very important commitment I was requested to represent him on this occasion. I would frankly mention that my attempt to represent Sri Ariyaratna would be a difficult task since his experience with the rural people and the poorest of the poor of our country for nearly twenty five years would be so rich, justifying to some extent the Mahabharatha saying that omniscient are those who associate the people.

(2) However I would like to draw much from the Sarvodaya organisation of Sri Lanka which had made an indelible impact on the community whereby nearly 10% of Sri Lanka Population benefits from the community development programme of Sarvodaya. The village awakening programme covers <sup>over</sup> three thousand villages and community participation is developed by means of involving the individual in the well being of himself and the community at large.

While sharing the experience of Mr. Ariyaratne founder - Leader of Sarvodaya, <sup>and</sup> also influenced by his writings. As he often emphasizes, The culture from which we come owes its value

212

to the teaching of Lord Gautma Buddha, a great teacher of India. Sarvodaya based on the philosophy of Buddhism which considers the development of the individual as important as against craving for excessive material 'development'. The movement which I represent introduced as Sarvodaya; Sarva' means all, 'Udaya' means awakening - awakening all. So, to me community means everybody - all of humanity. If I may go further, community means the entire living world, because in our culture, health or even medicine is defined as something that is found everywhere. It cannot be taken out of any experience or situation which affects the mental or the physical well-being of man.

When a government cannot deliver the fullest services to its community to satisfy the community's needs naturally community organizations at a non-governmental level spring up. I come from such an organization, the Sarvodaya Shramadana Movement in Sri Lanka.

Our organization always maintains four principal objectives:

Firstly, the total awakening of the personality of every human being, starting from oneself.

Secondly, awakening of the community; it may be the village community or it may be an urban community. In other words, considering that every human being belongs to a small community, the total awakening of that community.

Thirdly, these communities are organized in modern times as 'Nations', therefore, national awakening.

Fourthly, we can no longer talk in terms of individuals, communities or nations; we have to talk in terms of the world; therefore the world awakening.

These are the four aspects of total awakening.

For the human being to awaken himself there are certain basic human needs that have to be satisfied. With regard to these human needs, there must be a certain consensus of opinion

among communities and governments.

Therefore, in our work as village level workers, we always keep in mind ten basic requirements that we feel are essential to be satisfied if a human being's personality is to be totally awakened.

These are :

1. A clean and beautiful environment.
2. An adequate and pure supply of water.
3. The minimum clothing needs.
4. An adequate and balanced food supply.
5. A place to live - housing.
6. Basic health care services.
7. An access road to their community and also a path-way to their homes and communication possibilities.
8. Energy sources - to boil their water, to cook their food, to light their homes.
9. A formal and an informal educational programme, which is not confined to a particular age group but which caters to the needs of the community as a whole.
10. Lastly, they should have a cultural and spiritual environment in which those innermost needs of the human beings could be satisfied.

Within the context of these ten basic human needs, of course, come the primary health care programmes. When you think of these ten basic human needs, you cannot think of them in isolation. You have to think of them as one total process. Today, in the world when we talk of development, or anything as a matter of fact, we hear very much talk about people's participation. Here also we talk about community participation, community involvement, community action, mobilization of community resources for effective primary health care work and so on.

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Why only talk of community's involvement in something which is evolved by somebody else? Why not we talk of the governments and others getting involved and participating in what communities have thought about and developed also?

Now in my own country, in over 2000 places, especially over the last five years, we have evolved a system where pre-school children, needy school-going children, lactating and expectant mothers, sick and old people - these six categories of people - are being organized on their own to provide three essential services, namely, nutrition, health care and mental and social development services. This is being done in about 1000 places involving nearly 150,000 who are beneficiaries as well as participants. I say beneficiaries as well participants because they are not only recipients of certain services but they are also the promoters of those services.

No government service programmes, I know of, exist in my country that cater to this number of human beings in this type of organized and people-centred manner. In other words a non-governmental programme in Sri Lanka has succeeded in building up an effective children's service programme. This is a programme of the people by the people for the people keeping the mother and the child at the centre. Here is a programme that has been evolved by people themselves in response to their felt needs. What a government should do, what the social development planners and administrators should do, is to identify these programmes and render them all support to do their work better without trying to control or manipulate them.

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In an instance like this is it wrong to tell the planners' Look here we have succeeded in building up a children's service programme. Why don't you build into this programme what you intend to do in this field? Participation and involvement must be a two-way process with mutual respect and equality in association.

It must not be a process where some of us with great scientific and technical knowledge want to sit down and plan and expect the community to passively participate. This is wrong. When most development organizations, including the WHO set the minimum human needs satisfaction target for the year 2000 AD, for example, to give basic health services to every human being, do you think that most of the deprived communities in this world will accept it?

Can we organize community involvement and participation programmes into governmental and inter-governmental services so that they could meaningfully fit in? If we agree on certain basic principles of development we can do this.

There must be a common language of development which is equally intelligible to the elite and poor alike. We must stand on common ground. We should not take for granted that communities, because they are poor, or because they are illiterate, are also ignorant.

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**Best Available Document**

ometimes the most enlightened people are the illiterate and under-trodden people, because they have learnt through the university of life, the university of suffering. They have survived in spite of the fact that they have to walk eight to ten miles to get a bucket of water to drink. Therefore, it is very essential that on certain basic principles we should agree before we plan our programmes.

Development should be for the benefit of every human being. Development is not the mere production of goods and services and forgetting about the fact whether they have reached the people or not. Human being should be the target of all development. The last in society should be our first concern. Development should start from below; not from top downwards. Development should start with what people have their knowledge and their resources. Every community is in a process of development and has reached a particular technological level peculiar to that community. We have to start from that level, unless we can have the magic of giving them the best overnight, which is impossible. Then get the total community to participate in this process of decision making.

As much as we are concerned about their health - they too are more concerned about their health. When they are told that every six hours 4000 people die of malnutrition in this world, they themselves can understand this in reference to their own community. Now if you take the ten basic human needs I outlined and break them down to about 400 parts with them, which we have done and put it before the community they are capable of recognizing those fundamental needs which can be satisfied by their own efforts. That is an education for the community. Without education, without an awakening process, no participation can come about.

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Today in my own country ( I am sure this is the same in many other poor countries), there are a number of queues, people lining up, you can see. If you go to a co-operative store, you see people lining up to buy their rations. If you go to a member of Parliament's house, there will be people lining up to get a chit to get jobs. You go to the health service or medical clinic, people will be queing up there too to get medicine. Can't we turn these queues the other way. We can. And what is the principle of doing this? Make those very people for whom our services are meant not only the receivers but also the initiators of these service programmes. Then as I mentioned we, who belong to non-governmental or governmental organizations, do not have to waste most of our time trying to organize the community. The communities have the potential to organize themselves. Others have only to give the freedom and opportunities they need.

Government should essentially render other services which create the environment and supplement people's efforts. Firstly the government should give them social justice under the law. Government can give the expertise wherever necessary. Government can divide its resources according to the needs of the people , government can create that psychological atmosphere where the people can feel free for self-development. Governments can bring them face to face with the highest developments in the field of medicine or health or technology when they are of benefit to and appropriate for the people. ~~Leave the governments to do those big things.~~ Give the people the freedom to organize themselves to see to it that every pre-school child in the community gets those services of nutrition, health care and a good atmosphere leading to social and mental development.

In our countries we have in the age groups of 18 to 30 or 35 - many hundreds and thousands of young people who are unemployed -

unemployed not only in the sense of getting no income but also not having any useful work to do, which is very frustrating. It would not cost the government very much to take in these young people and give them a training in basic essential health care for a period of three months or so. Being a non governmental body we are training at one time about three hundred such people so that every three months we are able to start 300 new children's services centres.

You may call her a primary health care worker or pre-school worker or a young sister doing children's services in the village. There have been statistically proven improvements in the level of health of the groups they serve. There has been an improvement in the cohesive nature of the community they serve leading to self-development. There has been an all-round understanding that, after all it is self-reliance and co-operation on the part of the people that can bring about a change. I am emphasizing this aspect of people's initiative and leadership very much because what we decide for them in international conferences is not put into concrete practice at that lowest level.

We have had many visitors from international organizations seeing our programme in action but hardly any development administrator from my own country has visited us. Why is this? People are ready to get involved, participate and work, as long as they know that the programme is an honest and genuine effort to bring about development. They are ready to co-operate. I have yet to come across a community that did not co-operate, but we - the educated, the elite are not ready.

There should be a total awakening process not only on the part of the poor people but also on the part of the administrators and the leaders of our countries. This awakening cannot come about unless they all come down to the grassroots and work with the people.

too should come down and serve as primary health care workers at the village level. Then only a psychological integration can come about. The WHO has accepted, as a principle, the involvement of the community in health care work and the importance of the primary health care services. I would ask you to make a survey of our own medical practitioners and find out how many of them agree to this view. Most of them think that the level of their professional excellency is brought down by people's involvement. This mystified nature of the medical profession has to undergo a fundamental change. We need, like in China, the recognition of the need for and the value of bare-foot doctors. 85 per cent of our illnesses, you all have mentioned, can be prevented at the basic level. 85 per cent of our money should go there. But do we do it? When the political leadership asks from the health budget, 75 per cent to put up new hospitals, do you oppose it as a profession and say 'Please do not it, spend more money for the preventive services'. This is not done. Why? Because there is not enough experience and commitment among those who decide for our communities. Therefore there should be a concerted effort on your part to awaken our people, to get them into action, to give more knowledge, to train personnel from their own community and to send them back to the community. There also must be an educational process for the people who man these services at the top. Then only can we realise our objectives and the lofty ideal of the health of all.

<sup>we are</sup>  
~~I am~~ talking as <sup>people</sup> ~~a man~~ who has to face these problems every day. That is why I am talking with a feeling of conviction. Coming to concrete action programmes that we can implement at village level, I would mention again that Primary Health Care should be a part of an integrated programme of development.

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220

A lot of money and time and energy must be spared to be spent to bring the knowledge right down to the grassroots, in a simple and intelligible way. I do not think this is happening very much compared to the volume of high technical papers that are being produced. Very simple manuals should be prepared to be used at that level. We need a lot like that on every subject.

③ Now let me briefly mention how a Sarvodaya programme begins in a village. Our first objective is to build a psycho-social infrastructure in the village. When a village wants to join this Movement, we say 'all right let us organize a shramadana camp enabling us to do a labour intensive task while living together for three days'. By that what I mean is that the village community with those who come from outside, spend time living together, cooking together, eating together, discussion together, singing and dancing together and doing a community service project for two or three days according to a certain time table. To that camp we invite all the government personnel at the community level to participate as equals with the people. This is to break psychological barriers that exist. There are barriers of dependency and patronage and barriers of superiority and inferiority complexes. All these have to be broken down because a psychological infrastructure has to be created not only among the members of the community but also among the people who serve the community.

④ While people live together like that for a period of time, they may construct a series of latrines, wells, soakpits or tank bunds or a road to the village so that all share the joys of a beneficial physical achievement. But the most important outcome in the first stage is the opportunity the people get to think together, to plan together, to work together, and to feel that they have a great potential for self-development. This is community education in a true sense.

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We next come to a stage of organizing a mothers' group. Mothers' group selects one or two willing girls between the ages of 18 and 30 based on criteria commonly set to be sent for a period of training to a Sarvodaya Development Education Institute. We have six large Institutes of this type and several smaller ones. Training is also a type of community living. There you do not see any marked difference between trainers and students. They all live together and share experiences as members of one large family. ~~Our Regional Director Dr. Herat Guneratne and several of you have seen these institutes.~~ They learn theory through practise, so that within three months you can give them maximum practical knowledge. When those young people come back to the village, they not only take with them certain skills in the PHC field but they also take with them certain changed attitudes. They would not come back to the village as persons with certificates. We do not give certificatis. Only after two or three years we give a certificate for exemplary, creative and innovative type of work.

It is not for certificates that these people come. We are not paying them any salary. They first learn the science of serving their people and receive the joy of living by learning the art of loving their fellow men. This service is known as a pre-employment voluntary service. We believe that the government will say one day - 'Well, we pay 50 or 200 rupees per month to that village level worker because he or she has proved her worth in taking care of our children. Let all the 23,000 villages of our country have the services of such inspired and trained youth'.

The mothers' groups in the villages have to be in general charge of the children while the pre-school girls are in training. The youth groups in the villages put up the required buildings with local material.

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Other elders in the community help in these activities. When the trained youths return to the village it becomes very easy for them to start the Day Care Centres for children below 3 years of age, pre-schools for those between 2 and 6 years of age, community kitchens for the needy, pre-natal and postnatal care for mothers and child welfare activities for children with help from the public health midwife, Immunization and Environmental Sanitation Programmes with the help of Public Health Inspectors, home gardening campaigns and other community services. They maintain health cards for children and establish working contacts with governmental medical and health care personnel.

This is how we have tried to bridge the gap between the available governmental services and the real needs of the people. However it is not always that we get the willing co-operation of the governmental extension services. Therefore we have obtained the services of a group of doctors, nurses and health persons as volunteers who make use of their leave to come and help our village health projects in such situations.

If the governmental services give official support to voluntary bodies to organize mothers, children and youth in this manner without trying to lay down the law for them the outcome will be tremendous. Instructing the local bodies to assist the up-keep of workers and provide the basic material, providing the medical and health personnel to help the programme, making available simple health education and primary health care manuals are some of the ways that the government can help these people's efforts. Then the governmental resources would have been utilized much more effectively than it happens now.

Let me speak a few words about research. This is another area that needs demystification. We also do research at the village level.

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Not high powered research but very simple research useful to the people and the results of which become common knowledge to all people of the community.

Let me give an example. Everybody needs water for their personal use. We do research to find out how much hygienic water each member of the family needs a day and the total number of gallons of water the whole family needs. Similarly how much all families in the village need. In actual fact how much of water is available in the existing wells and how many more new wells have to be dug to give the village an adequate and a clean supply of water. A group of village youth with a simple training becomes the initiators of the research programme that is carried out with the villagers themselves. Next they become the well-diggers all-together once the research is over.

Now to build up these wells, they have to find money for cement, bricks etc. Either the government has to have a system whether through local bodies or through relevant ministries, when such a programme is going on, to give the material that is necessary or non-governmental organization has to support them. This also means that the village needs a group of young men and women who are skilled in certain technologies of well construction, house construction, toilet construction, etc. So this leads to a Movement of regeneration of the quality of village life. So I would plead with you to look on this as a total process one leading to another.

The village communities have to get committed to bring about better health as an integral part of total development. Those who are more fortunate than others to be in a position of making decisions that affect the people also have to make a serious commitment. This is much more difficult than awakening the village

communities because vested interests are more in decision making groups unlike in regard to the village people. So, if you face facts, we have to bring about commitments either by persuasion or by compulsion, if the governments really mean what they say. We have to get both these groups awakened as to the danger that we all are facing in the years to come and pull their weight together to avert it and promote good health for all.

To bring about a more healthy life for our communities we have to bring about changes in three related areas. Firstly, we have to bring about psychological changes, I have been taking about. Secondly, we have to bring about changes in methodologies and techniques where we try out not only the methods and techniques coming from top to bottom, but also think of those that have been evolved from bottom up. The latter could be linked to the national services. Thirdly, structural changes. This has to be elaborated upon a little.

To stress on the importance of changing structures permit me to give an illustration of a village experience. There was a high incidence of infective hepatitis that was prevailing in one of our villages where a primary health care worker was functioning. She found that at one time as many as twelve families had this disease. When she explored into the root of it she found that the source of water - which was running stream through the village - was being polluted by a newly started factory. Those who imposed the factory on the village did not look into how their actions would effect the health of the villagers. Are we turning a blind eye to this type of situation and only try to repair the damage done?

We have to turn our attention to structural incongruencies and injustices that are imposed on our peoples. If a poor farmer has to pay 100% interest for a loan he obtains for his cultivation purposes, how can we expect him to buy sufficient food for his family?

While accepting realities of our involvement in various specialized fields, such as health, when coming down to the realities of community poverty and ill-health let us not forget the need to liberate them from social, economic and political structures that are unjust. Consequently, a psychological, methodological and structural change is very necessary to bring about community progress.

One last word. I was talking about the environment. I think environment not only includes air or soil or water but it also includes very much the mental and psychological atmosphere we live in. There is a terrific pollution that is taking place in our psycho-sphere. There is an increasingly prevailing pollution taking place in our minds as a result of greed, hatred and ignorance that we nurture in this world. Therefore, all these things I was talking about have to happen in an environment where the spiritual values have to be brought to the fore-front in our times too.

**6. Texts of Illustrative Examples of  
Workshop Presentations**

## PRIMARY HEALTH CARE: "DIARRHETORIC" OR REALITY?

- Practical Considerations from Field Experiences

- Richard A. Smith, M.D., M.P.H.\*

## INTRODUCTION

Traveling through developing and developed countries nowadays one is surprised to find multilateral organizations, technical assistance agencies, lending institutions and private voluntary organizations with policies and plans in Primary Health Care (PHC) but with few action strategies. They know what they want to do, but have not yet discerned how they are going to work meaningfully in this rapidly emerging field. Without strategies for action they are going to continue to promote fragmented projects which are not part of national programs -- efforts of no long-term consequence.

Many developing countries face a similar dilemma. They have enunciated policies and plans in PHC, but little has changed from yesteryear. With some exceptions, there are only small PHC projects going on, <sup>and they</sup> <sub>are</sub> probably of little consequence in their present disjointed context. At this rate, we will see few significant strides taken over the next two decades to get basic services to a majority of populations.

Having in mind the recent PHC experiences of 17 countries, a few of which have had successful large-scale programs, serious concern must be expressed about the present state of this field. If developing countries

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do not go beyond the hollow theatrics of PHC and develop and implement national PHC programs, they will not be able to control the threat to PHC being posed by the present fragmented approach seen in many countries and fostered by well-meaning, but too narrowly focused, international organizations.

#### BACKGROUND

The primary health care movement today is being threatened by man-made phenomena which are carrying it down a road to disaster. Unless these phenomena are recognized and corrected soon, the promise of basic health services for the majority of the world's population will remain an elusive dream; PHC will become a mere memory in the history of health services development -- an opportunity lost. To avoid <sup>a</sup> disastrous demise of the PHC movement, to realize the full potential of this idea whose time has come, national programs of action (not just policy) <sup>need to</sup> be developed which pull together the present fragments of PHC to produce coherent, sustainable and effective improvement of expanded basic health services.

An approach to designing such national PHC programs has been used in a number of countries. The experiences of those countries and <sup>related</sup> technologies that have been developed can serve to help other developing countries, donor institutions, lending agencies, and private voluntary organizations to target diminishing development resources into successful implementation of national PHC plans. A rationale for developing such plans of action that actually work in the field is presented in this paper.

The most serious threat to effective primary health care today is the plethora of community or village health worker projects unconnected to functioning supervision and support systems in many developing countries. These small-scale demonstration projects are usually of limited scope and geographic coverage. They have problems with supervision, support and with inappropriate training methods. Most important, they may be offered as models for replication on a national scale, without adequate consideration of the new problems that expansion will entail, especially in management. Further, as local CHW <sup>or VHW</sup> pilot programs proliferate and many fall into disarray or otherwise prove not replicable, they produce the erroneous impression that national primary health care programs are not able to deliver appropriate health services for the majority of a nation's population. The erosion of confidence at the national as well as at the village level by short-lived demonstration programs which elevate expectations and then disappear, needs to be examined in the context of the future of PHC.

Second, PHC has been established as a vertical program in some countries. This phenomenon obviates the long-range success of a national PHC program since <sup>as</sup> a vertical program <sup>it</sup> will be treated as another "campaign" rather than a unifying force used to consolidate and focus the many components of the health system which are directed towards the periphery.

Third, PHC is frequently used as a label given to "old games" to disguise them under a rubric now in vogue. PHC is often the name given to the status quo. Programs in MCH, family planning, safe water supplies, immunization, nutrition, health education, other preventive and curative services are all components of PHC. However, extraneous concerns have

caused these PHC components to develop as vertical programs themselves with separate and often ~~complex~~<sup>duplicating</sup> support structures. Without a rational and cohesive approach to pull together these and other health sector program fragments, the impact of these undertakings will be seriously compromised.

The concept of primary health care could not have been more timely in terms of increasing the accessibility of essential health services for the world's population. It promotes the imperative that basic services <sup>as a part of development</sup> can and must be delivered by less expensive means -- by more appropriately prepared personnel than heretofore considered possible on a global scale. Concomitantly, the PHC concept comes at a time when resources for development are rapidly decreasing. We have before us an opportunity that comes but once in a generation; perhaps it is an opportunity rare even in a century.

What is being addressed is the restructuring of national systems of delivering basic health services through the mechanism of PHC. Changing and improving the image and operation of the health system and its providers is indeed a rare opportunity in our lifetimes. However, it appears that inertia and apathy on one hand and unrestrained zeal on the other may prejudice our chances of making the most of this fleeting opportunity. The possible loss of this chance for significant impact is being hastened by "diarrhetic" describing the potential of PHC <sup>within</sup> the perspective of small projects, while avoiding the tough decisions and actions required to make PHC a national reality.

One of the great problems in primary health care ~~program~~ is the difficulty of mounting significant programs with diminishing resources. As primary health care has become a rallying point for development in the health sector, rationales are needed for action strategies which go beyond policies and plans. Such action strategies have to be found if we are to take advantage of the promise that the primary health care movement holds in a world plagued by tough economic constraints.

It is possible to improve on the "bits and pieces" approach in international health in general, and PHC in particular. <sup>The</sup> fragmentary approach has given rise to many scattered, ineffective health projects in the Third World. They occur so frequently that a rationale considering their problems should be developed to focus efforts and resources onto country-specific targets fitting into the larger health sector objectives of a developing nation. In addition, public and private technical assistance agencies, international organizations and lending institutions need to look beyond ill-defined, cautious policy statements to a rationale for action which brings them closer to the real needs of the countries they try to serve.

If PHC action strategies of international institutions were developed from the same premises as PHC action strategies <sup>developed by Third World</sup> countries, the job of optimizing technical and financial assistance would be easier. Collaboration could produce more meaningful programs since everyone would be pulling in the same direction <sup>rather than simply looking for targets of opportunity.</sup> Such cooperation would be possible within the multiple sociopolitical and administrative divisions of nations if there were a common template or rationale for working together.

232

Any rationale that leads to a problem-solving action strategy clearly must respond to a known set of problems. Efforts in PHC have produced few truly useful descriptions of large-scale programs even though small-scale projects have been proliferating widely. The desire to share knowledge of failures along with successes has been minimal. Since there is no Journal of Negative Results, the most useful information has been passed (albeit guardedly) by word of mouth at international meetings and by visitors returning from countries involved in PHC. However, China, Colombia, Guyana, India, Lesotho, <sup>Micronesia</sup> Nepal, Pakistan, the Soviet Union, Tanzania, <sup>Thailand</sup> and a few others have helped some of us in this field to develop a balanced perspective from which to consider where PHC is now, and how it can fulfill its promise for the future. Some of us have taken our own experiences in the Third World and combined them with those of other operating programs to identify the major problems to be addressed in developing a rationale for action strategies in PHC -- problems that recur over and over again in PHC . . . in many countries.

Examination of these problems reveals the need for concerted action by various government entities at many levels. It requires action horizontally as well as vertically; it requires the participation of chief executives and village or neighborhood committees. The principles or rationale that must underly an action strategy have to be responsive to needs denoted by these problem categories. The following list of common problem areas in PHC is not exhaustive; but it is a starting point.

COMMON PROBLEMS IN PRIMARY HEALTH CARE

## 1. FRAGMENTED APPROACH TO DEVELOPMENT ("BITS AND PIECES")

This approach to development has frequently resulted from the lack of resources to implement large programs. This direction has been encouraged by donors, international agencies and PVOs whose own purposes and limited resources often greatly influence decisions.

There appears to be a bias towards using pilot and demonstration projects for development purposes because they fit into the short timeframe of project management, require relatively small inputs, and offer quick results. However, they rarely provide definitive solutions to problems and usually cannot be replicated or significantly expanded. Failure to produce a critical mass of supporting component parts (e.g., absence of infrastructure support for workers that have been trained) or the use of personnel resources and incentives that are unavailable on a national scale are but two of the reasons that such projects often are not duplicated or expanded.

Vertical programs (MCH, immunization, nutrition, etc.) which are part of this approach often compete for the same scarce resources and duplicate support systems, thereby reducing each others' effectiveness in reaching the periphery. In many cases, vertical programs produce dependency on outside resources. Related to this is inadequate planning for the interfacing of projects or for the needs of the larger health system. Such fragmentation discourages

self-sufficiency by spreading developing country personnel and financial resources too thin while allowing projects to remain dependent on donor interest.

Health projects designed with short development timeframes (dependent on 2-5 year funding cycles) produce support systems that cannot be sustained when artificial donor supports terminate, especially when the project has not been permanently institutionalized.

2. LACK OF BROAD BASE OF SUPPORT FOR A NATIONAL PROGRAM

Without a high-level political mandate or national commitment, PHC programs will flounder. If projects are initiated on a small scale, there is not significant mobilization of resources to set the stage for a national program. System changes necessary for national coverage will not occur; e.g., improved organizational structures and strengthened management support systems. Without broad-based support, ministries of health are constantly faced with the need for politically expedient "quick fixes" rather than definitive solutions to problems.

3. OBSOLETE ORGANIZATIONAL STRUCTURES FOR DELIVERY OF PHC SERVICES

Many such structures perpetuate over-centralization. They also propagate fragmented, uncoordinated vertical programs which set up their own structures, often parallel to others, often redundant. This situation frequently leads to inadequate support capability

for peripheral services. It encourages the persistence of a project management perspective (short timeframe, need to have close control, limited results) over a development management perspective (long timeframe, development perspective, more significant results).

Under many existing organizational structures, PHC is promoted as another vertical program unrelated to other competing health services. *(This is a danger signal for PHC!)*

#### 4. INADEQUATE MANAGEMENT SUPPORT FOR PHC SERVICES

The perspective of small-project management (as opposed to a development management perspective) does not promote expansion of management support services for the health sector. *Management support for peripheral services are frequently incomplete, unreliable, and neglected.*

#### 5. FAILURE TO DEVELOP A FUNCTIONING PHC PLANNING CAPABILITY

Frequently, resource allocation at all levels of the PHC program is not tied to a PHC planning entity. Inadequate planning for this developmental effort threatens the institutionalization and permanency of PHC. Resources are unprotected against erosion produced by the demands of secondary and tertiary urban-based services.

## 6. LACK OF OVERALL PHC MANPOWER PLAN

Without an all-encompassing plan for harnessing the skills and knowledge of all categories of health manpower, governments are unable to optimize personnel training, deployment and utilization. Physicians, nurses, other professionals and technicians are often trained without a realistic plan for their maximal employment in PHC. There is little planning to link peripherally oriented health workers with other health professionals; the isolation of PHC from other health services reduces effectiveness of all parts of the delivery system.

Teacher training institutions and curriculum development workshops have been created with the idea that training teachers or developing curricula would effect significant system change in the health sector. By themselves, they cannot. Perhaps as part of other ongoing activities, they can make a contribution.

Governments frequently agree to donor-endorsed, donor-promoted manpower pilot projects without concern for the impact that such projects can have on the larger health delivery system. Since most of these projects do not fit into a larger receptive framework and the demonstrations are frequently not capable of long-term maintenance or replication, they usually collapse or quietly disappear because of supervision and management support problems. Although there have been some notably successful pilots (e.g., Promotores in Columbia, Medicina Simplificada in Venezuela, CHWs in India, Health Guards in Pakistan), the landscape of some developing countries is strewn

with wreckage from failures. Such failures can destroy confidence at the national as well as the village level in the feasibility of effective primary health care. (*This is a danger signal for PHC!*)

Even when village-level health workers are trained in curative and preventive care, they have a tendency to deliver only curative services. Incentives for non-curative PHC services are difficult to devise even when they are consciously sought.

## 7. INEFFECTIVE AND INEFFICIENT TRAINING

There are numerous approaches being used to train health personnel. Many of these approaches are arduous, time-consuming and produce health workers who are not as competent as they should be. Many of these training methods are concerned with "seat-time" rather than learning, the academic rather than the practical, the esoteric rather than the typical. Traditional training is often concerned more with transferring theoretical knowledge than with developing adequate skills. Many times it occurs far from the worker's home and work place, influencing selection and reinforcing emigration from rural areas.

Training materials for PHC are being developed in numerous countries. Many programs have analyzed the jobs to be performed, identified job components, developed content and put it down in books; they serve as excellent reference manuals. Most of these publications, however, are not concerned with knowledge transfer, skills acquisition

or the process needed to do the job. Many of these materials are inadequately concerned with preparing people how to teach, and do not take into account how people learn.

8. FAILURE TO LINK PHC NATIONAL AND REGIONAL PHC PROGRAMS WITH LOCAL COMMUNITY INVOLVEMENT

A "bottom up" or "top down" development strategy is often used, rather than combining the essential aspects of each.

9. LACK OF ON-THE-JOB CONTINUING EDUCATION

Skills decay and no new skills are learned if continuing education linked to supervision is not an integral part of PHC from the beginning. Under such circumstances, there is no way to use the information gained from field experience. Furthermore, this lack of professional contact adds to the sense of isolation and abandonment of health workers.

10. COST

The initial capitalization for large-scale programs is discouraging to countries as well as donors. Recurrent costs of new programs pose serious difficulties. A frequent question concerns the issue of community support of CHWs: are villages able to maintain CHWs?

Demonstration programs sometimes set inappropriate precedents for primary health care (e.g., governments pay CHWs when villages could support these workers, on-site project managers provide close but temporary supervision). The lack of adequate attention to cost containment issues (e.g., generic drug lists, bulk drug purchasing, consolidation of management support systems) can discourage expanding <sup>important</sup> program ideas from the pilot stage to a national program.

It would be easy and safe to end this discussion after linking the above problems with the "what" that needs to be done. However, it is necessary at this point in the history of the development of the primary health care movement to present the rest of the discussion related to the "how" of issue and problem resolution with a rationale that can be used to develop an action strategy. This rationale is the result of PHC efforts and experiences by a number of countries, some of which meet at regular intervals to share knowledge, methods and technology that make primary health care systems work. It is a rationale that serves as a framework to respond with specific action to the major problems and issues standing in the way of successful primary health care programs.

A RATIONALE TO DEVELOP A COUNTRY-SPECIFIC  
ACTION STRATEGY FOR PHC

1. DEVELOP COUNTRY-SPECIFIC PHC GOAL AND OBJECTIVES

Initially, the long-range goal of the PHC program should be stated in terms of population coverage, services, indices and other relevant characteristics. Short-term objectives should be stated with schedules, geographic coverage and resources as some of the determinants. Personnel and finances are among the country resources that then need to be inventoried. Subsequently, an inventory needs to be performed for external resource assistance if necessary.

2. DEVELOP A TIERED PHC MANPOWER STRUCTURE AND A RECEPTIVE FRAMEWORK FOR NEW MANPOWER CATEGORIES DEVELOPED

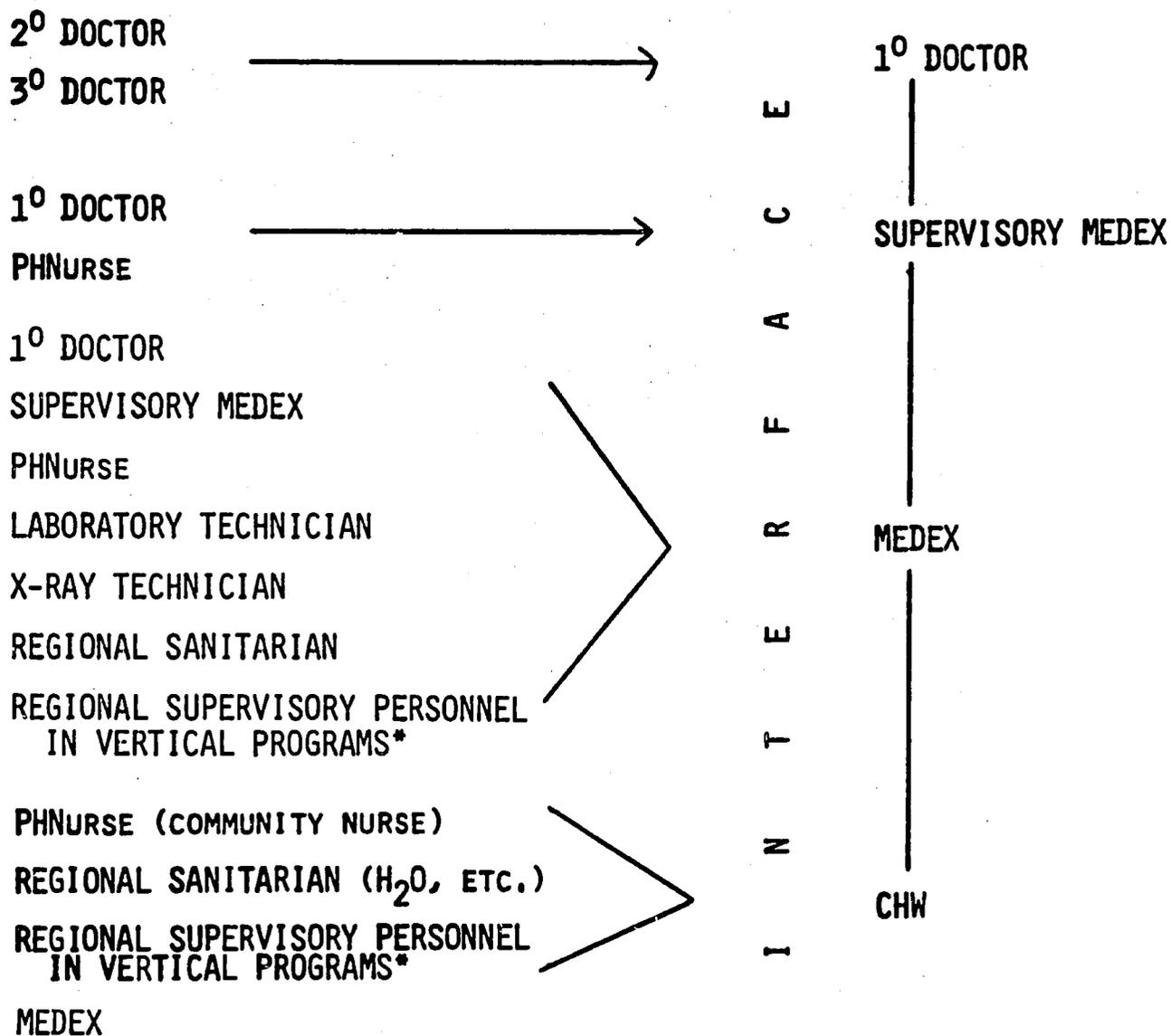
A manpower infrastructure should be developed which trains and deploys competent health workers to deliver decreasingly sophisticated health tasks as one moves towards the periphery. *FIGURE 1.* That structure should set the stage for using highly trained professionals in the best possible way, in concert with the primary health care workers. *FIGURE 2.* Each tier is involved in the training and supervision of the tier peripheral to it. Experience has shown that having MLHWs train and supervise CHWs is a most efficient way of obviating the problems associated with creating tutor training institutions and supervision of peripheral health workers. Also characteristic of this type of structure is the dependency of each tier on the tier central to it for referral.



*FIGURE 1*

243

### LEVELS OF INTERACTION AMONG PHC PERSONNEL



\*VERTICAL PROGRAMS:  
TUBERCULOSIS CONTROL, MALARIA, IMMUNIZATIONS,  
FAMILY SPACING, MCH, NUTRITION, ETC.

FIGURE 2

244

The greatest value of this type of structure is to have competent health manpower that stretches from center all the way out to the periphery. <sup>facilitates.</sup> FIGURE 3. This <sup>facilitates.</sup> the delivery of generalized essential services as well as specialized services promoted by vertical programs. The manpower, in this permanent structure, thus is not subject to the vagaries <sup>(the ups and downs of interest and resources)</sup> of specialized vertical programs.

For technical as well as cost containment reasons, many countries train present employees of the ministry of health as their mid-level health workers (e.g. nurses, dispensers, public health nurses, medical assistants, sanitarians, lady health visitors, vertical program personnel). Many of these workers have been forced by circumstances to do some tasks without prior training. These new programs provide an opportunity for workers to receive needed training for the essential tasks they must do. <sup>A</sup>To reduce governments' recurrent costs, CHWs are frequently supported by villages if the program is national in scope. Often the CHW is already a health service provider in the village (e.g., TBA, traditional medical practitioner). A mix of funding possibilities for CHWs exist:

- A. Village supports on a fee-for-service basis as they do present providers.
- B. Local or district political authority supports activities.
- C. Part-time volunteers.

245

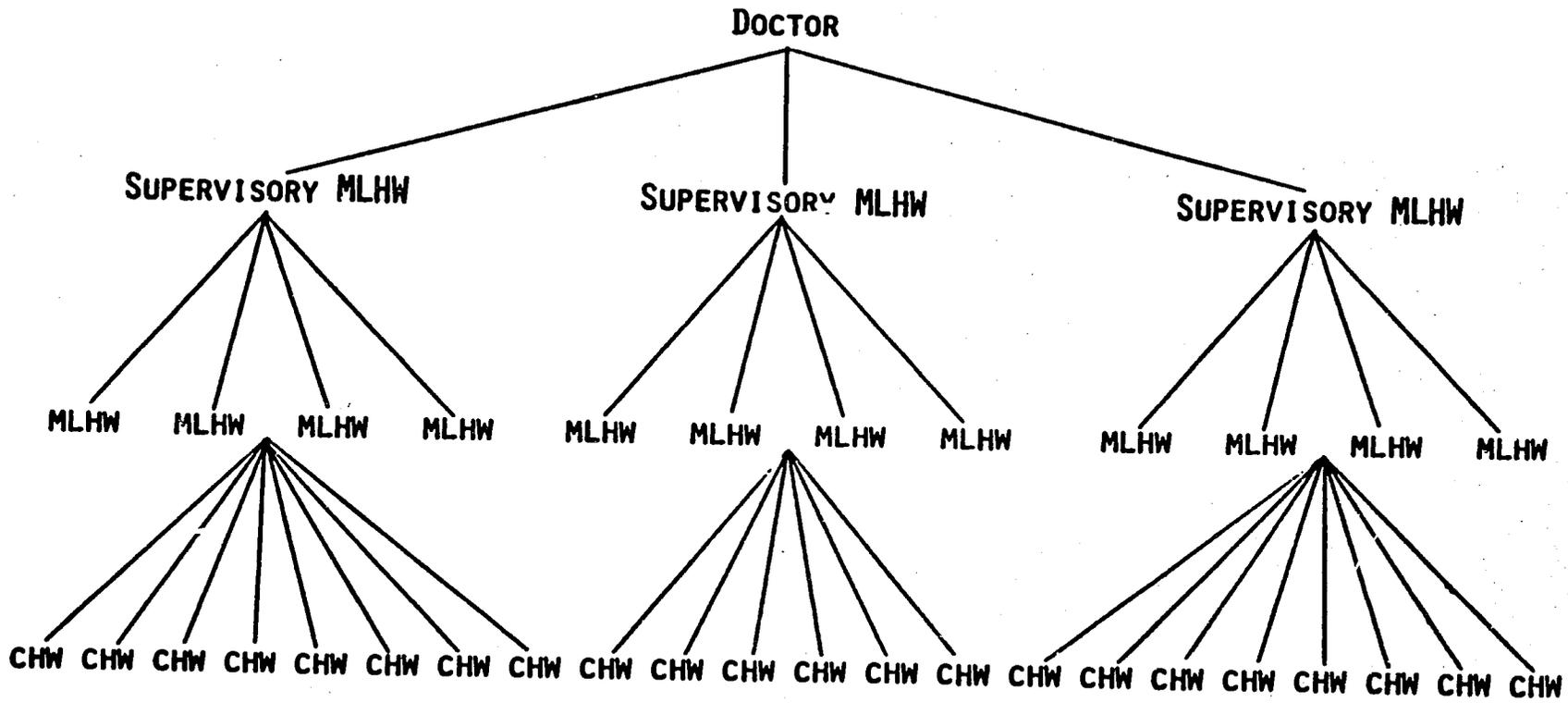


FIGURE 3

946

- D. District health center or hospital collects a surcharge for payment of CHWs.
- E. CHWs sell a one-time issue of medicines, replenishing supply and selling again.
- F. Village supports curative services and the government funds vertical preventive "campaigns." This is one approach that addresses the need for incentives to stimulate CHWs to provide preventive and promotive services as well as curative services. The need to find such incentives in each country is essential if long-term PHC services are to be available.
- G. Government pays total CHW salary.

### 3. USE EFFECTIVE AND EFFICIENT TRAINING METHODS

Varying approaches to training must be examined to determine which is most appropriate for a particular setting. There are traditional approaches which use standard textbooks, newly developed materials and/or ad hoc instruction. There are approaches which consider competency-based training and use selected teaching materials from various sources. Others teach educators methods of module development. Another approach uses available technology for the systematic country-specific adaptation of prototype training materials.

Collective experience dictates that manpower should be trained for competence. Competency-based training has been found very appropriate for training MLHWs and CHWs. Oral methods may have to be developed for training semi-literate and non-literate CHWs. There are a number of other approaches to training CHWs, including eliminating people of purely oral tradition from the CHW candidate pool, using materials prepared for literates or teaching literacy before training. By far the most effective and efficient approach to communities with low literacy rates is the use of oral methods of training.

Some of us have been working with field-tested prototype materials for health training and management training. These materials can be adapted by a developing country to <sup>accommodate</sup> its specific needs and resources. To date, this technology transfer and adaptation has occurred successfully in five different countries, saving immeasurable time and resources when compared to traditional approaches used in the past.

with special adaptation methods

#### 4. CONTINUING EDUCATION MADE PART OF STRATEGY

Evaluation of feedback from the field can be used to shape continuing education for primary health care. Built into the action strategy from the beginning and integrated with supervision and management, continuing education serves to reduce the time of initial training, upgrade performance and prevent the decay of skills and knowledge.

5. MID-LEVEL HEALTH WORKER USED AS CRITICAL LINK BETWEEN CENTER AND PERIPHERY

The mid-level worker can facilitate the combining of development strategies that "trickle down" or "bubble up". Mid-level health workers reduce the technical, social and cognitive distance between the district or center and the periphery. These personnel are important in helping villages organize for CHW selection, training and operations and in supporting the control exercised by villages over their health workers. This relationship once again emphasizes the critical training and supervision interlock that can exist between the MLHW and the CHW, a relationship which minimizes many of the serious problems encountered when CHWs are isolated from other parts of the health system. The MLHW acts as an interpreter and conduit of village needs from the periphery towards the center for integration into district and regional planning; he/she translates, facilitates and oversees governments' vertical "campaigns" into village-level action; he/she provides a mechanism for feedback from the periphery to the center on a multitude of additional matters. Importantly, he/she improves the accessibility, reliability, stability and longevity of PHC at the village level.

6. ANALYZE AND STRENGTHEN PHC MANAGEMENT SUPPORT SYSTEM

In order to strengthen the support of primary health care workers, the management support systems must be analyzed to determine where strengthening should occur. (Prototype systems analysis materials are available for adaptation to a country's individual problems.

The setting of priorities and strengthening of management support systems occurs through a number of mechanisms including the consolidation of resources, reduction of redundancies and other cost containment actions.

Rondinelli and others have aptly stated that if there is one single factor that can cause the failure of a development program, it is poor management. And management systems are where we see the most difficult problems in primary health care on a global scale.

7. ENCOURAGE DEVELOPMENT OF A PHC PLANNING CAPABILITY

A planning and evaluation system should be shaped to support PHC. It should enable a ministry of health to submit impact plans to the ministry of economic planning or the ministry of finance and other ministries which link intra- and inter-ministerial development efforts. Consolidation of resources producing cost effective and more efficient PHC operations are related to planning as well as to management. A management thrust may be the entrée to planning.

8. USE A SYSTEMS APPROACH TO RATIONALIZE THE ORGANIZATION OF THE PHC DELIVERY SYSTEM

If the organization which delivers primary health care services is viewed as a whole as well as a series of component parts, one can visualize the borders of what Katherine Elliot has described as the jigsaw puzzle of primary health care. A systems approach to the primary health care delivery system identifies the many parts of

the puzzle. However, as importantly, the approach clarifies how the parts relate to each other. Using a systems approach to the larger picture, action strategists with adequate political support can quickly:

- A. Reduce redundancies in structure and function.
- B. Promote consolidation of certain vertical program resources and PHC.
- C. Build on existing structures (without by-passing).
- D. Strengthen existing structures.
- E. Improve the practical functioning of horizontal relationships (within the ministry of health, with other ministries; relating public and private sectors).
- F. Improve practical functioning of vertical relationships with the ministry of health.
- G. Promote institutionalization of PHC by preventing PHC from developing as a vertical program.
- H. Promote self-sufficiency.
- I. Promote a *development* management perspective in the place of a *project* management perspective (see chart A).

251

## THE RELATIONSHIP OF PROJECT MANAGEMENT TO DEVELOPMENT MANAGEMENT \*

Development Management Approach		
Project Management Approach		
(1) Definition:	Specific inputs and output targets with defined intermediate events (end results oriented)	Broad long-range goals with phased inputs and flexible intermediate events (change process oriented)
(2) Objective:	Pilot/Demonstration	Permanently institutionalized improvements
(3) Scale:	Local or regional	Nationwide requiring national level commitment
(4) Time Frame:	Definite end point within 2 to 5 years	No definite end point
(5) Sectoral Involvement:	Usually one sector	Multiple sectors
(6) Institutional Involvement:	Usually few institutions	Usually many institutions
(7) Source of resources:	More from donors than from host country	More from host country than from donors
(8) Other donors:	Not usually involved	Often multiple donors with close coordination and collaboration required
(9) Impact on existing government bureaucracy:	Minimum, can by-pass	Maximum, should improve on what exists
(10) Political involvement:	Relatively little at national level; could be significant at local level	Should be significant at all levels
(11) Technical Assistance inputs:	For planning, implementing and evaluating	For advising and training host country counterparts
(12) Technical Assistance objectives:	To satisfy donor and host country by achieving output targets within time frame	To develop permanent self-sufficiency by the host country in planning, training and management
(13) Likelihood of showing short-term effects:	High	Low
(14) Likelihood of broad benefits if successful:	Low	High
(15) Evaluation:	Primarily to satisfy donor and host country re impact replicability, assimilation and general worthiness of Project	Primarily to provide feedback for improving ongoing planning and operations efforts

CHART A

\* Developed by Ernest E. Petrich and Eugene M. Boostrom (Health Manpower Development Staff, School of Medicine, University of Hawaii, Honolulu, Hawaii, U. S. A.)

252

9. OBTAIN A NATIONAL COMMITMENT

A national commitment enhances the development of a broad base of support for primary health care, helps mobilize resources and sets the stage for the systems changes which must occur for a large-scale national program to be developed. Primary Health care program parts brought together through a political mandate increase the potential to institutionalize for permanence and self-sufficiency.

10. USE COUNTRY-SPECIFIC PHC STRATEGY TO PLAN RESOURCE APPLICATION

The action strategy that results from a rationale such as this not only promotes the appropriate allocation of available resources but also prepares a coherent, comprehensive and rational basis for obtaining external resources. Such an action strategy can lead to a quality primary health care program that is cost-effective and efficient. Moreover, the program would be characterized by consolidation of resources and organizational support structures, with minimized redundancy. In addition, this kind of action strategy will permit the use of appropriate technology that has been adapted to a nation's special problems and resources for the strengthening of manpower and systems. Finally, a good action strategy will provide more alternatives with regard to independence or reliance on outside assistance.

INTERVENTION POINTS  
IN  
PHC DEVELOPMENT

TRAINING DEVELOPMENT/STRENGTHENING

SYSTEMS DEVELOPMENT/STRENGTHENING

- A. PREPARATION OF HEALTH PERSONNEL
  - COMMUNITY HEALTH WORKERS
  - MIDDLE LEVEL HEALTH WORKERS
  - MLHW (SUPERVISORY)
  - PHYSICIANS
- B. PREPARATION OF SUPPORT PERSONNEL
  - TUTORS
  - ADMINISTRATORS
  - PLANNING SPECIALISTS
  - MANAGEMENT SPECIALISTS
- C. CONTINUING EDUCATION
  - COMMUNITY HEALTH WORKERS
  - MIDDLE-LEVEL HEALTH WORKERS

- A. ORGANIZATION OF DELIVERY SYSTEM
- B. PHC PLANNING SYSTEM
- C. MANAGEMENT SYSTEMS
  - FINANCE
  - PERSONNEL
  - FACILITIES/EQUIPMENT
  - SUPPLY
  - TRANSPORTATION
  - COMMUNICATION
  - INFORMATION

CHART B

254

# A RATIONALE TO DEVELOP A COUNTRY-SPECIFIC PHC ACTION STRATEGY

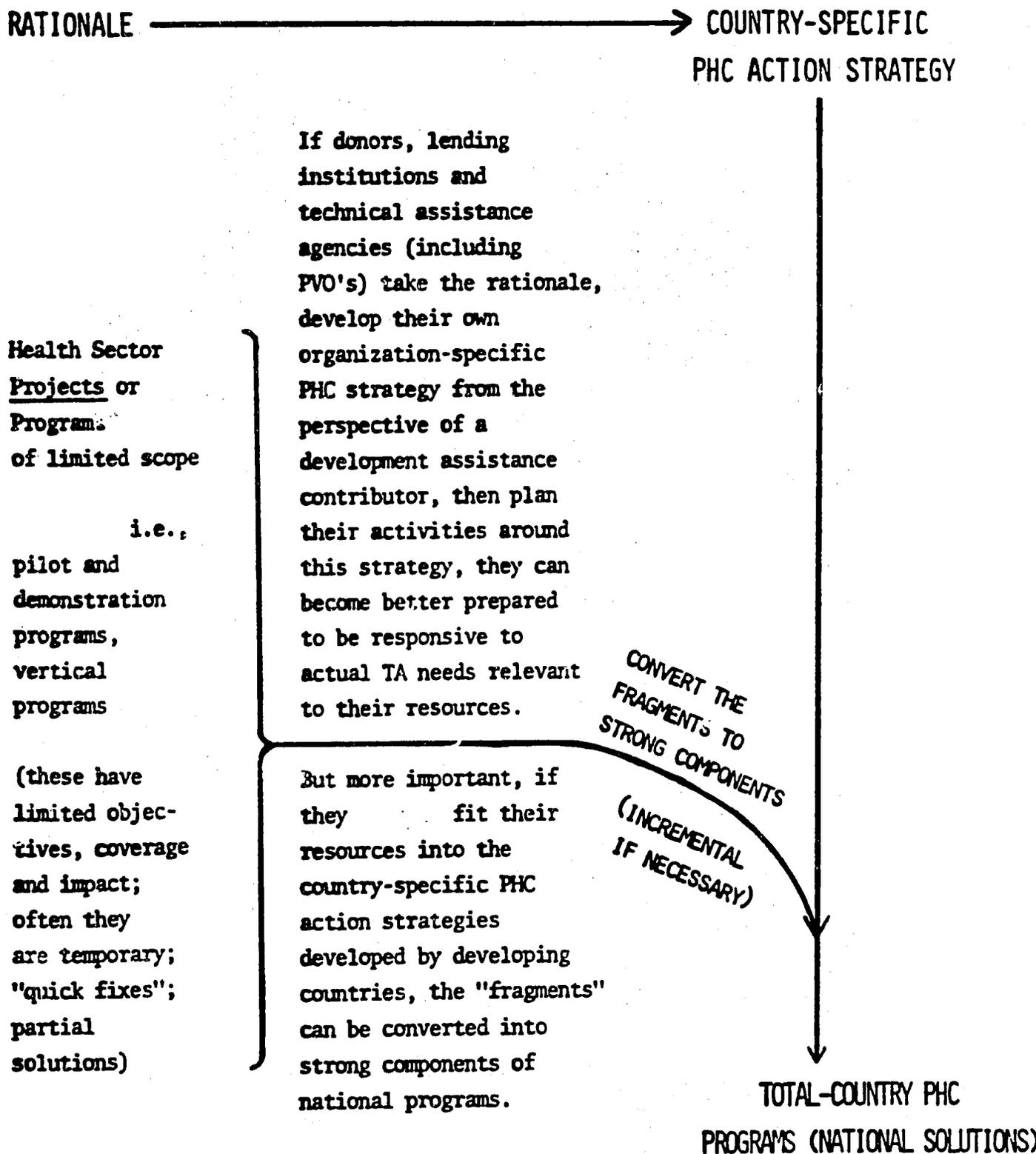


FIGURE 4

It should be obvious that the rationale being discussed has focused on the two critical intervention points in primary health care: Manpower Development and Systems Development. (See Chart B.) It may not be possible to implement a PHC action strategy that simultaneously affects all the facets described under personnel and systems development. With this rationale, however, strategists can visualize the interdigitation of the major components of PHC and plan a strategy that has direction and attainable objectives, to be reached incrementally if necessary. Moreover, inputs into the PHC system can be planned against the backdrop of the total (ideal) framework needed. "Bits and pieces," small health projects, vertical program resources and unsolicited contributions can be fit into a rational and coherent action strategy with minimum dislocation of personnel and resources. Responsibility for governance of PHC development resides in the professionals of a country. Foreigners will need constant guidance to work most effectively with their colleagues.

It is necessary for developing countries to formulate action strategies for PHC. Likewise it makes sense for international institutions and organizations to develop action strategies of their own. An organization's strategy will naturally be most productive if its aims mesh with the strategies of the countries with which it collaborates.

*FIGURE 4* summarizes the steps developing countries can take in concert with international entities to convert what might be called partial solutions (small projects, parts of vertical programs) into strong components of strong national solutions in the form of a PHC program that is country-wide.

256

Chart C summarizes the major differences between the action strategy rational for PHC described in this paper and the more traditional approaches to PHC.

257

CHARACTERISTIC DIFFERENCES IN APPROACHES TO PHC DEVELOPMENT \*

ACTION STRATEGY SYSTEMS APPROACH (Development Management)	TRADITIONAL APPROACHES (Project Management)  (pilot projects; demonstration projects; etc.)
(1) National in scope, an integral part of a national development strategy for PHC.	Usually quite limited in scope - by perspective - by geographic area - by program components
(2) Comprehensive systems perspective and implementation process.	Usually much less comprehensive in focus and/or implementation.
(3) Seeks to work with and build upon existing health system/s.	Often seeks to introduce entirely new operations outside existing system/s.
(4) Operational (action research) approach to planning.	More traditional static (or blueprint) approach to planning.
(5) Development approach to management: organization development and institution building.	More traditional approach to management, if included.
(6) Tiered system with MLHW's and CHW's, and infrastructure support for both.	Usually one level only--MLHW's or CHW's, frequently without adequate infrastructure support.
(7) Multi-functional workers and systems flexibility to respond to local variations and changing needs and priorities.	Usually workers with narrower training and responsibilities, and less systems flexibility to change.
(8) Competency-based training methods, including nonformal training techniques to meet specific needs of non- or semi-literate CHW's.	Usually traditional educational methods, if training is a project component.
(9) Use of field tested training and systems prototype materials for adaptation to specific needs of country.	Development of training materials on site through use of library and other miscellaneous sources.

\*Developed by Ernest E. Petrich and Lindsay M. Robinson (Health Manpower Development Staff, School of Medicine, University of Hawaii, Honolulu, Hawaii).

CHART C

258

Action strategies based on this rationale can be used to coordinate a mixture of public, private and voluntary organizations within a country to strengthen and expand its PHC program. Such a strategy provides a developing country with a framework to direct and focus the available resources of technical assistance agencies, international organizations, lending institutions, and private voluntary organizations. In this way, coordination of external inputs can strengthen PHC by increasing the appropriateness of all such inputs while strengthening the control of resources by national governments. Further, it appears that most international institutions would welcome the opportunity to finally move beyond PHC policy statements to action strategies based on field experiences that can be implemented and that are compatible with the real needs of developing countries.

PHC action strategies that work, based upon this or similar rationales, can be developed if available collective knowledge, experience and technology is harnessed and brought to bear on a country's specific problems. The mechanisms for bringing these collective ingredients together are available. The success of PHC thus does not have to depend upon serendipity<sup>or reinvention of medical wheels,</sup> but rather upon the shared experiences, technology and goodwill of all of us involved in improving the total well-being of people.

Targeting Sanitation Programmes  
Where it Counts: Mothers of Small Children

by

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260

## Targeting Sanitation Programs Where it Counts: Mothers of Small Children

Sanitation programs in rural areas of developing countries overlook frequently segments of the population that are most vulnerable to the ill effects of inadequate sanitation and at the same time in the past position to serve as agents of change. Unlikely as it may seem, infants, small children and their mothers form the population group to which sanitation programs should most be addressed. In the following sections the rationale, methods, and expected results of such targeting are examined.

### Rationale for targeting sanitation programs to mothers of small children.

Although usually considered to be innocent, the stools of infants and small children have in fact greater numbers of microorganisms per unit of weight than do those of older children and adults (Feachem, R. et. al, 1981). For this reason alone small children deserve special consideration in the planning and execution of sanitation programs. Means must be found to protect the environment against this highly infectious source of contamination.

From the stools of infants and small children contamination spreads to the environment through multiple routes (see Fig. 1). Via contaminated fingers of the child or his mother, microorganisms are transmitted (Academy for Educational Development, 1980):

- to household objects: especially cups, spoons, and other utensils associated with food and drink;
- to food itself;
- to water transported or stored;
- to the hands of other children;
- ultimately to the mouths of other susceptible individuals.

Under any circumstances there is a certain attrition in the number of bacteria as they are spread from the source into the environment. It stands to reason then that if the source (an infant or child's stool) has an initially high concentration of microorganisms, the natural attrition will have less of an impact and the ultimate dose delivered to the mouth of a susceptible individual will be greater. Special efforts must therefore be taken to protect the environment from the stools of infants and small children.

Fortunately, the habits of infants and small children are relatively malleable. Their general dependence on their mothers and older siblings, their strong tendency to imitate adult behavior, and their love of routine games and procedures frequently make the introduction of new habits a simple matter. If mothers and older siblings can be trained to dispose of the stools of infants and children in an adequate way, these little ones will usually respond. The payoff from focusing sanitation programs on mothers therefore is likely to be great.

The results may also be permanent. Hygienic stool habits once established in young children are likely to remain and may even be transmitted to future generations. When one considers that many young women become mothers at age fifteen or earlier, it becomes apparent that stool habits if reinforced through the first five years of life might stand a good chance of survival into emergent motherhood. Jelliffe (1968) has demonstrated that when mothers of malnourished infants learn that they can contribute to their infants' recovery by feeding them nutritious local foods, they tend to transmit improved weaning foods and practices to their daughters. Could not the same phenomenon occur in the case of stool habits?

262

The final advantage of focusing sanitation programmes on this group of the population is the opportunity afforded to conserve scarce human resources: sanitarians, health inspectors, health educators, and community health workers. Rather than diluting these resources by spreading them across an entire population, one can apply them where the impact is likely to be the greatest and the most permanent. We shall see in the next section just how these resources can be applied.

Methods for bringing sanitation programs to bear on the mothers of infants and small children.

Child-sized latrines.

The first requirement of an effective sanitation programme aimed at infants and small children is a child-sized latrine conveniently located. Features of importance include: the proportions of the plate, the size of the hole, the proximity to the house, and the availability of soap and water.

Typical adult-sized latrines (simple pit latrines or improved latrines and aquaprivies) present to the small child a fearsome combination of a dark interior, a large, dark, deep hole, a plate too large to accommodate the feet, and a long walk back to the house...scarcely an encouragement to their use. In Sri Lanka, reportedly, (Elmendorf, 1980) a child's latrine has been developed which is located conveniently in the patio just behind the house. The design is such that even a toddler can confidently go out through the back door, squat on the child-sized plate, with no fear of falling into the small hole. A table with a basin of water and soap permits the mother or older child to clean the child after defecation. The small size of the structure and the hole, and the relatively small volume of fecal matter should make it possible to maintain this latrine without risk to the environment for 1 - 1½ years before digging a new pit.

263

An alternative technique, used in several countries has been to place a child-sized plate over the normal adult plate, but this approach while reducing the fear of falling into the hole, still obligates the youngster to walk several hundred feet from the house.

For children under 18-24 months (that is before the time when most become interested in imitating adult defecation habits) the problem is different. Although there is considerable variation from culture to culture, the usual defecation practice consists of either fitting the infant with a diaper, trying to catch the infant's stool in a cloth or a piece of the mother's wrap-around dress, simply holding the defecating infant extended over the ground or the floor of the house, or in the case of toddlers, allowing them to wander about nude below the waist. Effective approaches to this age group must therefore focus on altering maternal behavior regarding disposal of diapers and soiled pieces of cloth and holding the defecating infant over a receptacle rather than over the ground or floor. The mobile toddler who defecates here and there in the environment poses the greatest problem. The only feasible approach seems to be for these children to wear a protective pair of shorts to be disposed of hygienically when soiled.

It should seem obvious that none of the above measures is possible without the cooperation of the mothers of infants and young children, older siblings, and other caretakers, such as grandmothers and other older relatives. Sanitation programmes, if properly focused, will carry with them a heavy input of health education. The objectives, messages, methods and possible settings for effective health education in relation to sanitation are discussed in the next section.

Health education of mothers and older siblings.

The objectives of health education in this case are behavioral and attitudinal. Methods used should aim at mobilizing mothers and others who care for children: (1) to insist on the design and installation of child-sized latrines or child-sized adaptations of adult latrines, (2) to provide soap and water for cleaning the child afterward, (3) to use diapers or an adequate wrap of another type on infants and young toddlers, and (4) most importantly to work with the child over 18-24 months in developing continuous latrine-use habits. Closely associated with the latter is the imperative of providing a role model for the small child to follow.

The message central to the health education component is that the stools of infants and children are dangerous and therefore to be avoided by every means possible so as to prevent diarrhea and dehydration. The purpose is to create in mothers and others who care for children an attitude supportive of those actions to be undertaken. The message can be transmitted by whatever means available: radiodiffusion, posters, talks at the health center, in the schools, in political meetings, at meetings of the village health committee, the credit cooperative, the women's association, and in the market place, i.e., wherever groups of mothers and young girls can be found.

Primary attention should be given to the methods used for mobilizing the target group. Ogionwo (1972) has shown that behavioral attitudes are more likely to change in the context of a community support structure than when an individualistic approach is used. Others (Isely and Martin, 1977; Isely, 1978, Fountain, 1973) have demonstrated the advantages of concerted effort for achieving concrete results in water and sanitation. A first requisite of health education methods applied to those

who care for young children then, is to obtain the support of community leaders, various types opinion-shapers, and persons of status. In this way a positively reinforcing context for expected changes in behavior can be created.

Key members of the leadership group are leading women of various families, particularly if these women are respected for their skills in midwifery, healing, or herbalism. Satgé and co-workers (1964) have emphasized the importance of village midwives in influencing the weaning behavior of younger women in Senegalese (Wolof) villages.

Within the context of the community support structure one should address the problems to smaller mutually-supportive groups of women. Women leaders identified earlier might be the primary catalyzers of these meetings. The accent should be on group identity of solutions to problems:

- Technical problems of constructing and locating child-sized latrines.
- Personal problems of training toddlers to use them.
- Practical problems of keeping track of toddlers too young to use the latrine and keeping them clothed.
- Economic problems of having soap and water in constant supply.
- Other problems related to disposal of pieces of cloth soiled by infants' stools, care of the child's stools when traveling, when at the market, or when the child is in care of a grandmother who "thinks differently".

266

The essence of the approach is to use the means already available in most communities for women to help each other with their child care problems.

In most cases the setting for health education efforts associated with a sanitation program should be a community itself. A community may encompass an entire village or urban neighborhood or only a part thereof. It is frequently necessary to identify the true "community" within what is only assumed to be a community, for example a village composed of many clans. In many societies these communities defined by kinship relations are the only viable contexts for effective community organization work.

Work in other settings should serve to supplement that taking place in a community. The schools represent particularly useful context because of the availability of a skilled teacher and the presence of pubertal and late pre-pubertal girls, many of whom are already thinking of motherhood and who generally respond quite positively to the teaching of child care methods.

Some advantage should also be taken of health centers and hospitals where women whose infants are suffering from episodes of diarrhea and dehydration may be more open to teaching about prevention. The Health Belief Model (Becker and Maiman, 1975) holds that if the threat of the condition to be prevented is greater than the inconvenience of the preventive measure, the individual will exercise the preventive option, assuming that sufficient information is available and the surrounding socio-cultural conditions supportive.

Expected results of targeting sanitation programs to mothers of small children.

If some or all of the changes mentioned earlier can be achieved, then certain beneficial results can be expected. Three probably results are supposed:

- o After 2-3 years of consistent training, children at age five should be habituated to latrine use, and thus hopefully able to continue the practice into older childhood and adulthood.
- o As young mothers and other young persons engage in changing the defecation patterns of infants and small children, they themselves develop new habits of child care which they can pass on to subsequent children and subsequent generations of children. Likewise, children who learn to use a latrine when they are very young, may train their own children.
- o Child-size latrines, use of diapers or other coverings for young toddlers and infants, and proper use of soap and water for anal cleansing and hand washing should lead to diminished contamination of the environment by fecal pathogens.

Conclusions

Infants and small children, whose stools have the greatest potential for contaminating the environment deserve special targeting in sanitation programmes. Despite the relative ease of introducing behavioral change in these small children, however, such change is necessarily dependent upon the

availability of a child-sized latrine, and on the cooperation of mothers and others who care for them. The latter can be achieved only through a participatory approach to health education. If these approaches are effective, beneficial results can be expected: children who know how to use a latrine, young mothers ready to teach latrine use to subsequent children and subsequent generations, and fewer intestinal pathogens in the environment.

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**7. Sample Evaluation Form and Results of Tabulation**

Based on 148 returned questionnaires

WORLD FEDERATION OF PUBLIC HEALTH ASSOCIATIONS  
FEDERATION MONDIALE DES ASSOCIATIONS DE LA SANTE PUBLIQUE

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EVALUATION FORM  
WFPHA THIRD INTERNATIONAL CONGRESS  
CALCUTTA, INDIA  
FEBRUARY 23-26, 1981

PLEASE FILL OUT THIS EVALUATION FORM ON YOUR LAST DAY AT THE CONGRESS AND LEAVE IT WITH THE CONGRESS OFFICE IN THE GRAND HOTEL OR AT THE GRAND HOTEL RECEPTION DESK.

I Participant Data

1. Country represented : \_\_\_\_\_
2. Professional position : (check one) : \_\_\_\_\_governmental\_\_\_\_\_ non-governmental on following level (check one) : \_\_\_\_\_ international\_\_\_\_\_regional\_\_\_\_\_national\_\_\_\_\_local.
3. Attendance at Congress stimulated by (check one) : \_\_\_\_\_invitation\_\_\_\_\_ publicity in journals or other publications\_\_\_\_\_ designation by government or international organisation.

II Content

1. I attended the following sessions :

<u>141</u> Inaugural	<u>48</u> 301 (Workshop-National Plans)
<u>134</u> 101 (Keynote)	<u>23</u> 302 (Workshop-Field Programs)
<u>129</u> 201 (Overview)	<u>28</u> 303 (Workshop-Manpower)
<u>82</u> 202 (Workshop-National Plans)	<u>28</u> 304 (Workshop-Special Projects)
<u>33</u> 203 (Workshop-Field Programs)	<u>53</u> 305 (Workshop-Community Participation)
<u>50</u> 204 (Workshop-Manpower)	<u>108</u> 306 (Regional Strategies)
<u>24</u> 205 (Workshop-Special Projects)	<u>113</u> 307 (Concluding Session)
<u>58</u> 206 (Workshop-Community Participation)	

272

- b. 301 Kalyan Bagchi Nutrition in PHC  
 g. 202 N.H. Antia PHC Strategy for Action  
 h. 306 Dr. S. Kessler Role of Prof. Orgs.  
 i. 201 Dr. T. Baker Manpower  
 j. 307 A.P. (Raj) Phasic Developments  
 k. 202 Dr. R. Smith Developing Nat'l Plans of Action  
 l. 306 S.C. Seal Role of Voluntary Orgs.

2. I took part in the field visit to Singur: —yes—no

3. I consider these the five best presentations in both plenary and workshop sessions:

	<u>Session No.</u>	<u>Presenter</u>	<u>Topic</u>
a.	<u>201</u>	<u>Dr. D. Morley</u>	<u>Health for All Children by 2000</u>
b.	<u>101</u>	<u>James Grant</u>	<u>HFA: Sincere Commitment or Cheap Hoo</u>
c.	<u>201</u>	<u>Dr. C. Taylor</u>	<u>Manpower</u>
d.	<u>306</u>	<u>Mya Tu</u>	<u>Regional Strategy for SEARO</u>
e.	<u>201</u>	<u>Dr. S. Banoub</u>	<u>Nat'l Plans of Action</u>

4. The two subjects of greatest interest to me were:

- a. Community Participation  
 b. Manpower Planning & Training

5. The balance among plenary sessions/presentation of papers/discussion was (check one):

- 48 appropriate  
24 could have included more plenary sessions  
23 could have included more presentations of papers  
100 could have included more discussion

6. The Congress was (check one):

- 77 of direct value to my work  
63 stimulating, but not of direct value  
2 not relevant

7. The most valuable part of the Congress was (check one):

- 30 meeting colleagues from different areas  
104 hearing about new ideas and sharing experiences  
16 learning about specific country programs  
4 visiting Calcutta

8. The Congress offered an opportunity to (check one):

- 120 meet colleagues from other countries  
33 meet colleagues from my own country  
6 neither

273

5 abstracts of all workshop presentations and overview session presentations

4 synopses and/or highlights of discussions during various sessions

9 examples from field programs

8 index of presenters

4 index of Congress participants

6 conclusions regarding lessons learned

\_\_\_\_\_ other (specify) \_\_\_\_\_

2. I would be interested in purchasing the proceedings : 81 yes 35 no.

3. I would recommend that the following individuals be contacted regarding purchase of proceedings :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THANK YOU FOR YOUR COOPERATION

275

9. The Congress was successful in acquainting me with some innovative approaches: 99 yes 48 no

Specify : see additional sheet

10. Congress documentation was ( check one ):

116 useful 25 not useful

Comments : \_\_\_\_\_

11. Overall, the Congress met my expectations ( check one ):

20 minimally 44 somewhat 63 quite a bit

15 exceeded them. 2 disheartening

### III Logistics

1. Overall organization

29 excellent 77 good 31 fair 9 poor

2. Transportation

17 excellent 54 good 42 fair 24 poor

3. Facilities

35 excellent 70 good 29 fair 8 poor

4. Cultural events

60 excellent 58 good 14 fair 4 poor

5. Meals

69 excellent 61 good 10 fair 2 poor

Comments : \_\_\_\_\_

### IV Congress Proceedings

1. I would recommend inclusion of the following in the proceedings (rank in order of priority beginning with number 1):

1 full text of major plenary speeches

3 full text of key workshop presentations

2 excerpts from presentations that focus on innovations