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expanding primary health care from projects to programs: report from a workshop

AMERICAN PUBLIC HEALTH ASSOCIATION

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EXPANDING PRIMARY HEALTH CARE FROM PROJECTS TO PROGRAMS:

REPORT FROM A WORKSHOP*

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LIST OF ABBREVIATIONS USED IN THIS REPORT

APHA	American Public Health Association
CHW	Community health worker
CP	Community participation
FP	Family planning
ICMR	Indian Council of Medical Research
LDC	Less developed country
MCH	Maternal and child health
MOH	Ministry of Health
NGO	Nongovernmental organization
PAHO	Pan American Health Organization
PHC	Primary health care
PVO	Private voluntary organization
TBA	Traditional birth attendant
UN	United Nations
UNICEF	United Nations Children's Fund
VHW	Village health worker

PREFACE

The question "can health and nutrition interventions make a difference?" is asked less frequently today than just five years ago. Experience has shown that basic health and nutrition interventions carried out in small- to medium-size projects can substantially reduce morbidity and mortality, especially among vulnerable groups.

Can the same activities which lead to reduced morbidity and mortality in small- to medium-size projects be scaled up to regional and national programs? What are the factors which aid or obstruct this scaling-up process? These are questions addressed in this report of a workshop on expansion of PHC organized by the International Health Programs staff of the American Public Health Association with the assistance of David Pyle, Joe Wray and Janet Wilcox.

The workshop, which was held December 14-16, 1981 at Coolfont, West Virginia, brought together participants who shared their field experience with a number of primary health care projects. A list of participants and their project affiliations is included in the appendix. Special thanks are due to Ronald O'Connor, John Field, Rita Thapa, Lessel David, Carl Taylor, Nicholas Cunningham, Susan Cole-King, Hossain Ronaghey, Rod Powell, Stanley Scheyer, Lukas Hendrata, and Don Ferguson for serving as discussion leaders for the workshop.

Each chapter of the report contains introductory material, some of which has been excerpted from "Implementing Primary Health Care," a paper commissioned by APHA and written by Morris Schaefer, Susi Kessler, and Betsy Stephens (APHA, 1981). In the discussion sections which follow each introduction, remarks attributed to participants are not direct quotations, but paraphrases. These paraphrased remarks have been edited for clarity and consistency.

The workshop and this report are part of an ongoing effort by International Health Programs of APHA to provide an overview of developments in primary health care for health professionals, program managers, and decision makers who plan and implement health programs around the world. This work is supported by the Office of Health, Agency for International Development, Contract DSPE-C-0053.

Chapter I

INTRODUCTION

A prominent failure of modern medicine has been its inability to deliver the benefits of fifty years of technical development to the large majority of humankind who need it most. Historically, most health funds in developing countries have been spent on urban hospitals and medical personnel. The theory was that the benefits of introducing modern health technology to developing countries would gradually "trickle down" and, as more doctors and nurses were trained and facilities were constructed, more people would be served. In fact, what has happened in most countries is that the high cost of doctors and hospitals has consumed an inordinate proportion of the budget, and health services have reached only a minority.

New ways to bridge the gap between rising expectations and the generally poor performance of health systems have long been a goal of experts and organizations engaged in international development. To this search can be attributed the emergence of the concept of primary health care (PHC), which the Declaration of Alma-Ata* defines as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation and at a cost that the community and country can afford."

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* In September 1978, an "International Conference on Primary Health Care" was convened at Alma-Ata, USSR. Attended by representatives of 134 countries, international and bilateral agencies, and many nongovernmental organizations (NGOs), the conference resulted in a declaration which proclaimed the goal of "Health for All by the Year 2000."

There is no universal formula for organizing primary health care; however, certain themes distinguish it. In contrast to earlier approaches, PHC makes maximum use of local resources and promotes personal and community self-reliance to ensure that health care remains affordable and accessible. Ideally, PHC services, including prevention, treatment, promotion, and rehabilitation, are integrated. PHC seeks to extend health services to the most peripheral areas possible, using trained community health workers. It attempts to reorganize other health service echelons to support peripheral activities by providing referral facilities, technical assistance, and supplies. And PHC promotes coordination between the health sector and other development sectors, such as agriculture, housing, public works, and communications.

A significant number of health and nutrition projects which incorporate elements of primary health care have been implemented around the world in the last three decades. Some of these projects have achieved impressive results in reducing mortality and morbidity. Gwatkin, Wilcox, and Wray (1980) reviewed the results of ten such projects and concluded that significant benefits can be obtained at a cost even poor nations can afford. However, what is achievable in a small- to medium-size project may or may not be achievable in a national or large-scale program.

The transition from a successful smaller project to a large-scale primary care program is not easily accomplished. The independence and small size of many PHC projects are widely thought to be significant factors in such projects' ability to provide effective services. One of the major challenges to those who plan expanded primary care programs is to determine how the effective elements of successful pilot projects can be replicated with minimal loss of impact in large-scale efforts operating under normal bureaucratic constraints.

The mobilization of a political constituency for primary health care is necessary to implement PHC at the regional or national level. Successful implementation also requires adequate supply to, and communication with, remote health posts; realistic task-oriented training and supervision for peripheral health workers; and the organization and stimulation of communities to participate in preventive and promotive health activities.

The task of implementing PHC strategies on the scale required to achieve broad coverage is complex. It requires the application of lessons learned from earlier and successful pilot efforts, and, equally important, the sharing of information to cope with and resolve the many difficulties that inhere to the PHC approach. Desirable goals, recommendations, guidelines, and theory abound in the growing literature on primary health care. But hard and critical assessments on how the elements of primary health care work in practice are scarce.

The knowledge and experience of the persons responsible for planning and for the day-to-day operation of primary health care projects, whether small or large, are among the most valuable, but least available, resources for PHC. It is, therefore, the purpose of this report to help remedy this situation by presenting the highlights of a workshop on primary health care at which participants with experience in 18 primary health care projects and programs shared their knowledge.

The primary objective of the workshop was to document the experience gained by the participants and provide for an exchange of lessons learned. In the short time available, it was not feasible to try to arrive at a general consensus; however, a number of conclusions and recommendations emerged in the course of the discussions. These are highlighted in the following chapters and summarized in Chapter X.

Chapter II

PROJECT TYPE AND STRATEGY

That the concept of PHC is "taking hold" is evident. Many governments have formulated national policies, strategies, and plans of action to launch and sustain PHC as a part of a comprehensive, national health system in coordination with other sectors. Successful small pilot and demonstration projects as well as a limited number of significant large-scale efforts have contributed much to the emerging concept of PHC. The real problem now is to determine how successful efforts can be replicated or extended more widely.

It is imperative to demonstrate that it is possible to apply the philosophy of PHC in other than pilot or demonstration projects. If real progress is not demonstrated, there is danger that the movement will become discredited, as some community-based strategies have been discredited in the past.

In order to scale up from small to large projects, it appears to be essential to have some government participation at all stages of a project. If universities, nongovernmental organizations or other agencies develop and carry out projects with little or no government participation, it will be very difficult for a government eventually to institutionalize these projects and implement them on a larger scale.

In order to clarify the foregoing discussion, projects can be classified into four categories, depending on their immediate objectives (all having the long-range objective of improving health): experimental and research efforts; demonstration projects; pilot projects; and action and service projects. A project's objective must be clearly stated so that expectations about results will be realistic and disillusionment avoided. The purposes and principal actors in each of these four kinds of projects are listed below.

Project Type	Purpose	Principal Actors
Experimental/ Research	Validate knowledge and technology	Researchers, often universities or NGOs
Demonstration	Show that something can be done	NGOs
Pilot	Develop support systems or operations to apply technologies	Governments

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Project Type	Purpose	Principal Actors
Action/Service	Deliver services	Project administrators

A further elaboration of the distinctions between demonstration and pilot projects may be useful, since they relate so differently to the scaling-up process. In essence, demonstration projects are intended to show that something can be done in an environment, or that some goals can be attained by virtue of doing certain things in certain ways. Accordingly, the inputs and operational characteristics are often exceptional and extremely difficult to replicate on an expanded scale. By contrast, pilot projects represent the humble beginnings of what is to be a larger (action/service) program in which the input ingredients and operational characteristics remain much the same as the effort unfolds. Pilot projects are supposed to be complete or near-complete microcosms of the macro program, the only real difference being scale. Demonstration projects, on the other hand, typically feature distinctive managerial, manpower, logistical, and process attributes and direct replication is usually not expected. Problems arise when this distinction is overlooked and governments attempt to expand demonstration projects which have developed in isolation from the bureaucracy.

Discussion: Project Type

FIELD: Project type is determined by purpose. Each type of project has implications for replication. The experimental/research project addresses the question of scientific validity and tests technologies or methods. Consequently, it is more highly structured than other kinds of projects and follows rigid protocols. The environment is controlled for the purpose of the exercise. Often the results are scientifically, but not necessary operationally, replicable.

TAYLOR: The research project focuses on whether an intervention works - its effectiveness, cost/effectiveness, and contribution to equity; in contrast, the demonstration project attempts to achieve effectiveness under field (real world) conditions.

WRAY: My experience has taught me that project designers are often confused about what they want to do; that is, conduct research or provide services. Service projects (often the best PHC projects) lack documentation, because they are concerned with service delivery. Research projects become immersed in the details of research and lose sight of the goal of PHC efforts: to provide basic services. We need to demonstrate to doubting policymakers and planners that a simple package of services can be delivered. And in demonstrating this fact, we can encourage program development.

PYLE: The Poshak Project in India demonstrates that project designers, directors, and government agencies considering expansion need to be conscious of their expectations. A project that simultaneously attempts to be both a research project and a demonstration project will be marked by conflicting priorities that will cause complications when it is time to expand.

O'CONNOR: Do we need more experimental and research projects in PHC? We already have technical knowledge. Now we must concentrate our efforts on ways to deliver that knowledge. However, for political reasons -- that is, to show governments that an intervention works -- experimental projects may still be necessary.

COLE-KING: Do we really require more research on effectiveness? We already know about the effectiveness of many interventions (e.g., immunization and breastfeeding), but we do not seem to be able to get them to people.

CURLIN: The efficacy of some vaccines (e.g., cholera and BCG) is still in question.

TAYLOR: That the same approaches continue to be used in small-scale projects indicates that they have an inner logic.

We should benefit from accumulated experience. But we find that it is impossible to keep project types distinct. The Narangwal project in India was undoubtedly primarily research in orientation, but it had the elements of both demonstration and action programs. How we proceed from a small-scale effort to a mass program should not be an intuitive or a chance process; it should be a specific question for a new kind of adaptive research.

WERNER: The Piaxtla Project in Mexico basically responded to a need. Although it never intended to do more than provide immediate service, the project has, in the mind of some, developed into a demonstration or pilot project. In fact, it contains the elements of the different kinds of project: the experimental and research project that investigates how things can be done better; the demonstration or pilot project that provides answers to problems; and the action and service project that helps people to meet their own needs.

COLE-KING: Project types are not discrete. What is important is that a demonstration area be provided which can serve as a laboratory to adapt and alter the approach and apply the experience to the national program. Such a site could also serve as a training facility.

FERGUSON: Another concern is sponsorship of a project. Funders' objectives can, and often do, differ, and the differences seriously affect the scaling-up process. Of the ten projects reviewed in the Gwatkin monograph, eight were run by universities. To gain government commitment and effective support, the involvement of the funders and principal actors is necessary at the outset. And this must be more than nominal involvement. Active participation will increase sponsors' willingness to expand a proven approach.

PYLE: The true test of an approach is to study it in a realistic environment. Only in this way can constraints that will face a large program be clearly identified. For example, participatory management, supportive supervision, accountability, and community participation may or may not be possible in bureaucratic and political contexts. For this reason, coverage of an entire large administrative unit (e.g., a district or a province) should be undertaken.

Chapter III

ORGANIZATION AND POLITICS OF PRIMARY HEALTH CARE

Among the most significant barriers to the implementation of primary health care are health politics, existing hierarchies, and the issues of territoriality and "turf." In many countries, political support for PHC programs will not be great among ruling elites, since PHC benefits primarily lower socio-economic groups, the least politically influential segment of society. Furthermore, physician-dominated ministries of health may not be favorably disposed toward PHC programs based upon CHWs and community involvement. It is often necessary to build political support for PHC among elites by orienting them regarding the program's objectives and explaining how PHC can help broaden their political constituency. It is also essential to obtain the support of physicians and nurses -- or at least persuade them not to oppose PHC -- by clarifying the program objectives and stressing the complementarity between community-based PHC and professional medicine.

Organizational factors also present serious obstacles to large-scale PHC. Primary health care calls for a considerable amount of decentralization of administration, effective linkages between front-line and advanced levels of health care, integration of categorical health programs/projects into comprehensive service delivery patterns, and intersectoral coordination of activities at the front line. To bring this about may require substantial changes in the existing configurations of organization within the health sector (including the structure of the Ministry of Health) and between the health sector and others.

The interdependency of health and nutrition, water supply, sanitation, and housing has fostered an emphasis on intersectoral coordination and collaboration. Numerous efforts in agriculture, education, and rural and urban development offer potential entry points for primary health care. However, while the need for intersectoral coordination may be clear, efforts to stimulate such coordination can exacerbate rivalries and competition among sectors, making it difficult to achieve in practice.

The problem of intersectoral coordination is not new. It has long been an impediment to all national development programming efforts and frequently constrains government from meeting its responsibilities. With few exceptions, modern nations have fallen short of achieving intersectoral coordination under the conventional patterns of organizing their public administration. Ministers are often chosen from among the leaders of interest groups, and their political survival depends on providing to those groups what they

perceive to be adequate services. In many countries, health authorities are unlikely to spearhead programs based on multisectoral coordination because the prevailing specialization, professionalism, and high technology in the health sector tend to isolate it from other sectors. Moreover, medical leaders often disdain politics. To implement PHC policies that require action in concert with other sectors, drastic changes in thinking are needed. Coordination is more difficult when a government is politically unstable, or when bureaucratic organization proliferates.

While both integrated (PHC) and categorical health programs have found it difficult to coordinate efforts among the MOH and other government ministries, as well as among the divisions of the MOH itself, it can be done. There are many examples of cooperation between health programs and various private and public groups. In Ceylon, large tea estates assisted with family planning education and services. In the Indian smallpox eradication campaign, the Ministry of Agriculture often provided refrigeration in rural areas.

The organizational fragmentation of health responsibilities and resources may make it difficult to achieve the coordination PHC requires, but it may also help meet PHC's requirements for decentralization. The division of responsibilities among the levels of government can provide a framework for local adaptation and increased community participation. A decentralized, flexible and democratic administrative structure appears to be the most favorable for developing participatory PHC. Participation within government organizations helps facilitate participation at the community level: bureaucrat/managers with a "top-down" orientation within their own organizations are unlikely to favor a "bottom up" approach to clients.

When it is not possible to implement a community-based PHC program within the traditional hierarchical, highly centralized bureaucracy, another organizational solution is to use alternative structures. These can include other governmental organizations or non-governmental organizations such as religious, social, or occupational groups. These alternatives may permit the results orientation and extended timeframe which are important factors in the success of small-scale PHC projects. Numerous smaller projects can be an alternative to scaling-up to a very large program, and may avoid some of the disadvantages of large organizations.

Still another organizational approach is to begin with a more categorical approach to health services and then expand services later. An expanded immunization program, a program to distribute oral rehydration packets, or a campaign to improve community water supply and sanitation can be the basis for developing a network of community health workers (CHWs) and a supporting management structure which will develop experience, skill, and acceptability, and eventually other services.

Discussion:

The Organization and Politics of Primary Health Care

FIELD: There is a need for congruity among the culture, structure, and strategy of PHC. For example, a basic goal of PHC is penetration of the countryside so as to insure effective access to health care by people in their home environment; but bricks-and-mortar expansion is likely to be neutralized if the personnel in charge of providing services are mostly urbanized elites. What then develops is a situation of socialist structure and bourgeois culture. Moreover, this particular incongruity is often perpetuated by the type of formal training which LDC medical schools impart, the aspiration being to meet Western standards of excellence in the practice of modern medicine rather than to meet the principal health needs of the society in question. A related incongruity is between the strategy of PHC, which emphasizes extensive outreach and a high degree of community participation, with the clinical passivity, professionalism, and facility-centered focus of much conventional health care. To be effective, PHC requires a health culture and structure consistent with its strategy, and that usually means reorienting the entire system.

PYLE: If intensive efforts are not made to reorient leaders, PHC programs will have little chance to ensure equitable participation. The higher socio-economic groups to which leaders belong are not interested in PHC because their health needs are met by existing health systems or by private practitioners. Consequently, there is lack of support for the PHC approach at the local level. One manifestation of this program is the widespread practice of selecting male village health workers (VHWs). Men often are chosen for reasons of patronage, even though official policy usually recommends that women be recruited.

THAPA: Political systems can be used to a positive end. Local politicians can be made to realize that a PHC program, if it is effectively implemented, will enhance their standing in the community. In Nepal, CHWs are recruited by the local panchayats. This practice is politically attractive to local elected officials, and has created a constituency for the CHW program. Once politicians become interested in a program, they will demand accountability and provide support to ensure that the program functions properly.

DAVID: PHC can be linked to the political structure. In West Bengal, for example, CHWs are recruited from the dominant political party (CPM), a practice which works very well and ensures political support.

MOEN: The political aspects usually are controlled or managed in small-scale projects. But increased self-reliance

and autonomy decrease dependence on the central government, and even on local politicians, who, as a result, can be expected to disapprove of projects that promote such characteristics. In Africa, for example, governments fear the secessionist tendencies inherent in local autonomy. Such fears can inhibit the implementation of the PHC approach.

Bureaucratic Constraints

DAVID: Any large-scale PHC program has to be supported either exclusively or partially with tax money. This being the case, unavoidable, built-in limitations have to be faced. The program will, for example, use a bureaucratic structure and bureaucratic norms; it will be oriented to procedures, as opposed to results; it will be oriented to roles, as opposed to tasks; it will emphasize financial propriety, and not cost-effectiveness; and it will use legal, in contrast to charismatic, authority. If we continue to propose without modification the approach developed in small-scale projects, we will achieve little impact in expanded programs. We must look at the structure within which scaled-up projects must operate and innovations from smaller projects that they can absorb.

PYLE: There is evidence that some health bureaucracies are trying to introduce the community-based PHC approach developed in small-scale projects into existing structures with little modification. The traditional hierarchical and centralized bureaucracy contradicts in spirit the requirements of the radically new PHC strategy.

CURLIN: An alternative approach is propagation rather than scaling-up: having many small community-based projects rather than a single large one. However, this alternative is usually not appealing to either large donors or host governments, because of the administrative costs involved.

BURGESS: PHC requires that communities, regions and nations develop a high level of self-determination. Because it calls for the sharing of power, PHC can be highly sensitive politically. The middle or upper-level bureaucrats (e.g., physicians and nurses) who normally play a major role in health care delivery must be willing to relinquish some authority in the interest of securing the participation of the community and facilitating integration with other bureaucratic agencies which can assist in PHC programming. Rivalry and territoriality within and without the health sector can pose serious problems and prevent the successful implementation of the PHC concept.

Chapter IV

COMMUNITY PARTICIPATION

The results of numerous experiments and demonstrations, large and small, underscore the importance of community participation, from initial planning through implementation. In practical terms, any serious effort to extend coverage rapidly requires that communities accept some share of the burden. Services that are designed by or in cooperation with prospective users are more likely than services imposed by outsiders to reflect users' expressed priorities, and thus be appropriately used and supported. It is also easier to effect changes in health behavior and attitudes through self-education and peer group pressure than through use of professional motivators.

Nevertheless, no matter how commendable and practical it may be to stimulate and facilitate community participation, serious obstacles are present that can impede its realization. Some of these obstacles are described below.

- Although PHC requires that communities, regions, and nations achieve a high level of self-determination, it also seeks to promote the efficient use of limited resources, which implies economies of scale, the establishment of priorities, and some degree of standardization. Policymakers must attempt to balance the efficiency of participation with the efficiency of standardization.

- Community self-awareness is politically highly sensitive; a highly aware community may make exacting demands.

- In countries where the governing ideology is technocratic, the very presence of health organizations may constrain the development of community participation and responsibility. Where social interventions are regarded as the exclusive domain of those who manage public and private organizations, and those outside such organizations have no significant role, services continue to be delivered to people, but they are not developed in cooperation with people.

- Middle- or upper-level bureaucrats (including physicians and nurses) who, logically, should play a major role in stimulating community involvement in health, often are the products of a hierarchical and authoritarian mold and may try to impose their own goals on the community.

- Promoting participation by working with community

leaders can lead to support of local elites, which enhances traditional patterns of exploitation.

Large-scale efforts to promote community participation require adaptations and innovations that make CP attractive both to the community and to the establishment. Where the community sets its own goals, participatory negotiation is possible, and self-help and assistance from the power structure combine to satisfy many of the community's articulated needs. Subsequently the community can become a pocket of support for the political authority.

To ensure that community participation in planning and implementation is constructive, planners have to define how participation can be fostered; identify what resources are available; establish the legal limits within which participation can occur; and identify opportunities and means for participation. Care must be taken so that the community approach does not become the rationale for inequities in health care. This happens when responsibility for the provision of services is shifted away from the established authority to communities, which are blamed for any failures.

Discussion: Community Participation

THAPA: Any discussion of PHC always includes a reference to community participation. Yet, little is known about how CP has been used in small-scale projects and what its implications are for large programs. Perhaps we should begin by defining the term itself.

FIELD: Community participation ranges from the minimal level of acceptance and use of services, through involvement in implementation and local decision-making, to collective demand-making on higher authority so as to achieve common goals.

RONAGHEY: In Iran, community participation usually meant getting people to pay for or build something, but never to make decisions.

PYLE: We need to distinguish between well-managed schemes that deliver services to the villages and effective community involvement. In some PHC programs, in the Malaysian health system, for example, CP may not be necessary to effect change. Malaysia's system is well-managed and effective, but it pays little attention to community involvement.

WILCOX: The principal focus of several of the projects included in our monograph was service delivery. Attempts were made to involve communities in a number of aspects of community decision-making, but, in general, these efforts were not very successful in generating CP, if we define success in terms of longevity or continuance of activities, once the project terminates and outside leadership and support are withdrawn. Health gains cannot be sustained without CP.

AGUINAGA: When we look at governments' efforts to deliver PHC at the community level, we find that the communities are resistant because there is no interaction, no attempt to identify needs.

MOEN: In Ethiopia and other countries as well, we see that just the provision of VHWs alone is insufficient to improve health status. The same logistical breakdowns as have always been present continue to occur, and the health system has no capacity to establish and maintain a relationship with community leaders.

MARTIN: The question of scale is important when you discuss CP. Small projects do not pose a political threat or require the involvement of many different levels of political and bureaucratic authorities, as do large programs. Program planners should realize that the political and bureaucratic environment does constrain community participation. Political problems include opposition to the decentralization which CP

implies and lack of support (at the local level) of elites, who have little perceived need for PHC services and who desire to control efforts.

HENDRATA: The experience of small-scale efforts in CP cannot be applied to large-scale efforts. It is safe to say that for CP to succeed in most countries (developed as well as developing) structural (bureaucratic) modifications have to be made. But to be realistic, we cannot expect to radically change the bureaucracy overnight. Thus, trade-offs between the desired strategy of CP and the existing structure must be negotiated. This is what was done in the Indonesian nutrition project. At the initial stage, at least, some degree of CP had to be sacrificed to achieve large-scale coverage. The program was simplified (big should not mean complex); the only activity was to weigh children. We wanted to do more, but for the sake of impact and because of structural limitations, we had to limit our strategy. Policy and goals were established centrally, but implementation was decentralized. The information system also was simplified; only one indicator (i.e., the number of children gaining weight each month) is used.

AGUINAGA/FIELD: To achieve success in community-based PHC programs, we have first to reorient the medical community. Physicians are dominant in most ministries of health (MOH), and they tend to be biased toward the provision of services to a passive community. All too often the medical profession is insensitive to community needs and reactions.

HENDRATA: Most ministries of health are engaged in providing institutional services (hospitals and health centers). Such a framework is neither conducive nor supportive of CP. It might be more appropriate to use alternative structures or organizations with broader perspectives to manage a community-based scheme which involves mobilization of the community, where technical medical services are not a large factor. PHC, much like family planning and nutrition programming, requires social engineering. This implies the need for more social science expertise than is traditionally found in most ministries of health.

Chapter V

FINANCING PRIMARY HEALTH CARE

Leaders in many countries want to extend basic health services to the entire population; yet, in many instances, the required political, organizational, and financial resources are inadequate for the task. Some governments and many nongovernmental agencies turn to local communities to provide labor, cash, and other resources to support primary health care.

Community financing requires considerable effort in organization and management, but its ultimate yield may be small in relation to total cost for primary care. A people's ability and willingness to pay must be ascertained. It appears that of the elements of primary health care listed in the Declaration of Alma-Ata, individuals are usually willing to pay only for personal curative services, not for prevention or community activities. A government's commitment to provide "free medical care" can discourage local financing and undermine establishment of a viable, self-perpetuating health system.

Donor agencies have a role in supporting primary health care, but care must be taken to ensure that the availability of donor funds does not stifle the initiatives of local institutions or discourage tests of promising approaches. The donor agencies themselves must become more flexible and less centralized in program design and implementation; they should encourage the development of indigenous NGOs and the private sector as alternative structures to deliver community-based PHC services.

Discussion: Financing Primary Health Care

O'CONNOR: Given the current experiences of small projects, it is fair to say that the community must contribute to the cost of supporting a PHC program. Governments do not have the resources to provide free care. People are willing to pay (and, in fact, are paying) for curative services; the cost of the preventive component probably will have to be supported by outside funds.

TAYLOR: It is estimated that in India a person spends between U.S. $6.00 and U.S. $7.00 each year for drugs and health services. This compares to U.S. $2.00 in Narangwal, and U.S. $0.70-$0.80 for government health services. The issue we are discussing may be as much a problem of scaling down (inputs and expectations) as scaling up (coverage).

RONAGHEY: A national government can hurt an expansion effort. The government in Iran made the mistake of paying all government workers a set wage based on the cost of living. The approach was self-defeating; all health workers received U.S. $480 a month (we had been paying health workers U.S. $50). Some highly paid workers saved their money and then moved to the city, where they could buy a shop or some land.

FERGUSON/MOEN: Variable forms of payment should be worked out locally, either as payment in kind or payment with labor. In many places, there is no such thing as a cash economy; barter is still the means of exchange. Some form of deferred payment is commonly used with traditional practitioners, and should be considered. We must avoid the "cookie cutter" approach; that is, rigidly proposing the same model everywhere.

PYLE: Supporting indigenous NGOs is one way to promote innovative activities and increase effective service delivery.

MOEN: In Ethiopia, the success of health projects externally funded by private organizations (PVOs) has been limited and local. It is questionable whether these projects can serve as a national model.

SCHEYER: Some governments budget money for rural outreach, but they do not spend it. You have to look at expenditures, in addition to the budget. Often, outside donors are paying for outreach efforts.

TAYLOR: People will not pay for preventive and promotive services initially, though they will support curative medicine. However, through education and field collaboration they can come to appreciate the need for preventive and promotive activities and thus will be more willing to pay for such services. At Narangwal, we established a surveillance

system and, through involvement and feedback to the community, helped people to understand their health problems. It did not take long for them to learn the importance of changes in life style and health habits.

WERNER: Whatever the type of project, the community must be involved. This means the entire population, not just the elites. The only way to involve people is either to break large programs into small units or have governments support small projects. Either approach will encourage rather than dominate or control people. If controlled from the outside, scaled-up national programs can become exploitive rather than beneficial. International donor agencies at times have a negative impact because they promote or fund centralized programs.

TAYLOR: The Hanover Project is an example of how donor rigidity can harm a program. A large loan from a multilateral lending institution was used to finance the construction of health posts in Jamaica; the presence of these facilities encouraged health workers to sit in the nicest buildings in the area filling out forms. For political credit at the national and international level, politicians pay for what people are willing to pay for. Instead, donors should pay for what people will not pay for: prevention, communication, supervision, transportation, and adaptive research.

HENDRATA: Many governments are reluctant to support PHC because the goals are vague and unclear and because the impact cannot be specified. External agencies can provide funds for PHC, enabling governments to see the benefits without incurring initial risk. External PHC financing is appropriate in at least three instances: to focus, or package, PHC to make it appealing to governments; to facilitate exchanges of experience (as in this workshop); and to give governments experience in appropriate systems. External assistance has its disadvantages, too. An influx of money (and power) can kill local initiative. It makes use of centralized, rigid procedures that can stultify PHC. Donors should be flexible and avoid imposing rigid systems which can discourage application of the concept of PHC. And, where PHC projects are successful, sometimes governments lack capability to maintain them after external assistance is withdrawn. Donors should be careful to keep aid within the limits of the government's capacity to continue once external assistance ends.

FERGUSON: Donor agencies are increasing their level of PHC assistance. A key problem is learning how to request assistance; that is, to put requests in terms meaningful to donor agencies. Dr. Lee Howard of the Pan American Health Organization (PAHO) has examined this issue. Also, donors and cooperating governments need to concentrate on the effective delivery of technologies, and not on technologies themselves.

TINKER: The role of the private sector in the delivery of PHC services is extremely important. The Office of Health at AID is exploring the subject to strengthen and support this potentially valuable resource, which has been largely untapped.

Chapter VI

PERSONNEL FOR PRIMARY HEALTH CARE

Community health workers (CHWs) have been used successfully on a large scale in China, and on a smaller scale in a number of other countries. They can be trained to perform selected tasks quickly and relatively cheaply. Recruited from underserved areas, they can fill a crucial need. And, because of their affiliation with the community, they sometimes are better able than highly trained professionals to do certain tasks. Frequently, they can bridge the gaps between the modern health sector, traditional healers, and the community. For these reasons, they should not be looked on as lesser-trained members of the medical hierarchy, but as agents of social change.

To gain credibility and the support of their constituents, CHWs must provide the services for which they are especially qualified and which the community finds attractive. CHWs should not be overburdened with tasks that exceed their capabilities. Tasks must be well-defined and training must be directly related to the job expected so that the workers can perform with reasonable confidence from the beginning. Rewards also must be well-defined, whether they take the form of monetary incentives, community approbation, or future career opportunities. Traditional health providers usually are powerful and respected members of the community; if PHC workers fail to achieve similar status they will eventually fall away.

In order to function effectively, CHWs must be supported by the other levels of the PHC system. This requires appropriate education and orientation for other members of the health team, particularly physicians and nurses. As noted in Chapter III, physicians and nurses are important in building a political consensus for PHC programs. Equally important is their cooperation on a technical and managerial level. Because PHC requires professionals to take on new roles, specific training and orientation are required to help them adopt a team approach and take on roles as managers, teachers and supervisors as well as clinical practitioners. Orientation is also often required by clerical and other support personnel. Lack of sensitivity to referrals by CHWs by health center receptionists has been cited in some programs as seriously weakening CHW effectiveness and credibility with clients.

Discussion: Personnel for Primary Health Care

WERNER: The typical staffing pattern for PHC is represented by a pyramid, with a doctor sitting at the top. The lines between the various levels of workers are rigid, with no movement between them. The pyramid should be tipped on its side so that physicians are "on tap, not on top." Divisions should be fluid so that appropriate knowledge can be shared. The first level of service delivery should comprise mothers and children, and the effort should be primarily educational to make community members responsible for meeting the needs of their own families.

CUNNINGHAM: At Imesi, in Nigeria, each child received 25 brief visits each year for the first two or three years. This enabled us to make an impact (e.g., to raise the immunization level to 90 percent). Our approach also allowed us to reinforce certain education points, such as new weaning habits and practices. Soon, mothers were able to do things themselves. Intensity of coverage by primary-level personnel is vital.

MOEN/AGUINAGA: Much time is needed to de-medicalize health and achieve acceptance for non-doctors. Paramedics have a great sympathy for and ability to communicate with and relate to a community. The myth of the indispensability of doctors has been explored in projects that have developed and supported effective paramedics. These projects have shown that, over time, the paramedics have gained the confidence of the community.

WRAY/COLE-KING: Most of the PHC projects we are talking about concentrate on the delivery of maternal and child health (MCH) services; hence, women (usually middle-aged women) are preferred as VHWs. This focus becomes diluted when the approach is scaled-up; the programs become primarily curative, with a weak MCH component, and men frequently are chosen to serve as VHWs.

TAYLOR: The CHW program in India is illustrative of this problem. The projects on which the program was based used female VHWs to a great extent. In the government's scaled-up version, approximately 90 percent of the local workers are men.

CUNNINGHAM: The Imesi Project in Nigeria worked because the VHWs were women who were satisfied with their work and lived among their clients (and therefore knew them well, and were trusted). They were not so well-trained that they were not content to go back to villages without electricity or running water to make their homes. They married, raised families, and had status in the community.

WERNER: In the Piaxtla Project in Mexico, the

community organizers are selected from among the VHWs themselves. They go to new villages and talk to people to determine the power structure (who controls whom), to identify opinion leaders among the poor, and to ascertain the attitudes of the elites. This social analysis and consciousness-raising help the villagers to express themselves at meetings. An outside leader directs discussion and ensures that vital questions are covered. Once selection criteria have been delineated, it is easy to screen out the headman's daughter, etc.

SCHEYER: In most cases, we do not create new mid-level workers. Usually, someone is already out there.

COLE-KING: It would be easier to fashion an effective PHC program by working from a clean slate than to build on an existing structure. One of the most difficult challenges facing PHC is to employ existing health workers and change their roles.

POWELL: One problem is that middle-level personnel and even VHWs have great aspirations; they want to become doctors or government paramedical workers. Our experience demonstrates that any model which feeds such ambitions should be discouraged.

RONAGHEY: At Kavar, in Iran, we worked with traditional birth attendants (TBAs). Instead of discouraging them, we worked out a mutually beneficial arrangement. Kavar gave the TBAs equipment (towels, scissors, and alcohol) in return for information on who was pregnant. Pregnant women were then given tetanus toxoid injections. The result was that neo-natal tetanus was virtually eradicated in the area. We also tried to work with other traditional healers, but were not successful.

TAYLOR: The most important part of our work with traditional birth attendants was to develop a process to identify practices as either dangerous, helpful, or neutral. Few practices were found to be harmful, and those that were, were the only ones we fought to change. We also tried to work with other traditional healers, but we made the mistake of lumping this highly diverse group together. In India, three-quarters of the medicines that traditional healers use come from standard scientific pharmaceutical sources, not traditional herbs and local products.

Physicians in Primary Health Care

PYLE: The socialization of a doctor during training is contrary to the interests of the community-based approach. What is required is a team approach, something which a doctor may find difficult to accept. The village worker with minimal training must be accepted as a vital and respected member of a

team; a VHW who is not so regarded becomes merely the occupier of the lowest level of the health infrastructure. The solution to this problem is to make medical education both more relevant and less sophisticated; however, politics makes this difficult. The socio-political elites demand high-technology medicine to treat the degenerative diseases from which they are suffering.

RONAGHEY: In Kavar, we manipulated and reversed roles to break down status barriers. Doctors were assigned to do the work of low-status workers (vaccinators and sanitarians) who, in turn, did clinical work. This exercise made all the workers more sensitive to the others' positions and improved their ability to work together.

WISE: Relationships among health workers too often reflect status in society. For example, in the Hanover project in Jamaica, doctors had a minimal functional role, and they were poorly informed about problems in the area. Nonetheless, doctors were required in positions of control to legitimize the project. As we get further away from sophisticated medicine and curative care, the physician's role is reduced, particularly if his training is not modified.

BLOOM: In Panama, established health staff had no idea about what new VHWs were supposed to do; nor did they know whether the new cadre would overlap or be able to assist them. When programs are scaled up, efforts must be made to conduct orientations to inform health personnel about VHWs and how the different workers relate to each other.

KESSLER: We cannot circumvent doctors. Without the support of doctors, PHC cannot go forward. Doctors are seen as providers of health care; therefore, we need their backing. We must develop appropriate training programs and change the orientation of doctors.

TAYLOR: More departments of social and preventive medicine are needed. It is important that doctors be required to serve rural areas, because such service helps to orient them to the needs of rural populations and influences them when they reach positions of power. Unfortunately, graduates of good training programs are being introduced into an unmodified system, and they soon lose their spark. This problem is being addressed by the Indian Council of Medical Research (ICMR), which is establishing six centers (each covering one district) as continuous research and training sites. With this approach, it will be possible to test new ideas and introduce successful or replicable concepts into the system and influence the rest of the services with technical knowledge and skills, new attitudes of caring, and the awareness that it is possible for personnel to change their values and relationships.

DAVID: Doctors are far too expensive to use in outlying areas; yet, doctors continue to be assigned to rural health centers as their numbers increase in the less developed countries (LDCs). In India, for example, there are now three medical doctors for each regional health center; however, the quality of care has not improved.

KELLER: Unemployed doctors present one problem. Another source of pressure to use fully-trained physicians in place of paramedics is due to community preference for physicians.

KESSLER: A major source of pressure for medical schools in developing countries comes from the elite to provide a channel for their children.

WRAY: To recruit and convert medical students to social and preventive medicine, we must make rural PHC challenging, just as other specialities are technically challenging.

SCHEYER: Because it is difficult to change curricula at medical schools, we have to recruit students to PHC who will reform medical education. It is helpful to have students serve in communities as part of their training, but, where the health establishment is not oriented to PHC, it is difficult to introduce such an activity.

CUNNINGHAM: It is diffucult to reorient doctors. Perhaps we would do better to identify those doctors who support the PHC concept and then support them. Currently, doctors often feel isolated and frustrated when faced with a huge monolithic curative system.

Chapter VII

TRAINING AND SUPERVISION OF HEALTH WORKERS

Initial orientation of health workers, followed by on-the-job training, has been found to be most effective in small-scale PHC projects. Continuing education based on feedback from field experience is important. This requires continuous dialogue between the trainee and the trainer and supervisor. Where supportive or educational supervision is provided, supervision overlaps with training. Supportive supervision contrasts with the strict superior-subordinate relationship found in most health ministries. Extended and intensive training is difficult in large-scale programs and calls for restructuring the academic or theoretical approach characteristic of some PHC programs.

Senior community health workers are capable of supervising other local workers, but health workers are usually not trained in supervisory skills; thus, to function in this capacity, they require training. A complete chain of managerial responsibility is needed. Gaps in the chain or high rates of staff turnover undermine support for field personnel. Frontline community workers need logistic and supervisory support. Minimally trained workers require bolstering to improve their skills and services. If they work near more highly trained clinicians, they may feel insecure, but if they work in isolation, they often feel helpless. The erratic provision of supplies adversely affects a worker's confidence and credibility, because at times when clients may need help, the worker may be able to offer nothing more than advice.

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Discussion: Training and Supervision

Training of Health Workers

WERNER: A lot of training turns people into sheep. The trainee is told what he will do, without regard for capability. If you begin a training program by examining problems with a worker, and defining what has to be done and how, you benefit from what the worker knows, and you therefore design a more appropriate program. Illiterates have the capacity to commit facts to memory, but literacy is important because training can then be tied to the use of a reference book as opposed to relying exclusively on memorization. Students should not be told answers; rather, they should be confronted with simulated or real problems and work together to solve them. The instructor stays in the background. The result is increased confidence and the ability to solve problems.

TAYLOR: At Narangwal, we changed the entire training program as we went along. Training started with a six-month course which emphasized memorization; this was reduced to a six-week field-practice course, and we achieved much better results. Of the six weeks, half (alternating weeks) were spent in the field. The CHWs learned by problem-solving. Later during training in the classroom, many questions were raised. Theory was given at the end of the training period, when the trainees were better able to appreciate why they needed this information.

RONAGHEY: At Kavar, we also used a problem-solving method in training. Trainees identified problems and they asked their tutor how to resolve them. This approach requires a new kind of teacher. Traditional teachers talk too much and interrupt the learning process. Training has to be problem-oriented and oriented to the learner, not the teacher, with concentration on what students want to learn. A feedback mechanism to encourage two-way communications also is essential.

TAYLOR: The confidence level of workers is particularly important. Women workers at Narangwal were very shy and would not talk directly to males. During training, however, they acquired self-assurance and later would converse directly with anyone. One VHW even confronted one of the most senior health officials in the central government and told him he was wrong and explained why. Similar experiences in Jamkhed have been reported; for example, a VHW stood before a national conference of physicians and explained why they were ineffective and what approach they should take.

COLE-KING: In small projects, training is usually staggered or alternated with work in the field. Such training is difficult to organize in large government programs, because governments seem to have trouble providing follow-up and

continuing field training.

PYLE: Nongovernmental projects can serve as training sites for government health personnel.

WERNER: It is vital to the training process that VHWs be involved in identifying problems and devising solutions. This approach makes them feel that the solution is their idea, not an outsider's. When VHWs become trainers, they go into the community with the attitude of being part of a team. They do not say, "Here I am and I have the answers" but "Let's look for answers together." The project manager usually is familiar with the basic problems, but he must be flexible. The role of an outside leader is to direct and draw out the issues so that the community can solve its own problems. The technique and process are as important as the content.

TAYLOR: Can you really consult with each group of people about what they want in a PHC program? Is it really making sheep out of people to have a curriculum package?

SCHEYER: Something is wrong with our discussion. On the one hand, we are looking down at "pill-pushing" as a chief activity for a health worker. On the other hand, we are saying, "give the people what they want"--which, in many cases, is "pill-pushing."

COLE-KING: People ask for what they know about--for example, dispensaries.

CURLIN: Do people really know what's good for them? People in the United States want laetrile, Tab, and saccharine. Can scaled-up training really take into account what people want?

KESSLER: I disagree with Werner. I don't think we have to have a community focus in every instance. The primary education movement has been rather successful around the world and this without asking all parents what they would like their children to learn. Dave's comments strike me as utopian.

CUNNINGHAM: The social orientation of workers is a concern in the projects. As the Chinese have found, and as has been shown in Nigeria, if a person is well oriented (s)he can do a great deal. Selection criteria should be applied to training, and if orientation and attitude are not good, a person should not be accepted for training. No one should be a trainer unless (s)he has done the task. Feedback from trainees is essential; it enables trainers to address trainees' concerns and answer their questions. Roles have been changed. Instead of saying, "Here I am, tell me all the wisdom," the trainee says, "I want to know this and that."

WERNER: There is a language barrier between professionals

and community health workers. We have a rule that workers can interrupt anytime a visiting professional uses a word that is not understood. Some professionals never get beyond the first sentence in an hour-long talk.

WRAY: Let me share a distinction which Don Fleischer made at a workshop in Indonesia on how people learn. People learn facts, skills, and values in different ways. As Fleischer pointed out, there are many ways to learn facts; method does not seem to be as important as motivation. There is only one way to learn psycho-motor skills: by doing! Problem-solving, too, can only be learned by doing. You can use simulated problems (as in math), however. People's values do not change as a result of lecture or exhortation. Value change occurs only when a person is challenged and when there is an available role model.

SABIN: Arole, in the Jamkhed Project in India, stresses value change, the last of Wray's four categories of learning, in training community health workers. Arole is not here, but I understand that consciousness-raising is one of the most important parts of CHWs training. Is this true?

TAYLOR: Yes, the Jamkhed Project has been very successful, particularly at breaking down caste barriers. It has been winning people over--something like a conversion. But Arole himself admits that he does not think it could be done on a large scale.

KESSLER: We must be aware that the implementation of PHC is more complex than we thought. We cannot implement an entire PHC program at once. Rather, we must specialize and select only a few priority items. Scaling-up requires retraining and reorientation of health staff at all levels. To date, we have concentrated mostly on the training needs of VHWs.

Supervision of Health Workers

RONAGHEY: The usual type of supervision is face-to-face, where a supervisor oversees the work of a field worker. It is important that supervision be educational; that is, the supervisor use the opportunity to teach the person being supervised. To reinforce the educational aspects of supervision, Kavar supervisors were evaluated in terms of the support they gave to workers. One result of this approach was that field workers wanted rather than feared a supervisor's visit.

TAYLOR: In addition to supportive face-to-face supervision, three other kinds of supervision can be identified. One is supervision through a record system. This is a systematic way to present results of field visits to various levels of managers and administrators. A second approach is supervision at a distance; that is, communication by telephone, radio, carrier pigeon, etc. Staff meetings are another way to provide supervision. At Narangwal, one day every two weeks was set aside for continuing education of the entire staff. Workers discussed their problems and how they could be solved. We learned from the workers. Even better results were obtained during meetings at subcenters, where community representatives were included.

KESSLER: An important feature of the project in Niger has been replicated in the large-scale program. The community serves in a supervisory capacity. This is primarily in the form of recognition and acknowledgment, not administration. This adds greatly to the worker's motivation and feeling of self-confidence.

WERNER: In Honduras, in the Rural Penetration Program, surplus teachers are trained to support VHWs. The teachers receive only brief training and have little technical knowledge, but they are extremely good in relating to the workers and to the community, primarily in health education.

POWELL: We have found that supervisory nurse-clinicians do a better job of supervision than doctors, because the latter do not have the time for supervision. In Guyana, tutors in the training course later served as supervisors. Continuity was thus maintained.

CUNNINGHAM: In the Gondar Project in Ethiopia, health workers were trained together and sent out in teams, with their teachers as supervisors; however, because supervision was inadequate, the teams eventually fell apart.

COLE-KING: Health center staff are health professionals who are usually not interested or trained in supervision. This weakness is a major cause of breakdown in large programs. Some

small projects (e.g. Dr. Were's project in Kenya) have a separate supervisory team. The best approach seems to be to select supervisors from among the village workers and give them additional training.

FERGUSON: An annual retreat is held for all health workers in Niger. This has had a significant impact on the improvement of health services. The free and open discussion of problems in the system and of ways to solve them is therapeutic. Somehow, authority is temporarily suspended so that all may speak their minds. This has been particularly useful for program managers. More than 50 percent of the decisions that have been made at these retreats have been implemented within one or two years. Moveover, those who have made suggestions have been identified and given credit. Practices as innovative as this participatory management exercise should be documented.

Chapter VIII

LOGISTICS AND SUPPLY IN PRIMARY HEALTH CARE

PHC is itself an effort to overcome the deficiencies in physical and economic infrastructure, particularly in rural areas. PHC attempts to respond to the most urgent needs of underserved populations, using strategies that accommodate deficiencies in transporation, communication, and technology. However, adaptations cannot fully compensate for deficiencies in infrastructure. For example, the articulation of basic services with other levels of health care may not be feasible where roads are seasonally impassable; and closely linked systems would be unrealistic where the best available communication system relies on one-way transistor radios. Even the introduction of relatively simple technologies may be restricted; for example, refrigeration of vaccines may be impossible. Drug lists may be limited to essentials, but administrators still must be able to resupply frequently, or stock sizable inventories at many distribution sites.

PHC technologies initially may involve relatively simple material resources. But no matter how simple the technology or the resources available, supplies must be delivered and replenished over substantial distances, patients and workers must move, equipment must work, and information about service problems must flow.

Decentralized control places part of the burden for logistics on local structures. Few communities, however, can assume full responsiblilty for supply and logistical support of PHC workers. Therefore, an infrastructure capable of servicing all local units has to be developed, and new project efforts cannot be allowed to outrun the necessary supporting networks.

Discussion: Logistics and Supply

CUNNINGHAM: Workers at any level will be demoralized when they lack drugs. The situation is like sending soldiers into battle without bullets. Basic medicines should always be available to health workers. Only in this way can we ensure job satisfaction.

WERNER: Part of the problem is the tendency to overmedicate patients. Half of all health problems require no medication.

KESSLER: We know that a large percentage of medication is unnecessary. We also know the effectiveness of placebos is, in part, due to the fact that we show we care by treating a patient. Overuse of drugs is the other side of insufficient drugs.

CUNNINGHAM: To get doctors to stay in rural areas, you have to supply them with drugs. But in Nigeria government drug supplies get hijacked. However, a missionary service has had good success in supplying mission hospitals with 30 basic drugs all over the country.

SCHEYER: In Mali, you can get frozen butter in many villages, but the Mali government does not use this private distribution scheme to provide drugs or vaccines.

COLE-KING: In many countries in Africa, the health budget has increased only five percent in the last five years--this, even though the average annual rate of inflation is approximately 25 percent. Hospitals are out of drugs. We cannot really talk about the reallocation of resources, because there are few resources remaining to allocate. Of course, there are still human resources.

WISE: Why do we think that health resources will be distributed any differently than any other resources in a country (i.e., unequally)?

WERNER: When we asked poor villagers in Africa, the Philippines, and Latin America to estimate the portion of their annual income spent on health care, we found that a high proportion was spent on medicines--medicines obtained without a doctor's advice. Besides posing a danger of potent side effects, this practice has led to increasing biological resistance to antibiotics.

CUNNINGHAM: People can and do pay for health care. In Nigeria, the problem has been government insistence on free medical care, an approach that undermines rural health services. Funds have to come from somewhere. In one project, a revolving fund established to pay for drugs was raided to pay for salaries; this nearly destroyed the fund.

Chapter IX

EVALUATION AND INFORMATION SYSTEMS

Large, sophisticated evaluations are not only time-consuming and expensive, but they also rarely delineate with any accuracy cause-and-effect relationships in PHC schemes. More appropriate and more operationally useful is a monitoring system which also serves as a built-in evaluation mechanism. Such an information system should be designed to collect minimum data which can trigger management actions.

An information system should trigger action and motivate staff. Local managers must have authority to react to the needs indicated by collected data. Community members can and should be involved in gathering data.

Focusing on impact of output indicators and expressing data in percent coverage are helpful ways to inform the community and local staff, as well as managers and policy-makers, about a program's progress. The results are useful in the orientation, education, and motivation of both health workers and communities. Vital statistics are good indicators of general health status, but they are not easy to compile, short of a major systematic area-wide effort.

The use of specific "at risk" definitions helps local workers to identify those who are most in need of services. An intensive surveillance system (e.g., home visiting) with a high worker-to-population ratio using "at risk" methods can produce results. In this way optimal cost-effectiveness can be achieved.

Discussion: Evaluation and Information Systems

FIELD: Evaluations which attempt to attribute cause and effect are rarely conclusive, despite the high cost of the exercise. There are just too many external factors at work. As a practical matter, it is more important to indicate change than to attribute cause for change. A system that continuously monitors operations to ascertain progress is most effective.

HENDRATA: Data should be collected on as few indicators as possible. In the Indonesian nutrition project, for example, only one piece of information is reported: the percentage of children who gained weight each month. The weight of a child at initial weighing becomes the benchmark for subsequent gain or loss. The system is designed for immediate feedback to mothers, but the data are useful at all levels, including the central level, which consolidates the statistics to give a figure on national nutrition surveillance. The information is also consolidated and analyzed at the village and district levels and triggers action and appropriate responses.

KELLER: An information system should sound an alarm to indicate and identify the location of a problem. In such a system, supervisors and managers can practice management by exception, concentrating their energies and resources on the people, workers, or places most in need.

HENDRATA: We must reject the idea that PHC programs are too complex to permit a few simple indicators. The rule should be "simplicity and specificity for the sake of generality." Comprehensive broad objectives are not realistic, especially in a large-scale program. A narrower focus is required to make a large program manageable.

SHEPPERD/MOEN: But the inclusion of social as well as medical goals is important to sell a program politically. A matrix of indicators may be necessary for such objectives.

FERGUSON: It is difficult to gather reliable vital statistics. In Narangwal, three different sources of death figures were compared; all three (official register, village guard, and health worker) had different numbers.

PYLE: If VHWs cannot collect such numbers, the chances are that the program is not reaching people effectively. The more curative a program, the more difficult it is to collect vital data, because there is less person-to-person contact with the entire community; contact is largely limited to those who seek services.

CUNNINGHAM: One aspect of supportive supervision is

follow-up: clinical information on past cases, as well as feedback on data. Without feedback workers get tired of collecting data and, generally, of doing their work. Good supervision and a good record system make people feel that they are part of the project or program.

COLE-KING: I'm reminded of a visit to Thailand, where I was shown wonderful charts, graphs, and records. I found out that health workers spent as much as one-third of their time completing these charts, but the information was not really being used. Often, forms are filled out only for supervisors. It is important that supportive supervision help workers use the information, because knowledge of how to use data is directly associated with motivation to collect statistics.

CURLIN: We must make sure that VHWs do not become burdened with collecting too many data which are of no use to them. The most important data are those which help the worker do his or her job.

SCHEYER/CUNNINGHAM: Students and teachers can be used for epidemiological surveillance or to define problems at the village level. The feasibility of using children in evaluations should be researched.

WERNER: In the Piaxtla Project in Mexico, school children and teachers, in conjunction with local health workers, have carried out overnight surveys on the incidence of diarrhea (how often smaller brothers and sisters had diarrhea in the past year) and breastfeeding practices. Because the survey questions were discussed at home, the exercise became a source of nutrition education.

WRAY: In Cali, Colombia, the Community Systems Foundation asked high school students to conduct a consumption survey. The students found that contrary to belief, in low-income families the father does not consume a disproportionate amount of food.

TAYLOR: It is necessary to have an epidemiological team to follow up on the village workers and to ensure that information is collected and interpreted properly. Spot-checking is needed to keep the VHWs honest. China does spot-checking to stimulate local workers to collect necessary data.

SCHEYER: The use of data as a management tool has both positive and negative benefits. Most data are for visits. Without denominators such as the at-risk population or the size of the group to be served, such data are meaningless. Also, when data are used for evaluation, there is a considerable pressure to fudge figures.

COLE-KING: Successful projects have been able to

build in a surveillance system (e.g., proper use of weight charts). Regular contact must be made with every family. If everyone does not come for child weighing, health workers must visit the homes of those who did not come and take the children's weights.

WERNER: A project in the Philippines maintains a list of children who are undernourished according to a "Road to Health" chart. This record is used for follow-up. The change in the number of severely malnourished children from month to month gives an overall indication of impact.

WISE: That was really all that was done in the Hanover Project in Jamaica. Children were weighed every two months, and high-risk children identified early and visited every week until they were out of danger.

Chapter X

CONCLUSIONS AND RECOMMENDATIONS

As the participants at this workshop have shown, primary health care in practice is a complex process which represents a major departure from earlier health care systems. The principal problems identified in this report are neither technical nor medical. The scientific validity or impact of the interventions delivered by various projects has been well established. In fact, the package of services required to reduce sharply infant and child mortality rates is, in most cases, clear, simple, and not inordinately expensive. This is frustrating! If it is so easy, why is it so difficult? The problem is not so much what services to provide, but how to deliver services to those in need in the community. This is primarily a management problem: the operational and organizational implications of the PHC approach must be identified and addressed before an effective program can be launched.

Planning and Management

Primary health care programs aim to expand public health coverage from perhaps 20% to 100%. This will require a much longer time span than many development programs have heretofore undertaken. Planners therefore should 1) set realistic objectives in light of available resources; 2) plan a gradual, long-term phasing in of primary health care; and 3) consider primary health care as a shared government/nongovernment enterprise requiring a maximum of community, intersectoral, and private sector participation.

Although PHC is a relatively low-cost health system, the costs and managerial demands of establishing, operating, and expanding such a program are nonetheless substantial. Both international and LDC health agencies must frankly face the fact that many governments are not ready for community-based PHC programs. For these countries it is more sensible to temporarily delay a community-based PHC approach until a strong foundation is established.

Donor agencies could improve the chances for effective programs by changing some of their operating procedures. The program planning process must be made more realistic. Intermediate-scale projects should be considered rather than trying to jump from small projects to national programs. The reward system must be changed to encourage programming personnel to achieve results rather than maximize monetary disbursements. Preliminary analysis should be carried out jointly by national and international cooperating agencies. The increased involvement of social scientists and management specialists experienced in rural health services is desirable.

PHC requires that management be flexible and more attuned to the realities of the national situation than to the general canons and conventions of traditional management. Decentralization, implicit in PHC, suggests that successful management is not attainable from the efforts of a separate set of workers regarded as "the managers." Instead, PHC requires the accomplishment of management tasks and responsibilities by numerous, varied and dispersed service and support personnel. Management tasks should be identified for each personnel category or position and appropriate training organized, focusing on concrete activities. Some countries will need assistance in this area. It is not unusual to find national administrative systems (either indigenous or inherited from a colonial period) in which the major emphasis is on the control of transactions, rather than on the enhancement of functions, and which are so centralized that no transaction is too small to require review and approval in the national capital.

Political factors can affect the operation of a ministry of health; for example, accountability can be compromised by political connections. In such circumstances, it is not likely that effective management methods will be adopted and institutionalized. When the PHC strategy is based on active community participation, the government may be reluctant to promote local self-determination and self-reliance, because CP raises expectations and can lead to political unrest.

While development planning and management, beset with uncertainties and incomplete data, is a difficult and complex process at best, additional complications can be expected in managing primary health care programs because of the decentralization implied by the PHC approach. The need for community participation in planning and action as well as the goal of intersectoral collaboration, imply exceptional use of consultation and negotiation techniques at every stage.

Inter- and Intrasectoral Coordination

Intersectoral involvement is not itself a panacea. Overemphasis on the relationship between socioeconomic development and improved health can be used to rationalize the delay of health program activities until progress is made in other sectors. The problem of achieving intersectoral coordination cannot be solved through expressions of good intentions and vague agreements. A PHC strategy should specify how coordination and collaboration will be achieved at each level of program responsibility and provide a schedule for accomplishment of tasks.

While national level planning and programming are likely to involve political leaders and the executives of the finance and

interior ministries, this may not be the case with sub-national levels of administration--regions, states, provinces, and districts/municipalities. More effort should be made to bring in non-health agencies and officials at those levels; they are potentially powerful allies in effecting intersectoral coordination and in fostering community participation in their jurisdictions.

Attention is also needed on coordination within the health sector. The extensive coverage and community penetration that is expected of primary health care will put a premium on effective support arrangements by different divisions of the MOH or other health agencies. Essential support services include supplies and drugs; transportation of patients and materials; communications between service sites and administrative centers; hiring and payment of health personnel; maintenance of vehicles, equipment and buildings; and recording and reporting of essential statistical data.

The importance of developing effective support systems has been amply demonstrated by breakdowns in both traditional and innovative health care programs due to the neglect of logistics. Often, the emphasis has been on construction of facilities and acquisition of equipment, with little attention to maintenance and systematic replacement of goods.

Community Participation

Where political or organizational obstacles are encountered, the PHC strategy can be modified to accommodate the political environment. It is possible, for example, to have a program which achieves a significant impact on mortality rates but which lacks community participation (e.g., an efficiently managed service delivery scheme using government health workers). But health improvement may be a short-term benefit and, if outside services end, health status may again decline because of the failure to organize the community to accept responsibility for its own health.

When a community participation strategy for PHC is planned, considerable effort will need to be expended to implement it. Some program plans seem to reflect the feeling that CP and effective community organization will automatically occur; no special efforts or resources are earmarked to make them happen. It is no wonder that CP has been judged ineffective in many PHC programs. Participatory development efforts rarely begin spontaneously, particularly among the poor who are often unaccustomed to exercising control over their own destiny. Participation, whether inspired by outsiders or initiated locally, requires a considerable and continuous organizational effort.

International development cooperation agencies, if sincere in their desire to foster community participation, must avoid being rigid. Planners may not be able to initially identify and budget all proposed activities as room must be left for community priorities to emerge. Donor agencies can avoid "tying" goods and services (e.g. U.S. procurement by AID). They can cover local and recurrent costs for limited periods until projects are well underway. They need to modify their reward systems to foster institution building. And they must avoid imposing administrative structures which work against local institutions; rather, cooperating agencies should try to strengthen local organizational capacity.

Personnel

To be effective, community health workers must be trained for specific, well-defined tasks; provided with frequent, supportive supervision; and adequately compensated and supplied with medicines. They should not be overburdened with unrealistic tasks.

It is especially important that CHWs be fully linked to other levels of the health system, in order to function effectively and gain the confidence of the community. CHWs and, indeed, the PHC concept itself are critically dependent on physicians and nurses who can function in other than conventional modes. PHC requires many medical professionals to act as managers, teachers, and exemplars of proper health behavior. It requires that they bring medical and epidemiological insights to planning, policy formulation, and decision-making. Medical staff must be reoriented to adopt the team approach that PHC requires. Reorienting medical professionals is critical to the development of realistic PHC strategies. In some developing countries with long-standing concerns about the lack of congruence between traditional medical curricula and the health needs of the country, the basis for obtaining the collaboration of medical educators and leaders of organized medicine already exists.

In attracting the support of new physicians to PHC, the challenge is to make preventive and promotive work as exciting as curative work. In curative work, sick children get better fast when the correct medicine and therapy are provided. The result is tangible. But prevention and promotion are slow. Results are more difficult to assess. Built-in measures of program success -- such as the percentage of children gaining weight in the case of a nutrition activity -- are necessary as indicators of program performance.

Need for Research

Health services research can be difficult and unpredictable. Important baseline data frequently do not exist or are unreliable and fresh data are costly to obtain. Service-oriented personnel may view research as a low priority. Experimentation in service delivery over the next few years will be extensive; research is an essential part of that experimentation. However, research efforts should not overwhelm or constrain delivery, and they should consume only a small portion of scarce resources.

Health services research goes beyond monitoring and evaluation; its results can provide useful information on the costs and effectiveness of various interventions, resources, tactics, and patterns of service delivery. Although much is known about the efficacy of numerous techniques for preventing and treating many of the diseases prevalent in the developing world, little is known about how to apply those techniques in the context of PHC. Operational research to fill this gap is essential.

Conclusion

The workshop discussions have indicated a number of problem areas in implementing and, especially, expanding PHC programs. This discussion is not intended to discourage PHC efforts, but to help those contemplating such undertakings to take a realistic approach. There are certain aspects of small-scale projects which are extremely difficult to replicate because of the time and resources they require or the opposition they arouse. Increased understanding of these constraints, however, can facilitate progress toward ultimate PHC goals. Wide-scale PHC is possible, but it takes much more time than has been allotted in the past, and requires much more attention to organizational and managerial factors to become a reality.

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