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**APPROACHES TO INTEGRATED PROGRAMS:
HEALTH, FAMILY PLANNING AND DEVELOPMENT**

A Strategy Workshop for Private Voluntary Organizations

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PREFACE AND ACKNOWLEDGEMENTS

One of the issues facing development planners, including health and family planning specialists, is whether programs should be implemented through tightly-defined categorical ("vertical") projects, or through more comprehensive "integrated" projects. U.S. private voluntary organizations (PVOs) are in the forefront of this discussion. Many PVOs are dedicated to providing a single service. Others provide services in an integrated project format.

The United States Agency for International Development (AID) is particularly interested in practical experience of PVOs in implementing vertical and integrated health programs. There are important lessons that can be learned from their collective experience. Therefore, AID provided a grant to the National Council for International Health (NCIH) to sponsor a workshop examining the comparative advantages of vertical and integrated projects. NCIH, in turn, enlisted the Center for Population and Family Health (CPFH) of Columbia University to assist with the design and implementation of the workshop.

A total of 34 participants representing 27 PVOs attended the workshop, which was held in Washington, D.C., April 12-14, 1982. The workshop included formal presentations by experts in the field (see list of speakers, page 30). In addition, participants were divided into three working groups, which reviewed the speakers' remarks and discussed examples from their own programs in order to identify key concepts and characteristics. Rapporteurs, provided by CPFH, recorded the discussions. At the closing session of the workshop, representatives of the work groups presented synopses of their groups' discussions.

The following report represents an edited synopsis of the formal presentations and group discussions at the workshop. Where an author is identified (see, for example, The Program Setting, Joe Wray, page 6), the text is based upon a formal presentation by that person. Every attempt was made to retain the integrity of content by the original speakers, but NCIH and CPFH take responsibility for this final document, with both its contributions and limitations.

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SUMMARY

Many millions of people in developing countries lack even the most basic health care services. They also need help in order to improve their lives in other ways, such as through better water and food supplies, and income generation. In recent years, professionals working in health and development programs in poor countries have come to realize that single-purpose programs are often neither the most effective nor the most efficient way of addressing these needs. Integrated programs take into account the fact that poor peoples' problems are interrelated. Such programs can also make more efficient use of the limited personnel and funds available to meet these many needs.

A Workshop on Approaches to Integrated Programs, attended by representatives from 27 private voluntary organizations (PVOs) involved in health, family planning and development projects, was held in April, 1982. The purpose of the workshop was to bring together people with extensive and varied experience in health and development programs so that they could share their knowledge and experience. This is essential for the development of successful integrated programs, which have many of the same requirements as single-purpose programs, but which are also qualitatively different in important ways.

In the course of the workshop, characteristics of successful integrated programs and their policy implications were identified:

- o Community participation is essential for the success of integrated programs. This means that establishment of a dialogue between the community and the program agency must be one of the first steps of program development.
- o The community must participate in the design, planning and management, so that the community can carry on the program after outside assistance is reduced or terminated.
- o In the most innovative and dynamic programs, there is usually a charismatic leader. The identification and training of community leaders is crucial to the success and survival of integrated programs.
- o Building an infrastructure that is extensive, but simple

and feasible, and which provides dependable supplies and support, is an essential prerequisite of adequate service delivery.

- o Community workers play a crucial role in delivering integrated services. Much is known about how best to select and train them, and what to expect of them, but all too often, this knowledge is not applied.
- o Care is needed to avoid overloading the community workers or the system in integrated programs. Gradual expansion of services is one way to accomplish this.
- o Donor agency and PVO policies have a profound effect on programs. Due to the qualitative differences between integrated and more conventional programs, agencies must develop new, appropriate and flexible mechanisms for funding, technical support, reporting and evaluation.
- o Integrated programs, by their very nature, will require more time to develop than will conventional programs. If unrealistically short time frames are imposed, they will seriously undermine the program.
- o When several agencies collaborate on an integrated project, it is important that they not overburden the program with their separate reporting and evaluation systems.
- o Collaboration on integrated programs among agencies and PVOs with different areas of expertise is much more sensible than each agency trying to expand its area of operation to encompass the various components of integrated programs. However, this requires a willingness on the part of the agencies involved to compromise and to change.
- o A viable, self-sufficient, ongoing program is the ultimate goal of an integrated program. Nevertheless, demonstration projects may have a place, even if they are unlikely to be replicated, since they can be instrumental in improving delivery methods, training personnel, and demonstrating the feasibility and effectiveness of integrated programs.
- o Evaluation of the final outcome of a program is often the main concern of donor agencies. Continuing evaluation should, however, provide feedback and guidance for program modification.

Although the development of integrated programs presents agencies with new and sometimes difficult problems, these can usually be overcome, and successful integrated programs have unique and important benefits.

INTRODUCTION

Allan Rosenfield

This workshop was convened for three principal reasons:

- o There is a global commitment to the delivery of basic health and development services to underserved populations. There is also an increasing awareness that many of these basic services are most appropriately delivered as an integrated package (for example, maternal and child health services, nutrition education, and family planning).
- o A great deal of experience had accumulated in recent years in the delivery of integrated services. Issues raised and lessons learned can and should be applied whenever improved service delivery is contemplated.
- o Private voluntary organizations of many kinds are involved in the delivery of a variety of services all over the world. Some of these are delivering categorical services and are interested in developing more comprehensive services; others are providing integrated services and would like to improve them. These organizations can benefit from opportunities (such as this workshop) to compare experiences and share knowledge gained about how to deliver services more effectively and efficiently.

The issue of integration of health and development programs is not new, but it is being discussed in a new way. The question being asked now is not whether to integrate, but under what circumstances and how to integrate.

During the last decade we have seen that single-purpose ("categorical") programs can be effective for some purposes. The eradication of smallpox is, of course, the most dramatic example. However, we have also learned the limitations of categorical programs. The many problems experienced by people living in the urban slums and rural areas of developing countries are interconnected: immunizing children against contagious diseases may not lower the mortality rate if they are malnourished and drink polluted water. It is the growing awareness of the interrelationships among these and other problems which has

provoked renewed interest in integrated programs. For professionals involved in health and development programs, the goal is not, for example, simply to lower the incidence of a given disease, but to improve the standard of living of the people served.

This workshop was designed to explore the role of private voluntary organizations (PVOs) in integrated programs in developing countries.

Among the rationales for integration are the following:

- o More efficient use of funds, personnel and other resources, together with elimination of duplication of efforts, are crucial given funding cutbacks and international inflation.
- o The integration of several programs can strengthen the infrastructure by reducing competition for scarce resources between programs.
- o Integrated programs make possible more flexible responses to the felt needs of a community.
- o Community participation is an important component of development projects, and since people in villages and urban slums do not experience their problems "categorically," they are probably more likely to participate in integrated programs.
- o Various problems, such as poor nutrition and high infant mortality, are functionally related and their solutions cannot be separated.

Even though family planning is a health program, it is mentioned separately in the title of this workshop because it exerts a major influence on both health and development. While mortality rates have declined dramatically during the last two decades, fertility levels have remained high in most developing countries, producing unprecedented population growth. This trend has made it more difficult for poor countries to provide their citizens with basic services, and in many cases has undoubtedly hindered development efforts. In addition to its effect on development, family planning directly affects maternal and child health: when women have access to modern contraceptives, they generally choose to avoid having children very close together, or when they are very young or near the end of their reproductive years. Generally, women also prefer not to have very large families, when they have a choice. It so happens that birth spacing, maternal age, and family size are important factors in both maternal and infant health, and through these choices women can reduce health risks for themselves and their children.

Integrated programs show great promise for improving delivery of many kinds of services. However, such programs, like categorical programs, have their strengths and weaknesses. Therefore, it is important for PVOs, with their wide experience in various kinds of programs, to review and discuss them, and then try to distill out of these discussions some guiding principles for donor agencies and their own agencies to bear in mind.

THE PROGRAM SETTING

Dr. Joe Wray

In discussing integrated programs, we must think first about the people we are trying to help and their social context. In many poor countries, the disparity between the circumstances of poor people, who constitute the majority, and those of the small social elite, is hard for people in developed countries to imagine. This is important because in most developing countries PVOs trying to establish a program must work with the elite. Government officials and physicians at the top of the health care system either belong to this elite or identify with it.

It is against this background of poverty and inequity that we need to examine health and development problems. First, we must identify priorities. For example, a large proportion of the preventable deaths in poor countries are among children younger than three. What is needed to prevent these deaths? In medical terms, the list is not long. A few diagnoses account for most of the visits to health centers and most of the needless deaths. This means that we do not have to integrate all the medical specialties in order to prevent the majority of deaths among children. In general, a limited program focused on priority needs will have a greater impact than a more comprehensive program which is over-extended.

Many health professionals have come to recognize the need for integration through their experience in the field. For example, pediatricians in the Third World are all too familiar with treating a young child for serious malnutrition, and then several months later seeing the same child back in the emergency ward for the same reason. Many physicians have concluded that categorical programs are just not effective in the face of interlocking problems.

What, then, is the best way of addressing the multi-faceted problems of poor people? The answer is that there is no magic solution -- no "best" approach for all situations. What is needed is to examine programs that work, and also those that don't, and look for the features which contributed to success or failure.

What are the common features of good programs, whether integrated or categorical? Certainly one of the first questions to ask is: "Is it appropriate?" A common element in many

unsuccessful programs is that they were based on the idea of a "technological fix." For example, some of the current enthusiasm over water programs ignores the complex relationships between water, food, and behavior. An important ingredient in successful programs is the motivation of the personnel. But even devoted and energetic people can accomplish little if they don't know how. They need information and training. Similarly, good training can be wasted if the program into which the trainees are fed does not provide them with adequate supervision, supplies and support.

While motivation, leadership, and many other factors are necessary for both integrated and categorical programs, there are certain program characteristics which, in general, favor one approach or another. A program which is highly technical, and requires little behavioral change on the part of the people it serves, may well be successfully implemented with a categorical design. Examples of this kind of program are immunization and malaria prevention programs. However, interventions which require a substantial amount of behavioral change, such as nutrition education programs, are more complex, and are probably better implemented in an integrated program.

Keeping in mind this general overview of the setting of programs in poor countries, it is worthwhile to consider some specific elements of the setting and their implications.

1. THE PHYSICAL SETTING.

The **geography and topography** of a district to be served by a program are important determinants of the accessibility of the services to be delivered. The transportation system in that district is a closely related factor. The amount of time required for travel by the personnel delivering services, or by the population seeking services, is an important factor in utilization.

Settlement patterns are another closely related and important factor. Whether the population to be served is widely scattered, settled in villages, or densely packed in urban slums, must be taken into account in planning services delivery. Where people live close together and transportation is easy, one health worker can serve many; that same number may be impossible for a single worker to serve where the population is widely dispersed and travel is time-consuming.

The **availability of water** and seasonal variations in water supply are other aspects of the physical setting that affect peoples lives. Whether or not better water supply alone will prevent diarrheal disease in children, there is no question that in many parts of the world obtaining sufficient water to meet minimum drinking, cooking and washing needs is an extremely time-consuming process and lack of water limits personal and household hygiene, agriculture, and other income-producing activities. It appears that within limits, quantity is more important than

quality. Efforts to increase the supply of water are surely warranted.

2. THE POLITICAL SETTING.

Political systems, whether leaning to the "left" or the "right," are important factors in the program setting. The challenge to leaders, whatever the political system of their country, is to find ways to work effectively within that system both to extend and to improve service delivery.

Political will is often cited as one of the essential elements for improved services. Where governments give sufficiently high priority to meeting basic needs, significant improvement can usually be achieved.

Political leaders tend to pay enthusiastic lip service to improved standard of living. Unfortunately, their commitment to this goal is often demonstrated through capital-intensive projects, such as the building larger and more costly hospitals and dams. What politicians need in many cases, is a convincing demonstration that improved primary health care and community development are possible within the various constraints that exist in most countries.

Linkages with the official programs need to be developed if experimental projects are to be used elsewhere in the system. Scores of well-intentioned, relatively effective projects have been carried out around the world, only to disappear eventually because they were not tied into the existing system and could not be scaled-up or continued.

Good logistic support is an essential element in any effective health care delivery system and is notoriously lacking in Third World health care systems. Many key activities do require supplies from the outside: antibiotics, oral contraceptives, and many other drugs simply cannot be provided locally, and must therefore be brought in from the outside in a systematic and dependable manner. Community health workers, however highly motivated or well trained, cannot perform their duties without necessary supplies.

3. THE SOCIAL SETTING.

The **social structure** of a given population is another factor that is important in planning projects. Cultures in which the community is cohesive and contains active community organizations provide a favorable setting for health care and development programs.

Community leaders. The support and cooperation of local leaders, (whether they are political, religious, or other) is important in health and development programs. Strategies for obtaining such support and cooperation must, however, be based on

sound knowledge of the relationship between the leading elite and the rest of the population.

Socioeconomic class. The neediest segments of the population tend to be in the lower classes, and programs require creativity and persistence in finding ways to reach these deprived groups. Providing services to these people may have to begin with explicit efforts at consciousness raising.

The status of women deserves special attention in health and development programs. In many traditional societies, women contribute a major part of the family's food and income. However, this fact has often been ignored in development programs, with the result that in some cases they have helped worsen women's lot in recent years. Both as childbearers and as the people most responsible for taking care of children, women are of central importance to the family's health.

Traditional health workers are found in every society. There is a tendency on the part of program planners to ignore them, yet experience suggests that they can be usefully incorporated. Perhaps the most widespread example of this is the incorporation of traditional birth attendants (TBAs) in maternal and child health programs through training.

While traditional health beliefs often do not conform to modern scientific concepts, many of them can be beneficial. Anthropological studies have suggested that educational efforts are most effective if they are based on sound knowledge of local beliefs; maximize beneficial practices; and, wherever possible, provide messages that are consistent with these beliefs and practices.

Educational levels and literacy rates will determine the most effective approaches to community education, as well as the kind of personnel available for training as community workers or for other positions. In planning programs, however, it is essential to bear in mind that experience in many projects has shown that where careful efforts are made, illiterate workers can be trained to carry out a great many of the basic activities that are needed.

Educational methods characterized by rote memorization prevail in formal educational systems throughout most of the Third World. However, in most of these cultures the skills that people use daily to survive and enjoy life -- food production and preparation, child rearing, weaving, singing and dancing, etc. -- are all acquired outside the formal educational system. People acquire these skills by doing them under the guidance of people who have already mastered them. There is a lesson in this, but that lesson has been forgotten in most training programs for community-level workers, which tend to rely very largely on didactic lectures and rote memorization.

4. THE ECONOMIC SETTING.

Poverty is an ever-present feature of life in the Third World. Furthermore, not only are families poor, but the official programs in such countries must operate on extremely limited budgets. The cost of minimum packages of services have, however, been shown to be within reason. For example, a number of simple but effective primary health care projects have been found to cost between 0.5 and 2 percent of the per capita GNP.

Community Resources. People are spending money on health care even where family budgets are minimally adequate. Many of the personal or family expenditures are for measures that are ineffective. One of the goals of an improved primary health care project should therefore be to educate the population to spend their available money on more effective measures.

Income-generating activities that can help poor families to improve their standard of living are clearly needed. Because of the relationship between poverty and health, such activities have come to be considered a legitimate part of health care in community-oriented health programs.

5. THE TIME SETTING.

Effective and efficient health and development programs are complex and take a long time to develop. But program planners, especially those who carry out such programs on a "project" basis, are almost always compelled to operate within a budget year context. The time-frame within which such projects must operate is always limited, sometimes to the detriment of effective program development. Finding ways to provide the kind of sustained support that is essential for good program development thus must be a major goal of all organizations concerned with improving health care.

COMMUNITY INVOLVEMENT AND PROGRAM DESIGN

The Importance of Community Involvement

Juan Flavier

The basic problems of the rural masses -- illiteracy, poverty, disease and civic inertia -- interlock. Therefore, success in solving one problem depends on success in solving the others. The key to solving these problems lies in the development and/or strengthening of community-level organizations. And this, in turn, cannot be accomplished without active participation of the community in planning, implementation and evaluation of projects. The reason for this is that the goal is the release of the people's potential for individual and collective growth, economic productivity, and social and political responsibility. Consequently, outsiders can help, but local people must do the work. Private organizations with limited resources should concentrate on developing techniques and methods for development in collaboration with the community. The best of these methods can then be implemented more widely by national agencies.

Some years ago it appeared that a project of the International Institute of Rural Reconstruction (IIRR) in the Philippines was going well. The field workers were highly motivated college graduates, providing a number of services. But the various services were not truly integrated. Furthermore, while the high educational level of the workers seemed at the time to have been an asset, this was not the case. To begin with, they spoke in language that was unnecessarily technical, so it was important for them to live in the villages and learn to express ideas in simple terms and concepts familiar to the villagers. There was an even deeper problem, however, in that these enthusiastic young people were in fact fostering the villagers' dependency upon them, which was an underlying problem. For these reasons, when an evaluation of the farmers' education school was conducted after years of operation, it was found that only 12 percent of farmers were using the techniques taught at the school. Of 44 villages where the IIRR staff had initiated programs and then moved on, leaving the program in the hands of the community, the program was still operating in only four villages.

This experience forced the IIRR to look at their program in a new way. Were they trying to develop a services delivery system? No. The government could do that. They were trying to develop the capabilities of the community, which means that concerns of the people have to be identified, and solutions must have their basis in the community. The new farmers' school was named by the community -- "School for the Children of Sweat". In local tradition, naming is a sign of ownership. The villagers helped design the curriculum and participated in the management of the program. Even more important, each village paid part of the cost of sending some of its members to the school, and it elected the trainees. In return, the village expected those who received training to teach other villagers what they had learned.

This kind of program has definite implications for PVOs and donor agencies. It is a process which cannot be rushed because it is not imposed on the community, but grows out of it. Rushing a project short circuits true integration. At times this process can be frustrating for professionals, but we must remind ourselves that if you have an egg and you want to scramble it, that only takes 10 minutes. If you want a chicken, that takes 21 days.

Case Studies

David Loretan

The projects of the Catholic Relief Services (CRS) in Latin America illustrate the importance of community participation in the planning and implementation of integrated programs.

In the high desert area of Bolivia, CRS representatives and Indian farmers worked together to develop a system for marketing a kind of wheat called "quinua" (pronounced keee-noo-a). This wheat is adapted to high altitudes, and the people grow it on their small farms. There were problems facing the project. For example, quinua has an outer husk which must be removed by a special processing step. With the help of the CRS staff, the farmers analyzed the obstacles, devised solutions, and designed a project which was successfully implemented. The government of Bolivia is now encouraging the use of quinua to cut down on the amount of wheat the country imports.

Another successful project was the development of a women's agriculture project in the north of Peru. Women and Indians have generally been neglected in development efforts in Latin America. The project was designed by a Peruvian sociologist, the head of the local chapter of Caritas (a CRS affiliate), and local women. Furthermore, local people contributed resources and labor to the

project, including the building of six agricultural substations. At these stations, various crops and farming techniques were tried out to see which would work best. Assistance in small animal raising was also provided.

In contrast to these two successful projects were two others which did not work well, in large part due to a lack of community participation and involvement. One was a project designed to provide 1,000 people with clean water. However, when the pump broke down, none of the local people could fix it. Another project, which sounded good on paper but failed in the field, planned for mobile health teams to go out into the rural areas from the hospitals. When the project had been funded, it was learned that the person who designed it was not familiar with the area's health problems, not even consulting the local nursing sister. Furthermore, some of the outreach workers (**promotoras**) were chosen on the basis of their political connections, rather than their interest in or aptitude for the work.

As these four projects illustrate, it is crucial to draw on local experience and expertise and involve local organizations (where possible), as well as to provide technical training and support.

CONSTRAINTS ON INTEGRATION

Recognizing the Constraints

Njoki Wainaina

While categorical and integrated programs require many of the same characteristics in order to be successful, there are certain constraints and difficulties which are more common in integrated programs. These difficulties are certainly not insurmountable, but they should be recognized at the outset. Some of the types of constraints faced by integrated programs are the following:

- o Collaboration is a key factor in developing integrated programs. Their success often depends on how well development agencies collaborate and coordinate their efforts. The flexibility that characterizes the work of most PVOs makes them the best collaborators with each other and with governments. With good coordination, PVOs can jointly fund projects. However, care must be taken not to over-burden projects with different donor funding, monitoring and reporting systems.
- o In financing projects, donors need to assess the capacity of local organizations and communities to continue projects after external funding ceases. This means not setting program costs -- buildings, machinery, salaries, etc. -- so high that they cannot be maintained. Many community and group projects need only small amounts of money to boost their self-help efforts. Most donors are not interested in this level of funding, as it presents problems, especially in terms of administration and accountability. Self-sufficiency should be a goal in all projects and communities should be helped to plan for it right from the beginning. Every project should include some contribution from the community, whether it is in the form of labor, materials or money.
- o In most countries, governments are structured vertically, while integrated programs require the development of horizontal working relationships. Government bureaucracies are often rigid, and the establishment of

such relationships can be a formidable task. However, without horizontal communication and coordination, the decision-making process becomes fragmented.

- o The policies of ministries within governments are generally not designed in a coordinated manner. Needs assessment and resource allocation are carried out in a sectarian fashion. The process of creating systems more appropriate to integrated programs is often slow and difficult, and often beyond the capacities of PVOs. In addition, many governments are sensitive to criticism from outsiders.
- o The personnel and other resources within organizations (both governmental and PVO) are oriented to a particular field of interest. Consequently, programs attached to them will tend to become focused along those lines. This raises the issue of where, among the various groups involved in an integrated program, to base the project. The question of donor orientation also affects evaluation. For example, are donors interested in family planning willing to recognize as successful integrated programs which do not increase contraceptive acceptance rates, but which do improve the health and nutrition of a community?
- o One of the barriers to collaboration is the fear of being taken over. Smaller agencies fear that their programs will be swallowed up by larger agencies, or that their efforts will no longer be identifiable.
- o While integration makes a great deal of sense to those who advocate it, it often calls for patience and more commitment than is available. For many agencies and individuals, it is easier to plan and implement their own categorical programs. Many agencies are quite happy to talk about the merits of integration, but their interest and enthusiasm wanes when it comes to the sharing of resources, taking joint responsibilities for successes or failures, tackling priority community rather than agency needs, joint planning and reviews.
- o The benefits of integration are most obvious at the program level. At higher levels of administration the benefits may not be clearly apparent. Therefore, it is crucial to educate and motivate officials at the top and middle levels.
- o Lack of managerial skills among program staff is one of the major constraints that face most projects. This could be overcome by providing short, to-the-point courses on such topics as planning, financial management, monitoring and reporting.

- o Documentation of project experience, whether success or failure, is necessary in order to share important lessons. Unfortunately, project staff often lack the time or skill to adequately document and disseminate their findings.
- o Donor agencies, in their enthusiasm, sometimes proceed with the design and implementation of projects without a full understanding of the local political, cultural and religious context. In so doing, they set goals and expectations that are not realistic. The entire design of a project, including the time table and reporting system, should reflect the actual situation and be realistic. Study missions before or during the planning period are a worthwhile investment.
- o Lack of infrastructure is a common problem. Motivating people to use family planning when adequate services are not available or accessible, or developing crafts cooperatives when marketing outlets have not been established, only leads to frustration for the community and the program staff.

While this list of constraints may seem formidable, the need for integrated programs is great. There are deep-rooted traditions of self-help and community action in many poor societies which need only to be encouraged and developed. Therefore, with commitment on the part of agencies, and with true involvement of the community, integrated projects can succeed.

Case Study

Sondra Zeidenstein

Several of the constraints which are particularly common in integrated programs emerged in a project for rural women in Bangladesh. The project was part of a rural development program of the government which had concentrated on activities which have traditionally been in the male domain in Bangladesh. The funding for the women's project, which encouraged the organization of economic cooperatives for women, was from the population branch of an international agency. Family planning education was a basic part of the project. This dual nature of the project created some confusion both at the administrative level and among the village women.

Lack of realism in the original plans was another problem. Developing and monitoring an economic program in rural areas involved learning about rural women's priorities; recruiting,

training and supervising field staff on an on-going basis; organizing women; helping them develop viable projects; and supporting them with credit and technical advice. The original plans allowed too little time for training. The budget system made it difficult to shift funds from one budget line to another, as the need arose.

Integrating the women's project into the existing rural development institute caused tensions, and the women's project had to struggle for acceptance at every level of the institute. However, the existence of already functioning management and administrative systems, and of established contacts in the villages, greatly facilitated the progress of the program. Both in terms of the number of cooperatives established and the proportion of women using contraceptives, the project exceeded the original goals.

There are now efforts to build on the success of the original project by adding a number of new activities. Certain activities fit in with little disruption. It was relatively easy to add business administration and cooperative law to the courses offered to the group-appointed delegates who receive special training. Other activities, however, are more difficult to integrate. For example, when the project staff decided to look for ways to improve the health care available to its members, the most sensible way to do this was to form a link with a PVO which had years of experience in training rural women as para-professional health care providers. When the training project got underway, however, it was clear that there would be friction as the two institutions attempted to work together. The slow and cumbersome movement of a government program is familiar to those who work within it, but frustrating to the staff of an organization with more flexibility and autonomy, such as a PVO. Some strain occurred whenever the women's project and an outside agency first worked together. The success of these collaborative efforts depended to a large extent upon how willing workers in the PVO or categorical program were to tolerate the frustrations and difficulties built into the situation.

This case study demonstrates both the potential difficulties of developing an integrated program and the rewards of successfully dealing with the constraints.

POLITICAL ISSUES

Political and Ethical Considerations

James Levinson

The philosophy behind integration implies that there are no easy solutions to the problems faced by the world's poor people. For example, there appears to be no situation in which it makes sense to carry out a child feeding program in the absence of broad maternal and child health care. In 1977 a five-country study of CARE child feeding projects found little improvement in malnutrition in the program areas. Among the reasons for this were: the children reached were neither the poorest nor the most malnourished; most of them were already past the first three critical years of life; feeding programs were not integrated with health and educational services. This example points up the need for sensibly integrated programs with broad community involvement, especially the involvement of mothers, who are primary change agents in villages. Programs such as Narangwal, Companiganj, the Health Guards in the northwest of Pakistan, and the **promotora** programs in Latin America offer greater hope for the success of community level programs.

However, such programs are neither simple nor inexpensive to develop and maintain. This brings us to the issue of political commitment to bettering the lives of the poorest people. With true commitment, it can be done. For many years, through the mid-1970s, Sri Lanka represented a model of governmental commitment to meeting the basic needs of all its people. This commitment was expressed in a broad range of services including food distribution, health care, education, transportation, land reform, a progressive tax structure and large scale employment of women. As a result, malnutrition and infant mortality were much lower in Sri Lanka than in other countries with similar per capita gross national product. Furthermore, due in part to the widespread accessibility of family planning services, the birth rate declined from about 40 births per 1,000 population to 27 in the space of 25 years. All these changes took place in the context of low levels of traditional measures of economic growth.

In the late 1970s a new government, heavily influenced by the International Monetary Fund, exchanged "expedient politics

with sound economics." Among other changes, major human services were cut back, food subsidies were eliminated and foreign private investment welcomed. As a result, increases in malnutrition were found in several parts of the country and there is preliminary evidence of an upturn in the birth rate.

The political climate of a government not only affects the likelihood of a program being successful; it is also a factor to be considered before deciding to work in a country. It may be legitimate to decide not to work in a particular country which has a repressive regime, although this will depend on the individual or organization and the country. In any case, the ethical implications of the decision to work with a particular government should be kept in mind, and not lost amidst the technical issues.

Integrated Programs and the U.S. Congress

Margaret Goodman

Since the passage of the New Directions legislation in 1973, Congress has repeatedly endorsed the concept of integration of programs. In Congress, as in PVOs, there has been a growing recognition of the interrelatedness of various problems in the Third World. However, the temptation to look for simple answers has not disappeared completely. In addition, the need for financial accountability creates pressure to fund categorical programs. There is also some reluctance in the Agency for International Development to combine funds from separate budget lines for integrated projects, although this is less true of the health and family planning offices than of some others. Despite these obstacles to integration, the general belief in Congress is that integration makes sense. A substantial number of studies would have to show that it doesn't work before Congress would seriously question this belief. Therefore, the issue before the workshop -- when and how to integrate programs -- is of great interest to Congress.

While "split-funded" programs (those funded from two or more accounts) are rare in AID, they are becoming more common, in part due to tight funding. In general, the outlook for development funding is not bright. The emphasis of the current Administration is on security assistance, and development assistance funding is likely to be "straight-lined" -- that is, continued at present levels. As for particular assistance programs, health is a low priority with the Administration, and has been drastically cut back domestically as well as in international assistance. While there have been some attempts to cut back international population funds, these efforts appear to have been fought off successfully.

Programs which truly involve the community take longer to get into operation than other programs. Some members of Congress have begun to realize this, and understand that initial expectations are frequently unrealistic. Nevertheless, appropriations committees want to see quantifiable results within a reasonable period of time, and they apply pressure to AID, which in turn pressures the people running the program.

MAJOR THEMES, CONCLUSIONS AND RECOMMENDATIONS

During the discussion group sessions, the following central issues and policy implications were identified:

Integration is a way of life at the village level. In the day-to-day lives of villagers and slum-dwellers, nutrition, health, water supply, income generation and family planning are intimately related. This fact affects the design and management of integrated programs. They differ from categorical programs in fundamental ways, and these qualitative differences must be reflected in all stages of program development and implementation in order for integrated programs to succeed.

True community involvement, which is an essential component of integrated programs, must be part of the earliest feasibility assessment. What are the expressed needs of the community? Are these needs compatible with the agency's focus and capabilities? If there is a substantial divergence between the community's felt needs and the agency's interests and experience, even after discussions between the community and the agency, it may be better to put community leaders in touch with some other agency which has experience in the area of community interest, rather than proceed with a project which does not have true community backing. The principle behind this is that, while a categorical program may in some instances succeed without community involvement, an integrated program must evolve out of the community, with assistance from outside agencies, but not their dominance.

Community workers are an essential part of integrated programs. How are they to be selected, trained, supervised, motivated, and compensated? The approaches chosen should be culture- and situation-specific, but experience suggests some useful generalizations:

- o The community -- not merely the local elite -- should participate in the selection process.
- o Workers' age, sex and marital characteristics should conform to local values, and may differ according to the service provided. For example, older, married women are usually best suited for maternal and child health services.
- o Training must be practical, and the tasks to be taught

feasible. A few days of training at monthly intervals, each session providing another set of skills, is a better approach than one long session.

- o Gradually increasing the range of activities to be provided is important in order to avoid overloading workers. A few appropriate services, effectively delivered, are far more useful than a textbook array of services, which cannot be delivered in a consistent or effective manner.

The limitations of existing health care infrastructures are a problem throughout the developing world. Perhaps only 10-20 percent of the rural people in poor countries ever see a doctor. Thus, extending the health worker network and the necessary support systems is a high priority. Once supply lines are functioning, and trained workers are providing a few services well, then other activities can be integrated. This should be done gradually, carefully avoiding overloading the system.

Despite the importance of preventive and promotive services, a community's felt need for curative services must be taken into account. Furthermore, prompt, simple, effective treatment of prevalent illnesses (such as oral rehydration therapy for diarrheal disease in children) can immensely enhance the credibility of the community health worker and the program.

Income generating activities as a part of community-based integrated programs are difficult to carry out effectively. Because poverty is at the root of many health problems, however, such activities are important. There have been many successful income-generating programs around the world, but success almost always requires going beyond merely teaching the requisite skills: materials must be supplied, quality controls and marketing cooperatives developed. Nevertheless, in severely deprived populations even small increments in income can make a substantial difference in the people's standard of living.

Politically repressive governments and grossly inequitable economic systems raise ethical questions. Should PVOs or other donors consider carrying out projects in such countries? There are no hard and fast answers, but several factors need consideration:

- o Those are usually the very countries in which the need of the poorest people is greatest.
- o There are almost always caring, committed people doing their best to provide better services in spite of constraints and they are often desperately in need of outside support and encouragement.
- o Well-executed projects can produce improved methods, better trained people, and institutional structures able to function more effectively within the existing system.

Replication of projects is a matter of major concern. Should a PVO or other agency undertake a project when there is little likelihood that it will be continued and expanded? There is no doubt that projects initiated with great fanfare and lavish promises, then discontinued when donor funds are exhausted, raise false expectations and can disillusion the community served. For this reason alone, project planning and implementation should always be carried out with existing constraints in mind so that scaling-up is possible. In addition, eventual self-sufficiency, to the greatest extent possible, should be a goal. Even where replication may not seem likely, however, good demonstration projects can sometimes be justified on the grounds that they may provide:

- o methods that can be used elsewhere, even if the whole program is not continued;
- o senior staff, capable of developing, testing and evaluating improved methods of service delivery;
- o a site for on-the-job training for lower level personnel;
- o a concrete demonstration to policy-makers of useful services that can be delivered under existing constraints.

Evaluation of integrated programs is needed both to demonstrate their effectiveness, *per se*, and also to demonstrate to donors that the funds were well spent. Aside from these considerations, on-going evaluation can identify problems requiring immediate attention and provide feedback to program workers. If evaluation is to be useful, the information on which it is based must be kept simple. A limited amount of data, collected regularly, will be far more useful than a large amount recorded sporadically and carelessly. Furthermore, outcome data are more valuable than activity data. For example, evaluation should focus on the number of children whose nutritional status has improved rather than the number of mothers who sat through nutrition education classes.

These issues and general principles have definite program implications for donor agencies and PVOs:

- o An effort must be made at the outset to obtain wide community representation, taking special care to include groups often left out of development programs, such as women, ethnic minorities and the landless population. Community involvement must, of course, extend past the stage of program design.
- o The ultimate goal should be an ongoing program. Given the realities of today's assistance programs, however, few agencies are willing to undertake programs in which their support will need to be continued at a high level

indefinitely. This means that eventual self-sufficiency must be part of the original program design.

- o Some degree of control over the program must reside in the community from the very beginning if the project is to continue after donor support -- financial and technical -- is reduced. This, in turn, necessitates new concerns, such as training community members in program management skills.
- o An important aspect of planning for self-sufficiency is the identification and training of local leaders. The importance of charismatic leadership can be seen in a number of the most innovative health and development programs currently operating.
- o Donor agencies and PVOs must search for new ways to facilitate integrated programs. Donor agencies need to realize that their policies and procedures have a profound effect on program design and development. For example, ways must be found to circumvent traditional "functional" budgeting systems, which do not lend themselves to integrated, multipurpose projects.
- o Agencies need to understand the special needs of integrated programs. Innovation and sensitivity are needed to develop flexible and appropriate systems of management, supply, reporting and technical support.
- o Realistic time frames and expectations for integrated programs are necessary. Creating pressure for quick results and rapid "replication" may have a deleterious effect on integrated programs, which of necessity will evolve in an individual and organic manner.
- o A number of areas in which further research is needed were identified. Among these are: When is it appropriate to use an existing categorical program as the base on which to build an integrated program? Is there an optimal sequence for introducing various components into integrated programs? How can collaborating agencies minimize reporting requirements and yet satisfy their own agencies' needs? How does one evaluate an integrated program? How can agencies and PVOs best learn from each other's experience and collaborate more effectively?

PVOs need to improve means of communication and collaboration among themselves. Rather than try to expand their areas of expertise, PVOs should seek out other organizations -- at the local, national and international levels -- with experience and expertise which complement their own.

Unfortunately, opportunities to exchange information and gain familiarity with other PVOs (especially those in other fields) has been limited. Meetings such as this workshop, organizations such as NCIH, and donor agencies can all play a role in facilitating communication and cooperation among voluntary agencies.

APPENDICES

AGENDA

Monday, April 12

OPENING PLENARY SESSION

Welcome: Davidson Gwatkin

Introduction: Dr. Allan Rosenfield

Keynote Addresses: Sondra Zeidenstein; Dr. James Levinson;
Dr. Juan Flavier

DISCUSSION GROUPS: Orientation

RECEPTION

FILM SESSIONS

Tuesday, April 13

PLENARY SESSION. The Setting: Dr. Joe Wray

DISCUSSION GROUPS

LUNCHEON. Margaret Goodman, Guest Speaker

PLENARY SESSION. Planning and Implementation: David Loretan

DISCUSSION GROUPS

Wednesday, April 14

PLENARY SESSION. Recognizing the Constraints: Njoki Wainaina

DISCUSSION GROUPS

CLOSING PLENARY SESSION

Discussion Groups' Conclusions and Recommendations

Closing Remarks: Dr. Allan Rosenfield; Katherine Piepmeier;
Dr. Russell Morgan

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Speakers

Juan Flavier, M.D., is President of the International Institute for Rural Reconstruction, which has its headquarters in the Philippines.

Margaret Goodman is a staff consultant to the Foreign Affairs Committee of the U.S. House of Representatives.

Davidson Gwatkin is Chairman of the National Council for International Health, Washington, D.C.

F. James Levinson, Ph.D., is an international nutrition consultant living in Cambridge, Massachusetts.

David Loretan is the Director of the Catholic Relief Services' Latin American activities.

Russell Morgan, Dr. P.H., is Executive Director of the National Council for International Health, Washington, D.C.

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Discussion Group Leaders

George Brown, M.D., Vice President, The Population Council, New York.

Susan Leone, Program Officer, the Helen Keller Foundation, New York.

Marion Fennelly Levy, Board Member, Save the Children Foundation, New York.

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Discussion Group Rapporteurs

Martin Gorosh, Dr.P.H.; William Van Wie, Dr.P.H.; and Joe Wray, M.D., M.P.H.; the Center for Population and Family Health, Columbia University, New York.

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Allan Rosenfield, M.D., Director, Center for Population and Family Health, Columbia University, New York.

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George Brown, M.D., Vice President, The Population Council, New York.

Susan Leone, Program Officer, the Helen Keller Foundation, New York.

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Katherine Piepmeier, Social Science Analyst, Program and Policy Coordination Bureau, Agency for International Development, Washington, D.C.

PARTICIPANT EVALUATIONS

On April 12-14, 1982, NCIH sponsored a two-and-a-half day workshop for private voluntary organizations (PVOs) on Approaches to Integrated Health Programs at the Marvin Center, George Washington University, Washington, D.C. Thirty-three attended, representing 27 Private Voluntary Organizations.* This brief report summarizes the response on the workshop evaluation forms returned by 30 participants (see evaluation form, p. 35).

The purpose of the workshop was to have PVOs assess the appropriateness, planning, and implementation of integrated health, family planning and development programs in developing countries. The objectives for PVO participants were the following:

- o To exchange information about past, on-going and future development programs that contain integrated family planning, primary health care and other development components;
- o To examine the major issues and concerns related to the design and implementation of such integrated programs;
- o To investigate the need for specific planning and program design skills, including guidelines for promoting integrated family planning/health/development programs;
- o To facilitate communication and cooperation among PVOs and various resource organizations interested in integrated assistance projects in developing countries.

The participants enthusiastically considered the workshop a success. Over half of the participants ranked the workshop a "4," indicating that nearly all of their expectations were met.

Of all the issues discussed at the workshop, the participants indicated that the following were most useful to them:

- o community participation;
- o support and self-reliance;

*Seven additional people preregistered, but were unable to attend.

- o donor attitudes and policies;
- o alternative community development approaches to integration;
- o constraints which PVOs face in designing and implementing integrated programs;
- o criteria for selecting and funding vertical vs. integrated programs; and
- o evaluation and management needs.

Some participants felt the group discussions would have been strengthened if there had been more indepth discussion of fewer issues. Other participants thought that more time was needed in order to address additional issues. Many participants responded that no changes were necessary and that the workshop format was very well suited to its intended purposes.

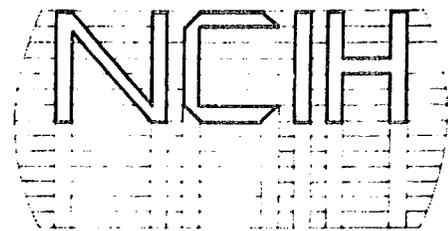
It was suggested that smaller, more directed discussion groups would have been beneficial and would have facilitated group work aimed at specific outcomes.

Participants suggested several follow-up activities, including the timely publication and distribution of the workshop report with strongly stated recommendations, and the development of articles in the **NCIH International Health News** describing successful and unsuccessful examples of PVO-operated integrated programs. On the question of future topics for NCIH workshops, more than half of the participants expressed interest in practical, "hands-on" or "how to" workshops, or a series of "clinics" on integrated programming. Some of the recommendations made for follow-up workshop themes are listed below:

- o how to integrate curative and preventive measures in primary health care (PHC) programs;
- o how to integrate PHC into existing health systems;
- o how to integrate health and population into other development schemes;
- o how to evaluate integrated projects; and
- o how to foster PVO collaboration on integrated projects.

Participants indicated that they are planning workshop follow-up activities for themselves and their organizations, including meetings with colleagues (and mailings to field personnel) to share their expanded knowledge and new ideas; technical assistance for in-service workshops for field personnel; and development of on-going communication links with workshop participants.

Additional comments made by participants reflected their appreciation to NCIH and Columbia University's Center for Population and Family Health for conducting a practical and well organized workshop led by speakers and resource persons of high caliber with very interesting and varied field experiences. One participant summarized feelings of many in the workshop by stating: "It seemed we were all a relatively united group, all feeling the strains and constraints of the times."



PVO STRATEGY WORKSHOP

APPROACHES TO INTEGRATED PROGRAMS:
HEALTH, FAMILY PLANNING, AND DEVELOPMENT

WORKSHOP EVALUATION

1. What three issues discussed at the workshop did you find most useful for your program?

a)

b)

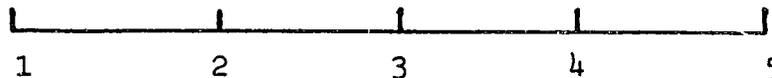
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2. What aspects of the workshop would you change?

3. Overall, on a scale of 1 to 5 how well did the workshop meet your expectations?

Expectations
were not at all
met

Expectations
were fully
met



4. What Follow-up activities would you recommend for NCIH and Columbia University?

FOLLOW-UP ACTIVITIES:

FUTURE WORKSHOP TOPICS:

5. What follow-up activities do you plan for your organization?

6. Additional Comments.

THANK YOU FOR YOUR ASSISTANCE