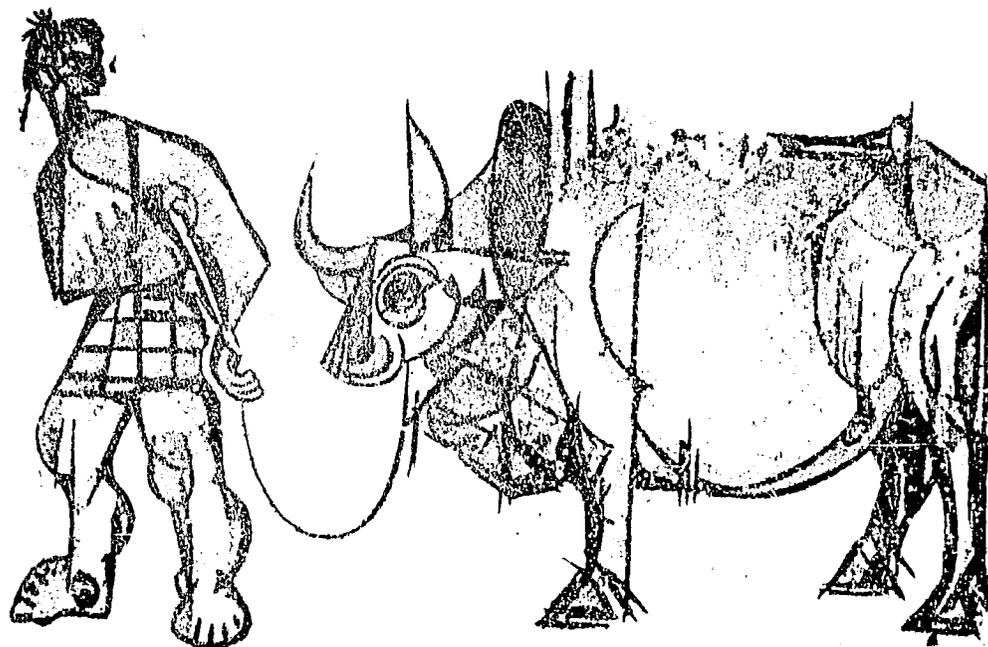


CORNELL UNIVERSITY

RURAL DEVELOPMENT COMMITTEE



*Special Series on Local Institutional Development No. 4*

**Local Institutional Development  
for Primary Health Care**

by

Rebecca Miles Doan

Gerard Finin

Norman Uphoff

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SPECIAL SERIES ON LOCAL INSTITUTIONAL DEVELOPMENT -- No. 4

**LOCAL INSTITUTIONAL DEVELOPMENT  
FOR PRIMARY HEALTH CARE**

A report prepared by Rebecca Miles Doan, Gerard Finin and Norman Uphoff for the  
Rural Development Committee, Cornell University  
with support from the Office of Rural and Institutional  
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U.S. Agency for International Development

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## PREFACE TO SPECIAL SERIES ON LOCAL INSTITUTIONAL DEVELOPMENT

This series of reports presents the findings of a year-long study by our working group on Local Institutional Development (LID). It was sponsored by the Rural Development Committee at Cornell University and was funded by the Office of Rural and Institutional Development in USAID's Bureau of Science and Technology.

Our initial concern was whether local institutional development could be adequately provided for by approaching it on a sector-by-sector basis, or whether it represents something needing and warranting attention across sectors. As with most "either-or" questions, there turned out to be merit in both views. Certain issues and provisions are particularly relevant for developing local institutional capacity for certain sectors. At the same time, individual sector-specific initiatives are likely to lead to neglect of more broadly-based capacities, which themselves are important for sector-specific kinds of LID.

Our analysis offers a firmer conceptual base for the often but ambiguously used terms "local" and "institution." It analyzes what kinds of LID are likely to be most appropriate for the different activities frequently initiated in rural areas. Finally, it examines how local institutional capacity can be strengthened by national and donor agency efforts.

Throughout the analysis, we draw on the experiences with LID which emerged from a review of the literature. Cases which proved particularly instructive are reported in annexes at the end of the reports. Not all readers will be interested in all the activity areas covered by our study, so we have organized the presentation of findings accordingly.

Five of the eight reports (numbers 2 through 6) are sector-specific, and readers may have particular interest in just one or two of them. We trust that all readers will find the introductory report (number 1) useful, as well as the observations and suggestions contained in the concluding reports (numbers 7 and 8) which are relevant across sectors. The full series is listed on page ix.

In condensing our observations and conclusions into these reports, we have not been able to include all of the case material and literature references which were covered in our study. We now know how broad and complex is the subject of local institutional development. Our discussions in this series present only what appear to be the most tenable and salient conclusions. We plan to integrate these analyses into a

book-length presentation of the subject for readers wishing a single continuous treatment of LID.

Though this project involved an extensive literature search and review on our part, it must still be considered more exploratory than definitive. Few of the available materials addressed LID issues analytically or even very explicitly. We thus cannot and do not attempt to provide "recipes" for local institutional development. This is an initial mapping of some important terrain not previously surveyed systematically. We welcome any and all efforts by others to contribute to the understanding and practice of local institutional development by adding to a more thorough knowledge base.

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## **SPECIAL SERIES ON LOCAL INSTITUTIONAL DEVELOPMENT**

- No. 1      ANALYZING OPTIONS FOR LOCAL INSTITUTIONAL DEVELOPMENT  
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- No. 2      LOCAL INSTITUTIONAL DEVELOPMENT FOR NATURAL RESOURCE  
             MANAGEMENT  
             Peter Doan, David Douglin and Norman Uphoff
- No. 3      LOCAL INSTITUTIONAL DEVELOPMENT FOR RURAL INFRASTRUCTURE  
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             Norman Uphoff and Katy Van Dusen
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             LOCAL INSTITUTIONAL DEVELOPMENT  
             Rebecca Miles Doan, Gregory Schmidt and Norman Uphoff

## LOCAL INSTITUTIONAL DEVELOPMENT FOR PRIMARY HEALTH CARE

### 1.0 ACTIVITIES IN HUMAN RESOURCE DEVELOPMENT

Among the major activity areas for rural development, human resource development is crucial for providing the energy and talent needed to transform economic and social conditions for the benefit of those who have been bypassed. Human resource development is usually pursued in four program areas of activity: health, education, nutrition, and family planning. We know that making human populations more productive and fulfilled entails far more than sectoral programs in these four areas. Influences such as culture, motivation, security, and "social energy" (Hirschman, 1984) come into play. Because such diffuse factors are difficult to deal with in government or donor-assisted projects, however, these factors are usually classified under the four sectors of health, education, nutrition and population.

The four areas are themselves each complex (Uphoff, 1980), and it is beyond our scope here to do justice to the local institutional requirements of each. We have chosen to address local institutional development for primary health care because it is such a basic requirement for human resource development, and because it presents so many of the institutional issues that arise in human resource development, especially as programs move beyond "curative" services into "preventive" programs. In any case, the four programmatic areas for human resource development are highly interactive.<sup>1/</sup>

The main elements of primary health care (PHC) as defined by the American Public Health Association include efforts to:

- \* motivate community members to take care of their own health needs and to encourage them to help identify and solve their problems;
- \* build or strengthen community institutions to carry out rural programs, using local resources to reduce operating costs;

---

<sup>1/</sup> Without widespread good health, efforts to improve people's education and nutrition are likely to be thwarted. Similarly, reducing population growth rates appears to hinge in large part on improvements in child survival. At the same time, it is clear that formal and non-formal education, nutritional improvements, and family planning services can contribute to better health in rural populations.

- \* train new cadres of paraprofessionals and community health workers;
- \* integrate health service delivery; and
- \* strengthen the institutional capacity of governments to support rural programs. (APHA, 1982a:14)

In recent years, primary health care (PHC) has received significant attention from both national and international agencies. Yet despite the great need and opportunity to improve rural health conditions, political and administrative factors continue to pose real obstacles to effective implementation of PHC (Bossert and Parker, 1982). First, there is often fierce competition over the scarce financial resources allocated for health care, which often total only three to five percent of the national budget. Resistance to PHC by bureaucracies or professional associations is not easily overcome. Further, broad-based participatory PHC efforts may be seen by central governments as potentially threatening and this perception may, in practice, overshadow public pronouncements about the desirability of establishing such a program.

The fact that these concerns find their way into the literature makes the central question of our local institutional development (LID) study all the more relevant: what kinds and combinations of local institutions are most likely to be effective (for PHC) and how can appropriate capacities be supported from outside the community?

In our analysis we assume some level of government interest and we recognize that strong national government support can contribute much to PHC. Yet we found numerous cases in our review of the literature where programs were operating with strong local support and mere central government acquiescence. We also noted, for instance, some PHC programs which avoided opposition from health professionals by initially developing local institutions to address health needs without the use of paraprofessionals. Hence, a review of local institutional options can offer insights as to how political and administrative constraints could be approached in various settings.

Although the 1978 conference of the World Health Organization at Alma Ata which endorsed a primary health care strategy described the need for local institutions for PHC, it did not indicate how external agencies and government ministries might best attempt to introduce the requisite changes and adaptations in institutions at the

local level<sup>2/</sup> (WHO, 1978). Even the recent health sector strategy statement of USAID, which is built around primary health care, gives little attention to the local institutions needed to give effect to the national policies and institutions, as well as to the health technology and research, which the statement very specifically addresses (USAID, 1984).

PHC strategies assume a high level of community involvement in planning and managing the curative and preventive aspects of such programs (World Bank, 1981). In the PHC programs undertaken to date, one can see various exploratory steps by national ministries of health, nutrition, rural development, social affairs etc. to begin working with local institutions. If these are to evolve into more than a series of scattered pilot projects, however, central authorities will need to transform national health systems that are now centrally concentrated and directed hierarchies into more dispersed, responsive organizations with responsibilities shared among many persons, including "patients," in a variety of roles (WHO, 1981). Such a transformation requires a major elaboration and strengthening of local institutions.

PHC presents a special challenge in the analysis and practice of local institutional development for another reason. Health care, especially in rural areas, comes from several sources including a variety of existing indigenous health care providers.<sup>3/</sup> More than in other areas of rural development activity, these existing roles and institutions can be viewed as both an opportunity and an added complication in efforts to improve rural health conditions. In any event, attention must be given to the issues associated with developing "new" institutions versus strengthening or modifying those presently in operation. This subject warrants discussion in a special section (3.0).

Rural health generally involves a combination of traditional and modern roles, as part of national and local systems, with a mixture of public and private support. While primary health care operates at the community level, its effectiveness depends on linking to and support by a more complicated system articulated at several levels which can handle referrals, provide supervision, and carry out research and evaluation.

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<sup>2/</sup> We are following the definition of "local" elaborated in Report No. 1. There are three "local" levels at which collective action can occur; at the level of (a) groups of individuals and households; (b) communities as residential areas encompassing individuals and households, and (c) localities as sets of communities which have economic, social and other connections that can facilitate cooperation among people in the communities.

<sup>3/</sup> In this report we will use the terms "indigenous" and "traditional" synonymously. For more precise discussion suggesting a distinction, see Pillsbury (1979:7).

PHC attempts to provide a wide range of simple and cost-effective health services, concerned not only with illness but with prevention and improvement of the public's general well-being.<sup>4/</sup>

## 2.0 LOCAL INSTITUTIONAL OPTIONS

When donor agencies, national governments, private voluntary organizations or rural communities (or some combination of them) decide to promote or strengthen a primary health care system, one of the main issues is to choose among local institutional options. The alternatives can be identified as:

- \*\* local administration (LA), the local offices and staff of national government agencies, usually of a Ministry of Health.
- \*\* local government (LG), where it exists, a locally elected body with multi-sectoral responsibilities, accountable to the local population;
- \*\* membership organizations (MOs), self-help groups dealing with members' problems and needs by service provision, lobbying, etc.;
- \*\* cooperatives, organizations where members pool some of their economic resources (savings, labor, purchasing power, etc.) for their respective and mutual benefit;
- \*\* service organizations (SOs), charitable organizations established to benefit persons other than (sometimes in addition to) members, such as religious or fraternal organizations operating clinics and hospitals on a not-for-profit basis; <sup>5/</sup>
- \*\* private providers, doctors, midwives, pharmacists and others who generally operate as individuals on a fee-for-service basis; these may include "Western," "traditional" or "indigenous" health practitioners (the latter two are discussed separately in section 3.0).

---

<sup>4/</sup> The USAID health sector strategy statement says: "Primary health care emphasizes increased access to basic and affordable health related services, community participation, reliance on paraprofessional workers, adequate referral and support facilities and systems, and inter-sectoral coordination, as opposed to hospital services dependent on high technology and specialized manpower and available to only a small proportion of the population. (USAID, 1984:1)

<sup>5/</sup> These three categories, membership organizations, cooperatives, and service organizations, all come under the general heading of "local organizations" (LOs) as analyzed in Esman and Uphoff (1984).

There are substantial issues of program design involved. The fact that a Ministry of Health is promoting primary health care does not necessarily mean that government agencies must be the "lead" actors in its PHC scheme. It may choose to work with or work through any of the other kinds of local institutions listed above. Similarly, a private voluntary organization (PVO) undertaking PHC could seek the active involvement of local government rather than work only with a charitable organization. Even if LG has in the past had only perfunctory responsibility for health care services, it might be able to make a significant contribution to fostering primary health care in the community.

This delineation of local institutional options should not be seen as presenting the institutions really as "alternatives." In most PHC situations, it will be advisable to work through some combination of local institutions which constitute a network of channels to undertake planning, mobilize resources, communicate needs, etc. The contrasts among options are presented here to show comparative advantages and disadvantages of each, but, under the appropriate circumstances all have positive contributions to make.

## 2.1 LOCAL ADMINISTRATION

Government agencies almost always constitute one of the "pillars" of a primary health care program. Their mandate is to give free or subsidized care as part of the government's commitment to assist the public. Of particular relevance, government staff can be posted in areas where private providers would not find practicing sufficiently profitable or personally attractive (though the levels of qualification and motivation for government staff under these conditions may be less than desired).

Most government systems can be characterized in terms of service attenuation the farther one goes from the capital city, where the most modern facilities are available in national-level hospitals. At regional or provincial levels, there are smaller hospitals with less specialization and equipment, and below that one finds clinics to serve market towns and possibly villages. The staff at all levels are employees of and accountable to the ministry of health.

Rural clinics are in general charged with serving as the frontline for curative care, referring difficult cases to higher levels of specialization. They also may be involved in preventive and educational programs aimed at improving the health status

of the community, such as through infant food supplementation or health classes. Even with the best of efforts, however, such facilities are seldom adequate in serving the rural populations, if only because few developing countries have enough resources to provide strong support to clinics and staff in a sufficiently large number of locations (Bryant, 1969).

Primary health care strategies attempt to compensate for the lack of more intensive rural health care by expanding outreach efforts to include those who need them most. The emphasis is on implementing community-based measures with widespread benefits involving the broader participation of rural people. Paraprofessionals, commonly called village health workers (VHWs), most frequently recruited from the community in which they reside to augment government services, can help to spread information and give access to the under-served (Esman et al., 1980).

However, government agencies involved in primary health care need to do more than add a greater number of minimally trained staff members to serve as "low rungs on the ladder." The role of government agencies changes from one of being a basic service provider to being an enabler (Korten, 1983). This means that local administration needs to be reconceived and reoriented to work as part of a support system for village-based health care.<sup>6/</sup>

## 2.2 LOCAL GOVERNMENT

Traditionally, local governments have not had a large formal role in health care services. In some cases, they have assisted in the provision of clinic or office space through donation of land or construction of facilities. But the view has been that they lack the expertise and staff to handle such "technical" tasks as health involves. A largely unexplored role for LG in primary health care is in assisting with "organizational" tasks that make technical services more effective and efficient.

A good example of this function is seen in the Pikine project in Senegal, where once health committees had been established in neighborhoods, a general assembly of representatives from all the committees was formed, with its own elected Executive Board operating under the aegis of the local government (Jancloes et al., 1981). Similarly in Burma, the Village People's Councils, which constitute the local government, are responsible for selecting and overseeing the work of volunteer

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<sup>6/</sup> For an analysis of what is involved in such reorientation for a bureaucracy, see Korten and Uphoff (1981).

community health workers. They also mobilize funds for the resupply of essential drugs and have substantial authority over how funds are allocated. The majority of volunteers in this nationwide program continue to perform their tasks several years after their initial training (Chauls, 1983). (Both cases are described in the Annex, pages 37-38, 43-44).

Local governments are also frequently in a position to support primary health care with sanitation initiatives in improving and inspecting markets, constructing latrines and similar measures. Such a role should be integrated into practically any primary health care program.

### 2.3 MEMBERSHIP ORGANIZATIONS

There have been many attempts in PHC programs to form village health committees to work in conjunction with government agencies. Too often these have been conceived and implemented as part of a prescribed "blueprint" which placed more emphasis on simply having a VHC than on matching its functioning to perceived needs of the community and to support of village health workers. It is common to find that VHCs were formed, subsequently selected persons for training VHWs, helped build local health facilities and then atrophied. This is reported from Cameroon (Isely, 1979) and the Sine-Saloum project in Senegal (Hall, 1982; see Annex, pages 43-49). The American Public Health Association found that of 52 PHC projects assisted by USAID, few had VHCs that functioned on a continuing basis (APHA, 1982a).

However the literature does note a number of VHCs that have successfully supported health workers. The Pikine project in Senegal, for instance, achieved active local participation buttressed by horizontal and vertical linkages among VHC groups through their larger Association for Health Promotion.

Local organizations identified in the APHA study as examples of useful contributors to primary health care are quite diverse; for example, the village development committees in Tanzania (which have worked better on health than on agriculture), the mothers' clubs in Indonesia which have responsibility for various health programs (APHA, 1982a). Similarly, the federation of village health committees established in Panama after 1969 worked closely with the ministry of health to resolve problems. Other activities of the federations included linking experienced health committees with recently organized committees and paying transportation costs so that health officials could regularly visit distant communities (LaForgia, 1984).

It may indeed be more effective to work with and through existing local organizations rather than to set up new ones, but there is not enough systematic evidence to prove the point one way or the other. Three-quarters of the projects APHA reviewed created special health committees and only one-quarter worked through existing groups. In either case, it is apparent that, more than in some other aspects of rural development, membership organizations in the health area need outside support and supervision.

## 2.4 COOPERATIVES

Cooperatives are not as common a form of local institution for providing primary health care as might be expected. For example, pooling patients' purchasing power through prepayment of medical costs is an ideal form of cooperative action, to get the benefit of scale economies, to give health consumers some influence on the care they get, and to have assurance of protection in time of need.

One very pragmatic consideration regarding cooperatives is that in certain countries, they are the only legally sanctioned forms of peasant organization. They may have special status from legislation with respect to taxes and subsidies that give them particular advantages not available to other local institutions (Tendler, 1981:48).

In Nepal, one government resettlement program in the terai decided to establish a local health post, but had no funds for drugs. To obtain funding, they required that anyone who wanted land had to "volunteer" to join an insurance scheme. To no one's surprise, there were many members. But the health post and its insurance scheme were well-managed, and in succeeding years, there was little difficulty getting people to pay their annual premium. Subsequently, the Ministry of Health decided to open its own health post, which offered free drugs -- whenever it had drugs, which was not frequently. Despite the flaws of the MOH health post, it destroyed the cooperative. People preferred to hope they would be sick only when free drugs were available rather than pay the costs of a sure, proven system. (Don Chauls, personal communication)

A worldwide review by the APHA (1982b) found documented cases of prepayment arrangements in fifteen Third World countries. Some of those with personal prepayment by members had functioned for a decade or more, with some highly satisfactory results in terms of low-cost access to health services. Yet renewal and premium collection rates were often low, and any scheme which requires monetized payment often runs into difficulties given the low level of cash incomes.

One way to deal with this problem is through production-based cooperative health programs. The Chinese commune system has been the largest such undertaking so far, but community or regional schemes are found in Bangladesh, Benin, Colombia, Ethiopia, India and Indonesia. The Mallur Milk Cooperative in India, for example, finances clinical services from a one cent surcharge on each liter of milk it collects and sells (APHA, 1982b:25-26). Such cooperatives are not usually set up initially for health purposes, however, being agricultural co-ops to which health activities are subsequently added.<sup>7/</sup>

One kind of cooperative institution relevant to PHC is the communal pharmacy, with examples including the Bajada medical cooperative in the Philippines, the chaquicocha in Peru, and the co-ops under the Santé Rurale project in Mali (APHA, 1982b). Such pharmacies are often started with locally mobilized capital and use volunteers for sales, inventory maintenance and restocking. By pooling purchasing power, people can buy drugs in bulk for cheaper prices or can ensure supplies in areas that private sellers ignore.

One of the more innovative uses of a cooperative mode of organization in the health sector is the recent initiative by the Kottar Social Service Society in south India, discussed below. KSSS leaders plan to decentralize their Community Health Development Project until each village is able to function autonomously as a health cooperative registered with the government and entitled to its financial support (Field, 1980). It is still too early to know how this strategy will fare, but it could offer important lessons for cooperatives' potential in PHC efforts.

## 2.5 SERVICE ORGANIZATIONS

Rural health care is an area where local service organizations are likely to be active. There is a long history of charitable provision of health services, especially by religious organizations. There is now an apparent trend among SOs which operate hospitals or clinics to develop broader, community-based PHC programs with strong

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<sup>7/</sup> An historical example worth citing is found in rural Japan, where communities began forming mutual aid societies around the middle of the 19th century and contracted with physicians at predetermined annual rates of compensation. "One rural district reported over a hundred mutual aid societies, with the largest having a membership of 330 households. Agricultural cooperatives began health-related work around 1920, and by 1940, over a million rural households belonged to cooperative-based prepayment schemes." (APHA, 1982b:26)

emphasis on preventive measures. Such organizations often operate where governments do not have effective services. Their presence in a region may span several decades, giving them stability and legitimacy not usually found in efforts of more recent vintage. Moreover, many SOs have extensive linkages both within and outside the areas they serve, enabling them to carry out innovative PHC programs with leeway for learning through organizational experimentation.

A good example of this type of transition by a service organization is the Project Esperanca in Brazil. Originated as an Amazon River-based hospital boat where U.S. surgeons performed dramatic operations on children, the project today focuses on primary health care serving some 30,000 subsistence farmers and fishermen in the area. Seventeen rural health aides work on a full-time basis with the support of 56 part-time health promoters (Favin, 1982; see Annex, page 37). Another example of a local service organization developing a PHC system is the Kottar Social Service Society. While KSSS itself operates at the sub-district level, it has begun to develop independent village-based institutions in some 124 communities in southern India (Field, 1980).

## 2.6 PRIVATE PROVIDERS

As noted already, health is one sector where private, for-profit institutions are widely established. By some definitions of PHC, much is already being provided by private practitioners. However, to the extent that one includes health education and preventive activities as essential elements of primary health care, the present role of private providers is less substantial. In several PHC schemes, village health workers have been allowed to operate on a fee-for-service basis while in some other projects, individual health workers receive a percentage of a set fee. Often, health workers are responsible for supplies of medicine, by operating a revolving fund, prescribing, selling and restocking basic drugs and keeping any profits as their own compensation (APHA, 1982b). This poses the danger, of course, of creating an incentive for prescribing drugs whether needed and effective or not.

Within the continuum of private providers one can often find "vaccinators." These individuals are often self-trained and, for a fee, will give an injection of some kind for almost any ailment. Unfortunately, such practices often play a major role in creating peoples' perception of appropriate health care. This in turn can create considerable

difficulties for VHWs and other better trained health care providers (Don Chauls, personal communication).

Several PHC programs have experimented with providing drugs and contraceptives through private businesses. Probably the best known example is the Community Family Planning Services in Thailand. The charitable organization which manages this program has been very effective in getting contraceptives to the rural population by supplying them to village storekeepers who sell them for a modest profit (see Annex, page 45).

Another innovation, backed by UNICEF, involves trying to sell through village stores, oral rehydration packets which can stave off the life-threatening effects of severe diarrhea in young children. In Bangladesh, these private channels are also being used to sell "birth kits," a bar of soap and sterile razor blades for cutting the umbilical cord.

While development of such private channels by themselves will not create a primary health care system, these examples suggest how the private sector can serve as an important conduit for delivering goods and services in ways that relieve village health workers of some tasks, allowing them more time to concentrate on other responsibilities. Moreover, private practitioners can and very commonly do provide a large share of the curative health care which is part of PHC.

## 2.7 COORDINATION

Because primary health care cuts across sectors like agriculture, public works (sanitation) and education, there are significant problems of coordination which complicate questions of institutional design. Private providers, for example, while quite flexible and efficient in providing services or medicines, are in no position to coordinate others besides themselves. Market mechanisms have a role even in PHC, but they cannot be used by themselves to determine the level and pattern of services.

Government personnel operating at the local level seem to have the authority for coordination, but they are themselves usually partisans in the inter-department battles that go on. An Indonesian government report on experience with PHC concludes:

Cross-sectoral cooperation is a beautiful concept. In many instances, however, each of the sectors is interested only in their own program... They may still feel that a better result might be achieved with their own individual conventional approach.

It is interesting to note that the efficacy with which coordination is achieved is inversely proportional to the level of administration (at which coordination is attempted). It means that the coordination mechanism works more smoothly at the village level than at higher levels of administration. (Republic of Indonesia, 1973)

There appear to be few cases of really successful coordination anywhere on which to base generalizations, but there probably needs to be some significant role for local government, perhaps through specialized health committees following the pattern often observed for rural infrastructure (Report No. 3).<sup>8/</sup>

### 3.0 INDIGENOUS HEALTH PRACTITIONERS

Efforts to introduce supportive local institutions must generally recognize that they are not moving into a vacuum, and this is particularly true with regard to health. Some "traditional" health services almost always exist. "Indigenous health practitioners are there already," as a study for USAID (Pillsbury, 1979) suggested in its subtitle. In Indonesia it is estimated that traditional birth attendants help to deliver more than 75 percent of the babies born in rural areas (Republic of Indonesia, 1978:25), while in Egypt, an estimated 10,000 dayas (traditional midwives), although they are supposed to be "illegal," help deliver at least 80 percent of newborns, in addition to their larger role in the community (Assaad and El Katsha, 1981:7). Indeed, such practitioners can be well organized, as seen with the Association of Ghanaian Psychic and Traditional Healers (reported in Annex, pages 39-40) and even powerful, as seen in the case of ayurvedic physicians in India and Sri Lanka.<sup>9/</sup>

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<sup>8/</sup> Coordination in Burma's PHC program is effective, primarily because the multi-sectoral LG unit (the Village People's Council) and the district government unit (the Township People's Council) play such major roles. Both these Councils have considerable authority, a fact which makes health personnel responsive and respectful. The order of the flow of information in beginning the PHC system in a township is important: first the Township Medical Officer (TMO) meets with the TPC and describes the system to them. Second, each VPC's representative at the TPC informs the remainder of his VPC. Only as a third step is there any interaction between the VPC and the local Rural Health Centre, with the latter coming to the VPC to clarify uncertainties, answer questions, provide schedules, etc. This chronological primacy of the TPC and VPC are factors in their continuing to perceive it as their program, and continuing to exercise effective coordination between the health projects and other activities. (Don Chauls, personal communication)

<sup>9/</sup> In India, there are 108 colleges teaching ayurvedic or other "traditional" health systems at the undergraduate level and 22 post-graduate departments. There are some 10,000 registered traditional practitioners in Sri Lanka alone (Nemec, 1980:4).

In general, indigenous health practitioners qualify as "institutions" that are not organizations.<sup>10/</sup> Acting as individuals they represent individual roles, not structured sets of roles which could be regarded as "organizations." Since these roles are widely accepted and are accorded high legitimacy within the community, however, they have an "institutional" quality.

Some of the roles such as that of traditional birth attendant are almost always reserved for women. Other roles, such as setting broken bones or making herbal medicines, can be filled by either men or women. Many times the health-related role is but one function of a larger role embedded in religious or cultural traditions. The range and degree of specialization among these existing health institutions vary greatly from place to place. What does not vary is the fact that these practitioners are often the predominant means of health care for the rural poor (Piilsbury, 1979).

All PHC programs face the issue of what kind of institutional arrangement or accommodation to seek with the existing system. Alternatives range from working exclusively with and through those who are already established in a community as health care providers, to the other extreme of trying to start anew by banning indigenous practitioners and permitting only newly-trained and fielded personnel to be consulted. Still other options include dividing various health-related functions between indigenous practitioners and newly-trained PHC workers so as to establish mutually exclusive spheres of competence, or organizing PHC activities in such a way that they can support indigenous healers by reinforcing those effective services. The latter relationship could include such support as providing sterile supplies to traditional birth attendants.

Presumably the most frequent users of primary health care services will be women, both for themselves and for their children. It is therefore not surprising that government and external agencies have made particular efforts to enlist in PHC activities women who are indigenous practitioners, since they know well the health problems facing their communities. Moreover, they are likely to be highly trusted by the local population.

One foreseeable problem with this approach is that women health practitioners may often be part of larger informal women's associations that come into action in times of daily difficulty or distress. Assistance is not motivated by some sort of contractual arrangement but rather rests on an interpersonal ethic of mutual obligation

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<sup>10/</sup> On this distinction between "institutions" and "organizations," see discussion in Report No. 1, pp. 11-14.

(March and Taqqu, 1982:41). If PHC programs are to avoid diminishing the effectiveness and possibly destroying the fabric of solidarity within informal associations, external agencies must be sensitive to the undesirable effects which "integration" into a PHC system may have.<sup>11/</sup>

Moreover, when mandatory fees or other forms of remuneration from non-traditional sources are made part of new expanded roles, effectiveness can be seriously undermined. For example, in the first phase of the Sine Saloum Rural Health Project in Senegal, many traditional birth attendants received three months of training to supplement their practical experience. After training was completed, they were formally incorporated into the PHC program, which operated on a fee-for-service basis. Since this required cash for payment, the number of women who requested assistance from these attendants during childbirth decreased dramatically (Hall, 1981:38).

In many situations, the delicate nature of these valuable and beneficial informal social relationships, often essentially a tacit compact, argues against working with indigenous practitioners. But whether a role or association is formal or informal is not always clear. In many circumstances the issue is to ascertain to what degree formality exists. To assume that all informal roles and associations will lose their effectiveness if they receive outside assistance is to underestimate the resourcefulness, flexibility and even the aspirations of rural people. There are several approaches for deciding whether or how to engage indigenous practitioners in PHC activities.

First, the extent to which an informal association is "active" or "reactive" should be considered as this will affect its viability as a vehicle for new services. March and Taqqu (1982) define an "active" informal association as one which has relatively explicit objectives coupled with resource capabilities to back up those objectives. Such associations contrast with reactive ones which perform more defensive or ad hoc activities. "Active" associations are more likely to be amenable to an expansion or extension of their functions, provided these benefit their members.

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<sup>11/</sup> March and Taqqu write: "The local midwife/healer cannot simply be turned into a neighborhood paramedic and pharmaceutical agent within the planned expansion of a western medical organization system. Instead of thinking of these midwives and healers as ill-trained and poorly remunerated quasi-doctors who only need more scientific training in order to bring the medicine of their communities into the 20th century, we must learn to respect not only their herbs but also their position within an informal associational network of clientele. (T)heir relative autonomy and legitimacy must be preserved. More centralized health delivery systems cannot subsume or fully rationalize the midwife's role if they expect to derive continuing benefits from traditional practitioners." (1982:106, 107)

A second strategy is to examine the development initiative itself to see how closely the procedures, roles and values involved might mimic those of existing institutions. For example, in relationships where money has not been exchanged before, as well as in communities where money is not very available or familiar, there will be more chance of getting medicines distributed as intended if their provision through traditional birth attendants can be handled on a gift or barter basis rather than for cash payment only. If the drugs must be paid for, some other local institutional arrangement would be more appropriate.

A third and more general strategy, discussed at greater length in Report No. 7, is to adopt a "learning process" approach (Korten, 1980). This involves planning and implementing a program in an incremental, participatory, experimental manner, adapting it in ways suggested by experience. With such an approach, the extent to which traditional roles and relationships can be modified without damaging them can be ascertained empirically. With such an approach, evaluation is not a concluding activity but an ongoing one, to make sure that resources are being used effectively and efficiently to attain objectives, which are themselves periodically reexamined and modified in light of experience, and in consultation with the intended beneficiaries.

This discussion does not presume that indigenous practitioners are always effective or even always ethical. It does assume that before trying to construct or strengthen any local institutional framework in support of PHC, the effectiveness of existing health care providers be considered and that, where practicable, such established capacities will be drawn into the emerging institutional structure.

#### **4.0 ISSUES IN PRIMARY HEALTH CARE**

A number of issues bear on the appropriateness of different local institutions for supporting PHC, such as differences in the way members of the public perceive costs and benefits of various aspects of a PHC program, or the extent to which a service can be provided as a private good. Here, we will address some of the most interesting issues affecting LID alternatives.

#### 4.1 ENSURING ACCESS

The need for good health is universal, though those in poorer circumstances, who are not well-nourished and have neither the means nor the information to practice good hygiene, will have greater risk than others. In any rural population, there are certain groups that may be considered "vulnerable" -- women during and after pregnancy, the young, the malnourished, the overworked. Local institutional development in the health care area needs to assure their access to PHC services.

In principle, this should be easiest through government agencies, but in practice, status and educational differences may contribute to discrimination and neglect. If local government is controlled by more privileged elements, they may take little interest in ensuring equal access. Membership organizations, including co-ops, that have poor members may be helpful in this regard. Private practitioners will have little incentive to serve the poor. It is likely that the local institutions most sensitive to this issue will be service organizations (religious or charitable), where they exist.

The location of a health facility such as a clinic or health post affects who has access to its services, especially in areas with high levels of social stratification, or where difficult terrain makes some areas remote. But even a highly accessible facility will be of little use if community members are uncertain about when personnel can be found or whether necessary supplies are available. PHC programs will gain credibility in the community's eyes when users know that their trip will not be wasted. To be sure, sometimes when a service is located so as to be quite accessible, its supplies and staffing may become less reliable. Where such a constraint occurs, decisions on location need to optimize accessibility and reliability to facilitate institutionalization, whatever the type of channel used for PHC.

In many localities conducting mobile clinics is an excellent way to increase geographical accessibility while simultaneously reducing social distance, especially when health workers walk or use public transportation to the location rather than arrive by government or private vehicle. To the extent possible, prior notification of an impending trip can increase effectiveness of such visits. The Burmese PHC system has found that the best way to increase accessibility is basically to close down its rural health centers three days per week to give the staff sufficient time to supervise community health workers and to conduct mobile clinics.

Accessibility of PHC services needs to be considered in terms of time as well as space. Many rural areas experience significant seasonal variation. As Chambers and

his associates (1981) have documented, malnutrition, morbidity and mortality commonly peak during the rainy season, when rural health services are likely to be at their least effective level because of logistical and staffing problems. The demand for medications goes up when keeping them in stock in rural dispensaries is most difficult. Supervision of staff is likely to slacken, and health personnel themselves are more likely to become sick or take leave. Simply getting to health services, even ones located in villages, can be arduous for rural people during these months.<sup>12/</sup>

The implications of seasonality for LID are not clear-cut though they need to be considered. If it becomes unprofitable to provide services during the difficult months, private channels lose their value when they are needed most, and LA or possibly LG will have to be relied on more. On the other hand, these alternative channels may be immobilized also during the same period. One of the reasons why the PCDA in Thailand turned to private shopkeepers to handle the distribution of contraceptives was because government supplies were interrupted during the rainy season, while the private sector tended to be more dependable and more accessible to villagers year-round (Korten, 1980; see Annex, page 45).

Probably the most frequent population to have contact with primary health services, if available, are women. In developing local institutions, whether government agencies, local government or other forms, encouraging the involvement of women in the management of PHC services is likely to make the services more accepted and effective. In countries as different as Bangladesh and Samoa, networks of women's committees have been integrated into health programs to good effect (Fonaroff, 1982).

The gender of health workers can affect accessibility because of socio-cultural norms within a society. It is frequently presumed that women can carry out a wider range of PHC functions and are therefore preferable as VHWs. Yet in some societies, women may not travel as freely as men either within communities (e.g. for emergencies) or outside their communities for training. Men, on the other hand, may be unacceptable for a wide range of tasks including attending births. One innovation to lessen gender-related problems would be selection of husband-wife teams for training as proposed for Guatemala's PHC program (Colburn, 1981:24).

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<sup>12/</sup> Chambers (1979) reminds us that while the rainy season generally presents the most health problems, in some areas like northern India, it is the hot dry season that creates severe health and nutrition stresses.

Such considerations as the gender of personnel or the location of facilities are not unique to any particular kind of local institution. Rather they bear on the institutionalization process, the acceptability of services and the acceptance of local responsibilities so that the benefits of PHC can be extended and sustained through channels enjoying moral and material support. These channels, as discussed in 5.0 should be integrated into a network of service and education providers so as to create a system for primary health care.

#### 4.2 RECURRENT COSTS

One of the features of rural health programs generally is that recurrent costs far outweigh initial or capital costs and can become a significant financial burden for any government. One reason why most governments have at least some interest in local institutional development in the health sector is to be able to mobilize additional resources for covering some of the ongoing expenses of providing health services. We address LID issues of financial resource mobilization in Report No. 7, but will touch on them here since they are so important for PHC.

The subject of recurrent costs is one of the few PHC issues which has been addressed with a broad and systematic data base, thanks to the American Public Health Association (1982b). Methods of community financing and their success have been reviewed for over 100 projects and programs worldwide. Some examples of community self-sufficiency or near self-sufficiency were impressive but could not be generalized for lack of adequate documentation (the same problem we have confronted often in this LID project). We would cite here the conclusions of that study:

The most common forms of community support are voluntary labor and direct personal payments, and both have limited utility. Voluntary labor is useful chiefly for one-time construction costs, while direct personal payments place the financing burden on the sick and limit access to persons who can afford to pay. Community financing, at best, is just one element of a balanced financing approach. It has not paid for supervision, logistical support, or referral linkages and can be effective only if these services are financed from other sources. (APHA, 1982b:41)

What can be most readily financed through community institutions are: construction and maintenance of physical facilities, provision of community health workers (paraprofessionals), and local currency costs of basic drugs. "These decisions generally

reflect national budgetary restraints, not communities' willingness and ability to pay. Community financing would be more viable if planners started by studying demand." (APHA, 1982b)

For local institutions to achieve sustained financial capacity to support health programs, there need to be major community mobilization efforts. Yet in order for mobilization efforts to become institutionalized, technical and managerial support is necessary in terms of assistance in setting up systems for financial accounting and accountability. The utility of the "goldfish bowl" approach, whereby the location and public "visibility" of funds is never in doubt, is critical to sustain the capacity for ongoing mobilization. Back-up resources are frequently desirable to cover temporary deficits.

Another potentially important aspect of the relationship between recurrent costs and LID is that continuing (or at least periodic) involvement by the local institution in addressing recurrent cost issues is an excellent means of sustaining interest. For this reason, it may be more desirable for the institution to be involved in the major recurrent cost items like VHW remuneration and drug resupply rather than the major capital cost item (building construction). If the community builds a structure at the beginning of the project, villagers may then feel that it is the government's turn to do the rest -- and involvement may suffer (Don Chauls, personal communication).

One difficult LID issue in this area is the fact that to the extent PHC relies on local financing, higher-income communities will generally get more and better health care (Golladay, 1980). The only way to compensate for this is to have the central government apply differential rates for subsidizing or supporting local programs, according to the economic levels and potential of each area. This could create undesirable "dependency" relationships, with poorer communities having an incentive to remain in the "poor" category, though this does not appear a necessary consequence.<sup>13/</sup>

The alternative of leaving the financing of PHC entirely up to each community is to have unequal (possibly quite unequal) health opportunities. Some effort to

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<sup>13/</sup> In South Korea, the Saemaul Undong (New Community) movement after two years of giving 35,000 villages the same level of material assistance, classified the villages into three categories: most responsive (self-standing), typical (self-helping) and least responsive (basic). Greatest assistance was given to the middle category, with enough to the first and third to provide some encouragement. The message to the latter category was to become more self-helping. In 1975, about one-third of the villagers were in the latter, but before long this number was negligible, and two-thirds had "graduated" into the top (self-standing) category, accepting reclassification partly because of pride and partly because there were still benefits to be received from the program (Lee, 1981:152-153). See Annex in Report No. 7.

compensate for existing inequalities in the level of resources seems appropriate, though this locks the government into financing at least some portion of recurrent costs. While we see no fully satisfactory solution to this problem, it should not be allowed to become an obstacle to devolving PHC responsibilities to a stronger and broader set of local institutions. Delaying LID only perpetuates dependency on central resources and continues the inadequacy of rural health services.

### 4.3 PREVENTIVE VS. CURATIVE PROGRAMS

One frequent issue in primary health care is the extent to which PHC programs should persist in emphasizing public health and preventive activities when the rural people to be served would give more weight to curative efforts. Such a preference is documented in a study of a rural health program using paraprofessionals in one of the more inaccessible corners of Guatemala (Colburn, 1981; see Annex, page 40). In its training of village health workers, the program stressed prevention of disease, but the communities were more interested in having medical services, for which the paraprofessional had limited qualification. Where PHC programs are able to develop effective approaches to health education, preferences for curative tasks are likely to be met by a strong interest in preventive tasks as well. This is seen in the Panama PHC program (Annex, pages 42-43).

To the extent that primary health care programs are turned over to participatory local institutions, particularly LGs or membership organizations, preventive activities, at least initially, may be downplayed. On the other hand, since one of the comparative advantages of LG or membership organizations is likely to be with organizing preventive activities, it is especially important to engender this role as early as possible. This reinforces the earlier conclusion that government or service organization staff, through local clinics and other facilities, must play an active role if the aims of primary health care are to be advanced.

The strategic response to this situation is often to use curative services as an enticement or a quid pro quo for getting rural people to accept and participate in preventive activities. The Esperanca project in Brazil, previously mentioned, in its early stages explicitly required adults who wanted to be treated in its clinics to agree to have all the members of their families immunized. Sometimes, some of the funds raised or allocated for curative care may be allocated for preventive measures. The Kottar Social Service Society in India has made the right to participate in decision-

making about expenditures from the primary health care fund contingent on mothers' regularly attending health education classes (John Field, personal communication at April 1984 workshop).

In practice, the choice between preventive and curative activities need not be "either-or." One suggestion that has been made is to phase PHC work, starting with a curative program and then introducing preventive measures once rapport and confidence have been built up. This would probably mean starting by working through government agencies and then bringing in other local institutions later on to add a participatory dimension to the program.

One could proceed in a more integrated manner. Where mobilizing resources and cooperation is easier for curative activities, these may be used concurrently as a springboard for other, less immediately popular efforts. Participation would be encouraged from the outset by such an approach, for example, in mobilizing funds for drug re-supply, or in making decisions about who should have fees for service waived because of inability to pay.

While it may be true that curative services can often be effective with minimal participation from beneficiaries, compared to preventive measures which practically always require widespread understanding and active support, the effectiveness of curative efforts can usually be improved through local assistance in scheduling, follow-up, and material contributions. Such participation in curative efforts can provide a basis of organization and experience for tackling the all-important preventive activities that undergird primary health care.

It is possible to start with a preventive focus if PHC programs move away from the common notion that the newly trained health workers are to "deliver" health care while "teaching" villagers, and instead seek to foster a climate of greater consciousness about the sources of ill health in the community. Such an approach was taken in Sierra Leone, where after a decade of trying to improve health through a mobile clinic, a church-affiliated hospital terminated this program for lack of results, and tried a preventive program based on group discussions and community participation. For the first several years, curative care in the community continued to be provided by indigenous practitioners. Only later were certain community members given responsibility for handling curative drugs (see Annex, pages 44-45).

One observation of PHC program in Burina suggests that those which spend more time on curative services are also likely to spend more time on preventive and promotive efforts, due in part to their involvement as well as their training and

supervision in general.<sup>14/</sup> Village health workers in the course of their daily work have opportunities for informing and motivating people, whether part of a formal training program or not. For instance one of the best times may be when a health worker treats a sick child. In the process of treating the child, there is often time to explain how to prevent a recurrence. Effective use of such opportunities depends on the orientation and skills of the health workers.

#### 4.4 PERCEPTIONS OF COSTS AND BENEFITS

Primary health care encompasses a wide variety of activities intended not just to cure illness but to prevent disease or, put positively, to increase vitality and well-being. Which institutions are most appropriate for undertaking which aspects of a PHC program will depend in part on the relation of perceived costs and benefits. According to whether individuals see the costs of participating in a particular activity as low or high, and whether they see the benefits of that activity as clearly resulting from the cost, one of four categories can be distinguished, with examples given in the following matrix.

		Connection perceived between incurred cost and resulting benefit	
Level of cost required		Clear	Not Clear
Low	(I)	Mosquito nets	(II) Contraceptives
High	(III)	Hospitalization	(IV) Public sanitation

The first circumstance (I) represents something which can be fairly readily handled through private market institutions, e.g., village shops, or membership organizations like cooperatives. The second (II) may also be handled through private channels, but some subsidy may be needed to attain a satisfactory level of

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<sup>14/</sup> This observation was made by Don Chauls at our Cornell LID workshop in April 1984. As a consultant for Management Sciences for Health, Chauls helped many establish a PHC program in Nepal, funded by USAID, and has studied PHC in numerous other countries.

participation. If the connection becomes quite remote in people's minds, public sector institutions become perhaps the only alternative when the social benefit is agreed upon. The third situation (III) is amenable to private institutions, but there would need to be some subsidization of lower income groups if there is to be equitable distribution of participation.

The likelihood of people seeking a particular health service reflects their seeing in it some clear benefit or minimal cost. As the benefit becomes ambiguous or uncertain, and/or as the cost rises, people become less likely to participate in that service without some special inducements or sanctions. The fourth combination of ambiguous benefits and high costs, illustrated by investment in public sanitation, cannot be handled by market means, at least not at the outset.

To be sure, these examples raise the issue of "public" versus "private" goods, discussed in Report No. 2 and in the next section. The first situation exemplifies a "private" good in that the divisibility of mosquito nets contrasts with the indivisibility of a sewer system, but the distinction made here turns particularly on the size and perceptibility of net benefits as incentives, not simply on the difference between public and private goods.

Somewhat less costly, but not less difficult, examples of the fourth situation would be building public latrines that people will use, or keeping animals segregated from the human population. Because such activities require a great deal of cooperation from individuals, they pose difficulties of organization that compound the inhibition of low perceived net benefit.

An intermediate example would be improving public health through disinfecting a village's water supply. This should show clearer, quicker results with less cost and little interdependence of action. There would have to be cooperation to the extent that persons used only the protected water source and kept it uncontaminated. Local government and membership organizations would likely have to be involved in such efforts even if they were first started by local administration.

Perceptions, quite obviously, are subject to change over time, for many different reasons. But in planning primary health care, one is best advised, at least at the outset, to accept existing perceptions and allocate local institutional responsibilities for different PHC elements accordingly, in order to gain initial cooperation and not to risk alienating those whose cooperation is desired (Flavier, 1978).

#### 4.5 PUBLIC VS. PRIVATE GOODS AND SERVICES

The nature of the goods and services provided, or supported, by PHC programs will have implications for the local institutions undertaking their provision. The most common and useful distinction resides in the "public" or "private" nature of the goods and services being made available.

Public goods are those which in practice are not subject to exclusion and are subject to jointness of consumption or use (Ostrom and Ostrom, 1977). This means that public goods cannot be readily divided into units which could be sold to someone or some group who may exercise ownership, excluding others from their use; also if others use the good in question, it is not appreciably diminished thereby. The classic examples of public goods are in the infrastructure area, e.g. roads. But in the health area, eradication of malaria or smallpox would equally illustrate the same idea.

Within the realm of public goods, there are further distinctions to be made, between activities where a degree of interdependence is present, often requiring collective action, and activities where there is little interdependence. With malaria eradication, all homes and adjoining areas must be sprayed to be successful. With smallpox eradication, each person gains the benefit by being vaccinated, regardless of whether others also get the vaccination (though if everyone participates and the virus is eliminated, vaccination may no longer be necessary).

Private goods can be sold to individuals or groups up to a level where they judge the benefit to be no greater than the cost. Curative health care such as treatment by means of antibiotics is an example of this.<sup>15/</sup> Market mechanisms can usually indicate a level of user fees that will cover the costs of provision, though there is no guarantee that all who need care will get it. In principle, any of the institutional channels can provide private goods, though private enterprises cannot purvey public goods (at least not without subsidy from public sources). In practice, public institutions tend to stay away from providing private goods through market mechanisms, though this would often be sensible.

In many health systems, government agencies have chosen to make private goods for curative health care available free of charge to all individuals, making them "public" goods in the sense of being provided by the public sector, but that does not

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<sup>15/</sup> To the extent that the disease is communicable, there would be a public goods aspect in its control. If people do not take steps to reduce and contain the spread of such a disease, there would be public interest in requiring or subsidizing care, or in imposing a quarantine if the disease is not curable.

change their nature as divisible and excludable benefits. In the Philippines, for example, not only curative health care but also some "preventive" measures such as family planning services are given free to all who come to government clinics. In Thailand, on the other hand, the Lampang project gave responsibility for determining the fees to be paid by each household to the village health committees (Coombs, 1980).

Where a high degree of social and economic inequality exists, PHC programs providing goods and services through private enterprises risk excluding poorer households from their benefits. Even so, regardless of the type of local institution serving as a channel for PHC, there are few if any private goods which could not reasonably be given with some charge to the recipients. This does not preclude partial subsidization to encourage utilization. Subsidization can even reduce problems of underuse, such as households storing free drugs in case of future illness, or perceptions that the drug is of little value because it is given free of charge.

In such analysis, there is a useful middle category of mixed goods -- those which are subject to some degree of exclusion but retain characteristics of jointness. Family planning services are an example of a mixed good in the health field. They can be given to some families but not others, yet one family's use of the counseling and services does not preclude others' use (unless there are definite constraints on staff time and supplies). How much of a public benefit there is from family planning can vary. To the degree that population is pressing upon scarce natural resources, family planning can be viewed as a more public good. Where resources are relatively ample, it can be seen as a more private good. In a broader sense, however, to the extent that people are able to have the number of children they desire, and the associated improvements in terms of opportunities for education, employment and health, most notably for women, family planning can be viewed as a public good. Potable water, another mixed good, varies similarly depending on the context of water availability.

To the extent that PHC activities are private goods, self-help membership organizations and private sector institutions are more viable options. Equity preferences can be accommodated through a variety of means including charges based on ability to pay and subsidization mechanisms. Public goods, usually exemplified by activities aimed at preventing health problems, call for greater involvement of local administration and local government. Since the demand for public goods may not be clearly articulated, especially in the early stages of the PHC program, and costs are not easily applied to users, collaborative efforts between LA and LG can significantly improve PHC performance levels.

## 5.0 ESTABLISHING LOCAL INSTITUTIONAL NETWORKS

The provision of adequate primary health care requires the functioning and cooperation of a number of local institutions. The hierarchical structure of government health agencies needs to be extended downward to provide care and education at the locality and/or community level. The level at which clinics and other facilities are located depends on the size of communities in the area and on the financial and personnel capacity of the government. Some appropriate role for private health care providers, both modern and "traditional," should be worked out in consultation with them, to take advantage of what they can do well. What division of labor there will be between public and private sectors for the distribution of medicines, contraceptives and other supplies needs to be determined by discussions and experimentation. The objectives of economy, reliability, accessibility and equity need to be balanced in arriving at a suitable arrangement.

What is not as clear is the role that other kinds of local institutions should play -- local government, membership (user) organizations, cooperatives, and charitable organizations (the not-for-profit private sector). This depends on the capacities of each and how well the more conventional public and private channels can perform PHC functions.

As primary health care programs have evolved, two particular innovations are usually part of the PHC support system -- one an organization, the village health committee (VHC), and the other a role, the village health worker (VHW). Neither is an "institution" at the outset but both can become "institutionalized" to the extent they acquire legitimacy on the basis of their performance. VHCs can be member organizations or adjuncts of local government; VHWs can operate under the aegis of LA, LG, membership organizations, cooperatives, or service organizations. As suggested above, they might even function as private providers on a fee-for-service basis, if their services were highly enough valued and not prohibitively expensive.

### 5.1 THE NEED FOR AN INSTITUTIONAL BASE

Primary health care programs often place VHWs in the unusual role of being both a direct service provider and a community organization catalyst. Given the almost universal interest in curative aspects of PHC, it is assumed that those who provide medicines will gradually gain legitimacy and be able to expand into areas of sanitation,

nutrition and health education (see section 4.3 for a fuller discussion of this). Yet the performance of VHWs' preventive and curative activities is very much dependent on the institutional base from which they operate.

The objective of primary health care is not so much to institutionalize a health worker role but to develop several complementary institutional capabilities to deal with the range of curative and preventive needs. While a government agency or regional service organization may serve as the "lead agency" in initiating PHC and in providing subsequent technical support, health workers require intensive connections with the community which are more likely to come from institutions that are directly accountable to rural populations, such as membership organizations or local government.

In a number of PHC cases reviewed, VHWs were given technical training and then returned to the communities to work with newly formed village health committees and to coordinate with other local institutions. Equal investment was not made by program authorities in the development of VHCs and those institutions. Instead, VHWs were expected to carry that load as well as handle more "technical" tasks. Two examples point up this key difference.

In Project Esperanca in Brazil, the service organization that served as the lead agency in introducing the PHC approach not only gave extensive training to health workers but also made an explicit effort to assure that a local institutional base existed from which they could work. Esperanca accomplished this in large part through perseverance over several years. Even when many of the original VHCs did not last more than a few months, Esperanca Foundation, recognizing the importance of having a local institutional base, made ongoing investments in training new VHC representatives to replace ineffective ones. Support included transportation expenses and a practical curriculum with subjects like simplified financial management and how to build up community confidence in VHWs.

The VHCs now oversee day-to-day administrative matters including the hours that health posts are open and charges for various services. Esperanca continues to provide in-service training and technical supervision for health workers. Linkages have been established with the Ministry of Health to provide medicinal supplies. In many locations, local government revenues provide remuneration for VHWs. Crucial to this development is the fact that the VHC rather than the VHW is responsible for managing the various linkages with other institutions, and it is backed by the Foundation, a service organization operating at the regional level.

In sharp contrast is the Sine Saloum project in Senegal. Its village health workers were envisioned as being direct service providers while simultaneously working as catalysts for transformation of the health situation. Although village management committees were established to oversee financial matters, they were limited in this domain and were not expected to play a promotional or mobilization role (Hall, 1981:21). As a result the VHWs were very much on their own, especially when the level of support planned by the Ministry of Health (MOH) personnel did not materialize. The project subsequently lost effectiveness when many VHWs left to find other forms of employment (see Annex, pages 43-44). The requirement for a solid local-level institutional base was overlooked. In this case, project managers were trying to institutionalize a role without attention to institutionalizing a viable grassroots organization.

Fortunately, many of the above inadequacies have subsequently been addressed by MOH and AID staff. With greater focus on LID, the project appears to be reviving. One of the most interesting changes has been the project's effort to organize a women's committee for each village health-hut. This is intended to give women greater voice by creating parallel community organization, a structure that is traditional to villages in the region (Bloom 1984).

## 5.2 USE OF PARAPROFESSIONALS

One way of possibly reducing the cost of health services and of increasing their accessibility is to refashion the roles of service providers, especially to introduce new paraprofessional roles in primary health care (Esman et al., 1980). Simply recruiting and training persons from the community is not the answer, however. Even if their salaries are less than those of more qualified professionals, their performance can be of negligible value, quite apart from their level of technical competence, unless two conditions are met.

First, as stated previously, there has to be effective periodic if not continuous supervision and back-up from higher levels (district or region), usually from a government agency but possibly from a non-governmental (church or charitable) organization. There is an accompanying necessity for supervision to be sensitive to the position of the health worker as well as the community itself. Both the amount and the way supervision is handled will have far reaching consequences for a program's viability. The intent of supervision is not only to monitor technical performance of the VHW and

to ensure that he or she is actually working at assigned tasks, but also to provide him or her with the status needed in the community's eyes to be accepted and respected. Otherwise, a local person is commonly "a prophet without honor." Supervision can also facilitate problem-solving by giving the VHW confidence as well as consultation in reaching solutions.

Second, there has to be accountability to the community. This can be achieved through its local government or some local membership organization. Outside officials, for the sake of getting a program started, have themselves often selected someone from the area or have let local influentials do the selecting (Colburn, 1981; Hall, 1981; Taylor, 1981). There has too seldom been some group to whom the paraprofessional felt responsible or who felt committed to working with him or her after initial training was completed. Yet such a relationship, as noted in the Brazil and Senegal cases above, is critical for success. Use of paraprofessionals without some concomitant local institutional development is not an effective strategy, even if it is superficially attractive on budgetary grounds.

Another important subject involves the amount of time that paraprofessionals devote to their work. While it is not possible to draw reliable conclusions concerning the advantages and disadvantages of full-time versus part-time paraprofessionals, the issue does relate rather directly to financial resource mobilization capabilities. Where a sufficient and reliable means of funding is not available, it is most unlikely that paraprofessionals will be able to work effectively on a full-time basis. Rather, local institutions in such circumstances are more likely to maintain ongoing activities if part-time paraprofessionals work voluntarily or for a small stipend. Several cases in the Annex detail the problems associated with paraprofessional health workers expecting one level of remuneration and receiving something less, all with discouraging results.

### 5.3 COMPARATIVE ADVANTAGES OF LOCAL INSTITUTIONS

Even if a PHC support network can involve the whole range of local institutions, not all are equally useful for all PHC tasks. A network should take advantage of what each channel can do best.

Government agencies are by their nature better suited to routine, repetitive tasks like health inspection or mosquito spraying which need regularity. This strength may have a converse weakness in inflexibility and inertia. PHC programs require regular

support and supervision, and government agencies can be reasonably effective in this if sufficient staff are available for the task, having offices and transport facilities at appropriate sub-district levels or district levels. Government agencies also have an advantage in being more able to mobilize and provide a higher level of technical skill than village-based institutions. They can also increase the status and legitimacy of health workers and committees at the village level (Colburn, 1981).

One limitation is that the orientation and methods of operation of government staff are commonly rather bureaucratic or technocratic, assuming a posture of superiority which discourages local responsibility and initiative. Such attitudes are quite inappropriate for PHC. For this reason, it may be desirable for government agencies to work through intermediaries who operate in more responsive and respectful ways. Private voluntary organizations have been nominated for playing such a role on behalf of the government to develop more supportive linkages with the public and with non-governmental bodies (Steinmo, 1982). However, it may be possible for government agencies to employ, train and deploy staff who will work in a new mode themselves.

Local government has rarely been found taking the lead role in initiating PHC, yet it does appear to offer a viable local institutional base for non-technical support and management. This is particularly true where alternative forms of health care are not readily accessible and where an absence of government or private providers has created a clear "demand" for health care. In these situations, LG may be preferable since virtually all households will have an interest in PHC. LG can work with VHWs in determining arrangements regarding when and where services are to be provided and can serve as the institutional base to which VHWs are accountable.

In any situation where LG exists and has some authority to manage public facilities, it can support PHC by introducing or enforcing protective measures associated with public sanitation. Municipal governments commonly oversee public markets. Through infrastructure provisions including waste disposal and running water, sanitary conditions in markets and in communities generally can be improved.

Where LG raises funds through various taxes and user fees, among other methods, it will be able to make allocations to PHC for specific services, e.g. health education for young children, or funds for VHW travel for training programs. Additionally, LG can oversee the work of government agencies or private organizations and can hold them more accountable to the public, an important contribution to PHC institutionalization.

Membership organizations can play various roles in PHC. For normative and practical reasons, health-related organizations are more likely to be "inclusive" than

"exclusive" (as defined in Leonard, 1982). Humanitarian considerations usually rule out not providing curative medical care, and the "public goods" nature of many preventive measures makes exclusion of certain members of the community self-defeating.

Moreover, the caution some would have about supporting inclusive membership organizations, that the benefits might be monopolized by richer or more powerful members, does not hold in the same way for PHC as it would, say, for an input supply cooperative. Not all of the goods and services for PHC are "joint" in a way that would make them "public." Many PHC goods and services have the characteristics of divisibility and excludability, so they can be given to some and not others. Some of the drugs and vaccines can be diverted to private gain,<sup>16/</sup> but compared with agricultural credit, forest resources and other similar goods and services, PHC does not usually provide things which elite groups would particularly like to accumulate. While elites surely want health practitioner's services to be available when they are ill, "capturing" educational or preventive activities is not likely to be worth a significant effort, and although one could get more than one immunization or parasite purgative, each is painful or at least inconvenient enough that additional ones are of little incremental value.

These considerations work in favor of inclusive organizations, and indeed suggest that PHC tasks generally can be devolved to local institutions with more confidence that benefits will reach the poor than exist in other development areas. One danger to be kept in mind for PHC is that local elites, if in control of the programs, could revise them to upgrade the quality of services at the expense of quantity (Leonard, 1982:9). This would apply for a local government role in PHC as much as for membership organizations and should be guarded against as much as possible.

Because inclusive organizations with large memberships are operationally very difficult to manage with regard to regular or specific tasks, supporting the daily workings of a village-based PHC program is often more feasible through a smaller elected village health committee. If constituted through procedures that are well-understood and accepted by the community, VHCs can perform certain management functions in the health area more effectively than "mass" organizations. However, retaining larger mass organizations still appears desirable in many instances when important decisions or activities (especially preventive) with broad effect are required.

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<sup>16/</sup> These questions of divisibility and divertibility as they affect human resource development generally are analyzed in Uphoff (1980).

Apart from having clear procedures, it is necessary for VHCs to have clear roles which will keep them active and keep members' morale high. Assigning responsibility for financial management and for overseeing the work of VHWs is the common minimum level of responsibility, but more tasks can be undertaken according to the level of competence and enthusiasm of members.<sup>17/</sup> As noted in section 2.3, the record of VHCs is rather uneven. The mode in which they are established is particularly important, as learned the hard way in the Cameroons where some of the pioneering experimentation with VHCs was done (see Annex, pages 38-39).

One kind of "exclusive" membership organization found useful for PHC is women's associations, often called "mothers' clubs." They have produced some impressive results in programs ranging from rural lunchrooms for poorly-fed children in Honduras to carrying out comprehensive programs of community improvement in South Korea (Ickes, 1975; Kincaid et al., 1976; F. Korten and Young, 1978). The success of such organizations has depended on the quality of local leadership that comes forward, primarily on whether it can convert a sense of common interest into collective action.

Service organizations have a long history of involvement in health care, particularly hospitals, and they have in recent years been quite active in refocusing their efforts toward community medicine. In general, they appear to have been better at providing "private goods" such as curative medicine than at promoting "public goods" like mosquito control. For the latter, some involvement with membership organizations is useful, to get community cooperation.<sup>18/</sup>

One strength of service organizations is that they are usually less constrained by the jurisdictional limits and rivalries that characterize most government agencies. This is a particular advantage in dealing with communities where administrative boundaries

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<sup>17/</sup> One of the most encouraging recent reports on VHCs is of their re-emergence in the service area of the Kasengeti Medical Center in Uganda, serving about 40,000 people. The population has been swollen by refugees from strife-torn neighboring areas, and the medical services like others in Uganda at present are disrupted and minimal. The Center was supported by the staff of the Makerere University medical school in the 1960s and 1970s and established VHCs in a dozen communities. These disappeared in the chaos surrounding regime changes and continuing political and ethnic struggle, but the VHCs have resurfaced to work with the staff of the Center, presently augmented by foreign volunteers, and they are making a contribution to coping with the abysmal conditions. (Personal communication, Dr. Carolyn McKay, University of Minnesota Medical School.)

<sup>18/</sup> An example of successful linking of service and membership organizations comes from Zaire, where a rural hospital in Bandundu province by working through VHCs to improve public sanitation was able to reduce ascaris infestation from 70 percent to less than 15 percent within one month (Fountain, 1973).

are incongruent with the social boundaries of kinship or ethnicity. Service organizations can work with people as individuals according to the SOs' convenience.

The types of service organizations which can be of assistance to PHC networks can even include non-health related groups such as Rotary or Lions or their equivalents. Similarly, youth groups such as Anak Bukid, Boy Scouts and Girl Scouts have the potential to become involved with such activities as motivational campaigns for oral rehydration therapy, immunization and so forth. In Latin America a wide variety of service (social activist) organizations have emerged in recent years. The members are generally better educated individuals dedicated to working at the grassroots level by assisting with capacity building activities in many areas, including health (Hirschman, 1984).

Another advantage of some service organizations, those which are church-affiliated, is that they can work through channels of communication that enjoy a legitimacy which secular institutions seldom match. That many religiously-supported mission hospitals have become such strong "institutions" in very difficult and unpromising locations is due in large part to the combined legitimacy of serving both "health" and "faith."

Private practitioners and private enterprises, as we have said, should be considered explicitly as part of any PHC system. Many of their advantages have already been discussed. Where there is a demand for goods and services and also purchasing power among the public, these private roles and organizations (institutions to the extent they enjoy legitimacy) can provide those goods and services more quickly and responsively than government agencies or even some service organizations.

Private channels can be particularly useful in the sale of contraceptive devices and in dissemination of family planning information, where there is demand for these. This was found in the PDCA case in Thailand (reported in the Annex, page 45). Similarly, small shops have been used to help control goiter in inland areas through sale of iodized salt.

In a two-year field evaluation in the Philippines of three nutrition intervention strategies to control vitamin A deficiency -- a public health and household gardening approach, distribution of vitamin A capsules through official channels, and sale of fortified MSG (a popular food additive) in small village stores -- only the last resulted in a significant reduction in the clinical signs of xerophthalmia (Solon et al., 1979).

A village doctor or storekeeper may have the added advantage of being more flexible than a bureaucracy in providing short-term credit. With few exceptions, the

location and setting of private practitioners and enterprises is more convenient, familiar and congenial than are public sector facilities. This reduces the transaction costs, social as well as economic, of getting goods and services for improving health.

These considerations argue for a definite and often larger role for the private sector in primary health care efforts. There is no evidence, however, that PHC can be brought within the reach of the rural majority simply through private channels operating on a fee-for-service basis. This reinforces the concern we have stated that planning for primary health care focus on establishing networks of local support institutions.<sup>19/</sup>

#### 5.4 STAGES OF HEALTH CARE DEVELOPMENT

The appropriateness of different institutions will be a function of the level of health knowledge and awareness in the community as well as of the evolution of institutional capacities for providing basic services. The contributions which self-help membership organizations can make to PHC, for example, may well relate to how much attention or "education" has been devoted to health issues in the past.

Improvements in health and nutritional status, as well as acceptance of practices that make these improvements more likely, depends on community standards and common activities as well as individual knowledge and motivation. Changing these is not simply a matter of individual persuasion. While health is an intensely "personal" matter, people's practices are influenced by what others are thinking, saying and doing. For any significant change to occur, people need opportunities to talk among themselves about health problems and possible remedies.

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<sup>19/</sup> An example of this type of local institutional network is found in Nepal's Community Health Leader Project. The Ministry of Health Training Unit initiated activities with technical and financial assistance from AID, an AID contractor, and WHO. The project trains staff of the Health Post (LA) to get the Panchayat (LG) to set up a Village Health Committee to support the activities of the community health leaders. Other foreign donors (SATA) and PVOs (BNMT, IHAP, SCF) as well as indigenous SOs (Nepal Red Cross and Women's Organization) are also involved in experimenting with project variations and implementing the basic project or variations in different parts of the country. In at least one instance, the VHC was expected to have representatives from village membership organizations. (the farmers' groups of the Small Farmers Development Project). Finally, assistance was also being sought from district-level SOs (youth groups, Lions' Club) to help in the villages on a voluntary basis (Donald Chauls, personal communication).

Such discussions do not occur readily in visits to government or private clinics. There need to be congenial forums for discussion, perhaps organized by a health educator or VHW, where health professionals and paraprofessionals can participate and a process of attitude and behavior change can be nurtured. This is more critical to improvements in PHC ultimately than are facilities, drugs and service providers. This realization is one reason why mothers' clubs are so often looked to in PHC programs, not just to get participation in specific services but to create a climate of opinion that supports a change in practices.

In most rural areas, there will be some indigenous private sector sources of health care, as noted already, and commonly also some government sources, however thinly and unreliably provided. The best health care and education are likely to be available from church-related institutions in those areas where government agencies and private practitioners, at least those practicing "modern" medicine, are not inclined to work.

Where other institutional channels are weak or not available, self-help efforts through membership organizations make a great deal of sense. They can introduce and support public health measures, construct facilities, raise money to attract medical practitioners, etc. They may be particularly effective when supported by local service organizations such as church-sponsored institutions like the Kottar Social Service Society in India (Field, 1980).

As rural people gain more knowledge, motivation and material means to deal with their health problems, they should be able to reduce their most basic needs for medical services. However, their use of health services is likely to increase because they will seek care for a greater percentage of their problems. As incomes and educational levels rise, it is often the case that more private doctors will seek to locate and practice in rural areas, and the spread of government health services should also be greater. For many parts of the world, however, this may be generations away.

One can project that the role of paraprofessional health workers is likely to change, as are local institutional arrangements, in latter periods of rural development. Membership organizations for health improvement may no longer support part-time VHWs, for instance, and instead may prefer to support a community health clinic with full-time professional staff. However, providing more advanced or specialized care does not preclude retaining community organizations for health.

## 5.5 CONCLUDING COMMENTS

The scope and complexity of primary health care requires that agencies support more than a single institutional channel. Developing a network of complementary local institutions will require more time and patience than introducing any one kind of institution, but the effectiveness of any one ultimately rests on the set of other institutions it can interact with horizontally, at the same level, and vertically, above and below.

Primary health care represents a departure from the traditional concepts of "providing" services and medicines. It involves a greater degree of self-help and self-reliance than in previous formulations of what role rural populations are to play. They are to become "participants" in their own health improvement rather than only "patients." For this to happen, it is clear that local institutional development is crucial.

## ANNEXES

To share with readers some of the most instructive LID experiences that we found in our review of the literature, we are presenting in these annexes some capsule descriptions of such experience, positive and negative. Readers are referred to the cited sources for fuller details.

### BRAZIL: Project Esperanca

This primary health care program has evolved from a curative program supported by a missionary organization with limited participation by beneficiaries to a regional program stressing community-based health. The transition occurred with assistance from private foundation funding. The participating areas have a population of over 30,000, served by 17 rural health posts and a training center-clinic complex with administrative offices in the city of Santarem. The complex has 40 employees who provide technical services and support to 17 licensed rural health aides and 56 rural health promoters.

Experience with full-time health aides suggests that older, functionally literate women seem to do better with maternal and child health and community organization work. In contrast, the more numerous volunteer health promoters, who work a fewer number of hours include farmers, fishermen, curanderos and traditional birth attendants. Incentives include a painted sign post in front of the promoter's house and free transportation, room and board for training. In addition to training aides and promoters, the clinic complex in Santarem reinforces their position by accepting patients with referral slips before non-emergency cases that have bypassed the rural health posts. Two U.S. surgical teams still visit annually but only perform types of surgery not available in Santarem.

Esperanca provides unusual support to the community health committees with special training in management and organizational tasks. Some committees are composed of representatives of existing local institutions, though this is not always the case. Federal and state government health agencies provide vaccines and medicines for the rural health posts, while local governments pay the salaries of 11 health aides (Favin, 1982).

**LESSONS:** Perhaps more than other activity areas, primary health care programs require a vibrant network of local institutions collaborating on several fronts. Strong vertical and horizontal linkages have enabled the rural health aides and promoters to increase their level of activity over time. This has been facilitated by having strong community health committees, not just health workers. Furthermore, by enlisting a substantial number of volunteer health promoters, Esperanca has increased the base of support and access among project beneficiaries.

### BURMA: Community Health Care Program

This program relies on volunteers who serve as community health workers (CHWs) and auxiliary midwives (AMWs). Nationally, health services are available from division and state hospitals, township (district level) hospitals, rural health centres and sub-centres, in ascending administrative order. There is about one sub-centre for every

twelve villages. At the village level, the CHWs and AMWs operate under the local government body, the Village People's Council, which serves as their institutional base. There are nearly 30,000 volunteer workers who are now in their fourth year of service.

Villagers have contributed their labor to help build the health centres and sub-centres. However, most health centres are fully staffed only three days per week with Thursday through Saturday devoted to field travel to supervise sub-centre CHWs and AMWs while concurrently conducting mobile clinics. Sub-centres are visited by health centre staff at least two or three times per month. Standard protocol for each visit also entails a meeting with a member of the local government.

Community health workers are chosen by LG but the fact that they are not paid tends to mitigate against selection of health workers as a "political prize." Tasks include distribution of drugs, encouraging people to construct latrines, taking malaria blood slides and assisting school programs, among others. CHWs work approximately two hours per day with no precise routine, however, the curative role clearly occupies the bulk of their time. Auxilliary midwives deliver two to three babies per month, often in conjunction with let-thes (traditional birth attendants). Since the AMW does not interfere with the traditional birth attendants income, friction is generally avoided.

Although CHWs receive a kit containing eleven types of drugs following their training, this supply is not replenished by the national government. Instead, each local government must devise its own system of raising funds. There is a considerable variety of systems that have emerged including fixed or variable payment for services, voluntary donation for services, fixed or variable household levy, donation by wealthy people only, periodic donation campaign etc. These efforts seem to be extremely successful. Unfortunately, shortages at the national level have at times caused delays in purchasing drugs even when local funds are available (Chauls, 1983).

LESSONS: Though it is not possible to list all of the reasons for the high level of activity which has been generated, one important reason appears to be that villagers consider CHWs to be part of "their" local government rather than an arm of the government health system (LA). But as seen by the frequency of supervisory visits each month, LA still serves an active and critical role. While there is strong cultural, political and religious support for volunteerism in general, the devolution of responsibility for health to more than the Health Department alone, especially in regard to financing, appears to have contributed to the program's vibrancy.

### CAMEROON: Village Health Committees

In 1972, the University of Pittsburgh medical school began a demonstration project in the Department of Mefou to promote self-reliant health care practices, with a special emphasis on preventive measures. To achieve this, auxiliary nurses already in government employment were selected by the Department physician for training as visiting health workers to assist village health committees that were set up in four pilot villages. The committee membership consisted of existing leaders. The VHCs functioned in a formal manner, probably not consistent with community practices.

Two years after the project ended in 1976, a survey found little or no change in health status, despite construction of a number of latrines, protected springs and

garbage pits by the communities. At best, one-third of the health committees continued functioning, and the impact of the VHWs was accordingly limited. (Isely, 1979)

**LESSONS:** One conclusion reached was that the VHWs had taken a very mechanistic approach to the formation of the committees. They were satisfied to have formal existence of the VHCs as having met their "targets." Also, the committees were probably less effective because they were composed of existing leaders, without establishing who had the most interest in improving community health and who had the most support of villagers.

The VHC which remained the most active had previous experience with community projects affiliated with a church group, suggesting that it had a reservoir of collective action capacity to draw on. More thought should have been given in project design to the process of setting up and sustaining a membership organization relying on volunteerism. Furthermore, four years is probably too short a time to expect a high degree of institutionalization and represents too little investment, to have a significant impact on health status.

#### GHANA: Association of Ghanaian Psychic and Traditional Healers

Indigenous health practitioners are organized into a national organization, which has formal membership requirements and fees. Practitioners to be members have to be licensed by the District Council (local government) where they practice.

A project to improve village health in Techiman District initially trained and relied on newly-recruited village health workers and traditional birth attendants. This proved rather unsuccessful because of lack of community support. (Communities were expected to pay VHWs' salaries but did not always do so.)

Then in 1979, it was decided to involve herbalists and other traditional healers. A training program was provided for them by staff from a private rural hospital. The Ministry of Health, which had had extensive informal consultation with healers through their organization before the course started, helped by encouraging attendance.

Pre-training interviews with the 45 prospective participants guaranteed that information about existing techniques and beliefs was taken into account in the course. Classes were held in the homes of healers with each participant paying a small fee to cover the costs of material received. Feedback from the trainees was actively sought from them in their homes on a weekly basis. All discussions and printed materials were in the vernacular.

The main focus of training and subsequent activity included environmental health, preventive and promotive health, family planning, and home remedies. Established remuneration practices were preserved and sufficient. (Warren et al., 1981)

**LESSONS:** The success of this program indicates the potential of working with and through indigenous health practitioners, although such programs might not work everywhere. Ghana had been experiencing severe shortages of professional medical personnel and an irregular supply of factory-produced drugs. Thus, such an approach made a low-cost contribution to rural health by upgrading existing local roles (institutions).

## GUATEMALA: Rural Health Paraprofessionals

Beginning in 1971, the Ministry of Public Health and Social Assistance initiated efforts to improve curative and preventive services in rural areas. With support from USAID and UNICEF, two new roles were incorporated into the health system. Subprofessional Rural Health Technicians were given a two-year training course in preparation for a four-year contract under which they would in turn train and supervise paraprofessional volunteer health promoters on a full-time basis. In their work training paraprofessionals' stressed preventive measures to promoters, although each promoter was given a kit containing simple medicinal supplies for which villagers paid a small sum to replenish or enlarge the stock.

Though the program did not take root everywhere, a 1981 study did find promoters working in a number of villages, usually devoting about one hour per evening, with some promoters actively working on preventive projects such as water supply construction. Promoters tended to be more active where they had worked in conjunction with the Rural Health Technicians to create elected village improvement committees.

Interestingly, these committees rarely contained a village authority figure but in many cases they had to be "reorganized" several times until they secured an energetic and effective committee. One paradox faced by the program was that although paraprofessionals from the community in which they lived were more easily accepted than outsiders, this tended to lower expectations about what these persons could accomplish.

The key to raising expectations appears to have been frequent visits by the Rural Health Technicians. These persons' information and friendship were highly valued by the promoters, and they enhanced the status of the promoters in villagers' eyes. The promoters maintained a sense of comradeship and collective endeavor via semi-annual training sessions and a self-run newsletter that shared experience and "tips." (Colburn, 1981)

**LESSONS:** Effective support and supervision of community health workers need not come from highly trained professionals, especially in programs attempting to reach the most remote and inaccessible areas. Subprofessionals are frequently able to give more support and supervision to community health workers and village health committees than higher salaried professionals. Having more than one health worker volunteering on a part-time basis to serve a smaller population may be a viable alternative to full-time paid workers. An active local committee adds greatly to the paraprofessionals' effectiveness.

## INDONESIA: Dana Sehat Health Cooperative

In 1972, staff from a church-affiliated health center in Central Java's Purworejo-Klampok subdistrict undertook efforts to reach relatively distant and poorer communities by devoting more time to preventive measures and opening three new health posts. Though these activities kept the staff quite busy, the center's director and his associates could see that the program had "no firm roots in the community." (Hendratta, 1976:3)

Following extensive discussions with community members, it was decided to recruit and train volunteer health cadres to work on a part-time basis, one cadre for

every 15 households. At the same time, local government officials and health center personnel worked to organize a cooperative health insurance program. This was implemented through the existing village administrative structure of neighborhood organizations. (Each city or community had been divided into districts and then into hamlets. These are subdivided into "blocks," or neighborhoods, of 50-100 families. This represents the "group" level in our analytical framework.)

Each household pays a contribution of 50 rupiah (or U.S.\$ 0.12) per month for curative services and medicines and this covers the cost of total family care by cadres which includes nutrition, health education, and public health services. The fee is collected by the block headman. If the funds collected are insufficient, the cooperative can get credit for one or two months from the health center. When there is a positive balance of funds, the community decides how to use them for health related activities such as building community latrines or improving the sewage system.

Some communities have used a balance to start a village credit cooperative. Funds generated from this activity provide a "reserve" to cover any shortfalls in the health program. The community meetings established as part of this program provide an excellent opportunity for practical health education by the cadres as well as for undertaking broader problem-solving for the community. (Hendrata, 1976)

**LESSONS:** By establishing village-based health cadres backed by community cooperatives, access to preventive and curative services was increased. Fee collection was facilitated by handling this through local government officials, to achieve self-sustaining financial status and low costs for beneficiaries. Where excess funds were accumulated, the development of semi-autonomous credit cooperatives provided further benefits and greater economic security. As predicted by Isely and Martin (1977), such village health committees can provide impetus and channels for more broad-based rural development.

### MEXICO: Project Piaxtla

This pioneering health project was begun in the mid 1960s in the village of Ajoya. Over almost two decades of activity, a program that initially centered on curative problems evolved to address preventive and social issues. The most interesting aspect of the experience was the way health professionals from outside were used to support a local health program without creating social hierarchies or dependency.

Project guidelines provided that outside professionals would come only by invitation of the community health team, and only for short visits, to make clear that the team itself was self-managed and not dependent on the continued presence of outsiders. Visiting professionals had to speak the local language and were asked not to dress in white. Doctors were to teach, not practice their skills, assisting the village's own primary health workers. Since doctors also came to learn, relations with VHWs were on a peer basis. To reinforce this, visiting professionals were expected to participate in agricultural work, too.

When persons required care beyond the village's capacity, they were referred to the nearest city, four hours away by bus. Several doctors in the city agreed to charge for their surgery on a sliding scale, giving substantially lower rates to the poor. The determination of financial status was left to the VHWs, who would send a note with each person indicating the family's ability to pay. The urban physicians provided

important services to the rural community while at the same time strengthening the status and legitimacy of the paraprofessional VHWs. The VHWs reciprocated in a small way by referring also their more financially prosperous patients, who paid normal fees and thus increased the size of the cooperating physicians' practices. (Werner and Bower, 1982)

**LESSONS:** The capacity for communities to operate quite autonomous PHC programs is considerable, if outsiders approach them in a respectful and supportive way. Some back-up with higher level technical services is needed for even the most idealistic PHC efforts.

### PANAMA: Community Health Program

In 1969 the Ministry of Health launched an ambitious national program in which over 500 health committees were established in rural areas during a five year period. Community participation through the legally recognized health committees was considered the principal mechanism for the planning, implementation and distribution of program services. Activities included construction of water supply and waste disposal facilities, establishment of community gardens, small animal projects, health education seminars, vaccination campaigns and health status surveys.

In those areas of Panama where the Community Health Program remains active, federations of village health committees at the district or provincial level are quite important. Federations provide a valuable intermediary service linking the communities and the health system. They serve as a mechanism by which individual health committees can approach and pressure the health system for more and better quality services. For example, during federation meetings (usually held twice a year), health committee representatives publicly present their problems and requests for assistance to a group of senior health officials, politicians and military officers from the region which the communities represent. These items are openly addressed and discussed by the health officials and a tentative solution is agreed upon.

During the week after the meeting, a delegation of federation officers (who are elected by the health committees) formally present a written summary of the requests and proposed solutions to the regional director of the health system. Informal meetings between federation officers and health officials continue until "all requests have been checked off the list." In some cases the officers visit the communities to confirm that problems have been satisfactorily resolved. In one list of 20 "problems" noted by La Forgia at a biannual meeting, 16 had been resolved within two months. Similar problems were never addressed in districts and regions lacking a federation.

Following a number of years of educational activity, a 1976 study by the Ministry of Health found 68 percent of the community members contacted requesting sanitation and potable water and only 4.5 percent interested in better health centers. Local health staff and VHCs pointed to diarrhea, gastro-intestinal disorders and malnutrition as the principle causes of ill-health while higher level officials continued to believe that curative services were in greatest demand by the communities. This apparent difference in perception suggests that in contrast to the early 1970s, health officials may not visit communities or attend health committee meetings as frequently as before.

**LESSONS:** The strong support for PHC at the national level clearly assisted local level efforts for at least a five year period. One of the key elements in the program involved the formation of VHC federations which were in a position to discuss and

negotiate issues with MOH personnel. While this level of support from the top levels of Panama's MOH have subsequently receded, continued interest by medical directors of district health centers as well as rural communities themselves, has resulted in ongoing activity in several regions (LaForgia 1984).

#### SENEGAL: Pikine Primary Health Services Project

This project was begun in a peri-urban area outside Dakar in 1975 to provide health care to dispersed rural hamlets. The plan was to have many small health units rather than a few large health centers. The project was started in a two-room private house, with staff provided by the Ministry of Health.

The community's contribution, apart from paying fees for treatment, was to co-manage the health services by electing a health committee, to control the internal financial procedures, and to provide a link between the primary care practitioners and the member families. At regular intervals, new health committees were formed and new health units opened.

All the health committees were unified into an Association for Health Promotion, officially recognized by the government on May 8, 1980. The role of the government in backing up its staff is to monitor the effectiveness of coverage, plan programs and logistics, stimulate community capacity to solve problems, provide efficient technical guidance, support the accounting system, and take care of seriously-ill referred patients. (Jancloes et al., 1981)

**LESSONS:** Such a well-conceived government effort can elicit an effective community response. Few PHC programs have had such a federation of health committees, providing vertical linkage, but this should strengthen the program. It may put some uncomfortable pressure on the government agencies to perform their tasks better, but it also creates a constituency for health care that can support the Ministry when political clout is needed.

#### SENEGAL: Sine Saloum Rural Health Project

This project, begun in 1977, was sponsored by the Government of Senegal and USAID to create a new and more extensive layer of health services for Sine Saloum regions' rural population. Instead of relying on a single health worker, the program enlisted teams of three "team members" for each rural health post -- a first aid worker (a dresser), a midwife and a hygienist. Midwives were chosen from among existing traditional birth attendants. Management committees were formed within each community to oversee financial affairs including payments to health workers who were to receive a percentage of the funds collected. The committees did not have a promotional or mobilizational role.

Unfortunately, the program encountered some serious difficulties. Information about the program was channeled through village chiefs, with the result that few women understood the program or considered it as "theirs." The high academic standards required for first aid workers meant that many were not from the community they were to serve, or were frequently not available. (Given their educational level, they left for more desirable jobs whenever possible.)

The participating midwives were required to charge a relatively high fixed fee and were therefore rarely called upon. Neither their traditional status nor their more modern training were attractive enough to overcome the barrier of a cash charge. The fact that only one person in the management committee had control over cash receipts also made the treasurer susceptible to requests for loans from his relatives, which undermined the program's financial viability. Finally, since USAID paid for part of the cost of construction, too many closely-situated villages went ahead and built health posts. As a result, the first aid workers found they had insufficient visitors to earn even a minimum salary. (Hall, 1981)

As these problems became apparent AID and the Government of Senegal undertook actions to save the project. Agency staff moved their office from Dakar to the Sine Saloum region. Efforts were made to improve supervision. Part of this involved the abandonment of a policy which gave a supplement for each supervisory visit. Senegal's Ministry of Public Health issued a directive endorsing VHC's responsibility for overseeing the activities of the health-huts, including financing. Significantly, all members of the VHC now receive training in health-hut operation and financial management so they are in a good position to support the health workers. Formation of women's committees for each hut, in keeping with traditional village organization, is intended to give women a greater voice and broaden the network of supporting institutions (Bloom 1984).

**LESSONS:** When educational standards for health workers are set too high, local residents may be ineligible to serve or may leave for better opportunities after a short period of service. Considerations of the size and distance of the population to be served by PHC is particularly important for staff selection. The use of traditional health practitioners is likely to be less effective when long-established forms of remuneration are substantially altered. This project like so many others would have done better if it had adopted a "learning process" approach instead of following a predetermined "blueprint." Also, involvement of a wider group of beneficiaries in the initial planning and management, getting beyond the village chief and his associates, would likely have avoided major pitfalls.

#### SIERRA LEONE: Serabu Village-Based Public Health Program

A missionary hospital at Serabu had sought to meet rural health needs by sending a mobile clinic around to villages on a regular basis, but after ten years it was apparent this approach was having little impact. The hospital changed its approach to one of having nurses make periodic visits (usually for two days) to the villages on foot, not even carrying medicines with them.

Committees including the village chief, a person with knowledge of "medicines" and traditional midwives were organized and would meet for informal discussions similar to traditional village meetings. Although the meetings were irregularly scheduled, they were frequent, usually held once or twice a month, and open to any interested member of the community.

Within three years, the committees were instrumental in building a number of wells, rubbish pits and latrines. They did not see a need for having individual health workers appointed and trained because their disease prevention activities always were

undertaken on a group basis after discussion involving the whole village. For the first several years, curative care continued to be provided by indigenous practitioners, with certain serious cases referred to the hospital. (Ross, 1979)

LESSONS: Villagers can be interested in public health programs if approached in a sustained and sensitive way. Although one normally finds a distinction between village health workers and the village health committee this case suggests there need not be. If the VHC members are active enough they may become de facto health workers. It is instructive to contrast this experience with that reported in the Annex above for the Cameroons, and also with a case study from Liberia documented by Sheppard (1981).

#### THAILAND: The Population and Community Development Association

This private, nonprofit service delivery organization has had great success in getting contraceptives to the rural population by supplying them at low cost to village storekeepers, who sell them for a modest profit. The shops also provide information about family planning methods.

The considerations were that for birth control to be practiced devices had to be available near the population and in a setting that was familiar and congenial. They had also to be available continuously, with no interruptions of supply as was common in government stores. (Korten, 1980)

The Association has trained family planning program participants in more than 16,000 villages, a third of all those in the country. However, efforts aimed at expanding activities to include control of parasitic diseases and pig production have not, unfortunately, been as successful. The program is credited in any case with having made a substantial contribution to Thailand's decreasing population growth rate, falling from over 3 to almost 2 percent within a decade.

Now that the acceptability of contraceptives has greatly increased, because they are so readily available, rural people are increasingly taking advantage of the free birth control pills distributed through the government's sub-district clinics. (Bruns, 1981) This presents a LID dilemma, whether the two channels can and should co-exist.

LESSONS: As stated in the report, there are some kinds of distribution tasks for which the private sector is uniquely well-suited, though paradoxically, the success of private distribution in this case has now bolstered the government's distribution system. The role of a dynamic leader (the PCDA's founder, Dr. Mechai) has been pointed to in many evaluations (Korten, 1980), yet his "genius" was most concretely expressed in his choice and development of local institutional channels.

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