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EFFECTIVENESS IN PRIMARY HEALTH CARE PROGRAMMING:
A STUDY OF COMMUNITY OUTREACH AND PARTICIPATION

Outline of a Proposed Study

by

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PREFACE

The proposed study was conceptualized in the spring of 1979 with the assistance of colleagues in the Studies Division and in AID's Office of Health and its regional bureau health offices. The motivation for proposing the study is outlined in the introductory section of the paper. Recognizing the difficulties of arriving at quantifiable measures of health impact, this study proposed to focus instead upon program effectiveness--and, therefore, intermediate process indicators. It was not the attempt of this proposal to disparage the search for impact measurement but rather to set forth a complementary path of inquiry.

Following preparation of this proposal, an informal health evaluation working group was brought together by Dr. David Dunlop, a health economist with AID's Office of Health, and myself. Participants in the working group are professionals, from all bureaus of the agency, who are concerned with one aspect or another of improving evaluation in and of health and nutrition projects and programs. Their enthusiasm and unflagging interest have been extraordinary. A forthcoming AID Program Evaluation Discussion Paper, "Toward a Framework for Health Project Evaluation," presents the initial consensus of this group of health evaluation managers and specialists. A second outcome of the preparatory activity that went into the present working paper is a series of health project impact evaluations that will be conducted during 1980 as part of a major agency-wide impact evaluation exercise.

Clearly, however, much remains to be accomplished. It is my hope that the activities presented here have helped us further along this important path.

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Executive Summary

AID has given support to the development of health care systems for low-income rural and urban populations for many years. Expenditures for health assistance have increased to \$135 million for FY 1979 with 27 percent of this going to projects categorized as integrated health, population, and nutrition projects. The Agency's 1980 project portfolio includes 45 planned and on-going projects categorized as integrated and, in addition to these, over 115 health delivery projects and 125 family planning projects.

Nevertheless, as February and March roll around each year there is a flurry of rushed activity as junior AID researchers attempt to identify projects in the health area (as in other functional areas) that can be presented to Congress as successful. Certain projects that were once lauded, however, now seem to be sources of embarrassment, and passed by in the search. Other projects are said to be too new to hold up as having succeeded. Little consensus is arrived at.

Project managers and health officers state it may take at least one or more decades before the impact on morbidity and mortality levels of health sector interventions can be accurately measured and that, even then, it will be difficult to directly attribute gains to specific AID projects. To some observers and critics outside AID it appears that the Agency is spending too much on these primary health care systems without being able to present clear evidence of the effectiveness of this approach. At the same time, however, there is uncontested clear evidence that reliance upon the physician-centered, high-technology approach earlier subscribed to will never, within the present resource constraints, succeed in meeting the basic health needs of the rural and urban poor in the developing countries. The challenge then is to determine what--within the primary health care approach--is proving most effective.

Helping the rural poor to improve their health means moving health and family planning services, education, and training out beyond the static urban facilities and into the villages. There health care is not simply a service to be "delivered" as a welfare commodity. Absolutely critical to the success of this outreach approach is community involvement--including and especially that of women, particularly in programs emphasizing maternal and child health. Indeed, virtually all the AID-supported health system projects are

premised upon the successful formation of community health committees, the selection and training of community members as village health and family planning workers, and enlisting the participation of community members in activities to promote health and prevent disease.

The present study seeks to understand and increase the effectiveness with which these AID-supported programs are reaching out to and achieving the participation of the rural poor. More simply stated, it seeks to bring together lessons about what works and what doesn't work in primary health care. It is proposed that several projects or project sites in each of six to eight countries in the four AID regions be visited by teams of at least two or three persons, one of whom should be a national of the country; the major but not exclusive focus will be AID-supported projects. The study's concrete goal will be to answer five questions:

1. What makes for effective community involvement in primary health care?
2. What makes for effective village health workers?
3. How are traditional practices best dealt with in improving health behavior?
4. What are the leadership patterns of successful programs?
5. What process indicators can be used to encourage and identify success implementation at a point in time too soon to reliably measure success in lowering morbidity, mortality, and fertility rates?

It is expected that the study could be completed in approximately one year working team on the part of participants. Allowing for additional lapsed time due to present U.S. Government contracting procedures, however, it is more realistic to expect completion 18 months after initiation of the study. Interim reports and findings would be made available during the course of the study.

Background

The Agency, and its predecessor agencies, have given support to health delivery projects for low-income, rural and urban populations for many years. Until the 1970s, however, health improvement did not have a high priority either in the national budgets of developing countries or in foreign assistance to those countries. Even in the period 1970 to 1976, for example, per capita public expenditures in the developing countries for health care grew only 20 percent in constant dollar amounts.¹ As of 1975, less than five percent of bilateral development assistance went for health improvement projects.

The basic human needs strategy promulgated during the early 1970s identified health improvement as a high priority for national budget allocation and for foreign assistance to the developing countries. The latter half of this decade is now witnessing corresponding shifts in actual allocations, at least in AID. Whereas the Agency spent \$54 million for health assistance in 1976, this figure has increased to \$135 million in FY 1979.

The category of health assistance that has grown most rapidly in the Agency is the development of health delivery systems that are described as low cost and integrated--or, alternatively, as primary

¹In comparison, per capita public expenditures for education doubled during the same period.

health care programs. In 1971 the Agency had only one project identified under this heading.¹ In 1977 "category 1" (integrated health, population, and nutrition) projects accounted for 27 percent of AID health funds. This percentage has grown to 43 percent for fiscal year 1979. The Office of Health identifies 45 "integrated, low-cost delivery projects" through which the Agency is providing or planning to provide technical assistance, financing, or training in 38 countries. Of the 45 projects, 17 are in the Africa Region, 16 in Latin America, 7 in Asia, and 5 in the Near East. (It may be noted with regard to the overall AID health budget that Asia contains almost two-thirds of the total population of all countries receiving health assistance from AID but that Asian countries will receive in FY 79 only 45 percent of the Agency's health assistance funds. Africa, relative to its population, will receive the largest proportion--one-third--of AID health funds.)

namely Bolivia, Colombia, Dominican Republic, Liberia, Nicaragua, Philippines, and Thailand. About two-thirds of the projects are regional or sub-regional; they generally assume, however, that if the value of low-cost rural health delivery can be demonstrated in one part of the country, it will be extended nationally, or at least to other regions. Broadened to include "delivery" projects additional to those classified as integrated, the 1980 inventory will include over 116 health delivery projects and about 125 population and family planning projects.

¹In fact, however, there appear to have been numerous earlier projects of similar orientation.

A recently-completed survey describes 39 of these projects which, taken together, specify a target population of 45 million people.¹ Summaries of the 39 projects are based on PIDs and Project Papers and present an excellent baseline for further investigation and evaluation of AID activity in supporting health delivery system development. Of the ongoing projects described, the oldest are in Thailand (1974-81), Colombia (1975-78), and Ghana (1976-79). The 45 ongoing and planned projects are located as follows:

Africa--Botswana, Chad, Cameroon, Cape Verde Islands, Central African Empire, Ghana, Kenya, Lesotho, Liberia, Mali, Niger, Senegal, Somalia, Sudan, Tanzania, and Zaire;

Latin America--Bolivia, Brazil, Colombia, Dominican Republic, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Nicaragua, and Panama;

Asia--Korea, Nepal, Pakistan, Philippines, and Thailand; and

Near East--Afghanistan, Egypt, Morocco, Syria, and Tunisia.

Several points should be noted for evaluation purposes regarding this 45-project portfolio.

1. The majority of the projects are in the planning stage or very early in the implementation stage. Less than one quarter of the 45 projects had become active as of mid-1978. About two-thirds of the 39 projects were scheduled to have begun before FY 78 and the balance are due to begin this year or in FY 79. Thus most of the so-called low-cost integrated health delivery system projects are themselves too new for ex-post evaluation.

¹"AID Integrated Low-Cost Health Delivery Projects." 2 volumes. (HEW Office of International Health, August 1978.) Produced by Naomi Baumslag, Karen Cox, Mark Laskin, and Ed Sabin under Contract No. TAB/Nutrition/OIH RSSA 782-77-0138-KS.

2. It is also increasingly realized and acknowledged that it may take at least one or more decades before the impact on morbidity and mortality levels of health sector interventions can be measured and that, even then, it will be difficult to directly attribute gains to specific AID projects.

3. It is also recognized that other factors--such as the greater availability of food or more equitable income distribution--may ultimately have greater impact on improving health than any health care system regardless how effective it may be.

4. Not all these "low-cost projects" have ended up low cost. In part this is because many are pilot or demonstration efforts that necessarily include larger research and evaluation components than is proportionately true of nation-wide schemes. It has been suggested in any case that "affordable" is a more appropriate term than "low-cost."

5. Regarding integration, it is increasingly recognized that while some form of integration is desirable, there is no one integration model that can be implemented cross-nationally. "Integration" was thus defined for the 45-project survey as referring to "any health delivery project that combines health, family planning, and nutrition elements." Integration occurs in these projects mainly through the use of multipurpose village workers or some other mix of health, family planning, and nutrition service

components. Health interventions are also integrated into projects in at least two other ways. One is integration into broader activities such as rural development projects.¹

Another is the "piggy-backing" of a health component onto an already implemented nutrition or family planning project (or of a nutrition component onto family planning and so on).²

Some of these should also be included in cross-national evaluation of integrated health delivery projects.

Despite the above, many of these health, family planning, and nutrition projects are far enough along in implementation so as to permit useful cross-project comparative evaluation of certain types of common project outputs, such as village health committees, village health worker training, indigenous practitioner upgrading, referral systems, and improved drug logistics systems. In addition, many of these projects are built upon and in some cases appear to be the continuation of projects initiated in the early 1970s, or even before, for which comparative ex-post evaluation would be possible and valuable.

¹See, for example, the "Preliminary Internal Report: Baseline Data in Health, Nutrition, and Family Planning for the Central Tunisian Rural Development Project Zone" by Carole Steere Ayad (submitted to the CNEA and AID, Tunis, July 1978).

²For example, the "East Java VFP-MCW Pilot Project" which was designed to test the integration of rudimentary nutrition and health services with the existing village family planning program.

Content of The Study

The proposed study, introduced in the summary section above, is a cross-national behavior and process-oriented investigation designed to produce qualitative findings complementary to the data gathered in more statistically oriented econometric studies.

Studies of this cross-national comparative sort can amass data according to two strategies. One is to prepare an elaborate document for data collection; such a document would typically consist of a large number of highly specific questions that can be answered with relatively short responses of the sort that fit easily on a few lines of paper and are subsequently relatively easily coded for computer analysis. Because the document has been so well developed in advance by central office planners it has the advantage of permitting field work using it to be conducted by individuals who are not necessarily well-versed in the subject matter or experienced area specialists. A second less procrustean strategy is to choose researchers who are themselves more highly qualified with regard to functional and area expertise and send them off to the field with a well thought-out yet less "rigorous" set of predetermined questions. It is acknowledged here that each of the two strategies has its advantages and disadvantages. This study, however, adopts the latter strategy.

For this reason the study will present answers to only five questions-- those outlined in the above summary. Researchers selected to conduct the study will be presented with a somewhat detailed outline of suggested "sub-questions"; these are intended to direct the researchers' investigations in specific ways and along comparable lines, but it is not expected that

they will necessarily produce answers to all the sub-questions. Rather their attention must be fixed throughout on producing answers for five "bottom lines." In each case however it is expected that the researchers will also consult questions contained in three studies AID has supported for the identification of critical issues in primary health care programming. These are: (a) "Issues in the Development of Health Manpower Projects" by HEW's Office of International Health; (b) "Innovative Practices in Low-Cost Health Delivery Systems in Developing Countries" by the American Public Health Association; and (c) the APHA's Health Delivery Systems State-of-the-Art study.¹

With suggested sub-questions, the five major "bottom line" questions are the following. It is to be noted that they are not mutually exclusive.

1. What makes for effective community involvement in primary health care?

*When and how did the community become involved in the project?

*Who have the main community supporters been and what incentives have motivated them?

*What existing community structures have been drawn upon? What new structures have been created?

*What social structural relationships within the community have facilitated or impeded project success?

¹For specific details see the section below, "Relationship to Other Studies."

*What has been the nature or relationships between community members and project actors from the level above the community (e.g., clinic personnel, trainers, supervisors, physicians, district officials, project central office and USAID personnel and so on)?

2. What makes for effective village health workers?

*What incentives motivate villagers to become health workers?

Why do some lose motivation?

*What is effective and non-effective in the relationships between village health workers and their trainers and supervisors?

*In situations based on volunteerism, how successful is it?

*What are advantages of part-time versus full-time health worker status?

*What advantages and disadvantages accrue from the health worker being single function (health or nutrition or family planning) versus multi-function (two or all three of the functions)?

*How are indigenous (traditional) health practitioners being involved?

*How important is sex in health worker selection and effective performance?

3. How are traditional practices best dealt with in improving health behavior?

*To what extent do project participants--at all levels--regard traditional practices as barriers or as building blocks?

*What are the community's patterns of health facility/practitioner utilization and how have they changed since the project began?

*What are traditional patterns of payment for health care and how do these relate to attitudes toward payment for "modern" services?

*Do supra-community trainers and supervisors understand and think in terms of traditional theories of disease causation?

*Are 'modern' interventions presented in terms of traditional theories?

*What examples can be cited of changes in health-related knowledge, attitudes, and practices as a result of the project? How did these come about?

*Do district and rural-level project actors believe that they have means for showing project success? If so, what are these? How do they correspond with reality?

4. What are the leadership patterns of successful programs?

*Has the project or program been inspired or led by a charismatic leader? If so, what motivated his involvement and what spread effects has this led to?

*What are and have been the status and other social relationships between village leaders and other villagers and between village leaders and supra-community responsible persons?

5. What process indicators can be used to encourage and identify success in implementation at a point in time too soon to reliably measure success in lowering morbidity, mortality, and fertility rates?

*What are the key indicators from the data gathered in response to the above questioning?

The presence and absence of disease can be measured relatively effectively according to quantifiable indicators. Health is now rarely defined, however, as merely the absence of disease. The World Health Organization, for example, defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." While aspects of this definition (e.g., "complete") are not unanimously accepted by all health professionals, nevertheless most agree on a more holistic orientation that takes into consideration important subjective factors of perceived well-being, which are not easily quantified.

It is argued here that the same is true for project evaluation. We need quantifiable indicators for measurement of a project's health--its progress and effectiveness. Given the difficulty of such measurement during the first few years of a project as well as the additional difficulty of ascertaining how much of the change can be accurately attributed to the specific project, program evaluation must also include a qualitative appraisal.

Methodology

Each country investigation will be conducted by a team of researchers. The team will consist of at least two persons, one of whom should be a country national and one of whom--given AID's policy emphasis on maternal and child health--must be a woman. It is assumed that teams will have professional competency in health-related areas; that is, that they will include MPHs, behaviorally-oriented physicians, medical anthropologists, or similar competencies. It is expected that there will be some continuity of team membership and that the project director will participate in at

least two of the teams. To the extent possible each team should possess competency in the local language; this is to be required for Spanish- and French-speaking countries.

It is expected that each country team will visit a minimum of four "project coverage areas," three of which must be AID-supported. By "project coverage area" is understood the villages and other rural territory for which a single town-based health facility or other office (e.g. district health office or rural health clinic) is responsible.

The minimum length of time to be spent in a country is one month. Of this at least 50 percent of the total working time is to be spent in villages with the major portion of the remainder spent in the rural towns whose health professionals supervise the village health worker. It is anticipated that about one week minimum would be required in the capital for orientation meetings with central ministry and foreign donor representatives and for compilation of field notes prior to departure from the country.

It is recognized that many centrally-funded projects are resented by AID missions and developing country ministries as too "heavy-handed," "top down," irrelevant to project development, and a burden on project implementors. This represents a set of facts and attitudes that cannot be ignored in planning the study. In the first place this set of facts and attitudes makes it difficult for field teams to get not simply mission concurrence to visit the country but the cooperation that is needed in order to get beyond superficial presentations (i.e., the so-called

dog-and-pony show).¹ This is essential for an in-depth understanding of what is actually happening in the villages and determination of whether or not the rural poor who are the intended beneficiaries are actually benefitting from the project(s).

It is, therefore, essential that the above outline of questions be adjusted and improved through discussions with persons actually involved in project implementation at the village level in order to assure that the study is developed and ultimately carried out in such a manner as to produce meaningful results that can subsequently be used for program guidance and policy development.

Relationship to Other Studies

The study will not duplicate earlier or on-going studies in the area of primary health care. Similar questions have been asked by researchers sponsored by agencies and funding sources other than AID, but they have not been focused on AID-supported projects. An active search of Agency research and study activities has identified several AID-supported studies or projects that share certain concerns in common with the proposed study but that nevertheless differ in important regards.

¹This is all too painfully illustrated in the report of the external review of Korean rural health project by a team that according to the report, spent only some three or four hours in the villages but many hours in formal prearranged dinners and reviews in government offices.

It is suggested here that in conjunction with and as groundwork for the present study a report be prepared that summarizes and briefly analyzes the findings and recommendations of the earlier and already on-going studies. Not only would this assure that the present study builds upon existing knowledge, rather than duplicating aspects thereof; it would also facilitate the greater utilization of the findings of the earlier studies by bringing them together in such a manner as to be easily accessible to those whose responsibility it is to make decisions regarding health programs and projects. This could be done under a personal services contract and could be undertaken in co-sponsorship with PPC/PDPR/HR and or DS/H.

Studies that this report and the proposed study should draw upon include the following. Assistance is requested in bringing to attention other relevant studies.

1. "AID Integrated Low-Cost Health Delivery Projects" (2-volume report based on AID project papers and prepared for AID by HEW Office of International Health, August 1978);
2. "Issues in the Development of Health Manpower Projects" (paper prepared for AID by Kenneth Farr and Scott Loomis of HEW Office of International Health, August 1978);
3. "Comparative Analysis of Health Manpower Issues in Latin America" (by Scott Loomis and Karen Cox of HEW Office of International Health, April 1977);
4. American Public Health Association State-of-the-Art Study (mailed questionnaire survey conducted for AID's Office of Health);
5. "Innovative Practices in Low-Cost Health Delivery Systems in Developing Countries" (mailed questionnaire survey conducted by APHA for the Office of Health);
6. "Ex Post Evaluation of Activities Aimed at Providing Rural Health Services" (six-country study directed by Don Block, 1976, of "older" health projects);

7. "Can Interventions Make A Difference? The Policy Implications of Field Experiment Experience" (Report to the World Bank by Davidson Gwatkin, Janet Wilcox, and Joseph Wray);
8. Robert Grossa (University of Michigan School of Public Health) study for PPC/PDPR on cost effectiveness of alternative health interventions in Indonesia;
9. "Relevant Experiences Package on LA Health Delivery Systems" (memorandum prepared for LA/DR by Peter Theil May 2, 1978);
10. "Lofa County Rural Health Project, USAID/Liberia" (Consultant's Technical Report prepared by Reginald Gipson for APHA and AID);
11. Narangwal materials prepared for AID by Carl Taylor;
12. Danfa materials prepared by Alfred Neumann et al.; and
13. DEIDS materials prepared by APHA.

Finally, it should be noted that the Office of Nutrition has developed a three-year project, "Nutrition Evaluation," that addresses community-level issues related to those outlined above. It will send researchers to the field in about five countries and should be taken into consideration as the study described here is carried out.

Selection of Countries

Countries for this study are to be selected on the basis of six criteria that have been presented in greater detail elsewhere. (See Appendix A.) These criteria are: (1) extent to which the major AID-supported health delivery project depends on community outreach and participation; (2) "age" of this project; (3) existence in the country of other relatively "mature" primary health care projects; (4) feasibility of carrying out successful research given constraints currently existing in the country (e.g, recent political coup, policy on foreign researchers, etc.); (5) availability of competent, experienced field researchers; (6) mission and regional bureau support and interest; and (7) existence of special opportunities or other fortuitous circumstances that can be capitalized upon.

On the basis of the first two criteria, the following countries and projects would appear to be appropriate for selection as case studies. From project papers (as summarized in the two-volume Office of International Health report) and computerized summaries (from the Office of Development Information and Utilization), all the following appear to utilize village health workers. Some also appear to be utilizing traditional healers and birth attendants, in which case this is indicated with "TH" and "TBA" respectively.* The date is that of project initiation.

Africa

Ghana	Danfa Rural Health/Family Planning (TBA; 1976)
Mali	Rural Health Services Development (TBA, TH; 1977)
Senegal	Rural Health Services Development (1977)
Tanzania	Manpower Training for Maternal and Child Health Aides (TBA; 1973)
	Hanang District Village Health (1977)

Asia

Indonesia	East Java Health/Family Planning (TBA; 1977)
Nepal	Integrated Health Services (1976)
Pakistan	Basic Health Services (TBA?; 1977)
Thailand	Lampang Province Project (TBA, TH; 1974)
	Rural Primary Health Care Expansion (TBA, TH?; 1978)

*The present study is by no means proposed as a study of traditional practitioners but recognizes them as a major community element. Countries in which AID-supported projects do not feature "village health workers" but do utilize traditional practitioners are the following: traditional birth attendants--Brazil, Costa Rica, Cape Verde Islands, Central African Empire, Liberia, and Niger; traditional healers--Central African Empire, Kenya, Niger, and Brazil. All this country-specific information is to be confirmed with regional bureaus.

Latin America

Bolivia	Rural Health Service Delivery (TH; 197) Rural Health Delivery Services (1978)
Colombia	Health Delivery System, PRIMOPS (TBA, 1975) Health Sector Loan II (1975)
Dominican Republic	Health Sector Loan (1976) Health Sector Loan II (197)
El Salvador	Rural Health Services Delivery (TBA, 1978)
Guatemala	Rural Health Services Evaluation (TBA, 1976)
Haiti	Rural Health Delivery System (1978)
Honduras	Integrated Rural Health/Family Planning Services (TBA; 1976)
Jamaica	Health Improvement of Young (1976)
Nicaragua	Rural Health Institutional Development (TBA; 1975)

The reader's comments for the improvement and further development of the above outline are welcomed and appreciated.