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A REPORT ON
THE PERFORMANCE OF
COMMUNITY HEALTH WORKERS
AND RELATED PROJECTS
IN PAKISTAN

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LIST OF ABBREVIATIONS

ABES	Adult Basic Education Society
ADHO	Assistant District Health Officer
AIOU	Allama Iqbal Open University
BFEP	Basic Functional Education Program
BFW	Bread for the World
BHU	Basic Health Unit
CHW	Community Health Worker
CIDA	Canadian International Development Authority
CRHP	Comprehensive Rural Health Program
DHO	District Health Officer
E&C	European Economic Commission
FMT	Female Medical Technician
FP	Family Planning
GOP	Government of Pakistan
HT	Health Technician
IRHC	Integrated Rural Health Complex
LHV	Lady Health Visitor
MO	Medical Officer
MOH	Ministry of Health
MPHW	Multi Purpose Health Worker
MT	Medical Technician
NGO	Non Governmental Organizations
NGOCC	Non Governmental Organizations Coordinating Council
ODA	Overseas Development Authority
PHC	Primary Health Care
PRICOR	Primary Health Care Operations Research
RHC	Rural Health Centre
USAID	United States Agency for International Development
UNICEF	United Nations International Children's Educational Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

I. INTRODUCTION

When Pakistan became independent in 1947, poor health status of the people formed a major share of its inheritance. This, coupled with extreme paucity of trained manpower, presented a challenge to the health planners. The government's efforts to provide accessible health care at the grass root level date to back long before Alma Ata. Several attempts were made to provide Primary Health Care to the rural population. The Comprehensive Rural Health Program, The Pesh Imam (Religious leaders) scheme and the Health Guards Project were some of the forerunners of the present Primary Health Care (PHC) Project which started in 1982. This project was a followup of the Basic Health Services program which had started in 1977. With financial assistance from USAID and technical assistance from WHO and the University of Karachi (MEDEX Group).

Utilizing many of the lessons learnt from previous experiences the PHC Project was designed to provide comprehensive preventive, promotive and curative services to the rural population. To make the services affordable and acceptable community involvement is exercised and volunteer Community Health Workers (CHWs) are selected from the Community, trained and assigned tasks to assist their communities in the promotion of health and prevention of disease. They form the basic unit of a formal health care delivery system which consists of Integrated Rural Health Complexes made up of one Rural Health Centre, 5-10 B+Us and at least one Community Health Worker for each village.

Over the years the CHW has emerged as an interim answer to the Community's basic health needs. Therefore not only are they being trained and utilized in the Public Sector but the Private Sector is also making use of this category of health workers.

The GOP/MOH and USAID required an assessment of the performance of CHWs both for the Public and the Private Sectors in Pakistan. This was proposed to be done through a study of selected projects utilizing CHWs in the Public and Private Sectors.

II. OBJECTIVES OF THE STUDY

- Identify and describe past and current programs utilizing CHWs.
- Analyse the unique circumstances contributing to the success/failure of programs making use of CHWs.
- Study potential for sustainability and replicability of project activities.
- Recommend actions to assist in future health plans and ongoing activities utilizing CHWs.

III. METHODOLOGY

From a comprehensive list of almost all the projects utilizing CHWs in Pakistan a short list of nineteen projects was prepared. The major criteria for selection were the presence of the CHW as defined by the team and different approaches being utilized to involve the CHW in the project activities.

Of the nineteen projects selected, five were implemented by the Public Sector and fourteen were implemented by the Private Sector. Of these three of the projects of the Public Sector have been completed.

Tools used for collecting data were a comprehensive questionnaire, site visits, interviews of planners, managers, trainers, field and support staff, Community Health Workers, Community members and others related to Primary Health Care in Various capacities. A total 75 of sites were visited and a total of 180 individuals were interviewed.

IV. LIMITATIONS

- The team had no control over selection of sites of the projects chosen. This was the prerogative of the organizations implementing the project.
- There is extreme shortage of documented literature on PHC for Pakistan.
- Time constraints did not allow for inclusion of all projects on the comprehensive list. Therefore a representative sample had to be selected.

V. FINDINGS AND CONCLUSIONS

A. PLANNING

1. Needs Assessment: Both in the Public and Private Sectors the need for scientific approaches to needs

assessment were not utilized. Planning was based on the needs felt to be important by the groups or individuals involved in planning.

2. Statement of Objectives: While broad and general objectives were stated in most project proposals, specific objectives which are measurable, quantifiable, attainable and in which the time frame and target population are specified are not defined in most projects.

3. Project Design and Strategies: The Public Sector projects are designed with the help of international consultants while in the private sector the planners seldom use outside help excepting in some of those projects where funds are provided by International donors. Utilization of international experts might ensure scientific planning but certain cultural, traditional and human factors are not always fully taken into account.

In strategies, Pilot and Demonstration Models are not replicable in all cases because the facilities provided for the Pilot Models are not always available for replication.

Vertical programs e.g EPI, while providing certain facilities to the PHC Project tend to create confusion and extra expense through some degree of duplication of activities.

In contrast all the projects in the Private Sector are offering packages of services and seem to be doing a lot with limited resources.

4. Funding: The current funding of the GOP Project has been provided by USAID. In other projects the major sources of funding are various international organisations like UNICEF, CIDA, FPIA, The Pathfinder Fund, etc.

The funding, by and large, is performance related. The advantage of this system is that it ensures a certain amount of accountability. The drawback is that the grantee organisations, particularly NGOs, cannot make long term plans and at times emphasis on output results in exaggeration while reporting performance.

5. Community Involvement: In the Public Sector there is very little community involvement in the preplanning and planning stages.

In the Private Sector there were visible efforts to involve the community at the preplanning and

planning stages. But by and large the importance and relevance of community participation and involvement in project planning does not seem to be recognized by most planners. This is due to the misconception that the educated urban planners know best.

B. IMPLEMENTATION

1. ADMINISTRATIVE SET UP: The management was found to be centralized in the GOP PHC Project and a mixture of centralized and decentralized in the other projects. Delegation of responsibility without authority is the norm. At times, even when there is a certain amount of delegation of authority, the managerial environment is such that the authority cannot really be exercised. This poses many problems particularly those related to the ability to take disciplinary action.
2. THE COMMUNITY HEALTH WORKER:
 - 2.1 Nomenclature: Seven different names were being used for the CHW. The name was dependent on the function being performed by the worker. This contributed towards confusing the planned, perceived and actual roles of the CHW. The Team eventually decided to ignore this nomenclature and adhere to the following operational definition of the term Community Health Worker:

"A person of either sex who lives in the community and, after some training, provides health and/or related services to that community as a part of some form of health care delivery system".
 - 2.2. The Selection Process: Four different approaches being used to select CHWs were observed. In the first one the CHW was chosen by the village leadership representing the community. In the second, the selection was done by the project staff with no community involvement. In the third, both the community and the project staff participated in the selection and in the last approach, a combination of all the above methods was seen i.e. in the same project. Some CHWs were selected by one approach, some by another and so on.
 - 2.3 The Selection Criteria: Respectability topped the list of selection criteria in all projects. Age was not of crucial importance but sex was. One project employed only male CHWs but even in that project the staff had expressed the limitations of male workers regarding female clients.

In this connection it is interesting to note that many projects seek out the practising TBAs to enroll as

CHWs because experience has shown them that those belonging to this category of traditional healers have already established a certain amount of creditability through their usefulness and has exhibited a desire to extend their midwifery role.

2.4 Training:

-Curriculum: Curriculum is by and large understood to be a list of topics and a manual or a book or some written notes to be followed to cover those projects.

In the GOP PHC Project an Urdu translation of the book 'Guide to health' is used for training CHWs. Only one proper curriculum was seen in use in some projects. This was the one developed by UNICEF for TBA training. Otherwise the curriculum, as defined by educationalists was not found in use.

-Trainers: Medical Technicians (MTs) were responsible for training CHWs in the GOP PHC Project. During their training the MTs, now called the Health Technicians, are given some orientation for their role as trainers but it seemed that they were not trained in the art of training. Their bias for curative medicine trickles down to the CHWs who also perceive their role as mini doctors.

In other projects the respective project staff is responsible for training CHWs with occasional help from outside trainers.

-Duration, Site and Methodology: In most cases training is provided in the community and the duration of training varies from six consecutive days to one year.

In the GOP PHC Project training consists of informal discussions usually on a one to one basis but the onlookers join in if interested. The number and schedule of the discussion sessions are dependent on the ability of the MT to reach the village for training and the interest and availability of the CHW.

In other projects the CHWs are trained in small groups and sometimes on a one to one basis. The commonly used method is discussions at time with the use of some visual aids.

In the Village Health Educator Project (Annex .5) a unique approach was used which consisted solely of audio visual aids. This methodology was developed by the Allama Iqbal Open University and, with their help, adopted for the project by the project staff. This approach to training of CHWs is worth considering for nationwide use.

Evaluation of the teaching-learning outcome is by and large, not a defined part of the teaching methodology. Some projects have an oral questioning session while in one formal examinations are conducted during and after training.

- 2.5 **INCENTIVES:** By and large CHWs work as volunteers for the prestige accorded to them by the community. Other incentives, in some cases, include salary, kits, certificates, upon completion of training etc.

It is important to point out here that most planners and volunteer expressed the need for some sort of remuneration. Keeping human nature in mind this would influence positively the commitment of the CHW and justify accountability.

- 2.6 **DISCENTIVES:** Surprisingly among the discentives observed remuneration was not on top of the list. The most common disincentive was lack of supervision and support for the CHWs. Others included withdrawal of kits and termination of services where applicable.

Only in one project was attrition cited as a problem. This means that the continuity rate of CHWs is fairly high with or without incentives but this is no indication of their standard of performance.

2.7 **ROLE AND FUNCTIONS:**

-Planned role: According to the planned role the CHWs can be categorised into 3 groups. (1) The PHCW, whose functions include ORT, arranging for immunization, growth monitoring, sanitation/hygiene, health education, treatment of common injuries and diseases, referral, data collection and reporting. (2) The TBA, whose functions include routine antenatal care, arranging for immunization of pregnant women against tetanus, conducting deliveries, high risk referral, giving advice on child spacing and reporting births and (3) The Family Planning Motivator, whose functions include providing Family Planning information education, distribution of prescribed contraceptives, follow up of complications and referrals.

-Perceived and Actual Roles: Both the community and the CHW lay emphasis on the curative functions to be performed by the first category of CHWs and perceive him/her to be a mini doctor. Therefore the actual role of the CHW, in most cases, is not as planned but as perceived. Hence, quackery is common particularly among male CHWs.

- 2.8. MANAGEMENT INFORMATION SYSTEMS: In all projects the CHW was required to maintain some records. In the project utilizing literate CHWs, the records kept were more detailed than average. At times the purpose of collecting large amounts of detailed information was not clear.

In the case of illiterate CHWs the requirement for record keeping are simple, and the CHW seeks the assistance of a literate relative or friend to record the required information. In The Afghan Refugee Project of SCF/UK (Annex 14) a system has been developed to enable the illiterate CHW to maintain fairly detailed and accurate records.

Most CHWs maintained records under the impression that they were going to be used only to monitor their performance. The use of records by the management was not explained to them. Only in a few cases were the records regularly collected and utilized by the management to assess project performance. These were the projects in which monitoring and supervision were regular features.

- 2.9 SUPERVISION: In the GOP PHC Project the CHWs are supervised by the MTs at the BHUs and RHCs. In some situations the MOs make occasional supervisory visits.

In other projects supervision was usually done by the mobile teams and other personnel. In two projects the community was formally involved in sharing the supervisory functions.

Supervisory visits are, by and large, dependant on the convenience of the supervisors and facilities available for mobility. The commonly cited problem was the non availability of public/private transport and/or transport allowance.

In the GOP PHC Project another factor which affected regular supervision was the MOs' perception of the MTs' role which was that the MTs be present in the clinic during clinic hours to assist the MOs and that their supervisory functions are to be performed after clinic hours. This attitude reflected the little importance given to the support and guidance needed by the CHWs. In addition to the above at times the FMTs face problems related to the cultural environment which does not permit females to travel alone. They also face problems of security when they have to work in unfamiliar surroundings.

Supervision of MTs is the responsibility of the MOs, the ADHO and the DHO. They pay occasional visits to supervise the MTs and supervision is usually limited to the curative work of the MTs.

In other projects, supervision is comparatively organised due to the fact that the NGOs function at a much smaller scale and can keep track of their work and workers.

The purpose of monitoring and supervision seems to be inspection rather than assessment of performance for the purposes of guidance and improvement.

C. EVALUATION:

1. Purposes: The main purpose of evaluation in all projects studied emerged as an assessment of the degree to which the projects' broad objectives had been achieved. Of the projects that have ended The Health Guards Project of the Northern Areas was evaluated at the end of the project period and it was found that all the objectives had not been achieved. The VHE Project and the ARI Project have also ended and are in the process of being evaluated. With a few exceptions in most ongoing projects evaluation has been planned at the end of the project period.

The GOP PHC Project was evaluated in its third year and mixed results were obtained as far as achievement of objectives was concerned.

Similarly many other projects followed a pattern of evaluation whereby the findings of evaluation could not be fed back into the planning cycle.

With one exception cost effectiveness was not one of the major criteria the evaluators seemed concerned with.

Plans for sustainability or self sufficiency in the projects in terms of funding were observed only in one project studied. This project has achieved its scheme of self sufficiency to a great extent.

Use of evaluation results for specific purposes like replication of a successful model was observed only in one organization. Conversely, one organization, in spite of the evaluators' recommendation of consolidation rather than expansion, went ahead with replication of the project in other sites.

The frequency of evaluation did not follow a specific pattern.

The team feels very strongly that there were some success stories worth partial replication. On the whole, evaluation emerges as another area where a lot of training is required.

VI. RECOMMENDATIONS

1. A national body be formed to provide guidance, support and technical assistance to the NGOs through the performance of the following functions:

-Identifying NGOs for involvement in health programs.

-Encouraging and assisting NGOs in development of appropriate projects.

-Identifying training needs of NGOs and facilitating training inside and outside Pakistan.

Reviewing and approving projects submitted by NGOs and proposing the level of funding for each project.

-Acting as a channeling agency for funds from Government and International donor agencies.

-Monitoring, supervising and evaluating activities of approved projects.

-Keeping the policy makers and the planners in the Health Sector informed of the contributions of the NGOs.

2. At least two senior officers each from the Provincial Directorates of Health and the Federal Ministry of Health be sent abroad for formal training in Health planning, and that,

Upon their return assisted by planning consultants from major donor agencies in Health like USAID, UNICEF, WHO etc. conduct nationwide workshops the specific contents of which include needs assessment, statement of well defined objectives, development of strategies, project proposal writing, training of manpower, management, monitoring, supervision, MIS and evaluation.

3. Foreign technical assistance in planning of health programs be selectively utilized for areas where national expertise is lacking or limited.

4. Involvement of the community in the Project be enhanced by formally involving the members of the local government and other community leaders in planning for the community's health needs.

5. Planned programs be field tested on a small scale through demonstration/pilot projects before being implemented on a national level, using the same resources which will be available in the implementation of larger programs.

It is further recommended that:

Details of tested models be made known to interested and relevant organizations for possible replication.

6. Planning of integrated/comprehensive health services be encouraged for maximum utilization of funds, material and human resources.

7. To strengthen the role of the CHW in health education, the Government use the mass media for endorsing the message of healthy living communicated by the Community Health Worker.

8. The name "Community Health Worker" be change to 'Health Educator' or "Community Health Educator" to highlight their preventive role.

9. The major share of responsibility of selecting the CHWs be allocated to a group of community leaders e.g. the members of the Union Councils who be guided by the project management regarding adherence to eligibility criteria.

10. The TBAs be trained and utilized as Community Health Workers to extend coverage of the female population.

11. The tasks be assigned to the CHW to be clearly defined and limited after careful analysis of the need and time requirements of each task and the total time commitment of the CHW to the project.

12. A certain number of years of schooling not be an absolute requirement for enrolment as CHWs. Instead efforts be directed to utilizing the already developed as well as further developing educational and performance related technologies suitable for semi literate or even illiterate CHWs.

13. The printed learning materials be developed using graded vocabulary keeping in mind the local traditions and cultures.

14. A basic national curriculum on the lines of the TBA training curriculum be developed and the trainers of CHWs be fully cognizant of this curriculum and the training needs of the CHWs and be also familiar with simple educational technologies.

It is further recommended that:

That the training courses be organized according to predetermined timings and venue and that a post test be conducted after each training course to evaluate the outcome of the teaching-learning activities.

15. Regular refresher activities be planned as a part of the project workplan and implemented to upgrade and evaluate the knowledge and practices of the CHWs.

16. Each situation be evaluated realistically and efforts be directed to find ways and means of minimizing the problems associated with non availability of transport and other facilities for supervision.

17. Monetary and non monetary incentives be included in the project plan to sustain the interest of the CHWs. The monetary incentives be performance related according to clearly defined indicators of assessment of project impact and that non monetary incentives be in the form of certificates upon completion of training and certain other facilities like preferential treatment for government loans for house building, agriculture etc.

It is further recommended that:

Withdrawal of incentives also be performance related and that the CHW is made aware of the incentives and disincentives during the training period.

18. The CHW be made responsible for replenishing the supplies of their medical kits through income generated by the sale of medicines at prescribed prices.

It is further recommended that:

This practice be supervised by a Project Committee consisting of Community Leaders formed in each village by the project staff.

19. Clearly defined written job description be provided to each health worker at all levels at the start of his/her involvement in the project activities and that each worker also be briefed about his/her role and the role and functions of the other categories with whom he/she will be working.

20. Quackery be discouraged particularly among CHWs and efforts be directed towards providing alternatives to the community so that laws regarding quackery can be enforced.

21. All concerned be aware of the purpose of each record and that simple mechanisms for both literate and illiterate CHWs be evolved to collect and record minimum, pertinent and useful information and that there be a regular and clearly defined flow of information to and from the CHWs by the next level of management.

22. The practice of formal involvement between the project staff and local elected representatives of the people be encouraged and that the involvement be in the form of participation in project planning and implementation, selection of and guidance and support to the CHWs in the performance of his/her duties.

23. Monitoring, supervision and evaluation be included in the project plan to be carried out at regular intervals, that the result be utilized to improve project performance and tha the findings and utilization of results be made known to all concerned including the policy makers.

SECTION I

INTRODUCTION

A. BACKGROUND

1. HEALTH CONDITIONS IN PAKISTAN IN 1947

When Pakistan became independent in 1947, poor health status of the people formed a major share of its inheritance. The Bhore Committee's report submitted a year before independence, describes the situation accurately; "Environmental Sanitation in the country is at a low level in most parts. Malnutrition and under-nutrition reduce the power of resistance of an appreciable section of the population and the existence of health services are altogether inadequate to meet the needs of the people while lack of general education add materially to the difficulty of overcoming the indifference and apathy with which the people tolerate the unsanitary conditions around them and the large amount of sickness that prevails" (1).

At the time of partition this situation became worse. Belonging to the privileged classes, the Hindus and Sikhs, who constituted a large majority of medical and paramedical professionals, either remained in India or migrated to India. The central Public Health institutions of the sub continent eg the Central Research Institute, Kasuli, The All India Institute of Hygiene and Public Health, Calcutta, The Malaria Institute of India, The Central Drug Laboratory, Calcutta, all remained on Indian soil (2). So in the field of Public Health, as in many others, Pakistan started with a disadvantage. It was faced with severe problems and inadequate resources to deal with them. Most severely affected by this predicament was the rural population that constituted 85% of the total population of Pakistan.

2. ATTEMPTS OF GOVERNMENT OF PAKISTAN AT PROVIDING PHC

Government of Pakistan's commitment and efforts to provide accessible health care at the grass roots level date back to long before Alma Ata. The sequence of events is as under:

2.1 Comprehensive Rural Health Program:

In 1959, a Comprehensive Rural Health Program (CRHP) was launched to provide integrated curative and preventive services to the rural population. This program envisaged linking villages to the District Hospitals through a network of Sub Health Centres, Rural Health Centres and Tehsil Hospitals. Each Rural Health Centre had 3 Sub Health Centres in its catchment area and provided coverage to a population of 50,000. The RHC was provided with comprehensive curative facilities and accommodations for the staff. This project could not continue for various reasons.

Since then till the start of the Basic Health Services project in 1977, the Government of Pakistan made several attempts to provide PHC to the rural population. The two following projects deserve a special mention as in these projects the approach of making the community responsible for its own health was utilized for the first time in Pakistan.

2.2 The Pesh Imam Scheme:

In 1972, the Integrated Rural Development Program was started with the aim of improving the quality of life in rural areas. As a part of this program, a pilot project, called the Pesh Imam Scheme, was started in the administrative area of the Daudzai Police Station near Peshawar. A population of 108,000 was covered in 89 villages. 135 Pesh Imams (religious leaders) were selected by a newly formed village organization and trained by a medical Technician at the Markaz (Centre) to provide primary care for some common diseases and screen patients for referral. These Pesh Imams were volunteers and were supervised mainly by the Village Organizations. This project ended in 1976.

2.3 Health Guards Project:

In November 1973, another project called the 'Health Guards Project' was started under the Plan for Rural Health in 121 sites in the Northern Areas in the districts of Gilgit, Diamer, Ghizer, Hunza, Baltistan and Ghanchi. The aim was to train intelligent male and female community members to provide basic curative and preventive care and act as referral agents. This project ended in 1977.

2.4 Primary Health Care Project:

The present PHC project was started in 1982 as a follow-up of the Basic Health Services Program which had started in 1977. Financial assistance for the project was provided by USAID and technical assistance from WHO and the

University of Hawaii (MEDEX Group). This project was designed to provide comprehensive preventive, promotive and curative services to the rural population and is a significantly improved version of the earlier CRHP. Services are provided through Integrated Rural Health Complexes (IRHCs), each consisting of one Rural Health Centre (RHC), 5-10 Basic Health Units (BHUs) and Community Health Workers (CHWs) at the village level.

The RHC is staffed by one male and one female Medical Officers (MOs), and 4 Medical Technicians (MTs). Each RHC is managed and supervised by the District Health Officer (DHO). The RHC provides primary health care, serves as a referral centre for its affiliated BHUs, plans and manages preventive/promotive programs including Family Planning, and acts as an equipment warehouse for the BHUs.

The BHU is the most peripheral facility of the IRHC. It serves 5,000-10,000 people and is staffed by an MO, MTs and support personnel. The BHU provides basic health care, serves as a referral point for the CHWs in the villages, helps in selection and training of CHWs, plans and supervises activities of the CHWs and supplies them with drugs and equipment.

The third tier of the IRHC is the volunteer CHW. The CHW provides a limited range of preventive and curative care to his/her community and refers patients requiring professional medical attention to the BHU. The secondary level of health care is provided by the Tehsil Hospitals while tertiary care is provided by District Hospitals.

THE INTEGRATED RURAL HEALTH COMPLEX

RURAL HEALTH CENTRE
(50,000 Population)

BHU
(5,000 - 10,000 Population)

Community Health Worker
(one per village)

3. PHC IN THE PRIVATE SECTOR:

The participation of Non Governmental Organizations in PHC in Pakistan is a fairly recent phenomenon. At the time of partition, the Missionary organizations were about the only NGOs involved in providing PHC in rural areas. With the passage of time, more NGOs were formed and became concerned with the poor health status of the rural population. Health delivery programs were developed but were usually limited to periodic visits of mobile teams to villages. Community participation however, was non-existent.

With the emphasis placed by the Alma Ata declaration on community participation and self reliance, the concept of community involvement gained recognition and momentum in those NGO PHC programs where leadership was provided by health professionals. At present, many NGOs are involved in projects employing innovative approaches to provide PHC to the underserved rural population through community participation. The concept of utilizing a Community Health Worker (CHW) to provide PHC is becoming popular and many NGOs are designing ways to utilize them effectively.

4. THE CHW IN THE CONTEXT OF PRIMARY HEALTH CARE IN PAKISTAN

As the deadline for reaching the Alma Ata Goal of 'Health for all by the year 2000' draws near, efforts to bring health care within easy reach of everyone are being intensified. The developing countries are the ones most affected by poor health care and this is reflected in the high mortality and morbidity rates in these countries. Among other problems financial constraints seem to be the major cause of inaccessibility to and unequal distribution of health care. The Community Health Worker (CHW) is gaining popularity as one possible solution to this problem.

In the next Five Year Plan, the Government of Pakistan aims to upgrade the Primary Health Care System by strengthening those aspects of the present program that require attention. The idea of utilizing Community Health Workers (CHWs) effectively as a paid extension of the health services to provide PHC to the rural population is being explored. Stress is being laid on factors which influence the performance of CHWs e.g their selection, training remuneration, supervision etc. and efforts are being intensified to find workable solutions which can help ensure an effective PHC program in Pakistan.

4.1 Meeting Community Health Needs:

Over the years the CHW has emerged as an interim answer to the communities' need for accessible, affordable and acceptable health care. The importance of such a worker is

universally recognized and is based on the following rationale:

- Coverage with minimum services can be achieved rapidly as it is quicker and cheaper to train CHWs than highly trained health professionals.
- Acceptability of services is enhanced when they are offered by those who are familiar to those being served.
- Continuous accessibility is ensured since the service provider is available in the Community.
- CHWs can encourage community participation in PHC and facilitate the delivery of other related services to the population.
- CHWs can facilitate the provision of integrated health care and can help link preventive and curative services and can collaborate with agents and activities of other sectors (3).

4.2 Social & Cultural Environment of the CHW:

As the CHW is expected to act as an agent of change of health habits of the community, it is important to view the social and cultural context in which the CHWs are functioning in Pakistan. The role played by culture and traditions in determining the health status of the community cannot be denied. In order to bring about change in the health status of a community some of its traditions may have to be modified in such a way so as to ensure permanence of change. This is only possible when the change is initiated from within and adheres to the cultural parameters defined by the community. The main advantage of a CHW is that he/she belongs to the community and is familiar with and usually shares its culture, customs and traditions. She/he can easily relate to the problematic situations and can apply his/her knowledge to deal with the situation in a culturally sensitive way.

Pakistan is a country inhabited by people of different cultures and races. Punjab, the most populous and agrarian province of Pakistan, is the home of Punjabis. Punjabis are comparatively modern and broad minded as is reflected in the literacy rate of rural women here which is the highest in the country. The purdah system is not so strict and the women help the men in the fields. Economically it is the richest province because of good, flat agricultural land, abundance of water, rapid industrialization and easy accessibility to major trade centres. A considerable population of Christians and Hindus lives in parts of Punjab.

Sindhis, the people of Sind, are conservative and traditional. Primarily an agrarian society, the province of Sind is not as developed or as affluent as Punjab. The literacy rate of the women in rural areas is low and the women do not often appear in public. After the partition of Pakistan and India in 1947 a large number of Hindus migrated to India from Sind. The influence of Hindu culture, however, is still visible in the Sindhi lifestyle and traditions. A minority of Hindus still live in some parts of interior Sind.

Baluchistan and NWFP are the most conservative areas of Pakistan. NWFP is the home of the Pathans while in Baluchistan live the Baluchis, the Brohis and the Makranis. The literacy rates, specially for women, are extremely low. Being highly male dominated muslim societies, the role of women is limited to being a wife, a mother and a daughter within the confines of the four walls of their homes.

The Northern Areas of Pakistan are inhabited by three sects of muslims i.e. the Sunnis, the Shias and the Ismailis, and offer a mixture of races and cultures. Being religiously motivated by the Aga Khan, the Ismailis are the most modern, prosperous and educated lot. Their contribution in the development of northern areas cannot be denied. The Sunni muslims are conservative and their culture and traditions are very similar to those of the people of NWFP.

Such a mixture of cultures makes the concept of a CHW even more necessary and important. Only a person belonging and adhering to and respecting the local customs and traditions can act as a change agent in a way acceptable to those he/she serves.

B. PURPOSE OF STUDY

This study is a step towards gaining a better understanding of the various issues related to the performance of CHWs in Pakistan. Though lessons can be learnt from countries that have had similar experiences with CHWs, it was considered pertinent by the Government of Pakistan and USAID to study Pakistan's own experience with CHWs in the light of its unique mixture of cultures and traditions.

The purpose of this study is to document Pakistan's experience with CHWs and to analyze the different approaches that have been or are being used to select, train and utilize them. The study will analyze the reasons why some approaches have been more successful than others and identify factors which have contributed to the degree of achievement. The aim is not to criticize but to view critically in the hope that some workable suggestions and

recommendations can be made as a result of the analysis which will help both the policy makers in the Public and the Private sectors to develop future strategies in Primary Health Care. (Annex I for Scope of work).

C. METHODOLOGY OF STUDY

1. REVIEW OF LITERATURE:

To strengthen the background of their own knowledge about PHC, the team reviewed all available related literature. This included the PHC Project document, the PHC Midterm Evaluation Report, PRICOR reports on CHWs, the Sixth Five Year Plan, draft of the Seventh Five Year Plan for the Health Sector and other reports and publications.

2. COMPILATION OF A LIST OF PROJECTS:

A list of projects known to have utilized or currently using CHWs in Pakistan was compiled after meetings and interviews with health officials, international donors, senior workers in the NGOs and after consulting inventories of NGOs in Karachi and Rawalpindi Districts.

3. OPERATIONAL DEFINITION OF CHW:

Fairly early in the study the team realized that the term 'Community Health Worker' was being used very broadly and could be applicable to anyone ranging from trained TBAs to quacks who live in the community and provide any type of health care. In the absence of an agreed upon definition, the team decided that the operational definition of a CHW, for the purpose of this study, will be "a person of either sex who lives in the community and, after some training provides health and/or related services to that community as a part of some form of health care delivery system".

4. SELECTION OF PROJECTS FOR STUDY:

A list of projects was compiled in which the definition of CHWs coincided with the operational definition. The final selection of projects was made on the basis of the different approaches that had been or were being currently utilized e.g the Management Information System (MIS) for illiterate CHWs in the Afghan Refugee Project (Annex 14), the training methodology using audiovisual aids in the Village Health Educator Project (Annex 5) etc. The final list consisted of nineteen projects of which sixteen were ongoing and three had ended.

5. TOOL FOR INVESTIGATION:

Prior to beginning field work, a detailed questionnaire was developed (Annex 2) which was used in the field as a tool to ensure uniformity, comprehensiveness and accuracy of the information collected.

8. DATA COLLECTION:

For the ongoing projects the information was collected during field visits to various project sites, through interviews with persons involved in the project and through documents made available to the team. For the projects, that have ended the team had to rely on the available documents and on interviews with those who had been personally associated with these project in one way or another.

D. LIMITATIONS

The main limitations of this study are:

1. Sites for field visits were selected by the implementing organizations. These were usually those of which the organizations were proud or those which were convenient to visit in a short period of time.
2. There is a deficiency of literature both in the Public and the Private sectors regarding community health programs utilizing PHC approaches in Pakistan. Therefore a lot of reliance had to be placed on statements made by resource persons and others related to the projects studied.
3. Due to time constraints, all projects that have utilized or are currently utilizing CHWs in Pakistan could not be studied therefore a representative sample had to be selected.

E. SUMMARY OF FIELD WORK

For the GOP PHC project, 10 project sites were visited in Punjab, 5 in Sind, 5 in NWFP and 2 in Quetta.

For the other projects field work was undertaken in all 4 Provinces and in the Northern Areas. Multiple field sites were visited for 7 projects in Punjab, 4 in Sind, 1 in Baluchistan, 2 in NWFP and 2 in the Northern Areas. During field visits persons involved with various levels of the projects as well as members of the community were interviewed (Annex 19 for places visited and people met).

Three projects (2 in Sind and 1 in the Northern Areas) were visited but are not included in the findings due to non availability of adequate information.

SECTION II

FINDINGS AND CONCLUSIONS

A. PLANNING

1. NEEDS ASSESSMENT

In most projects studied, the concept of needs assessment prior to planning is missing. Planning is based on assumptions and conclusions on the basis of existing data and the ideas and preferences of planners. In some cases a survey is conducted after the project has been planned, targets set and staff employed. The purpose of the survey in such cases is to have baseline data to judge project impact at the time of evaluation. Examples of such surveys were seen in the ARI project (Annex 13), the BIAD project (Annex 17) and a few others. There were, however, a few exceptions.

1.1 Informal Needs Assessment:

In the Comprehensive Rural Health Program of CMH, Sialkot (Annex 8) an informal procedure was adopted. The need for services was expressed by the community during informal discussions with the Project Director. This was at the time when the Project Director was initiating outreach services by establishing mobile medical camps in various villages. The CRHP started with immunization and has added other services over the years as the need for these became apparent during interaction with the community.

Another example of informal needs assessment was seen in the Family Planning through Health Guards Project (Annex 15). This project was started as a result of requests received by the FPAP from the Northern Areas for Family Planning services. The Zonal Director of FPAP made visits to various parts of the Northern Areas and held informal discussions in which the need for FP was confirmed. This in addition to the data of the Contraceptive Prevalence Survey '84-85 of GOP, served to convince FPAP of the need for Family Planning in the Northern Areas and the Project was planned.

In other Family Planning projects, the Contraceptive Prevalence Survey (CPS) of Pakistan '84-85 has served to provide information about the need for FP in different parts of Pakistan. This information has been taken as an indication of the community's felt needs by the NGO Coordinating Council, the government coordinating body for all population related projects. Many NGOs interested in Family Planning plan their projects according to the results of the CPS.

Formal Needs Assessment:

A few of the projects studied formally assessed the community's needs before planning interventions. In the ABES Project (Annex 4), health services were added to their existing programs as a result of a needs assessment survey in which health topped the list of the community's felt needs. The Behbood Association follows a formal needs assessment procedure before embarking on a project in a new site. A survey is conducted in the community and services planned only after a need for them is confirmed. Before the CBS project, Gilgit, (Annex 16) was planned a needs assessment survey was conducted to define the priorities of the community.

In some projects where the NGO had evolved out of the community itself and consisted of community members, e.g. the HSTWA PHC Project (Annex 11) and the JWA Projects (Annex 12) needs assessment was not a requirement as the community itself was identifying priorities and planning interventions.

ANALYSIS:

In the Public Sector the need for scientific approaches to needs assessment is evident. In the Health Cell of Ministry of Planning, eleven panels for various fields of health and one coordinating panel are involved in planning health programs for the country. Needs assessment is done by members of these panels based on their personal experiences and perception of the country's health needs and on the background information provided. No examples were seen of utilizing scientific approaches, e.g making use of empirical data and neither was the community seen to be involved in setting priorities. To compound the problem, there is almost a lack of trained specialists in health planning in Pakistan to lend their expertise in these matters. This is another reason that plans developed for the health sector, as for many other departments, do not always address the core of the problem to be solved.

In the private sector, most planners base their programs on the needs felt to be important by the implementing organization. In situations where planning was based on needs assessment, strategies have been planned to adequately address the community's needs. In most of the cases where formal procedures for needs assessment have been followed, the factor of the additional cost involved had to be taken into consideration. For NGOs functioning with limited financial resources, doing needs assessment can prove to be an additional financial burden. The fact that such an exercise may prove to be cost effective in the long run is something that does not seem to be recognized in the private as well as public sectors.

2. STATEMENT OF OBJECTIVES

In most projects studied no scientific procedures were adopted to define objectives. Most targets were set according to what the planners felt would be possible in the given amount of time. In almost all projects general long term goals and objectives have been specified while operational or specific short term objectives have not been developed.

The understanding of the role of specific objectives as milestones in reaching the project goals is not clearly apparent. The knowledge of project objectives is usually limited to the top management while the peripheral staff are not informed about the objectives nor of their role in achieving them. Only in the two FPAP projects namely the CBS Project, Lahore (Annex 9) and Family Planning through Health Guards Project, Gilgit (Annex 15) were the peripheral staff aware of the project objectives. Not only that each worker had also been given a monthly target in order to contribute towards the achievement of project objectives.

ANALYSIS:

The role of objectives that are quantifiable, relevant, attainable and in which the time frame, target population and measurable results are specified does not seem to be recognized and appreciated by most organizations. In the absence of well defined objectives the planners and implementers do not share a common goal, the planning does not have a specific direction and the implementers perform tasks rather than purposeful activities.

In the NGO sector this fact has been recognized and the NGO Coordinating Council has conducted five workshops on project development in all provinces. In these workshops writing of objectives and using them as a monitoring and evaluation tool was given due importance.

3. PROJECT DESIGN

3.1 Designers and Planners

The GOP PHC Project (Annex 3), was designed by the Basic Health Services Cell with the help of USAID Advisors.

Most other projects were designed by the implementing organisation itself. At times help was provided by donor agency/agencies, particularly international donors, to ensure compliance with their own requirements.

3.2 Strategies

-PiloProjects

The GOP PHC Project (Annex 3) is a pilot project. The approach of adding CHWs as the third tier to the PHC System was tried for the first time in Pakistan. Though not formally specified as pilot projects, most other projects studied were trying new and different approaches and hence could be utilized as models for future projects.

-ReplicateTesteModels

Only in one project studied did the staff acknowledge the fact that the main concept of the project was based on another project. The concept of the BIAD project (Annex 17) was based on the UNICEF funded Baldia Soakpit Project in Karachi. A few modifications were necessary in order for it to be replicable in the prevalent conditions in Baluchistan.

-IntegrateanVerticaPrograms

The GOP PHC Project (Annex 3) was designed as a vertical program and has a number of other vertical programs, e.g EPI, working through it.

Most other projects which offer a number of services have an integrated set up with each service being provided as a part of a package. Examples of such projects are the RHCP of CMH, Sialkot (Annex 8), ARES Project, Gujranwala (Annex 4), CBS project, Gilgit (Annex 16) and the BIAD Project (Annex 17).

ANALYSIS:

Project planning is an art and a science. Not only are keen and perceptive minds required to develop innovative ideas and approaches but also scientific knowledge specific to planning is needed in order to translate these ideas into

realistic and workable plans of action. The need for formally trained professionals in health planning is very apparent in the Public Sector. To meet this need the government often seeks the assistance of international experts. In this situation problems can arise when the consultants/advisors involved in planning are not fully conversant about the cultural, traditional, climatic, topographic etc context in which the project is to function and might develop projects which are unsuitable/inappropriate.

In addition, at times the consultants expect results similar to those in their own working situations and hence the objectives are set accordingly. This can lead to problems when the project's performance is evaluated and is found to be lagging behind. If human resources were available for scientific health planning, even few in number, they would be able to ensure proper utilization of imported expertise.

The situation is similar in the private sector. Most NGOs, though possessing dedication, enthusiasm and some good ideas, lack the professionalism and technical expertise required to develop workable programs and projects. Some organisations go ahead and develop plans inspite of this shortcoming while others get help from those knowledgeable in this field, usually the donor agencies. In the first instance the chances of developing projects with both overt and hidden weaknesses are high. In the second instance they run the risk of ending up with inappropriate projects as described earlier.

The importance of a Pilot Project cannot be denied. The advantage of a Pilot Project preceeding the main project is that it can bring to light any inherent flaws or shortcomings in project design or implementation and thus save time, effort and money in the long run. The concept of a Pilot Project was negated in the BIAD Project (Annex 17) in which the Pilot Project and the main project were started almost simultaneously before the Pilot Project had been evaluated. This defeated the purpose of the Pilot project with the result that the weaknesses and the flaws got magnified in the main project which never got off the ground and by the end of five years only one phase had been implemented against the four planned.

Replication of a tested model also needs a lot of time and thought. No project, unless it is being implemented under identical circumstances in an identical situation, can be replicated en bloc. Modifications have to be made according to circumstances particular to the area, the people to be served and the implementing organization. Perhaps this is the reason why tested successful models have

not been tried for replication e.g the ABES Project (Annex 4). Not only that the organizations, even though convinced of the success of their model, do not always have the means and the resources to replicate them on a large scale. Again the ABES Project is an example of this constraint.

The Government has also in the past and for the future developed projects with the aim of replication if successful. The Pesh Iman Scheme and The Health Guards Project discussed earlier are examples of past Government Pilot Projects. The ongoing Mansehra Pilot Project has been developed by the Government to assess the feasibility of the idea of paying CHWs in the next Five Year Plan.

In GOP PHC Project a number of parallel programs are functioning in it's project sites. The main reason for this is that the PHC project is utilizing the existing intra-structure of the health department and thus has to deal with the vertical programs being implemented by the department. While this has certain advantages e.g available institutional structure, in the final analysis it is an expensive and difficult way as it can give use to problems generated by territorial rights. In situations when two categories of health workers are allocated the same task there is either duplication or the task does not get done because of reliance on the other person.

4. FUNDING

In the GOP PHC Project (Annex 3) funding comes from USAID. The project was initially funded for five years but has been extended for another year till September 1988. The funds are released in instalments and are can be withheld if desired results are not being achieved. So far such a situation has not arisen as the activities are closely monitored by USAID.

In other projects studied, the major source of monetary funding were the various International donors the most prominent of which were UNICEF, CIDA, FPIA, Pathfinder Fund, EEC and ODA. The grantees are funded by the donor agency with government's permission while those wishing to implement Family Planning Projects have to go through the NGO-Coordinating Council of the Population Welfare Division. The Government also played a role in funding some of the project studied.

In most of these projects short term funding is provided initially, renewals being dependant upon desired project performance. Some grantee organisations have to agree to certain conditions other than adequate project performance before they can be granted funds e.g. any

organization receiving all or a share of its funds from USAID directly or indirectly through another agency has to certify in writing that it does not and will not engage in abortion related activities.

ANALYSIS:

In a majority of cases, the funding provided by almost all International donors is dependant upon "satisfactory project performance". The definition of satisfactory is dependant on the degree of implementation of the planned activities and is clearly understood by all concerned.

There are both advantages and disadvantages to this form of funding. The advantages are that as certain results have to be achieved in a defined time period, the potential threat of withholding of funds acts as a constant source of inspiration/obligation to achieve those results. The accountability of the grantee to the donor is also increased. This accountability tends to force the grantee to monitor their activities regularly for timely action. The disadvantage is that in some cases the necessity to produce the required results for the satisfaction of the donors is such that, at times, it can give rise to mis-reporting and misrecording of facts by those interested in receiving the funding. In addition the uncertainty of funds after a specified period does not encourage long term planning.

In a few cases where the project is planned for a short term the total funding is usually provided at the beginning of the project. In these cases the accountability of the grantee to the donor is low and since evaluation takes place at the end of the project period, modifications cannot be made as and when needed.

5. COMMUNITY INVOLVEMENT

In the GOP PHC Project (Annex 3) the community was not involved in the preplanning and planning stages.

Only in a few of the other projects studied was the community involved to a significant extent in needs assessment and planning. In the CBS Project, Gilgit (Annex 16) and in the ABES Project (Annex 4) proper needs assessment surveys were done and the project developed according to the needs expressed by the community. In the RHCP of CMH, Sialkot (Annex 8), there was an informal involvement of the community in needs assessment.

In projects of the HSTWA and The Jokhio Welfare Association the community was fully involved in project as

staff of both these the NGOs consisted of members of the community and they were the ones responsible for project planning.

ANALYSIS:

Community involvement is one main factor in successful project performance. Not only does the community easily accept the services being offered, it also participates in their implementation and accepts a certain amount of responsibility for their success or failure.

With a few exceptions the role of the community in project planning is limited. The importance and relevance of community participation and involvement in project planning does not seem to be recognized by most planners. The fact that services are to be provided mostly to illiterates in rural areas usually gives rise to the misconception that only the planners in the city know what is best for them. The villagers are given very little credit for intelligence and awareness of their own needs. This is the start of differences which can later become magnified enough to cause major problems for the project.

In the projects where community involvement was invited right at the beginning, the projects are functioning without problems from the community. The sense of ownership and pride is evident in those directly involved with the project. In other cases where planning was done by outsiders and the project was forced upon the community as more or less a surprise, serious problems have been made for the project by the locals who have not been involved in the project activities.

B. IMPLEMENTATION

1. Administrative set up:

In the GOP PHC project the management is highly centralized with all the major policy and administrative decisions being made at the higher levels. The reason for centralized management in the PHC project is that it has been incorporated into the already existing health infrastructure and is utilizing the Health department's existing line of management. The DHOs are the ones with almost all the responsibility and authority for matters pertaining to the subordinate staff. The authority below that level is limited e.g the MO at the BHU, other than providing curative care, can only supervise the subordinate staff. He does not have the authority to sanction simple expenses like purchasing soap for the BHU let alone hiring or firing subordinates.

Problems are also faced by the DHO who, though possessing the authority to make changes, is at times in no position to do so because of pressure from his supervisors or other influential individuals. This is a constant source of frustration and dissatisfaction to the DHO. His confidence and ability to make changes are undermined and therefore, his performance is adversely affected.

This situation was discussed with the staff at all PHC sites visited. All interviewed could foresee improvement in project performance if more authority was allocated to the MOs at the BHUs.

In the private sector a mixture of centralized and decentralized management is seen. In those projects, where the management is comparatively decentralized, the problems mentioned above are not so numerous. A certain amount of authority accompanies responsibility at the periphery and the channels of organisation are clearly defined. An example of such an arrangement working effectively is the Salvation Army's CPHC Project (Annex 6). This project is being implemented through ten Salvation Army BHUs. Each BHU follows the broad policy outline specified by the Head-quarters but is otherwise functionally independent i.e. the staff at each BHU has the authority to make changes, define operational objectives and develop their own plans of action irrespective of the functioning of other BHUs.

In some cases though on paper the management is decentralized and there is delegation of authority at the periphery, the actual authority is retained at the higher level by one person and he/she makes all the administrative and management decisions.

ANALYSIS:

According to the general principles of management responsibility without authority does not promote overall efficiency. If a supervisor does not have the authority to take any action for the inadequacies of those working under him then the subordinate staff does not feel accountable to him and the impact of supervision is diluted. When a manager of any level does not have the authority to take certain decisions and implement them then, in all fairness, he/she should not be held accountable by the next level of authority for any deficiencies in the management.

The effect of responsibility without authority was evident in most projects visited. This obviously created problems particularly of discipline for the immediate supervisors because the subordinates know that at the most the supervisors can lodge a complaint against them to the next level of authority but cannot take any action himself.

In cases where, on paper, the decision making power is given to a person but he/she is in no position to exercise it the results are the same as when he/she does not have any authority. Moreover the workers become very sensitive to where the real authority lies and act accordingly.

The overall reluctance on the part of the management to delegate real authority is perhaps not so unique to some of these projects. This is a practice common in Pakistan as in most countries of the developing world. Hence it would perhaps be unrealistic to expect an entirely decentralized system of management in these projects. But a certain degree of decision making power is needed at all levels if efficiency is expected.

2. THE COMMUNITY HEALTH WORKER

2.1 NOMENCLATURE

Other than the term Community Health Worker, many projects differ in the name given to describe "a person living in a community who after some training, provides health and/or related services to that community as a part of some form of health care delivery system". Some names being used for this category of health workers in the projects studied are:

Village Health Educator	Village Health Educator Project, ABES, Punjab
Village Health Worker	Comprehensive PHC Project, Salvation Army, Punjab
Field Workers	Community Based Services Project, FPAP, Lahore
Motivators	Jokhio Welfare Association Projects, Sind
Primary Health Care Workers	Acute Respiratory Infection Project, Ayub Medical College, Abbottabad

Health Guards

Family Planning
through Health
Guards Project,
FPAP, Gilgit

Community Health & Nutrition
Workers

Community Basic
Services Project,
AKF, Gilgit

These names have been given by the respective NGOs according to the functions being performed by the worker. An exception was seen in the Behbood Project (Annex 10) where the worker is called a 'motivator' when her role is limited to informing the LHV about married couples in the community, accompanying the LHV on her rounds and keeping the centre clean.

ANALYSIS:

The term "Community Health Worker" is not clearly understood by those interviewed. It is associated with confusion, misconception and, at times, apprehension. In a majority of cases it is used in place of the term 'Health Auxilliary' which itself has a generic meaning and refers to "All health personnel below the professional level who assist a fully qualified person" (4). In Pakistan's context, then, the term 'Health Auxilliary' could include the Medical Technicians, the Health Technicians, the Medical Assistants, the Multi Purpose Health Workers, the TBAs and the CHW, as defined in the GOP PHC Project.

Many people disagree with the term "Health Worker". It, they feel, attaches mainly curative connotations to the role of the CHWs and immediately upgrades them in their own eyes and in the eyes of those they serve. This encourages quackery. Other terms like Health Guards, Motivations and Primary Health Care Workers also have the same implications. The term 'Village Health Educator' used by UNICEF seems appropriate since it emphasises and highlights the health education aspect of their role. This distinction, though slight, can have a great effect on the CHWs' performance and will remove ambiguity between their expected and actual roles.

2.2 THE SELECTION PROCESS

By the community:

As a general rule among the NGO projects CHWs were usually identified and selected by community members. This is either done through consensus of the Village Health Committee (at times called the Project Committee), consisting of village leaders or through the village

Headman. The person thus chosen is usually an 'opinion leader' of that community. In the Government PHC project the above process, though being actively pursued on paper, does not seem to be uniformly applicable nationwide. In actuality the selection of a great majority of CHWs is based on the ease and convenience of the MT responsible for his/her training. In many cases, the CHW is a regular visitor of the BHU/RHC or is someone who is known to the MT personally. Community participation in selection is therefore usually minimal.

By Project Staff:

An example of this method was seen in the Urban MCH Complex Project of the MCWA (Annex 7) that is employing full time CHWs. Advertisements for the positions of CHWs are placed in the newspaper and the applications received in response to these advertisements are screened by the project staff according to the defined eligibility criteria. The final selection is done by the project staff and there is no community participation.

Through mutual agreement:

This was also seen to be utilized by some projects employing full time CHWs e.g in the ARI Project (Annex 13) applications were invited for the posts of CHWs. Final selection was subject to the agreement and acceptance of the local Union Council members.

Combination of above methods:

In the CPHC Project of the Salvation Army (Annex 6) a combination of all the above methods is seen. Some CHWs are selected on the nomination of the Village Headman, some are recruited directly by the staff and some by inviting and screening applications and conducting interviews.

ANALYSIS:

All the various selection processes discussed above have their own merits and, at times, demerits. The results depend entirely on the method of utilizing the process. With the community selecting it's own CHW, acceptability of the person and of the services he/she provides is ensured to some extent. Also, the responsibility of sustaining the CHW is enhanced. It will, however, depend on whether a representative group is responsible for the selection or it is done by a single leader representing the community.

When a group of community leaders is given the responsibility of selecting the CHW, the likelihood of selecting a person who is respected by all concerned is

increased. Yet the other side of the coin is that in a tribal system or a clannish society like Baluchistan and NWFP problems can develop due to the leaders not reaching a consensus because of rivalry between the different clans or tribes which they represent.

On the other hand if a single village leader like the Headman or a member of the Union Council is given the entire responsibility for selection, the elements of nepotism or favouritism can affect the final decision.

When only the project staff is in charge of selection, adherence to the eligibility criteria is more likely. This situation, though professionally favourable, almost eliminates community participation and the chances of low acceptability of the selected CHW are high.

When the CHWs are selected jointly by the community and the project staff, the chances of meeting the selection criteria of the community as well as those specifically related to the project are greatly increased. The acceptability by both parties is enhanced and the responsibility for the success or failure of the selected CHW is shared.

2.3 SELECTION CRITERIA

Irrespective of the selection mechanism 'respectability' was cited as one of the main criteria for the selection of CHWs in all projects. Other criteria were:

-Age:

No specific upper or lower age limits were defined. Most CHWs were young or middle aged. In those projects where a certain level of education was a requirement, most CHWs were of a younger age group. In the Family Planning projects studied, the Motivators employed were usually middle aged.

-Sex:

Each project defines its own criterion regarding sex of CHWs. e.g the projects studied, eight utilized only female CHWs, ten utilized both male and female CHWs while only one project, i.e. the Afghan Refugee Project of Save the Children Fund/UK (Annex 14) utilized only male CHWs.

-Education

Literacy, though preferred, was not a requirement with most projects. A few of the projects specified the number of years of schooling required e.g the ARI Project specified at least 10 years of schooling. Considering the high literacy

rate in and around Abbottabad, no problems were faced in finding candidates who fulfilled this requirement. The Urban MCH Complex Project of the Maternity & Child Welfare Association (Annex 7) requires 8-10 years of education for girls to become CHWs. As the project is based in an Urban slum no difficulty was expressed by the staff in finding girls with that level of education. In the ABES Project (Annex 4) only functional literacy is required. This too is not difficult to achieve since the ABES's Health program has been started only in those villages where adult literacy courses have been completed. In the Home School Teachers PHC program (Annex 11), no defined criterion for education was needed because all the CHWs are teachers. The rest of the projects are utilizing literate as well as illiterate CHWs.

-Marital Status:

Even though it was not a required criterion, married CHWs were preferred in Family Planning projects. Other projects did not give any consideration to the marital status of their CHWs.

ANALYSIS:

In most projects the eligibility criteria for CHWs were not very well defined. In cases where the community was involved in the selection process, 'respectability' was the main criterion for selection. Other criteria, eg functional literacy, which could directly influence the performance and/or the acceptability of services offered by the CHW were not always clear.

In projects dealing with sensitive issues like Family Planning, married and middle aged women preferably with children, were selected to function as Motivators. In this case middle age was considered an asset as the Motivator gained a certain amount of respectability and credibility normally attributed to older age in the Oriental societies.

In those projects that specified education as a criterion workers of a younger age group, particularly females, was indicative of comparatively recent trends towards female education in Pakistan.

An expressed preference for females by the staff of projects utilizing male CHWs reflects greater acceptance of female CHWs. This is because of the difficulties being faced by the male CHWs due to the prevalent cultural and traditional values restricting interaction between men and women.

Experience has proved that women are ideally suited to provide PHC to the women and children of their communities. They have access to other women even in the most conservative societies. In addition to being the main sufferers of ill health, they are the ones ultimately responsible for the health status, health habits and health care of their families, especially of the children. In addition, the Pakistani women prefer the advice of other women when it comes to every day problems of life. All these factors combined, make it essential to include women in any type of health activity being planned. An added advantage is that attrition rates among women are lower than among males as they are more likely to stay in one place because of family ties and commitments.

In this connection, the Traditional Birth Attendant (TBA) has emerged as an available, appropriate and functioning resource whose credibility is already well established in the community. In the Government PHC Project sites visited the majority of female CHWs trained by the FMTs are TBAs. This and other projects that have utilized or are currently utilizing TBAs as female CHWs all reconfirmed this notion that TBAs make successful CHWs.

The TBA is the right choice for a CHW. The one limitation, as some planners would consider it, is that the TBAs are usually illiterate and will not be able to maintain records. There is, however, evidence available that illiterate CHWs can maintain records just as accurately as literate ones provided a system has been developed to enable them to do so. This has been proved in the Afghan Refugee Project where an excellent system of record keeping has been developed for illiterate CHWs (Annex 18).

One assumption that was seen to be common among most planners is that intelligence and capacity to learn and retain information are dependant on the educational qualifications of individuals and the more educated you are the more you can learn and retain and vice versa. This assumption can prove to be a positive hinderance especially when national scale programs are being developed. This is more true for female CHWs than their male counter parts. The literacy rate for women is extremely low in Pakistan. Punjab is the most economically and culturally advanced province and the female literacy rate is higher there than in other parts of the country. Even in such a place recruiting literate females as CHWs may present some difficulties. In the other provinces, however, this may be close to impossible because of the low female literacy rates due to the extremely conservative cultural values prevailing.

2.4 TRAINING

-Curriculum

The GOP PHC project (Annex 3) utilizes the book 'Rehnuma-e-Sehat' to train CHWs. This book is an Urdu translation of the book 'Guide to Health'.

In most other projects the curriculum for training CHWs has been developed by the staff of the implementing organisation and is usually in the form of a list of topics to be taught and details of those topics. In the ABES Project (Annex 4) teaching-learning material called 'curriculum' with graded vocabulary has been developed for CHWs. In some other projects curricula developed by other organisations are being utilized e.g many projects training TBAs as CHWs are utilizing the UNICEF TBA training curriculum.

-Trainer's Background

In the GOP PHC project, the MTs at the BHU and RHCs are responsible for training CHWs. These MTs have been posted at the peripheral facilities after completion of an eighteen month long course from the MT training schools. The teaching-learning material used for training of MTs is in English and includes classroom sessions as well as field placements. Until recently the curriculum stressed on curative care as the MTs were manning the BHUs in the absence of the MOs and needed a curative background. Now with appointments of MOs at the BHUs the role of the MT has changed and become predominantly preventive. Therefore, the curriculum has now been changed to one mainly preventive in order to meet the demands of this new role. Along with this change the title of Medical Technician has been changed to Health Technician with the aim of emphasising their curative role.

In other projects training is provided either by the project staff or, in a few cases like Family Planning through Health Guards Project (Annex 15) and the AKF's CBS Project (Annex 16) by the project staff with occasional assistance from guest lectures. In all cases the trainers were literate with some background in Primary Health Care.

-Site

In most cases training is provided in the community. In cases where large groups of CHWs have to be trained together, it is usually conducted at a common site e.g the BHU, RHC or the nearest town.

-Duration

The duration of training in various projects ranged from 6 days to 1 year.

-Methodology

In the GOP PHC Project (Annex 3) training consists of informal discussions in the local language in the form of oral messages reinforced through repetition. No use is made of audiovisual aids. No schedule for training is made. Other than the CHW training is attended by anyone else who seems interested in the subject.

In most other projects training methodology consists of discussions usually with the help of some audiovisual aids. The Afghan Refugee Project (Annex 14) utilizes clear and useful visual aids to ensure comprehension and retention.

The Village Health Educators Project (Annex 5) utilizes the Basic Functional Education Program methodology of the Allama Iqbal Open University. This methodology makes use of audio cassettes and visual aids and invites participation from the trainers.

-Evaluation of Teaching-Learning Activities

No uniformity exists in the post training evaluation of the teaching-learning outcome. There are no examinations as such but in a few projects some oral exercises are conducted to evaluate the teaching-learning activities.

-Continuing Education

In most projects training is a one time activity with no efforts being made to provide refresher courses. There were a few exceptions. In the Health Guards PHC project refresher courses were planned and provided in some cases. In the Family Planning through Health Guards Project (Annex 15) and the CBS Project of the FPAP (Annex 9) regular refresher courses are provided to the health guards to refresh their knowledge. In the Rural Health Care Project of CMH, Sialkot (Annex 8) the Project Director gives regular refresher courses the contents of which depend on the need of the moment. e.g before the summer season he teaches them about diarrhoea and its management, before the monsoon season about malaria etc.

ANALYSIS

The "curriculum" as defined by educationalists does not exist in a majority of the projects. A list of topics to be taught is compiled. Some teaching learning material is prepared and this is called the curriculum. This is due to

the fact that neither the planners nor the trainers have any formal preparation in educational technology. The only exception noticed was UNICEF's TBA training curriculum which was prepared by a committee of experts in the field.

In the GOP PHC Project there seems to be confusion at all levels regarding the precise background and role of the trainers of CHWs i.e. the MT, at all levels. As discussed, the Medical Technicians were trained to provide curative medical care to the rural population. Since the doctors, for various reasons, were unwilling to serve there, the MTs had a flourishing private practice and made enough money to enable them to live comfortable lives. With the posting of the MOs at the periphery, the MTs role has become limited to assisting the MO and doing preventive work. In addition their private practice has been adversely affected. All this has led to severe dissatisfaction and frustration for the MTs. The main cause is that in their minds they have been 'demoted' to doing preventive work when their training prepared them for curative work. To combat this issue the curriculum was changed to that predominantly preventive along with the designation of the Medical Technician being changed to Health Technician. The aim was to curtail the curative role of the MTs. This move, though made with good intentions, can have some not so good repercussions.

The concept of the role of an MT/HT has not changed in the minds of the trainers or the other project staff. This, and the fact that the HT students are not taught how to identify, select or train CHWs but are expected to do so after completion of training, can present a serious problem for the CHWs. Another factor that affects CHWs indirectly is that both the old and the new curricula for the MTs are in English. Since most old MT & new HT students are matriculates with barely a working knowledge of English, they face a great deal of difficulty in comprehension and retention of information taught. Thus the level of competence of these MTs becomes questionable.

Most other projects do not face such problems. In those projects which utilize services of external consultants to train CHWs different types of problems can arise. In some cases interpreters have to be used when the trainers do not know the local language even though they are Pakistanis. In others, problems can arise with the consultants not being sensitive to certain cultural and traditional issues.

The selection of site is an important factor in training. In cases where training is given to individuals rather than groups, it is usually provided in the setting where the CHW is to function. This is appropriate since the surroundings are familiar to the CHW and familiar examples are available to them in that setting.

In other cases where large groups have to be trained, a common site is usually chosen. This has the advantages that it is organised, completes within a given period of time and the trainees can learn a lot through group interaction. In almost all such cases the trainees are provided a stipend during training in order to cover the expenses for transport, boarding and lodging. In the case of female trainees problems can be faced because of cultural traditions prohibiting movement away from home unescorted. The AKF CBS Project in Gilgit (Annex 16) dealt with this problem by providing travel, boarding and lodging allowance to female trainees' as well as to their male guardians.

The duration of training is dependent on the course content and the methodology used. In most projects the duration of training is well defined but exceptions were seen. In the GOP PHC project, the training of CHWs lasts from one to six months. The time taken for training is dependent on factors like the distance between the health facility and the village, the interest taken by the MT and the interest and learning capabilities of the CHW.

In most projects the methodology for training was clearly defined with a few exceptions. In the GOP PHC project the training is informal with no set time, site or methodology. This makes the whole concept of CHW informal. In many cases the CHW is 'trained' in presence of any onlooker who happens to be there. The position and 'seniority' enjoyed by the CHW by virtue of training are, thus, adversely affected.

In other cases the usual methodology employed for training is through verbal communication in the form of lectures, at times using visual aids and with minimal trainee participation. In this connection the BFEP methodology employed in the Village Health Educators Project (Annex 5) deserves a special mention. Training was imparted to large groups entirely through audio visual aids. This is an excellent methodology for the following reasons.

- It is cost effective. The only costs involved are those of the teaching materials, which can be reused a number of times, and the cassette player which is almost always available in villages and can be borrowed for the purpose.

- The need for an educated trainer is minimized.
- As the information is transferred directly from the source to the recipient there is no need for good teaching abilities and there is no dilution of knowledge.

- Training can be provided to large audiences at one time and in one place.

- The methodology invites discussions and participation and thus evokes interest.
- It can be used a number of times to refresh and reinforce the message.
- It can be conducted by anyone with minimal orientation and training.
- It can be conducted at any site. This is a positive advantage as it may not always be practical or possible to collect people in a common place at one time. This assures convenience and a larger attendance at training sessions.

On the other hand in the CPHC project of the Salvation Army (Annex 6), the training methodology was not very well defined. It consisted of 2 days of verbal orientation and/or workshops (number not specified) and on the job training. The educational qualifications of the trainers range from illiterates to matriculates but they are all provided the same training.

In most cases there is no evaluation of the outcome of training and the CHW goes into the community presumably as a trained person. There is no scientific assessment of his/her level, competence or accuracy of knowledge.

2.5 INCENTIVES

In a large majority of projects utilizing volunteer CHWs the commonest incentive, as expressed by the CHWs interviewed, was the prestige and improvement in their status in the community as a result of being selected and trained as CHWs. In the projects being implemented by the Christian Missionary Organizations e.g the Christian Memorial Hospital, Sialkot and the Salvation Army, Lahore, the main incentive was self fulfillment through service to humanity and an investment for life hereafter.

-Monetary Incentives:

Five Projects studied were utilizing salaried CHWs while two projects offered honoraria for out of pocket expenses incurred during the execution of project related duties.

In projects providing Family Planning services, performance related monetary incentives were offered to workers depending on the numbers and types of cases referred by them to the source of contraceptive services.

-Non Monetary Incentives:

As a form of non monetary incentives, many projects provide CHWs with 'Kits'. The contents of these kits depend on the functions to be performed by the CHW e.g. TBAs receive instruments and medicines to be used during and after labour while the kit of a PHC worker contain medicines for first aid, treatment of minor ailments, bandages etc. Some projects allow CHWs to sell the contents of the kits at prescribed rates and replenish them with money thus made e.g. The CBS Project, Gilgit (Annex 16), The Family Planning through Health Guards Project (Annex 15) and The BIAD Project (Annex 17), while in others the CHW provides free services and the kit is replenished by the project management e.g. the GOP PHC project.

Volunteerism:

In some projects, though continuing to work as volunteers, most CHWs are not satisfied with their volunteer status and a majority expressed the desire and need for payment. This need, in almost all cases, was due to their poor economic status. Most CHWs interviewed were married, had a number of children and limited means to provide for their families. They felt that if they were expected to spend time, effort and energy doing something for others, they should be compensated for it. Not one CHW, however spoke of ending this work if money was not provided. The reason cited for this was the prestige enjoyed as a result of this work and a sense of duty to answer the community's needs. For those CHWs who were financially well off, the only incentive was the prestige and respect resulting from their title. Money, if given, would be welcomed. In the opinion of some CHWs volunteerism can only work if the CHW has a regular source of income.

The planners interviewed hold different views regarding the role of volunteerism. A large majority believe that monetary compensation for the CHWs is a must if they are to function effectively as, not only does payment instill a feeling of responsibility in them, they also become accountable for their actions thus facilitating supervision and maintenance of standards. They also feel that, to some extent, it is unfair to ask someone with financial problems to volunteer his or her time.

In the opinion of other planners to pay CHWs would go against the spirit and purpose of volunteerism. They give examples of missionary projects where the volunteer approach has been successful in spite of economic pressures. They feel that giving money would suppress that spirit of self reliance in the community that the Alma Ata has so clearly emphasised. If money is to be paid only to upgrade

performance by ensuring accountability, then in their opinion other approaches like improved monitoring and supervision can be employed to achieve the same result.

It was, however, agreed by all that some sort of incentive, not necessarily monetary, was needed to motivate the CHWs. Interesting examples of such incentives were seen in the GOP PHC project. In one RHC, the MTs procured certificates of achievement from the MO incharge for those CHWs who had completed their training. In another case the MO incharge of the BHU gave preference to the patients referred or accompanied by the CHW by attending to them first. He also made house calls at the request of the CHWs and exempted them from paying money for private consultation. In both these situations, the CHWs were working regularly and performing their duties well.

In many projects, kits were provided as an incentive for the CHWs. But this has backfired in many projects and the replenishment of these kits has become a major issue. In the GOP PHC project, kits were given to many CHWs and were to be replenished by the MTs at the BHUs & RHCs which themselves are chronically short on drug supplies. Thus replenishment of supplies in the Kits is infrequent and irregular. In other situations where the CHW was supposed to replenish the kit by selling the drugs it contains, payment is often not made by patients for the medicines bought by them. Replenishment, in these cases also is infrequent and irregular.

The issue of participating in the next government health program as paid workers was discussed with all CHWs interviewed. With one exception, all CHWs expressed willingness to work for the Government and accept the accountability and supervision that would accompany the payment. The Home School Teachers however, declined to show interest in such an arrangement. The reason given was that they are all independent workers and like being able to make quick independent decisions within their small NGO. With the government program bureaucracy and political factors would make such independent working impossible.

ANALYSIS

Though most projects were utilizing volunteer CHWs, the spirit of volunteerism was most evident in the projects of the Christian organizations. In these projects, volunteers work because of love for God and with the aim of making Him happy. This is enough of an incentive to make them spend some of their time helping and serving others.

In Pakistan, economic conditions of the rural population being what they are, the idea of paying CHWs

being utilized in the public sector is one that can prove to be feasible in the long run. This step by itself, however, cannot achieve the desired level of performance of the CHWs unless it is accompanied by improvement in supervision of and support provided to the CHWs.

2.6 DISINCENTIVES RESULTING IN ATTRITION

Disincentives of two types seem to be at work, those that were performance related and planned and those that were unplanned and could lead to attrition.

-Planned or Performance Related Disincentives:

Only in three projects were performance related disincentives being utilized. In the FP through Health Guards project, the HGs has to achieve a monthly target of new acceptors. If over a specified period of time, the HG is unable to achieve this target he/she is dropped from the project. In the BIAD Project (Annex 17) and the Salvation Army CPHC Project (Annex 6) the kits given to some CHWs were retrieved when their performance was not found to be upto standard.

-Unplanned Disincentives:

Disincentives like lack of support and supervision were seen to be at work in many projects. This was seen to be more in the Public Sector projects and in projects utilizing volunteer CHWs.

ANALYSIS:

The role and effect of performance related disincentives seems to be unclear. In some cases where a specified level of achievement is required, the presence or threat of disincentives can actually act as an incentive for the achievement of that level. On the other hand, irrespective of the underlying causes it can encourage falsification and misrepresentation of records e.g in one project, the Family Planning motivators were buying contraceptives from their kits themselves and throwing them away to ensure the achievement of the monthly target for the contraceptives distributed. Such a situation is seen in projects that stress only on quantifiable results and do not concern themselves with important unmeasurable results like changes in behaviour and attitudes etc.

Unplanned disincentives like lack of supervision and support are seen to be at work in many projects, especially those utilizing volunteer CHWs. A volunteer will continue to provide services as long as he/she gets guidance, support and recognition not only from those he/she serves but also

from the management. In situations where this support is missing, the CHWs performance suffers to a great extent. This was seen to be the case in the GOP PHC Project especially in some villages that were far from the BHU or RHC. Once the CHW had been trained by the MT, he/she was left to function in isolation because of the problems faced by the MT in making supervisory visits. This lowers the morale of the CHW.

Another factor that acted as a disincentive was the non replenishment of kits of the volunteer CHWs. In almost all projects where kit replenishment is the duty of the project management, some unforeseen problem, like shortage of medicines at RHCs & BHUs, no POL for visits of the mobile teams etc, create difficulties with kit replenishment so that this activity becomes extremely infrequent or is stopped altogether. An empty kit adversely affects the performance and credibility of the CHW and hence, his/her performance.

The above and other similar factors can lead to severe dissatisfaction which can result in attrition. In most NGO projects attrition was not found to be a major problem. There was more evidence of this in the public sector. Other causes of attrition that were evident were not directly related with disincentives. In one project female CHWs dropped out after being selected and trained when they realized the extent of the field work involved in their job. In a few others problems arose when a few CHWs, volunteer males who were also government employees, e.g. school teachers, dispensers etc, were either transferred out of the villages they had been chosen to serve or left of their own accord in search of gainful employment.

2.7 ROLE AND FUNCTIONS

Planned role

According to their planned roles in projects studied the CHWs can be placed in one of the following three categories.

1) Primary Health Care Worker: The functions of this category include:

- Oral Rehydration Therapy
- arranging for immunization
- growth monitoring
- sanitation/hygiene

- health education
- treatment of minor ailment and first aid
- referrals
- data collection and reporting

Most CHWs can be placed into this group as they perform all or a majority of the above functions. In some cases a few duties have been added to or subtracted from the above list e.g in the ARI Project (Annex 13) the main focus was acute respiratory infections and the duties of the PHCW emphasised this.

2) TBAs: The functions of this category of CHWs include:

- routine antenatal care
- arranging for immunization of pregnant woman against tetanus
- conducting deliveries
- high risk referral
- giving advice on child spacing
- reporting births

3) Family Planning Motivator: The functions of this category include:

- providing information and education about Family Planning
- distribution of prescribed contraceptives
- follow up of complications/dropouts
- Referrals

PERCIEVED ROLE

Of the three categories above, the planned roles are fairly well understood by the last two. In the first category the perception of the role as planned is confused. There is the common misconception that emphasis is to be laid on curative tasks while the importance of preventive tasks is considered secondary.

ACTUAL ROLE:

By and large, the last two categories of workers are performing their jobs as planned. In a few instances problems were observed with workers overstepping their level of competence. In the first category, which includes a majority of CHWs, a lot of disparities were seen between what was planned for workers and their actual performance. Preventive duties were usually neglected while a lot of emphasis was being laid on the curative tasks. A common result of this was that CHWs were observed to be functioning as 'mini doctors' in their situations.

ANALYSIS

In almost all projects disparities were seen between the functions planned for CHWs and those actually being performed by them. The main reasons for this are:

-Confused perception of planned role:

The perception of the role to be performed by the CHW is at times different in his/her mind from what is planned. This is largely because no clear written or oral instructions are provided to the CHW regarding the exact nature of the duties to be performed by them, their schedule of work and the overall objectives and targets of the projects and their contribution towards its achievement. They are dependent on the instructions of the trainers or supervisors whose perception of the CHWs role is also confused at times. This is because they too have not been provided clear job descriptions for the CHWs. In addition, as is the common tendency, a lot of importance is given to curative care by the community as well as the trainers. This attitude, which usually matches that of the CHW since he/she is a member of that community, frequently limits the role of the CHW to one that is mainly curative while other duties are neglected.

-Over burdening of the CHW:

The number of duties expected to be performed by the CHW is at times so large that he/she becomes overburdened with the result that the CHW does what he/she can conveniently in the time available.

-Infrequent supervision and support:

Disparities are also seen to arise when there is no regular system of monitoring and supervision to ensure adequate performance by CHWs. When the CHWs are left to function in isolation they do so according to their own perception and interest.

-Volunteerism:

In those cases where CHWs are volunteers, they perform the duties of a CHW when there are no other demands on their time. When these demands are increased then their volunteer role becomes limited to the performance of those duties that are perceived to be important, are convenient and do not require much time.

All these factors affect the performance of the CHW. A common result of the combination of above factors, especially in the case of volunteer CHWs, is quackery.

In many cases it was observed that CHWs were performing curative functions well outside their level of competence. In one village in Sind not far from an RHC, a male CHW was interviewed who was called "Doctor Sahib" by the whole village including his own family and the MT who had trained him. He possessed and used a stethoscope and had a flourishing medical practice going on 7 days a week, with Fridays being "reserved for God's work" i.e. providing free medical care. The man diagnosed and treated all illnesses, commonly prescribed and administered Penicillin injections and "by the Grace of God seldom had to refer cases to the RHC". In another instance, an LHV at a nearby health centre had taught the local TBA the correct procedure for administering intra-muscular injections. This was done for the convenience of the villagers requiring repeated injections prescribed by the doctor at the health centre which was situated at a considerable distance. This illiterate TBA, after sometime, started administering injections with the help of a literate male relative who would learn the names of some drugs and repeatedly prescribe them to the sick. Many other similar cases of quackery were observed.

The motivation for quackery in most cases was seen to be an honest desire to alleviate the suffering of the community and thus gain their respect. In the absence of easily accessible health care, the importance of the CHW in the community is magnified. He/she becomes the 'knowledgeable one' in the community, the one who has the training to make the sick better. The fact that his/her training is limited that he can actually harm the patient is not appreciated. The CHW, under such pressure, slowly starts modifying his/her role to suit the needs of the community. Monetary gain is an added incentive especially among volunteer CHWs.

Quackery among CHWs is a fact that is known to and, to some extent, accepted by all. Many accept it as it is answering an important need of the community which may not

be answered through other means for quite some time. According to one official in the Health Department "what does it matter if a few people are harmed because of the incompetence of these quacks? Look at the thousands they are helping".

Though policies and regulations against quackery exist, it is becoming a flourishing 'profession' not just limited to CHWs. Some NGOs have been able to control it in their project sites through constant vigilance and supervision. At a national level, however, unless regulations are strictly enforced, this manace will continue to grow.

2.8 MANAGEMENT INFORMATION SYSTEMS

-Recording & Reporting:

In all projects the CHW was required to maintain some records of his/her work. In projects utilizing literate CHWs the records maintained were detailed with the aim of providing sufficient data for evaluation. In some of these projects there was a tendency for collecting very detailed and, at times irrelevant, data e.g in the Jokhio Welfare Associations's Community Based Distribution Program (Annex 12). One CHW spent 2 hours a week doing field work and five and a half days a week filling up registers with the information collected during these two hours. On the other hand the Urban MCH Complex of the MCWA (Annex 7) has developed a record keeping system that is accurate, efficient and simple.

In projects utilizing illiterate CHWs, the requirements for record keeping are simple. The usual practice is for the illiterate CHW to maintain records with the help of a literate relative or friend. In the Afghan Refugee Project of Save the Children Fund/UK (Annex 14) a unique system has been developed for the maintenance of detailed and accurate records by illiterate CHWs. A sample of the form used by the CHWs for recording their performance is attached as (Annex 18).

Many CHWs interviewed had not been informed of the need for collecting information. They had assumed that it was used by the management to assess their performance and in many cases it was found to be true. Many of the mid level personnel responsible for supervising the work of the CHW were also under the impression that the presence or absence of records was an indication of the level of performance of the CHW. Only in a few cases were the records kept by the CHWs actually utilized to assess project performance and progress and in these projects monitoring and supervision of the CHWs were regular features.

In many projects the information recorded by CHWs is not collected by the supervisors. In the projects where this information is collected various methods are utilized to disseminate the information collected by the CHWs to the project management. In most projects a well thought out and clearly defined mechanism is missing. In some projects, e.g. the CBD Project of FPAP, Lahore, CHWs verbally report to their immediate supervisors. An interesting methodology for disseminating information was seen in the Family Planning through HGs Project in Gilgit. The CHWs record information on forms provided by the management and give them to the Area Health Guard leader weekly. This leader collects all the forms, compiles the information and hands it to the Field Supervisor monthly, who in turn reports to the Field Officer monthly. In a similar fashion information about project performance reaches the Project Director and the donors quarterly.

ANALYSIS

With a few exceptions, there seems to be a trend for collecting exhausting amounts of data especially in projects utilizing literate CHW. It seems that instructions for record keeping, in many cases, have been issued without much thought being given to the relevance of or requirement for the data collected or the time spent by the CHW on this exercise.

In case of illiterate CHWs, by and large, record keeping requirements are simple. The need for the data collected by the CHW in some situations though, is debatable as it stays with the CHWs and is not collected by the supervisors, thus defeating the purpose of data collection. This is attributed to 2 main reasons (1) In some cases facilities for maintaining contact between the CHW and the management are not always available with the result that in spite of a genuine need and desire on the part of the management to effectively utilize information collected by the CHW, collection of information becomes difficult and at times impossible and (2) at times not much reliance is placed by the management on records maintained by the illiterate CHWs. This is because of the common misconception that illiterate means inaccurate. This concept, however, has been proved wrong by the Afghan Refugee project mentioned above that has developed a simple record keeping system for illiterate CHWs. The system not only ensures accuracy but provides the CHW with a sense of achievement.

The main function of collecting information is to facilitate management and to monitor progress and achievement of a project. When maintenance of records becomes an objective in itself rather than a tool for

facilitating the achievement of objectives then changes are in order. What is needed for a majority of implementing organizations is training on the relevance, objectives and methodology of collecting information. This can positively contribute to the project performance.

2.9 SUPERVISION

-Supervisors:

In the Government PHC Project, the CHWs are supervised by the Medical Technicians at the BHU and RHCs. In some situations, the MOs at these facilities also make occasional supervisory visits.

In other projects, supervision was done either by members of mobile teams or by other personnel. In some projects i.e. the CBS Project of AKF (Annex 16) and the Rural Health Care Project of CMH, Sialkot (Annex 8) a formal relationship had been developed with the community by the project staff and the responsibility of supervising the CHWs was shared.

-Methodology:

In the GOP PHC project there is no defined methodology for supervising the CHWs. Supervision is usually done during unplanned visits, in informal settings, usually through verbal reporting of the CHW and at times, discussions with the community leaders.

In most other projects the visits of the supervisory staff are planned and the CHW is aware of the schedule. This is more true for projects employing paid CHWs. In some cases surprise visits are also made. Supervision is done by checking the records maintained by the CHW, verbal reporting by the CHWs regarding their performance, discussions with community representatives or by a combination of all the above methods.

-Facilities for Supervision:

-Transport:

In the GOP PHC Project, transport facilities for supervision at all levels are either limited or lacking. A few senior male MTs have been provided with motor cycles in order to facilitate their work of supervising other MTs and CHWs. The other MTs, both male and female, do not have any transport facilities for supervision. Some male MTs use their personal bicycles or motor cycles for field work while the FMTs make use of public transport like horse carts or buses if and when available.

In other projects transport is usually available for the supervisory staff. In those projects that offer other services besides health, one vehicle is provided to a team consisting of supervisory staff for the various project components.

-Transport Allowance:

In the GOP PHC project only the MTs in Punjab receive Rs.100/- month as transport allowance. MTs in other provinces do not enjoy this privilege and have to spend money out of their own pockets for making supervisory visits.

In most other projects travel allowance is not given but transport is provided for supervision.

ANALYSIS:

Monitoring and supervision are terms not understood clearly and are often used interchangeably. Even when used both usually stand to mean inspection.

In the GOP PHC Project monitoring and supervision are two of the main areas requiring attention. Supervision and support of CHWs is inadequate. This can be attributed to the following reasons.

-MTs Concept of Supervision:

In the minds of most MTs the only purpose of supervision is to check the performance of subordinates so that they can be taken to task if the performance is not upto standard. The actual need for supervision and the importance of support are not recognized by the MTs. They feel that since the CHWs are not being paid they are not accountable to the MTs and thus the whole purpose of supervision, in their minds, is defeated.

-Lack of Facilities for Supervision:

This was the main contributing factor for poor supervision of CHWs. In places like rural Sind and Baluchistan there are great distances between villages and in many cases, no public transport operates in these areas. Supervision in such cases is almost negligible and is limited to those villages that are easily accessible. Many MTs try and make use of locally available transport like horse carts for their trips but have to pay out of their own pockets for doing so. In one case the MO at the BHU uses patients' transport for sending MTs on their supervisory visits.

-Stress by MOs at manning the BHUs & RHCs:

Many MOs, at BHUs and RHCs are of the opinion that the MTs' main job is at the health facility and that field work should be done after clinic hours. This attitude is a reflection of the little importance given to preventive care, support to and supervision of the CHWs in the minds of the MOs. Since these activities are not considered important by the MOs the MTs themselves attach little importance to them.

-Issue of Security of FMTs:

Most FMTs are strangers to the BHU/RHC where they are posted. This is specially true in the case of Baluchistan where girls from Punjab come to serve as MTs as tradition does not allow Baluchi girls to leave home and work. Many FMTs face problems with security during their posting in strange areas. Around some BHUs, there is no boundry wall for protection. In addition, being strangers in a new place and travelling long distances alone to supervise CHWs is frightening. Unfortunately some of the FMTs who tried to make these long trips have had unpleasant harrassing experiences with the local males. All these factors act as deterrents to frequent supervisory visits away from the BHU.

-Supervision of MTs:

Since the supervision of MTs by the MOs and the DHOs is usually limited, there is almost no check on their activities. The supervision of MTs by their supervisors is largely limited to their curative work and there is almost no accountability for their preventive role. Thus many MTs ignore their preventive role and do not make supervisory visits.

In most other projects supervision is comparatively better. This can be attributed to the fact that since these projects are being implemented at a much smaller scale than the nationwide PHC project they have more funds, facilities and expertise for regular supervision.

In the Urban MCH Complex of the MCWA (Annex 7) the main concept behind housing five centres under one roof was to facilitate supervision of the CHWs as well as other project staff. This approach not only cuts down on time and facilities required for supervision but to some extent also encourages peer support and supervision among the workers.

In some projects it was noted that supervision was not being used to assess the worker's performance or to solve their problems but only to collect reports from the

CHWs to send to the donors in order to satisfy them that the project was performing well. This activity was not in any way resulting in improvement of project performance.

To improve monitoring and supervision at all levels in the projects studied many factors need to be addressed. Training should be provided regarding the purpose and methods of monitoring and supervision and their role towards evaluation of project performance and progress.

C. EVALUATION

1. PURPOSES

-To Assess Achievement of Objectives:

The main purpose of evaluation in all projects studied was to assess the degree to which the projects' broad objectives had been achieved. Of the projects that have ended, the Health Guard's Project of the Northern Areas described in Section I was evaluated at the end of the Project and it was found that the objectives had not been fully achieved. The Village Health Educators Project (Annex 5) and the ARI Project (Annex 13) are in the process of being evaluated. In most on going projects, evaluation has been planned for the end of the project. Exceptions, however, were seen.

The GOP PHC Project (Annex 3) was evaluated in its 3rd year Mixed results were obtained as far as achievement of objectives was concerned.

In the third year CPHC Project of the Salvation Army, (Annex 6) an evaluation was done by Management Sciences for Health. Results of the evaluation were used to modify certain approaches especially those pertaining to training methodologies.

In the BIAD Project (Annex 17) an evaluation was undertaken 3 years after the project started. The performance was found to be severely lagging behind in the achievement of objectives. As a result the objectives, targets and strategies were modified, changes made in the administrative and management structure of BIAD and activities restarted.

-To Determine Cost Effectiveness:

Only in the ARI Project (Annex 13) was the management overtly concerned with evaluating cost effectiveness of the project. In the opinion of the Project Director,

though the results promise to be excellent, they are not likely to be cost effective as a lot of funds, human resources and time have been invested in the project.

In all other projects that have been evaluated or will be evaluated the issue of measuring cost effectiveness has not been taken into account.

-To Predict Sustainability:

In almost all projects self sustainability does not seem to be the aim of the implementing organizations. Therefore the potential for self sufficiency and sustainability seems to be extremely limited.

The HSTWA's PHC program, however, is one that is more or less financially self sufficient and its health centres as well as home schools are financed almost entirely by the HSTWA.

-For Replicability:

Many projects are designed as a one time activity with not much thought being given to replication. In some cases replication was done in the form of expansion of the project to other sites by the implementing organizations, or by replicating certain methods of doing things.

2. FREQUENCY OF EVALUATION:

In the GOP PHC project, a mid term evaluation was done in the project's third year of operation. The final evaluation is planned for the end of the project in 1988. In some projects the frequency of evaluation depends on the time frame specified by the donors as the funding for the next period is tied to the results of the evaluation e.g. the CBD Project, Lahore (Annex 9) and the Family Planning through Health Guards Project (Annex 15) evaluated annually and or 4 months before renewal of commitment of funding by the donor. In most other projects, evaluation is planned for the end of the project.

3. METHODOLOGY:

In most cases, external evaluation is usually done by the donor agency/agencies by checking records, analysing periodic reports, meeting with project staff and making site visits. The information thus obtained is analysed to assess performance. In the ARI Project (Annex 13) the information collected by the field staff is being analysed on computers.

ANALYSIS:

The purpose of evaluation as a tool for the assessment of achievement of strengths and weaknesses of programs for feedback into the system as well as for the guidance of planners and policy makers is missing. The concept of formative and summative evaluation is not understood and hence is not utilised.

The main reason seems to be that usually the objectives are broad and general. That is why even though some sort of evaluation is carried out it does not measure what it is supposed to measure because what is to be measured has not been defined clearly. The use of the findings of evaluation for improvement of future planning was found to be an exception rather than the rule. Evaluation carried out at the end of projects does not provide an opportunity for corrective measures during the life of the project.

Over the years, evaluation has moved from inspection to supervision to the art and science it is now. In the projects visited the team did not come across anyone who was trained in this science. This is why at times evaluation is done by outside experts knowledgeable in the field.

In most cases the desire to show results overshadows the factor of cost effectiveness. The results of a project seem to be excellent but at the cost of large amounts of money, time and human input. This is often true of the so called Pilot or Model Projects. In such cases replication becomes difficult because such abundant resources are not always available in another setting. Replication of certain aspects of projects however, may be possible.

The question of sustainability is one that requires the attention of both the Government and NGO health planners. By and large, the potential for sustainability is limited in most projects. The main reasons for this are:

- Most organisations and communities cannot generate the funds required for sustaining projects on their own.
- The professional and technical expertise required to implement projects is not always available within an organisation or the community and has to be brought from without.
- Many planners and implementers plan and run projects as a one time activity without any built in plans to move towards self sufficiency over a period of time.

SUMMARY OF FINDINGS - 1

VARIABLES	PHC PROJECT	ABES PROJECT	VILLAGE HEALTH EDUCATOR PROJECT	CPHC PROJECT	URBAN MCH COMPLEX
IMPLEMENTING AGENCY	GOP	ABES	Directorate of Health Punjab	The Salvation Army	Maternity & Child Welfare Association
STARTING DATE	1982	1979	1986-87	1982	1987
DONORS	USAID	BFW, Christian Aid, ICCO	UNICEF	USAID matching grant	NGOCC
SITES	Nationwide	5 Districts in Punjab.	2 Districts in Punjab	10 Salvation Army BHUs	Urban slum in Lahore
PROJECT ACTIVITIES	Primary Health Care	Health, Adult Literacy, FP	Health Education	Health	Health Care & FP
COMMUNITY INVOLVEMENT (on a scale of -to +++)	+	++	++	+	+
SELECTION OF CHWs	MT at BHU/RHC, Village Committee	Village Committee	Village Committee	Through applications & interviews by village Headman or by Project Committee.	Through applications
SELECTION CRITERIA FOR CHWs:					
- SPECIFIED AGE	-	-	-	-	-
- SEX	Male and Female	Male and Female	Female	Female	Female
- SPECIFIED EDUCATION	-	Functional Literacy	-	Unclear criterion	8 - 10 years
TRAINING:					
- DURATION	Approx. 6 Months	Unspecified	6 days	Unspecified	1 year
- SITE	In BHU/RHC, Village	Village	BHU near village	BHUs, Village	Centre & Community
- TRAINERS	MTs at BHU/RHC	Mobile teams	District Nutritionists	Mobile teams, Nurses, Doctors	Doctor & LHV's.
INCENTIVES					
- PAID/VOLUNTARY	Voluntary	Voluntary	Rs. 20/day during training	Rs. 150/month for CHWs & Rs. 750/month for health & FP workers	Paid
- KITS	+	+	-	Given initially but later retrieved	+
SUPERVISORS	MTs at BHU & RHCs	Mobile teams & village committees	District Nutritionists & MPHws	Mobile teams	LHV, Medical Director, Nursing supervisors

SUMMARY OF FINDINGS - 2

VARIABLES	RURAL HEALTH CARE PROJECT	COMMUNITY BASED SERVICES PROJECT	BEHBOOD HSSW PROJECT	HSTWA PHC PROJECT	FAMILY WELFARE CENTRE PROJECT
IMPLEMENTING AGENCY	CMH, Sialkot	FPAP	Behbood Association of Pakistan	Home School Teachers Welfare Association	Jokhio Welfare Association.
STARTING DATE	1978	1987	1984	1984	1986
DONORS	USA/Code1, ICCO, BFW	Pathfinder Fund	Population Division, AVSC, CIDA, CRS.	UNICEF, MATEH, Canadian mission, HBL	CDA
SITES	Villages around Sialkot	20 villages around Lahore	Nationwide	Baldia, Golimar, Grax village	15 villages around Karachi
PROJECT ACTIVITIES	Health, Sanitation, Income Generation	FP	Health & FP	Education & PHC	FP & Health
COMMUNITY INVOLVEMENT (on a scale of - to +++)	+++	++	+	+++	+++
SELECTION OF CHWs	Village Committee & CMH staff	COs Community Project Staff	Behbood Staff	Community	Project Staff
SELECTION CRITERIA FOR CHWs:					
- SPECIFIED AGE	-	-	-	-	-
- SEX	Male & Female	Female	Female	Female	Male & Female
- SPECIFIED EDUCATION	-	-	-	8 - 10 years	10 years
TRAINING OF CHWs :					
- DURATION	Unspecified	Unspecified	Unspecified	1 Month	Unspecified
- SITE	Villages	Villages	"	Community	Karachi
- TRAINERS	Mobile teams	Project Director, COs	"	Outsides Experts	NGOCC
INCENTIVES					
- PAID/VOLUNTARY	Voluntary	Rs. 200/month	Rs. 200/Month	Rs. 5/Month from each family attending health centre	Paid
- KITS	+	+	-	+	+
SUPERVISORS	Mobile teams	COs, Community Supervisor	LHV & Mobile teams	Doctor	Field Coordinator

SUMMARY OF FINDINGS - 3

VARIABLES	JWA CBD PROJECT	ARI PROJECT	AFGHAN REFUGEE PROJECT	FP THROUGH HGs PROJECT	CBS PROJECT	BIAD PROJECT
IMPLEMENTING AGENCY	JWA	Ayub Medical College	Save the Children Fund/ UK	FPAP	Govt. of Northern Areas	Govt. of Baluchistan
STARTING DATE	1985	1984-87	1986	1986	1982-87	1982
DONORS	PVHNA	Arab Gulf Fund Through WHO	SCF/UK, UNICEF, UNHCR	Pathfinder Fund	AKF, UNICEF, AKHS	UNICEF, EEC, CIDA Govt. of Netherlands
SITES	2 Villages near Karachi	33 Villages in NWFP	Refugee Camp in Peshawar, Dir, Haripur, Bejaur	Gilgit and Skardu	150 Villages in Gilgit, Baltistan, Diamer	140 Clusters in Baluchistan.
PROJECT ACTIVITIES	FP & Health	PHC	PHC	FP	Health, Nutrition, Sanitation, Water, Income Generation	Health, Water, Sanitation, Adult literacy, Income Generation.
COMMUNITY INVOLVEMENT (on a scale of -to+++)	+++	+++	+++	+	+++	+
SELECTION OF CHWs	Project Staff	Project Staff, Union Council Members	Project Committee, CHS, SCF team	FPAP Staff, Project Consultant	Village Project Committee	Community & Project Staff
SELECTION CRITERIA FOR CHWs:						
- SPECIFIED AGE	-	-	-	-	-	-
- SEX	Females	Male & Few females	Males	Male & Female	Male & female	Male & female
- SPECIFIED EDUCATION	?	10 years	10 years	-	-	-
TRAINING OF CHWs						
- DURATION	2 months	6 months	Unspecified	Unspecified	Unspecified	8 months
- SITE	Karachi	ANC, Community	BHUs	Community	Gilgit	Villages
- TRAINERS	PVHNA	Project Director	CHSs	FPAP	AKF	Mobile teams
INCENTIVES						
- PAID/VOLUNTEER	Paid	Rs. 750/month	Volunteer	Rs. 100/month	Volunteers	Volunteers
- KITS	+	+	+	+	+	+
SUPERVISORS	Field Coordinator	Mobile teams	CHS	Area HG Leader, Field Supervisor, Field Officer	Community	Mobile teams

PHC

SECTION III

RECOMMENDATIONS

This section deals with the general recommendations of the Team regarding the projects studied. Recommendations specific to projects have been discussed along with the programmatic details of the projects in Annexes 3 to 17.

1. Appreciating the dedication and enthusiasm of NGOs but also recognizing the need for improved organisation and technical and financial assistance,

It is recommended that:

A national body be formed to provide guidance, support and technical assistance to the NGOs through the performance of the following functions:

-Identifying NGOs for involvement in health programs.

-Encouraging and assisting NGOs in development of appropriate projects.

-Identifying training needs of NGOs and facilitating training inside and outside Pakistan.

-Reviewing and approving projects submitted by NGOs and proposing the level of funding for each project.

-Acting as a channeling agency for funds from Government and International donor agencies.

-Monitoring Supervising and evaluating activities of approved projects.

-Keeping the policy makers and the planners in the Health Sector informed of the contributions of the NGOs.

2. Whereas there is a shortage of trained manpower in health planning in Pakistan,

It is recommended that:

At least two senior officers each from the Provincial Directorates of Health and the Federal Ministry of Health be sent abroad for formal training in Health planning and that,

Upon their return assisted by planning consultants from major donor agencies in Health like USAID, UNICEF, WHO etc. conduct nationwide workshops to include training on needs assessment, statement of well defined objectives, development of strategies and workplans, project proposal writing, training of manpower, management, monitoring, supervision, MIS and evaluation.

3. Whereas national experts trained in all aspects of health planning are not yet available in the country,

It is recommended that:

Foreign technical assistance in planning of health programs be selectively utilized for areas where national expertise is lacking or limited.

4. Whereas most projects are planned and implemented with minimal community involvement which contributes to limited commitment on the part of the community and low chances of moving gradually towards self sufficiency,

It is recommended that:

Involvement of the community in the project be enhanced by formally involving the members of the local government and other community leaders in planning for the community's health needs.

5. Recognizing the importance of field testing the new approaches planned to provide health care on a large scale,

It is recommended that:

Planned Programs be field tested on a small scale through demonstration/pilot projects before being implemented on a national level, using the same resources which will be available in the implementation of larger programs.

It is further recommended that:

Details of tested models be made known to interested and relevant organizations for possible replication.

6. Whereas vertical programs targeted towards specific interventions may be effective in terms of achievement of objectives and whereas they are expensive and heavy on human resources,

It is recommended that:

Planning of integrated/comprehensive health services be encouraged for maximum utilization of funds, materials and human resources.

7. Recognizing the importance of the impact of the mass media, particularly the radio and TV, and the fact that the radio has penetrated all corners of the country even in the absence of electricity,

It is recommended that:

To strengthen the role of the CHW in health education, the Government use this media for endorsing the messages of healthy living communicated by the CHW.

8. Considering that the term Community Health Worker is often associated with treatment of diseases rather than their prevention and recognizing that there is a need to highlight the preventive role of CHWs as health educators rather than providers of curative services,

It is recommended that:

The name "Community Health Worker" be changed to "Village Health Educator" or "Community Health Educator".

9. Whereas at present the community's role in the selection of CHWs is either non-existent or minimal,

It is recommended that:

The major share responsibility of selecting the CHWs be allocated to a group of community leaders e.g. the members of the Union Councils, who be guided by the project management regarding adherence to eligibility criteria.

10. Whereas the TBA, by and large, is already functioning in a specific health care area in all communities, and whereas the majority of CHWs are men,

It is recommended that:

The TBAs be trained and utilized as a Community Health Worker to extend coverage of the female population.

11. Recognizing that the average CHW is a volunteer and is overwhelmed by the nature and number of tasks to be assigned to him/her,

It is recommended that:

The tasks to be assigned to the CHW be clearly defined and limited after careful analysis of the need and time requirements of the various tasks and the total time commitment of the CHW to the project.

12. Considering the low national literacy rates particularly in rural areas.

It is recommended that:

A certain number of years of schooling not be an absolute requirement for enrolment as CHWs. Instead efforts be directed to utilizing the already developed as well as further developing educational and performance related technologies suitable for semi literate or even illiterate CHWs.

13. While for certain levels of functioning the need for literate CHWs will continue,

It is recommended that:

The printed learning materials be developed using graded vocabulary keeping in mind the local traditions and cultures.

14. Whereas the training of a majority of CHWs does not follow a prescribed curriculum or course,

It is recommended that:

A basic national curriculum on the lines of the TBA training curriculum be developed and the trainers of CHWs be fully cognizant of this training curriculum and the needs of the CHWs and be also familiar with simple educational technologies.

It is further recommended that:

That the training courses be organised according to predetermined timings and venue, and that a post test be conducted for the CHWs after each training course to evaluate the outcome of the teaching-learning activities.

15. While the current practice provides for one time training of the CHWs and while there is no mechanism for regular monitoring and incidental teaching,

It is recommended that:

Regular refresher activities be planned as a part of the project workplan and implemented to upgrade and evaluate the knowledge and practices of the CHWs.

16. Realizing the fact that distances and lack of transport facilities adversely affect both training and supervision of CHWs,

It is recommended that :

Each situation be evaluated realistically and efforts be directed to find ways and means of minimizing this problem.

17. Appreciating the fact that almost all CHWs are providing voluntary services and recognizing that human enthusiasm needs constant nurturing,

It is recommended that:

Monetary and non monetary incentives be included in the project plan to sustain the interest of the CHWs. The monetary incentives be performance related according to clearly defined indicators of assessment of project impact and that non monetary incentives be in the form of certificates upon completion of training and certain other facilities like preferential treatment for government loans for housebuilding, agriculture etc.

It is further recommended that:

Withdrawal of incentives also be performance related and carried out very discretely and that the CHWs be made aware of the incentives and disincentives during the training period.

18. Endorsing the practice of providing medical kits to the CHWs for giving first aid and treatment of minor ailments,

It is recommended that:

The CHW be made responsible for replenishing the supplies of the kits through income generated by the sale of medicines at prescribed prices and that this practice be supervised by the Village Project Committee.

19. Pointing out the need for improvement in the knowledge and understanding by the management and the health

worker, of the tasks and functions to be performed by various categories of health personnel both in the Public and Private Sectors,

It is recommended that:

Clearly defined written job descriptions be provided to each health worker at all levels at the start of his/her involvement in the project activities and that each worker also be briefed about his/her role and functions of the other categories with whom he/she will be working.

20. Not denying the fact that quacks meet some of the health needs of the communities in the absence of professional care and pointing out that the results of quackery are often unfavourable and dangerous,

It is recommended that:

Quackery be discouraged particularly among CHWs and efforts be directed towards providing alternatives to the community so that laws regarding quackery can be enforced.

21. Noting that methods, extent and purpose of obtaining and recording information is not clear to most CHWs,

It is recommended that:

All concerned be aware of the purpose of each record and that simple mechanisms for both literate and illiterate CHWs be evolved to collect and record minimum, pertinent and useful information and that there be a regular and clearly defined flow of information to and from the CHWs by the next level of management.

22. Whereas the formal involvement between the project and the local elected representatives of the people have proved beneficial in some of the projects studied,

It is recommended that:

This practice be encouraged and that the involvement be in the form of participation in project planning and implementation, selection of and guidance and support to the CHWs in the performance of his/her duties.

23. Whereas in most projects evaluation is carried out at the end of the project period and whereas this practice neither provides an opportunity for corrective measures

during the project period nor for the utilization of the findings of the evaluation in improving project performance,

It is recommended that:

Monitoring, supervision and evaluation be included in the project plan to be carried out at regular intervals, that the result be utilized to improve project performance and that the findings and utilization of results be made known to all concerned including the policy makers.

LIST OF ANNEXES

1. Scope of Work
2. Questionnaire
3. PHC Project
4. Adult Basic Education Society Project
5. Village Health Education Project
6. Comprehensive Primary Health Care Project
7. Urban MCH Complex
8. Rural Health Care Project
9. Community Based Services Project
10. Behbood Health Services and Social Welfare Project
11. Home School Teachers LWelfare Associations PHC Project
12. I. Family Welfare Centre
II. Community Based Development Program
13. Acute Respiratory Infection Project
14. Afghan Refugee Project
15. Family Planning through Health Guards Project
16. Community Basic Services Program
17. Baluchistan Integrated Area Development Program
18. Record Keeping Form of illetrate CHWs in the Afghan Refugee Project
19. List of Places visited and Persons met

SCOPE OF WORK

A report is required to assist the USAID and GOP/MOH in an assessment of the performance of Community Health Workers (CHWs) and related programs in all the four provinces of Pakistan. This will consist of a study of anthropological/analytical Pakistani experience with CHWs to date. The study should include an assessment of program planning, management/administration, monitoring, supervision, budgetary/accounting successes and failures of CHWs and related projects. The contractor will identify and utilize the services of a sociologist/anthropologist to provide specialized input to this report.

The specific content of this report are to include:

1. Description of Community Health Workers projects in Pakistan:
 - a) Identification of past and current programs working with CHWs, organizational history, cultural, sociological environment in which they exist and training programs.
 - b) Funding history from GOP and non-GOP sources.
 - c) Administrative/managerial structure (paid and volunteer).
 - d) Function of volunteerism.
2. Assessment of the strength/weakness/special situations or unique circumstances of CHWs/programs with analysis of factors contributing to success/failure of programs.
3. Sustainability of project activities, past and ongoing. Addressing issues such as availability of funds for operation, potential for continuation, successorship of leadership (volunteer and professional).
4. Analysis of replicability of NGO projects/components of NGO projects by GOP/MOH.
5. Recommendations as to actions which are desirable to assist in health plans and ongoing activities with CHWs.

QUESTIONNAIRE

I. ORGANIZATION IMPLEMENTING THE PROJECT

1. Name
2. Category
3. Location
4. Goals & Objectives
 - 4.1 General
 - 4.2 Specific Related to PHC
5. Organisational History
6. Other Activities
7. Staff Structure (paid or volunteer)
8. Collaborating Organisations/Agencies

II. PROJECT

- A. General Information
 1. Name
 2. Location
 3. Need for the Project - How Identified
 4. Duration
 - 4.1 Starting Date
 - 4.2 Ending Date
 5. Goals & Objectives
 - 5.1 General
 - 5.2 Specific, Particularly Those Related to CHWs

6. Population in Project Area

6.1 General Characteristics

-Size

-Literacy

-Religion

-Ethnicity

-Economic status

-Community leadership

6.2 Target Population for Project

-Size

-Age Group

-Sex

7. Workplan Exists . Yes/No

If yes,

7.1 Monthly

7.2 Quarterly

7.3 Annual

8. Any Field Testing Done

8.1 Pilot Project

8.2 Replication of Tested Model

B. Community Involvement

1. In Needs Assessment

How ?

2. At Project Planning Stage

How and by Whom

3. Input During Implementation
 - 3.1 Cash
 - 3.2 Kind
 - 3.3 Human Resources
 - 3.4 Identification & Selection of Staff
 - 3.5 Training of Staff
4. In Monitoring and Supervision
5. In Evaluation
6. In Future Planning
7. In Receiving Regular Feedback from Project Staff

III. RESOURCES

1. Funding
 - 1.1 Funding Agency/Agencies
 - 1.2 Length of Funding
 - 1.3 Conditional or Unconditional
 - 1.4 Type of Funding (community based, in association with local governing body etc.)
2. Human
 - 2.1 Categories

For Each Category

 - Numbers (Approved & Planned)
 - Part Time or Full Time
 - Paid or Volunteers
 - interest
 - Job Satisfaction

-Potential for Long Term Involvement

-Potential for Career Growth

3. Material

3.1 Building

-Adequacy

-Facilities

3.2 Equipment and Supplies

-Appropriate

-Adequate

-Arrangements for

-Maintenance

-Replacement

-Replenishment

3.3 Transport

-How Many

-What Kind

-How Often Used

-For What Purpose

- By Whom

IV. MANAGEMENT STRUCTURE

1. Technical Project Staff

1.1 Defined Job Descriptions Exist Yes/No

1.2 Selection Criteria for Each Category

-Sex

-Age

-Literacy

-Prior Experience

- Training
- Religion/Ethnicity
- 1.3 Training
 - Trainers
 - Duration
 - Training of Trainers
 - Site
 - Curriculum
 - Teaching Methods & Mater
 - Continuing Education
- 1.4 Staff Role & Performance
 - Planned Role
 - Actual Role
 - Perceived
- 1.5 Relationship With Other Practitioners
- 2. Support Staff
 - 2.1 Categories
 - 2.2 Numbers
- 3. Management System
 - 3.1 Centralized
 - 3.2 Decentralized
- 4. Management Information System
 - 4.1 Recording
 - 4.2 Reporting
 - Programmatic
 - Financial

4.3 -Channels

5. Referrals

5.1 Within the Project

5.2 To Other Agencies

6. Supervision & Monitoring

6.1 Personnel

6.2 Methodology

6.3 Facilities

6.4 Frequency

7. Evaluation

7.1 Internal/External

7.2 Frequency

7.3 Utilization of Results

V. OVERALL PICTURE OF PROJECT

VI. ANALYSIS

- Major Strengths & Contributing Factors
- Major Weaknesses & Contributing Factors
- Potential for Self Sustainability
- Potential for Replicability

PRIMARY HEALTH CARE PROJECT

IMPLEMENTING ORGANIZATION

Ministry of Health, Government of Pakistan.

PROJECT SUMMARY

Funded by USAID the PHC project was started in 1982 with the objective of providing comprehensive preventive, promotive and curative services to the rural population of Pakistan. Services are provided through Integrated Rural Health Complexes (IRHC), each consisting of one Rural Health Centre (RHC), 5-10 Basic Health Units (BHUs) and Community Health Workers (CHWs) at the village level.

The RHC is staffed by one male and one female medical officers (MOs), and 4 medical Technicians. Each RHC is managed and supervised by the District Health Officer (DHO). The RHC provides primary health care, serves as a referral centre for its affiliated BHUs, plans and manages preventive/promotive programs including family planning, supervises all workers under it, collects data and serves as a drug and equipment warehouse for the BHUs.

The BHU is the most peripheral facility of the IRHC. It serves 5,000-10,000 people and is staffed with an MO, (MTs) Medical Technicians and support personnel. The BHU provides basic health care, serves as a referral point for the CHWs in the villages, helps in selection and training of CHWs, plans and supervises activities of the CHWs and supplies them with drugs and equipment.

The third tier of IRHC is the Volunteer CHW. The CHW provides a limited range of preventive and curative care and refers sick patients to BHUs.

Various PHC project sites were visited in each province and project personnel at all levels of hierarchy were interviewed. The following is a summary of the findings of the team based on the information provided to them by the interviewees, found in the various available documents and their own observations. Recommendations made by each category of personnel interviewed are included without the comments of the team. The team's recommendations are included at the end.

FINDINGS - Through interviews with DHOs & ADHOs

1. Understanding of primary health care, its philosophy, concept and role of the health personnel.

The underlying philosophy of primary health care as an approach to HFA by the year 2000 by community involvement and through its eight essential elements seems to be clearly understood theoretically by those who were interviewed at various levels. The Primary health care concept, as envisaged, defined and designed by the planners and understood by the team does not seem to be present in most situations. Where successfully implemented, it is dependent on the dedication and efforts of the MOs at the RHCs and BHUs. Where the MO is self motivated (eg RHC Havelian, NWFP, RHC Farooka, Punjab), there, in spite of existing problems, results are being achieved.

Regarding the self image of the MOs, it was found to be similar to what is common in most countries of the world i.e. a large majority of doctors perceive their main role as healers and providers of curative services to the sick. This attitude trickles down to their subordinates particularly medical Technicians (MTs) who also feel the same way and function as 'mini doctors'. No ambiguities were noticeable regarding the role expectations of the CHWs.

2. Administration of RHCs and BHUs.

-Location: It is a proven fact that the location of a health facility plays an important role in its effective utilization. Many of the RHCs and BHUs are strategically situated because location of the land purchased by the government or donated by the community was carefully selected. But many of the earlier buildings were constructed on readily available land which was unused or unwanted by others. eg near a graveyard or a vacant plot lying at a considerable distance from the village. Therefore some of those facilities are not being fully utilized.

-Management: Rules and regulations are understood by the senior employees but by and large administration is carried out following the instructions received from their superiors and/or other influential persons. A constant flow of such instructions is confusing and, at times, a source of irritation and frustration.

-Funds: There is a constant shortage of available funds at various levels with the result that many activities have to be postponed awaiting release of funds.

-Monitoring and Supervision: Inadequate supervision is a fact known to all concerned. Long distances, difficult roads, inadequate public transport, lack of official transport, none or insufficient provision for transport allowance were cited as the reasons for irregular and inadequate contact between the field workers and the supervisors. Inadequate contact is a deterrent for regular feedback from and to the next level of hierarchy.

3. Other findings:

-Government grades for certain categories of personnel differ from province to province. This obviously is a source of frustration and dissatisfaction for the employees concerned.

Unauthorized medical practice is quite common since the laws prohibiting quackery are not enforced. As the DHOs are not in a position to take any legal action against the quacks, they seemed to have settled for a peaceful coexistence

RECOMMENDATIONS BY THE DDH, DHO & ADHOs

-Supervision should be strengthened at all levels by increasing both the supervisory staff and the facilities available for supervision.

-If CHWs are to be paid then the MO concerned should be the hiring and firing authority to ensure objectivity in selection and accountability. The idea of selection of CHWs through Union Councils should be dropped as it will invite political interference.

-The payment made to CHWs should be performance related.

-Duties of CHWs should be clearly defined and recording of births and deaths should be added to their present responsibilities.

-Till such time that regulations are enforced to address the increasing problem of quackery, it might be a good idea to train quacks to become CHWs and during training try and modify some dangerous practices being employed by them.

-The economic conditions of villages must be upgraded if the PHC concept is to be accepted there.

-Outreach work by MTs should be done after clinic hours as clinic hours are for assisting the MO at the RHC/BHU.

-The government should try to strengthen the existing PHC system using the MTs & MPHWS as CHWs rather than invest additional funds, time and energy for training and paying CHWs as is being planned.

FINDINGS - through interviews with MOs

-It was refreshing to observe how much could be achieved under the existing conditions at RHCs and BHUs if the MO is motivated. e.g (1) The perpetual transport problem, especially for FMTs, was solved by one MO by making use of the patient's transport. (2) To raise the credibility of the CHWs, the MO gave preference to the patients referred by CHWs by examining them first, exempting the CHW and his family from paying hospital fees for private consultation and making house calls at the request of the CHW.

-No written job descriptions were available to the MOs at the time of joining. All instructions given were verbal and usually provided by subordinates or colleagues.

-MOs do not have any authority to hire or fire subordinates.

-Supervision is difficult due to lack of transport or transport allowance. Supervision of FMTs in the field and female CHWs is more of a problem in NWFP & Baluchistan because of strict the 'Purdah' system.

-The quality of residential facilities provided to MOs at BHUs & RHCs are not always of a desired standard. This, in addition to the fact that no special incentives are given to MOs for going to far off places, causes dissatisfaction and the MOs try their best to get transferred quickly. These quick transfers also lead to low performance of these health facilities.

-Some BHUs, where the MOs have made the effort to establish contact with Family Welfare Centres, are providing family planning services with contraceptives provided to them by these centres. Other MOs seem to work under the impression that providing family planning services is not a part of their job.

RECOMMENDATIONS BY THE MOs

-The MTs should do their outreach work after clinic hours because the MO needs their services during clinic timings. If this cannot be arranged then arrangements should be made to provide the MO with help by increasing the staff at BHUs & RHCs.

-The MOs should have the authority to hire and fire subordinates.

-The MOs at BHU should have some budget/emergency funds provided to them to be used at the MO's discretion.

-The MOs should be actively involved in field work before asking subordinates to do so.

-Incentives like hardship allowance, regular workshops etc. should be provided to MOs to provide job satisfaction. This would reduce the frequency of transfers.

-The CHW must be paid but instead of Rs.1000/-month, a lesser amount should be given directly and the rest used for replenishing their medical kits.

-The CHW should receive formal training in a formal setting if they are going to be paid.

FINDINGS- Through interviews with MEDICAL TECHNICIANS (MTs):

-Reasons cited for becoming MTs were (a) To get enough knowledge to start/improve their private practice and (b) To enjoy the prestige and income as a result of their knowledge.

-Most MTs are unclear about their role. Different views exist. Some see themselves as being incharge of the BHUs in the absence of the MO providing only curative services, the preventive aspect being limited to supervision of the EPI teams. At one BHU the MO and the MT enjoy a classic symbiotic relationship, again limited to curative functions.

-Majority of them are unconvinced about the importance of preventive care including CHW training. Many feel that only the MTs that are a part of the IRHC should train CHWs.

-Reasons for little preventive work were:

- 1) Unawareness regarding their preventive role.
- 2) Catering to the community's demands for curative care in order to fulfill a need and gain acceptance of their communities.
- 3) Non availability of transport facilities making supervision of CWs difficult and at times, impossible. Only the MTs, in Punjab get a transport allowance of Rs.100/month. In some places public transport is unavailable and outreach work is limited to villages close to the BHUs.

- 4) No regular supervision by or accountability to the MOs. Supervision by the ADHO and the DHO is also infrequent and irregular.
- 5) More stress is laid by the superiors on manning the BHUs than going out to the community. Exceptions were noted in those BHUs where the MO incharge takes a lot of interest in his MTs. There, a number of CHWs have been trained and are functioning. In one case other than simply training CHWs the MTs insisted and obtained from the MO letters of recognition for the work done by the CHWs in their communities. This gesture of appreciation has greatly increased the importance of the CHWs in their own eyes as well as in the eyes of the community they serve.
- 6) Dissatisfaction with present salary scales. There is concern that if the CHWs are going to be paid Rs.1000/month, then their pay is going to be higher than that of the MTs and that will create problems with supervision of CHWs as well as with the morale of the MTs.

-In Baluchistan no hardship allowance is given to FMTs while LHVs, who are of the same grade as the FMTs, get a hardship allowance and other benefits.

-The change of curriculum from predominantly curative to predominantly preventive has led to a lot of concern and dissatisfaction among under training HTs. They feel cheated of a chance to earn money through private practice and feel threatened as they will no longer be incharge of the BHU because of the presence of the MO.

-The HT students do not receive any practical training on how to identify, select and train CHWs and yet they will be expected to perform this function once they complete their training.

-In addition to the above, some FMTs working in remote areas expressed the need for security because many of these young girls face certain harassing situations which they cannot report for fear of tarnishing their and their family's reputation.

RECOMMENDATIONS BY THE MTs

- Improved salary scales.
- Provision of transportation for effective supervision.
- Regular replenishment of supplies of the MT kits.

-A career structure for MTs to provide opportunity for professional advancement.

-Involvement in the planning of any National scheme that proposes to employ them.

-Certain amount of authority for decision making and allocation of some funds at the periphery. eg the MO at the BHU should have the authority to hire and fire his subordinates.

-Developing a manual with clear job descriptions of various categories of health personnel so that all categories are aware of their role obligations.

-Providing opportunity for MTs to enter Medical Schools to get license to do what they are already doing i.e. private medical practice.

-Provision of monetary incentives as well as non monetary incentives like recognition in the form of certificates of merit and/or achievement for CHWs.

-MTs should be officially allowed to do private practice. Dispensers who in the past received only nine months' training are registered with the Pharmacy Council and allowed to practice whereas MTs who receive one and a half years training are not allowed to do so.

FINDINGS - Through interviews with Community Health Workers

-The main reason for becoming CHWs was cited as "a desire to serve the community".

-The selection of CHWs is based more on ease of selection rather than their capabilities/qualifications. Problems are also faced when government employees like school teachers, dispensers etc are trained and then they are later transferred leaving the village with no CHW.

-There is no regular system of organized training, supervision or support.

-The need for overt recognition and compensation for services rendered is great.

-Many CHWs have a private practice in their villages. Services rendered range from prescribing simple antipyretics to prescription and injection of Pencillin.

RECOMMENDATIONS BY THE CHWs

-CHWs should be paid in order for them to be used effectively.

- The authority to hire and fire CHWs and the MTs should be with the MO at the periphery.
- Quackery among CHWs and others should be discouraged and strict national policies enforced to deal with this issue.
- The role of TBAs as CHWs should be investigated in detail.
- The MTs should be given performance related incentives to encourage them to do outreach work.
- The MTs' job descriptions should be clearly defined and they should not be used intermittently to replace MOs at BHUs as this creates confusion in their minds regarding their role.
- The Village Committees should be delegated the responsibility for safe guarding the young FMTs working in their villages.
- If the CHW is going to be paid then the salary scales of the MTs should be revised accordingly.
- Training of MTs and CHWs should be provided in the local language.
- The MTs should be made directly accountable to MOs at BHUs or RHCs.
- Travel facilities for outreach work in areas where public transport is not available should be provided to the MT.
- Detailed area maps should be available to each DHO and MO for them to plan realistically their field work and supervisory visits and make travel arrangements for their work.
- Transport or travel allowance should be provided to MOs and senior supervisory staff to facilitate regular supervision.
- The MOs should be offered incentives like hardship allowance, recognition of rural service as a requirement for post graduate studies, attractive living quarters to encourage them to serve in far flung areas.
- In consultation with the DHO, the MOs should devise means for constant vigilance of subordinate staff.

-The selection of CHWs is based more on ease of selection rather than their capabilities/qualifications. Problems are also faced when government employees like school teachers, dispensers etc are trained and then they are later transferred leaving the village with no CHW.

-There is no regular system of organized training, supervision or support.

-The need for overt recognition and compensation for services rendered is great.

-Many CHWs have a private practice in their villages. Services rendered range from prescribing simple antipyretics to prescription and injection of Pencillin.

RECOMMENDATIONS BY THE CHWs

-CHWs should be paid in order for them to be used effectively.

-They should receive some sort of certificate after completion of training.

-Training should include topics on diagnosis and treatment of all common diseases.

-Two CHWs, who were Government employed school teachers, suggested that the volunteer system will only work if those people are selected who, among other qualifications, are financially independent.

RECOMMENDATIONS BY THE TEAM

-CHWs should be given formal training through a prescribed curriculum at a fixed place according to a schedule. This will help to formalize the whole concept of CHWs.

-Supervision should be strengthened at all levels. In addition a Village Project Committee should be made in each village and utilized to support the CHW.

-The responsibility of selecting, monitoring and supervising the CHWs can be delegated to the Union Council in which they function. A formal relationship should be developed with the local government.

-Performance related incentives should be offered to CHWs. The role of non monetary incentives is worth exploring as this can help curb corruption at that level.

ADULT BASIC EDUCATION PROGRAM

IMPLEMENTING ORGANIZATION:

Adult Basic Education Society - Gujranwala

INSTITUTIONAL FRAMEWORK

This non profit voluntary social welfare organization was formed in 1961. It's main aim is to promote the cause of literacy in Pakistan. Based in Gujranwala, the ABES serves districts of Gujranwala, Gujrat, Sialkot, Sheikhpura, and Jehlum. However, the training courses methodology via television, books and audiovisual aids serves the whole country. The activities of ABES include functional education classes for adults, development and production of books, teaching aids and audiovisual equipment using innovative technology and use of television to provide education. Health, family planning and income generation have also been included in it's services.

PROJECT SUMMARY

In this project health services were introduced in centres where the Adult Literacy Program has been declared successful. Funded by Bread for the World, ICCO (Dutch) and Christian Aid, the project initially started in 1970 when village volunteers were trained to conduct six month long courses to provide functional education. Health was introduced as a follow up activity in 1979. This was the result of a needs assessment survey in which health care topped the list as the most urgent requirement of the community. CHWs were nominated by the already formed Village Committees and the final selection was done by the ABES staff. These CHWs are literate, usually men, sometimes TBAs or those who were teachers in the ABES education program. Teaching-learning material with graded vocabulary was developed by the ABES and is still being used to train CHWs. The CHWs after training are paid an honorarium of Rs.150/-month. Those CHWs who have also received FP training under the PVHNA sponsored family planning component, receive Rs.750/-month.

Now there are 19 health centres, (one per village) with 1 CHW per centre covering sometimes 2-3 nearby villages. The Community Health Workers provide primary health care and maintain records. They are supervised fortnightly by mobile teams and by the village committees. In addition the four Community Health Workers/Family Planning Workers are supervised by a family planning supervisor once a week.

OBSERVATIONS

-The Project Director, Mr. Vincent David, is a highly motivated and qualified person. He is respected by his staff and is well known in the community because of his work on television. His popularity has contributed to the creditability of the project.

-Since health services were introduced as an answer to an expressed need of the community, they were accepted easily and were supported by the Community.

-The vocabulary used in the teaching-learning materials is graded according to the educational capabilities of the reader hence it is easier to comprehend and retain.

-The community has been actively involved in the project from the beginning. The Village Committee, consisting of village leaders, is responsible for selecting the CHW, for providing space and electricity for the health centre, for supervising the CHW and keeping track of his/her activities.

-The literacy classes utilizing female teachers to train female students were more successful than others. The same is true for performance of female CHWs. Now the ABES is trying to involve more women in its programs.

-In areas where a local person could not be found to fill the eligibility criteria for a CHW, the idea of establishing health centres was abandoned rather than bringing in an outsider.

-The mobile team consists of an LHV, a male health educator, a literacy supervisor and an agriculture specialist. This way services are offered as a package rather than offering just one component.

-All the CHWs interviewed were interested in receiving more training in diagnosis and treatment of disease. Also they all agreed to work for the GOP CHW program provided the salary is good.

RECOMMENDATIONS BY PROJECT STAFF:

-In all such programs providing PHC, more women should be involved to reach a larger population.

-The community should be involved at all stages if a project is to become self sustaining.

-A new 'bottom up' approach should be adopted for effective utilization of CHWs in Pakistan.

-The Teaching-learning material for the National CHW training program will be more effective if the vocabulary is graded according to the comprehending capacity of the trainees.

Note: The team agrees with all of the above recommendations.

VILLAGE HEALTH EDUCATOR PROJECT**IMPLEMENTING ORGANIZATION**

This project was conducted by the Provincial Department of Health, Punjab, in collaboration with UNICEF.

PROJECT SUMMARY

The project was developed with the concept that between the monthly visits of the Multi Purpose Health Worker (MPHW) team a trained person should be available in the village who can provide health and nutrition education and first aid, identify problems and make referrals to the nearest health facility and act as a link between the community and the MPHWH team. The funding of this program came from UNICEF and the teaching materials and methodology to provide health education was from the Allama Iqbal Open University (AIOU). The following strategy was used:

One Union Council in each of the districts of Rawalpindi, Jehlum and Attock were selected. Activities were started in a total of 15 villages, in 3 phases over a period of 2 years. With the help of the Union Council members women's groups were made in the selected village and one leader, to be called the village Health Educator (VHE), was chosen from this group. The leader was someone who was intelligent and showed leadership qualities. The VHEs were trained for 6 days at the nearest BHU/RHC to act as group facilitators. The training was provided by the District Nutritionists, who had been trained at the AIOU to become supervisors, and by the MPHWHs who were going to act as the Assistant Supervisors. These VHEs were volunteers but were paid Rs.20/day during training. In some villages where the Literacy and Mass Education Commission (LAMEC) was setting up centres for adult literacy, their teachers were chosen to become VHEs. These VHEs received Rs.250/month according to LAMEC rules. The VHEs returned to the village and according to the Basic Functional Program (BFEP) methodology conducted 3 courses on child care, sanitation and poultry.

This methodology consists of recorded lessons using audiovisual aids to impart training. The VHEs were supervised by the district MPHWH team during its monthly visits and by the district nutritionists who were mobile and made regular supervisory visits.

In some villages, all the 3 courses had not been completed when the project ended in December 1987.

The observations below are those made while interviewing the concerned persons and on reading the relevant literature regarding the project.

OBSERVATIONS

-The teaching methodology was excellent since the need for an educated VHE was minimized as she only acted as a facilitator and not a teacher. Also this way, good teaching abilities were not required and there was no filtration and dilution of knowledge because it passed direct from the primary source to the recipient. The methodology treated the recipient as being intelligent and invited participation. In addition, it was cost effective as the only cost was that of the teaching material.

-Supervision was regular since the supervisors were independent and mobile.

-Problems were faced in convincing the VHEs to go to the BHU/RHC for training since the cultural traditions prevailing did not allow them to go unescorted to another place.

-The teaching material was taken back from the VHE after the project. It might have been a good idea to leave the material in the village so that it could be used for other groups or for refreshing the knowledge of the same group.

RECOMMENDATIONS BY THE PROJECT STAFF

-The LHVs or MTs at the government BHUs/RHCs should have been involved in the project and utilized as supervisors.

-The VHEs should have been paid. LAMEC teachers using the same methodology were paid but the VHEs were not.

RECOMMENDATIONS BY THE TEAM

-The methodology is good and can decrease the need for employing educated CHWs in the GOP program. The course content could be modified according to the needs of the program.

-Health education should be imparted to groups rather than individuals as the chances of retention and dissemination are better.

COMPREHENSIVE PRIMARY HEALTH CARE PROJECT (CPHC)**NAME OF ORGANIZATION:**

The Salvation Army

INSTITUTIONAL FRAMEWORK

Formed in 1885, the Salvation Army (SA) is a worldwide, professionally staffed voluntary organization currently working in 86 countries and speaking 121 languages. Operating within a Christian setting, it has a complete network of worldwide field and social activities activated by the principle of "Love for God and service to mankind". It's mission is to 'love the unloved' and towards this end in Pakistan it is involved in many activities eg shcools, boarding hostels for boys and girls, orphanages, vocational training programs, social relief and tracing of missing persons, adult literacy, disaster relief, refugee services and religious programs for village uplift. In addition the Salvation Army has 10 BHUs in Pakistan which are staffed to provide curative and preventive services. Each BHU follows the board policy outlines of the organization but is otherwise independent.

PROJECT SUMMARY

The CPHC project started in 1982 with a matching grant from USAID and the Salvation Army World Service Office (SAWSO). Initially it was a pilot project in 5 BHUs for 5 years. Later it was extended to include all 10 BHUs as the project continues. The project strategy used is as follows:

Those villages from the BHU catchment area are selected which are close to the BHU and where there are no other health facilities available. Some Village Health Workers (VHWs) are nominated by the Village Committee formed by the Salvation Army while the final selection is made by the SA staff. Other VHWs are selected after screening of applications and interviewing the candidates. The criteria for selection are that the VHW be a married and respected female with some basic education. After selection women are given 2 days' intensive orientation and then further inservice training is provided through regularly held seminars and on site training by trainers. The curriculum for training was developed by the Salvation Army. In addition; those VHWs who are dais also receive dai and family planning training. Previously kits were provided to the VHWs, but now only a few basic medicines are provided to them. A total of 35 VHWs are currently employed by the SA.

The full time workers are salaried at Rs.700/-month but this pay scale will be revised soon. The part time VHWs who are illiterate and only assist the field team once a week are paid Rs.250/-month. The workers do growth charting and provide health and nutrition education and maintain the literate ones also antenatal, births and deaths registers. Those workers with family planning training also maintain family planning registers. They all work out of rooms provided to them by the Community. Patients needing treatment are referred either to the mobile team or to the SA BHU. Monitoring and supervision is through weekly visits of the mobile teams, surprise visits and at monthly staff meeting. The mobile team consists of 2 Community Health Supervisors, a physician, a medical assistant, a dispenser, a handicap technician and a driver.

OBSERVATIONS

-The project is being carried out by a group of workers who are dedicated to the cause.

-Each SA BHU is independent so differences in functioning were observed eg some BHUs awarded certificates to the VHWs after training while others did not.

-Since the SA has been doing outreach work in these villages for quite some time the acceptability for the CPHC project was high to begin with.

-Villages were selected primarily based on proximity to the BHU rather than need.

-There seems to be some confusion regarding the selection and role definition of the VHWs. eg some VHWs were selected by the village headman, or the Village Committee while others were selected through applications and interviews. The criteria for selection, are also seen to be different. eg some VHWs are illiterate, some have some prior health related training or experience while others have had none. The training, however, was more or less similar for all. The training itself was not very well defined, being provided at various places at different times using various methodologies.

-Kits were given to VHWs to begin with but were later very wisely retrieved. This was because VHWs began overstepping their bounds of training and started 'practising' on their own. Also because the medicines that were provided by the VHW at low cost or free of cost were thought by the patients to be no good and so were wasted.

-Initially the field staff faced a lot of difficulty in identifying educated women from the village who were willing to work. So outsiders had to be trained who lived not too far from the village. Problems were faced with acceptance of these outsiders but with time have been resolved.

-There was no involvement of the community or the government in planning and implementation of the project. Some villages had to be dropped because of non cooperation. Had the community been involved these problems may not have been faced.

COMMENTS

An indepth evaluation of the CPHC Project was carried out in 1985 by Management Sciences for Health which outlined areas requiring attention. Hence the SA staff is all aware of the strengths and weaknesses of this project. Though by no means so extensive, the team agrees with the recommendations made which relate to coordination and collaboration with the government during planning and implementation, selection of villages, more strict criteria for selection of VHWs, development and improvement of training methodologies etc.

THE URBAN MCH COMPLEX**IMPLEMENTING ORGANIZATION**

The Maternity and Child Welfare Association

INSTITUTIONAL PROFILE

The MCWA is a nationwide voluntary social welfare organization formed in 1981. With branches in all 4 provinces, its aim is to develop and demonstrate good quality health and related services and to stimulate people to participate in health programs for mothers and children on a self-help basis to supplement government efforts. Activities include preventive and curative health services offered through static centres and outreach programs, income generation, training programs for medical and paramedical personnel, research and publications etc.

PROJECT SUMMARY

This project was started in May 1987 in an urban slum of Lahore. Funded by USAID through NGOCC this project employs a unique approach to answer the health needs of the community. The Urban MCH complex houses 5 centres. Each centre is responsible for a population of 5,000 and is staffed by an LHV, 1 trained TBA and 1 under training Dai. The complex works under the supervision of a Medical Director and a Nursing Director. Working towards decreasing mortality and morbidity in mothers and children, the project provides health and related services to the community through the complex and through outreach work. The strategy used is as follows:

The LHVs and trained TBAs are selected by advertising in the newspaper and by word of mouth. In addition, women are selected from the community to become TBAs. These are young girls with basic education but no prior experience with delivering babies. These girls live in the community and during and after training provide antenatal, natal and post natal care to pregnant women, arrange for immunization of children, provide health and nutrition education, motivate for family planning and provide first aid in their communities. Training is conducted by the Doctor and LHVs and after completion of training they become salaried employees of the MCWA. Training includes classroom sessions and practical field work. Two undertraining Dais are on duty daily after clinic hours and work under the supervision of one trained TBA.

In the field the work of these community workers is supervised by the outreach team i.e. the LHV and the TBA of the concerned centre. The outreach teams do home visiting and follow up patients for immunization, ante and post natal care, and contraception. Patients with potential complications are referred to the hospital. The complex staff besides providing ante and post natal services, immunization and family planning counselling and services, also conduct health and nutrition classes.

OBSERVATIONS

-The MCH Complex is efficiently run by a group of workers who are dedicated and proud of their work.

-The idea of integrated MCH complex is unique. This is because being under one roof not only saves on resources but also time required for supervision. Here workers are directly under the eyes of the supervisors. Also there is a lot to be said for the role self evaluation plays in the success of the project. The workers are always comparing their performance with that of others and striving for better results. The drawback in such a set up is that the distance to be travelled is not equal from all parts of the area served. So unless such a facility is centrally placed it could lead to under utilization of services.

-The record keeping system is excellent. It is simple and yet provides complete information about families, patients, dropouts follow ups etc.

-24 hour coverage for pregnant women is provided by the complex staff. This not only helps undertraining TBAs to get practical experience after hours but also allows the community to have access to these services.

RECOMMENDATIONS BY THE STAFF

-This project can only be replicated in a thickly populated urban area.

-A comprehensive and integrated approach should be tried by the government to provide PHC to Pakistan.

-Those persons who, in any capacity, are providing health care to the community should be trained and registered so that not only can they do what they have always been doing properly but by being registered they will be obligated to follow certain rules and will be accountable for their actions.

-A CHW has to be paid in order to function effectively. Also a good support system is required.

-NGOs cannot replace the Government to provide health care nationwide. They are only there to show ways of addressing the problems.

RECOMMENDATIONS BY THE TEAM

-The MIS developed here could work with some modifications if used at the periphery in the National program.

-The integrated approach can work well in congested urban areas and may not be applicable to the rural population.

RURAL HEALTH CARE PROJECT**IMPLEMENTING ORGANIZATION**

Christian Memorial Hospital, Sialkot

INSTITUTIONAL FRAMEWORK

The Christian Memorial Hospital is a non profit private hospital located in Sialkot. It was started in 1888. Working under the motto "flow into the stream of systems and bring transformation" it works to provide health care and related services to 123 villages around Sialkot. The main aim of this organization is to improve the health status of the community by preventing and treating disease. It's activities in addition to providing health care through the hospital and outreach teams, include training, building drains, pit latrines and income generation.

PROJECT SUMMARY

The project was started in December 1978 and is still continuing. It's MCH components are funded by USA/CODEL and ICCO while the sanitation activities are funded by EZE & BFW. The project started with immunization in 1978 and is now offering MCH services, family planning, drain and latrine construction and income generation. The following strategy is used:

The Project Director and the project staff form a Village Project Committee (VPC) in each village consisting of formal and informal leaders. The leaders select male and female voluntary CHWs, who are respected members of the community. Some CHWs are chosen from among the VPC members. Others are TBAs, dispensers working in these villages, pastors etc. The community health workers are trained by mobile teams to provide health and nutrition education, act as case finders for immunization and family planning, provide hygiene and sanitation education and first aid and to refer patients to the hospital. The TBAs in addition to the above receive TBA training at the end of which they are given a TBA training kit. The dispensers are also provided informal training by the project director in order to try and regularize some of the harmful practices being carried out by them. In addition to this regular training all CHWs are given frequent refresher courses according to the health hazards most prevalent at that time in the area.

The CHWs are supported by the VPCs and work under their guidance. Formal supervision is by the mobile teams consisting of two staff nurses, one student nurse, one auxiliary worker and a driver. There are two mobile teams covering 113 villages. Each team visits two villages in which 15-20 houses are visited in each village to provide preventive and curative services.

The mobile teams are supervised by 2 supervisors. In addition to supervision these supervisors have the responsibility of establishing relationships with village leaders, coordinating activities in villages and supervising the work of the sanitation teams. These supervisors are in constant contact with the project director and work under his supervision and guidance.

OBSERVATIONS

-The Project Director, Dr. Gill, is a highly motivated man. He personally supervises each aspect of the project and the project staff is directly accountable to him. That accounts a lot for the success of the project. His motivation trickles down to the grassroot levels.

-The community is involved at each level. Each village has a VPC. The Chairman and Secretary of each VPC is represented in the Union Health Committee at the level of each Union Council. The Chairman and Secretary of each Union Health Committee are represented at the Markaz level in the Inter Health Committee. All decisions related to the project take place at the Inter Committee level. This committee meets regularly with the Project Director once a month and decisions are made. The Project Director imparts training to the Inter Health Committee which then passes the information down through the Union Council Health Committee to the VPC which disperses it to the village. So the government as well as the community are informed. Also other community members like Moulvis, Priests, school teachers, TBAs etc are utilized to provide health education to people.

-Contrary to what has been seen in other projects, Health was the main activity and from it the need arose for sanitation.

-The record keeping system for growth monitoring used by the nutrition teams is simple and effective providing a clear picture of the progress of a child.

RECOMMENDATIONS BY THE STAFF

-The community is ready to take over the project in some areas and thus self sustainability will be achieved.

-NGOs can be utilized to provide FHC to the rural areas only if they receive proper guidance and continuous support.

RECOMMENDATIONS BY THE TEAM

-The involvement with the local government should be critically studied as it can provide clues to using the same kind of set up for the Seventh Five year plan of utilizing CHWs.

COMMUNITY BASED SERVICES LAHORE**IMPLEMENTING ORGANIZATION**

The Family Planning Association of Pakistan.

INSTITUTIONAL FRAMEWORK

Established in 1953, the Family Planning Association of Pakistan (FPAP) is a voluntary social welfare organization. An affiliate of IPPF, it aims to promote Family Planning and responsible parenthood for the betterment of the country. Working out of a head office in Lahore, it manages its activities out of 5 Zonal offices, 8 field offices and 158 work units spread all over the country. More than 3000 workers, from the grassroot level to professionals from various disciplines are enrolled as volunteers. The FPAP provides family planning services through static clinics and mobile teams. IPPF and Pathfinder are the major donors while other national and international organizations also contribute funds.

PROJECT SUMMARY

This project aims to provide door step contraceptive services to the 20,000 fertile couples in 20 villages in the periphery of Lahore. The villages were selected because the rate of population growth is high in these villages due to a large influx of immigrants settling here because of industrial development in the surrounding areas. The idea was to introduce Family Planning in these villages before slums develop and the population problem increases further. Also, the villages are far enough from the city to be classified 'rural' and yet close enough for regular monitoring and supervision of project activities from the FPAP Head Quarters in Lahore.

The project is funded by the Pathfinder Fund, an American organization. The project started in January, 1987 and will end in Dec 1989. The following strategy was used:

A Management Committee of 25 community leaders was formed by the Project Director and the CBS supervisor. The committee nominated young, educated girls for becoming Community Organisers (COs), and older well respected and intelligent women, many of them TBAs, for becoming field workers (CHWs). The COs were trained by FPAP and now work under the supervision of the CBS supervisor. There are 20

centres, one in each village and these are run by one or two COs depending on the population of the village. These COs are paid Rs.800/month.

The CBS supervisor supervises the work of all the COs and each CO is responsible for the work of 5 field workers. These field workers trained by the FPAP are responsible for 200 homes and are paid Rs.200/month. Their job is to motivate couples to practice family planning. Those couples who agree to do so are referred to the FPAP mobile team, made up of a doctor and an LHV, which visits every fortnight. Between the visits of the mobile team, patients are referred to the nearby government BHU or to the Family Welfare Centres. The field workers report to the COs daily. The COs, other than supervising field workers, also do home visiting and motivation and maintain records of their own activities as well as those of the field workers. The COs are supervised weekly by the CBS supervisor. Monthly staff meetings are also held with the project Director.

OBSERVATIONS

-The project is a successful one as targets have already been reached. The change in attitude of the community towards Family Planning has changed and acceptance is gradually increasing.

-A great deal of dedication and enthusiasm is evident in the workers, especially the COs.

-The project is unique for two reasons. Firstly because it entered the community with Family Planning and after the acceptance of that concept is now considering planning community development activities and secondly, because it as hired young, mostly unmarried girls to provide for Family Planning motivation and to supervise the field workers.

-There was confusion among the field workers regarding their role in dispensing contraceptive pills. Some were sure that they could dispense pills on their own to first time users while the others were convinced that the patient had to be examined by a doctor or an LHV before pills could be given. The COs interviewed were also confused about the role of the field workers regarding this practice.

RECOMMENDATIONS BY THE PROJECT STAFF

-For a project to be successful it must be modified continuously to accommodate the rapidly changing needs of the community.

-In the Project Director's view replication of this project, as is, in other areas, or on a National scale it is not possible. It took years for FPAP to establish rapport with the community before a project was started here and without this rapport the project would not have been so successful. He feels the problem with most programs is that they are under pressure to show quick results and not much time is spent on developing a relationship with the community.

-A successful project in which a great deal of dedication is apparent at all levels, especially among the community organisers.

RECOMMENDATIONS BY THE TEAM

A situation like this in which young educated girls are being utilized effectively to provide Family Planning services makes one ponder on the rationale behind many projects in which the selection criteria for female Family Planning Workers is that they be middle aged and married. If a sensitive topic like contraception can be discussed by these girls and their services accepted by the community, one wonders why they cannot be successful for other activities too.

BEHBOOD HEALTH SERVICES AND POPULATION WELFARE PROJECT**IMPLEMENTATION ORGANIZATION**

The Behbood Association of Pakistan

INSTITUTIONAL FRAMEWORK

The Association was founded in 1967. It is a multi functional resource development organization for women and has branches in several cities of Pakistan. The main aim of the organization is to develop a spirit of self-reliance and self respect among the under privileged by helping them to earn a living. The activities of the organization include activities in the areas of Health, Family Planning, skill development and income generation. The funding of these activities comes from the government and many national & International donors like AVSC, CRS, CIDA, SIDA, USAID, UNICEF and many others.

PROJECT SUMMARY

The Project was started in 1984 with the aim of decreasing morbidity and mortality in the urban slums and rural areas of the country. The major funding for the project was provided by the Population Welfare Division. In addition AVSC, CIDA and CRS have made significant contributions.

The Project provides health, MCH and family planning services through 39 static and mobile centres in and around Rawalpindi, Lahore, Karachi, Quetta, Peshawar, DG Khan, Jhang, Multan & Gujranwala. Activities of each group of 4-5 static centres (exact number depends on the population served) are coordinated through the Headquarters based in the nearest big city. Each centre is staffed by an LHV and a female motivator (CHW) who lives in the community. The motivator is selected from the community by Behbood staff after sending around word that a person is needed for the centre. The only selection criterion is that she be well known in the community. The motivator is paid Rs.200/- month and her role is to identify fertile couples in her area, inform them of the services available at the centre, and accompany the LHV on her outreach work and keeping the centre clean. She is provided no training regarding motivation or Family Planning. The LHV in addition to supervising the motivator, conducts surveys, does outreach work and runs the centre. Weekly visits are paid to the centres by a doctor and an LHV supervisor to treat the sick, provide Family Planning services and supervise the centre staff.

OBSERVATIONS

-This project is an impressive one providing services to a large population.

-The 'Motivator', though called a motivator, is actually performing the work of a 'Peon'. She cleans the centre and accompanies the LHV on her rounds. She is unclear about her job description and has received no training in motivation or family planning.

-Selection criteria for motivators do not seem to be very clearly defined. Most are illiterate while the two who are literate are the only ones who have been provided training in motivation.

RECOMMENDATIONS BY THE PROJECT STAFF

-The project supervision needs to be improved.

-The Project Chairperson feels that their project centres are working better than the Population Welfare centres of the Government though they both have the same staff structure. She feels that weak supervision, inappropriate targets and transport problems are the main reason for the comparatively low performance of the government centres.

RECOMMENDATIONS BY THE TEAM

-The motivators should be given basic training in Family Planning motivation and contraception and her role should be expanded to one that is more oriented towards outreach and less centre based.

-The supervision structure should be strengthened.

HOME SCHOOL TEACHERS' PRIMARY HEALTH CARE PROGRAM

IMPLEMENTING ORGANIZATION

The Home School Teachers' Welfare Association

INSTITUTIONAL FRAME WORK

The formation of the Home School Teachers' Welfare Association (HSTWA) was a result of the activities of the Baldia Soakpit Project (Baldia is a Kachi Abadi in Karachi). During the interaction with the community for the Baldia Soakpit Project, the community expressed a need for improving its educational standard. The idea evolved that those young educated girls who, for some reason, could not continue their education beyond class eight or nine should be utilized to educate young children who could not afford to go to regular schools. In 1981, 2 batches of 25 girls, trained by the Soakpit Project staff, began operating home schools. The children were taught the syllabus of class I & II and they paid Rs.5/month for attending school. Those who could not afford to pay were taught free of charge.

The Home School Teachers became organized and formed an NGO called the HSTWA in 1983. The goal of this association is to involve educated women to promote education and national development. The activities of the HSTWA are planned and managed by an Executive Committee. Besides home schools HSTWA's other activities include health centres, an industrial home, income generation programs and a magazine. Funding for the various activities is provided by UNICEF directly to HSTWA and indirectly through BASTI an (NGO arising out of a need to institutionalize the Baldia Soakpit Project), MATEH a Canadian Women's organization, the Canadian Mission, The Businessman's Relief Fund and Habib Bank Ltd.

PROJECT SUMMARY

The project was started in 1984 when the need to improve the health status of the community became apparent. 13 Home School Teachers (HST) were trained to provide PHC through their home schools. The initial training lasted one month and was provided by experts in the various components of the course i.e. ORS, Immunization, growth monitoring, ante and post natal care, breast feeding and health education. Today 24 health centres are being run out of 70 home schools in Baldia. The trained HSTs (who fit the operational definition of a CHW) operate weekly clinics out

of their homes. The women pay Rs.5/month for any number of visits made to the health centres and any number of family members seen.

During weekly clinics the teachers do growth monitoring, carry out immunization, provide first aid and health and nutrition education. A doctor, hired by the HSTWA to supervise the work of the teachers, provides services to the sick and carries out ante and post natal checkups. Though no formal outreach program has been developed, the teachers make home visits for follow up and case finding. The teachers report weekly to the doctor who reports quarterly to UNICEF.

A static medical centre under the management of the HSTWA will start functioning in the near future. This will provide curative care to the sick and needy of Baldia. The funds for this centre have been donated by The Businessman's Relief Fund and technical support will be provided by BASTI.

OBSERVATIONS

- An excellent example of what community involvement can achieve. The HSTWA started as the community's answer to a need. This later became a formal NGO and is now slowly expanding its role.
- Since all the members of the HSTWA are from that community and serving that community, the sense of commitment is strong.
- One striking result of the activities of the HSTWO has been the tremendous change in the behaviour and attitudes of the community. Initially the girls involved with the NGO were ridiculed and problems were created for them. Now, the same girls are respected and considered important members of the community. Even their parents feel proud of them since they are no longer a financial liability. The girls too are proud of their work and this is reflected in the confidence with which they work and talk about their association.
- As far as the health centres are concerned, the attendance of women for immunization, growth monitoring, antenatal checkups etc has gone up. This has slowly taken place over a period of time and reflects a positive shift in attitude from entirely curative oriented to one in which the importance of prevention is realized.
- The projects of the HSTWA are slowly becoming self sufficient. eg the schools and the health centres are running with almost no external monetary funding. Technical support is still provided, as needed, by Basti.

-There is confusion regarding the relationship between HSTWA and BASTI.

-The activities of the HSTWA are being replicated in Golimar and Grax village, another Kacchi abadis of Karachi.

RECOMMENDATIONS AND OBSERVATIONS BY THE STAFF

-The HSTWA should be allowed to take independent decisions and these decisions should not necessarily be tied to the funding provided.

-The teachers would not like to work as CHWs for the GOP project as this would lead to complications because of the beaurocracy involved. Also as a small NGO, the members are relatively independent and have the power to make changes as and when needed. In a government program they would be very restricted since such a relationship would not be possible.

RECOMMENDATIONS BY THE TEAM

-The concept of involving educated girls to provide PHC through their homes is culturally and economically feasible. Though it may not be applicable to all areas of Pakistan since educated girls are not always available and willing to participate in such programs but where such women can be found they can function effectively.

-The members of the HSTWA should be provided training in program planning, implementation and management in order for them to improve their functioning in the future.

I. FAMILY WELFARE CENTRE

II. COMMUNITY BASED DEVELOPMENT PROGRAM

IMPLEMENTING ORGANIZATION

Jokhio Social Welfare Association

Since both the above projects are being implemented by the above organization out of the same static health centre, they are described together for the sake of convenience. Recommendations of the team regarding each project follow the project summary and observations. As there is overlapping of the coordinating staff their collective recommendations are provided at the end.

INSTITUTIONAL FRAMEWORK

The Jokhio Social Welfare Association (JWA) is a voluntary social welfare organization formed in 1982. Formed by the young men of Mazar Khan Jokhio and surrounding villages. This Association aims at upgrading the quality of life in the community on a self help basis. Funding for its activities have been from both government and non government sources eg the Rangoonwala Trust, Steel Mills, PVHNA etc. Its activities include a Health centre, adult literacy, sanitation, income generation and water supply.

I. SUMMARY OF FAMILY WELFARE CENTRE PROJECT

Funded by the ODA through NGOCC, the Project started in 1988. It aims at providing health and Family Planning services to about fifteen villages in the Darsano Channo, Union Council, 25 km east of Karachi. The strategy used is as follows:

1 male and 1 female 'motivators' (CHWs) were selected by JWA and trained by NGOCC to provide family planning information, education and health and sanitation education to the selected villages. The motivators in turn impart informal training to 'assistant motivators, who are usually satisfied clients, to help them with their outreach work. The motivators provide health and nutrition education and do Family Planning motivation. The clients interested in practising contraception are referred to the LHV and to the mobile team at the health centre in Mazar Khan Jokhio village. The motivators are supervised by an LHV who is

stationed at the Centre. The LHV accompanies the female motivator during her outreach work.

The LHV is supervised by a mobile team and a coordinator from the JWA. The mobile team consists of a doctor and an LHV who provide treatment for general problems, provide Family Planning guidance and counselling, inserts IUDs and deal with user side effects at the Centre and during field visits. Monitoring of the project activities is also done by the NGOCC Project Officer.

OBSERVATIONS

-The members of the JWA seem very proud of their achievements.

-There appears to be some confusion regarding roles of the motivators & the LHV.

-Though Family Planning is the main focus the health component seems to be neglected.

-Supervision is not regular and this is evident by the LHVs and motivator's behaviour and practice. e.g in the presence of the Doctor the LHV removed sterilized syringes from the sterilizer using dirty forceps that were lying flat on the table.

RECOMMENDATIONS

-Supervision needs to be strengthened before the quality of work is improved.

-The Coordinator should also receive training in Family Planning, health and nutrition to monitor and supervise effectively.

II. SUMMARY OF COMMUNITY BASED DEVELOPMENT PROGRAM

Funded by FPIA through Pakistan Voluntary Health and Nutrition Association (PVHNA), the Project was started in 1985 to provide health and nutrition education and Family Planning services to 2 villages in the Darsano Channo Union Council through community based workers. JWA is one of 13 NGOs currently implementing this project. The following strategy is used.

Two local literate girls were selected by JWA and trained by PVHNA for 2 months to become CHWs. In addition, one male health educator was also trained to motivate men to practice Family Planning. After training, the CHWs become

paid employees of JWA. Each CHW forms a Village Committee of four to five local women and with their help contacts other women of the village. The CHWs have monthly meetings with groups of women in the village and teach them about health, nutrition and Family Planning. They also do home visiting and maintain records of these activities. The CHWs work under the supervision of a Coordinator from JWA. The field and regional supervisors from PVHNA also visit regularly to assess project performance. The Program Officer from NGOCC also conducts regular supervisory and monitoring visits.

OBSERVATIONS

-There is confusion regarding the role of a CHW in her mind as well as in the minds of other project staff. e.g one CHW, who lives in Karachi and commutes daily, was hired to be an adult literacy teacher. She has now been trained as a CHW. Her work as a teacher, however, continues and her CHW role is limited to 4 hours of outreach work every week.

-The selection criteria for CHW is also not well defined. One CHW is literate and an outsider while the other is a local but illiterate. The outsider also had language problems as she did not know Sindhi and it took quite some time for her to learn the language and become accepted in the community.

-The literate CHW spends 4 hours/week in the field other than 2 hours a day for teaching, about 5 days a week filling registers with information regarding the work she has done in the 4 hours plus that regarding the work done by the illiterate CHW.

-Since the project is very target oriented, some CHWs, as stated by them, in order to save their jobs would buy the contraceptive supplies themselves to meet the required target of the number of contraceptives distributed monthly.

-The transport provided for the use of clients was not always available when needed.

RECOMMENDATIONS AND OBSERVATIONS OF THE STAFF

-The one thing that the project staff at all levels seemed to be concerned with was transportation. Everyone wants transport for their own use.

RECOMMENDATIONS BY THE TEAM

-Supervision needs to be strengthened a lot if desired performance and results are to be achieved.

-The selection criteria should be well defined and uniformly applicable to all CHWs.

-The project staff receive training in project development and implementation.

ACUTE RESPIRATORY INFECTION PROJECT (ARI)

IMPLEMENTING ORGANIZATION

Ayub Medical College, Abbottabad

INSTITUTIONAL FRAMEWORK

The Pakistan Medical Research Centre was established in the Ayub Medical College in 1982. It is, as the name suggests, dedicated to research on various health related issues in Pakistan. It's various research activities are funded by government and non government agencies.

PROJECT SUMMARY

The ARI Project started in 1984 and ended in 1987. It was funded by the Arab Gulf Fund through the World Health Organization. The specific aim of the project was to decrease mortality from acute respiratory infections in children 0-5 years of age. The Strategy used was as follows:

A control population of 8 villages similar to project villages was selected and survey done to assess incidence, morbidity and mortality from ARI in these villages. No interventions were done.

The project intervention area consisted of 33 villages. For each village Primary Health Care Workers (PHCWs) were selected by advertising the job and conducting interviews. The Criteria for selection was that the applicant be matric and respected in the village. The final selection was made with the help of the Union Council members. Though applications were also invited from women, very few applied. So except 4 PHCWs who were females all others were males. These PHCWs were trained for a total of 6 months. This included classroom sessions as well as field work. Training was given at Ayub Medical College, was conducted in Urdu and covered basic anatomy and physiology of the respiratory tract, etiology, signs and symptoms and complications of ARI, preventive and supportive measures for ARI and simple treatment of ARI.

During and after training the PHCWs were paid Rs.750/month. After training they were provided with kits containing basic medicines for the treatment of ARI, a watch and a stethoscope. They conducted baseline surveys in their villages, educated mothers about ARI using visual aids and

made home visits to identify cases of ARI. Mild ARI was treated with supportive measures as suggested by the PHCW, moderate cases were referred to the nearest BHU while the severe ones were also referred to the BHU but a single dose of antibiotic was given to the patient before referral. The doctors at the BHUs treated these patients according to a specified protocol and with medicines supplied by the Project for this purpose. The doctor maintained records of the number of patients referred by the PHCW and the medicines used for treatment of ARI so that it could be used to check the accuracy of the PHCW's records.

The PHCW maintained records of the numbers and types of cases seen and the action taken, if any. A mobile team which consisted of a nurse, an LHV and a local Dai made regular visits to the villages to provide general health coverage and to supervise the PHCWs. The mobile team met with the Project Director daily to discuss project performance.

OBSERVATIONS

-This was a successful project with good quantifiable and non quantifiable results. The morbidity and mortality due to ARI in the intervention villages were significantly lower than in the control villages. Also, there was a definite change in the attitude of mothers from a tendency towards cure to prevention.

-A tremendous amount of money was spent to address only one problem of small a population.

-There was a working relationship with the government through the Union Councils and the BHUs. Existing facilities were utilized and an effort was made to integrate the project activities with those of the government facilities.

-The PHCWs were very carefully selected. Only those who qualified after careful screening were recruited. Though the importance of involving women in the project was realized, it was difficult to find educated women because of the cultural and traditional values in the area. Even among those who were selected, the attrition rate was very high.

-The PHCWs were supervised individually and at no time did they all meet together in one place to discuss problems encountered and develop solutions.

-The PHCWs, other than being paid Rs.750/month, also received other performance related incentives e.g they were paid Rs.50/- for each latrine they helped build in their villages.

OBSERVATIONS AND RECOMMENDATIONS OF THE PROJECT STAFF

-The project achieved excellent result but at a great cost in terms of finances, time and resources.

-The protocol for treatment of ARI developed for the project can be easily replicated nationwide.

-The various vertical programs in the health department e.g EPI should be integrated and presented to the community as a package.

-The name 'Community Health Worker' should be changed to a community worker and the word 'health' should be dropped. This is because the perception of the role of a CHW changes to one that is primarily concerned with curative work.

-It may be more feasible to train and supervise the staff at the BHU to provide Primary Health Care than to identify train and supervise thousands of community Health Workers.

The team agrees with the first three recommendations of the Project Staff.

THE AFGHAN REFUGEE PRIMARY HEALTH CARE PROJECT

IMPLEMENTING ORGANIZATION

Save the Children Fund/UK

INSTITUTIONAL FRAMEWORK

Save the Children Fund/UK is Britain's largest charity. Formed in 1919, it is an independent professional staffed voluntary organization. SCF is primarily concerned with disaster relief and long term welfare of children in hunger, sickness and need irrespective of the country, nationality, race or religion.

PROJECT SUMMARY

The PHC project was started in 1986 in the Badaber refugee village near Peshawar with funds from UNICEF. Now it covers refugee camps in Dir, Haripur, Peshawar District and Bejaur Agency. The aim of the project is to provide the refugees with a provider of primary health care in their camps and to decrease the load on the government health facilities. The following strategy was used:

A Project Committee was formed in each camp and informed about the project. On the nomination of the committee interviews were held to select educated men for the posts of Community Health Supervisors (CHS). One CHS was selected for a population of 7,500 refugees. The CHSs, were trained for 3 months in Badaber in the following topics: sanitation, hygiene, health education, MCH, nutrition and first aid. During training the CHSs were paid Rs.500/- per month. Upon completion they returned to camp and started receiving Rs.1000/month from UNHCR.

The CHSs, with the help of the project committee, selected one CHW for every thirty families. The selection was based on the amount of respect enjoyed by the candidate in his extended family (which usually consisted of 30 families) and his interest and willingness to work as a volunteer CHWs. Literacy was not a must. Each CHS was responsible for recruiting and training 30 CHWs in Primary health care. After training, the CHWs were provided with a medical kit and basic medicines, dressing scissors etc.

The CHW works under the supervision of the CHS. He provides health, nutrition and sanitation education and also provides first aid when required. Any patient requiring

medical attention is referred to the CHS at the BHU. The CHW maintains records of the number and types of cases seen and treated and the number referred.

OBSERVATIONS

-The project is working well. The people performing services are highly motivated and consider this service a form of 'Jihad'.

-The level of education of the CHS is high ranging from matriculates to those with Masters in Science. This ensures good comprehension as well as good training and managing abilities.

-The methodology for training CHWs has been adapted to teach illiterates. Using simple yet explicit visual aids it is effective and easy to comprehend.

-Since the CHW is a member of the larger family he serves, he is comparatively easily accepted as are the services offered by him. In spite of this considerable difficulties have to be faced in order to bring about some sort of behaviour change because of certain cultural and traditional values among the Afghans.

-The population is geographically well defined and is concentrated in one place not too far from the BHU. Hence supervision and monitoring are regular and not very difficult.

-The Management Information System in use is excellent. Designed for illiterate CHWs, it ensures accuracy and reliability of the information collected. A copy of the form used to maintain records is attached as Annex 18.

-There is regular feedback to the CHW regarding their performance. The reports submitted by the CHWs are checked regularly by the CHS and discussions are held with CHWs to assess their performance. In addition, patients referred by the CHW to the CHS are referred back to the CHW so that he can check and see if his referral was correct and also to carry out regular followup.

-The workload of the CHS is fairly heavy. Other than his responsibilities related to CHWs, he has to accompany the dispenser, the LHV, the vaccinators and the malaria supervisors on each of their visits to the camps in order to facilitate their movement inside the camps. This, at times, interferes with their other duties.

FAMILY PLANNING THROUGH HEALTH GUARDS PROJECT**IMPLEMENTING ORGANIZATION**

The Family Planning Association of Pakistan.

INSTITUTIONAL FRAMEWORK

(See CBS Project, Lahore for Institutional Framework).

PROJECT DESCRIPTION

Funded by the Pathfinder Fund, the project aims to provide community based family planning services through government trained Health Guards. Between 1973 and 1976, the Planning Division of the GOP, keeping in view the health needs of the Northern Areas, trained 2600 male and 900 female CHWs and called them 'Health Guards' (HGs). They were trained along the concepts of the Chinese Barefoot Doctors and were provided with medicines for the treatment of common ailments. The project, for various reasons was suspended in 1980 and since then the HGs were not being utilized. Then in 1986, the FPAP selected and trained 140 HGs to provide Family Planning information, education and services (condoms & pills) to their communities. The HGs are paid an honorarium of Rs.100/month for out of pocket expenses. Refresher course are regularly conducted both for family planning and to refresh and update the training originally provided to them under the GOP project. So along with Family Planning motivation and services, the HGs provide health education and deal with minor ailments. The initial kits provided by the GOP will soon be replenished as a one time activity.

Contraceptives are bought by the HGs at a subsidized rate from the FPAP and sold to the clients. 25% of the profit is kept by the HGs while the rest goes to FPAP. The complicated cases or those requiring injectables or IUDs are referred to the mobile team for their next visit. The mobile team consists of a doctor/LHV from the clinic as well as a helper and a driver. Patients are also referred to the static clinic in Gilgit city which caters to the health as well as the family planning needs of the clients. Sterilization procedures are conducted by a mobile team which comes from Lahore once a year.

The HGs work under the supervision of the Area Health Guard leader (AHGL) and the Field Supervisor (FS). Weekly

records are maintained by the HGs. Four AHGLs collect reports from their HGs and give it to the 2 area supervisors, one for Gilgit and one for Skardu. He in turn reports to the field officer who reports to the Project Director in Islamabad. Supervision, is regular and is done through checking of records, field visits and monthly meetings.

The project has also involved a few private practitioners in Gilgit. They provide Family Planning information, education and services with Contraceptives provided to them by the project which they sell at suggested prices.

OBSERVATIONS

-This is a successful project as 300% of the yearly targets of the projects have been achieved in the six months. The causes for these include:

-The HGs are well known in their respective areas and have been known to be connected with health activities in the past. So their word about family planning being beneficial for health carries a lot of weight.

-Supervision is regular and the support is good.

-A part of the reason for success can be attributed to the fact that the majority of clients are shias and Ismailies. In both these sects of Islam, the religious leaders have declared family planning to be according to the teachings of Islam. So religion is not a barrier with them.

-Since a great majority of the HGs are men, they can only approach husbands to allow their wives to practice contraception (contraception among men is negligible in these areas). The absence or presence of contraindications is also ascertained through the husbands. Thus the danger, though small, of giving the pill to a woman with absolute contraindications without a proper check up remains. A few isolated cases have been reported to the FPAP model clinic in Gilgit where women came with complication resulting from improper prescription of the pill to them by the HGs.

-Problems with shortage of staff remain. The clinic in Skardu has not started functioning as an LHV cannot be found to work there. Because of the traditional values prevailing it is difficult to find an LHV who belongs to the area and no one from outside is willing to come and work here. Arrangements are now being made to train some local girls in Peshawar to become LHVs. In the meantime an LHV and a vehicle will be sent from Islamabad every month for a week to provide these services.

-In spite of the fact that the Project Director is stationed thousands of miles away in Islamabad, the project is working well. The secret is the high motivation of the staff and the conscientious way in which they are carrying out their duties.

-Problems are faced during winter when for about 3 months the outreach work is at a standstill because of avalanches and bad road conditions.

-Almost all HGs have some sort of an established private medical practice in their villages where they are considered qualified doctors. This fact is well known and yet nothing is being done to discourage it.

RECOMMENDATIONS AND OBSERVATIONS BY THE PROJECT STAFF

-The FPAP should make a separate Zonal office in Gilgit with a Zonal Director stationed in Gilgit. This would make it easier to manage and supervise FPAP's work here.

-Appropriate transport should be provided for outreach work. At present FPAP has provided the project with a station wagon which can only operate on roads and not on jeepable tracks. So a lot of difficulty is faced by the mobile team during its outreach work.

-Lack of transportation is also a problem for the AHGLs. They have to make weekly visits to each village and face many problems.

-The Health Guards suggested the following:

-They should be given further training in curative care and provided with an office space and a stethoscope to impress their patients.

-The honorarium paid to them should be increased. They cannot be expected to do outreach work if they are not paid

a "substantial" amount of money - (No amount was suggested).

RECOMMENDATIONS BY THE TEAM

-The system of supervision should be strengthened further to control quackery and prescription of the Pill for the first time without consultation with a trained person. Those HGs with a formal medical related background should be given further training e.g in checking Blood Pressure, so that the chances of inappropriate prescription of pills are minimized.

-Efforts should be made to involve more women in the project in order to reach a maximum number of clients.

COMMUNITY BASIC SERVICES PROGRAM

IMPLEMENTING ORGANIZATION

The Project was implemented by the government of Northern areas with funding and technical assistance from the Aga Khan Foundation (AKF) and UNICEF.

PROJECT SUMMARY

The CBS program started in 1982 and ended in 1987. It covered 150 villages of Gilgit, Baltistan and Diamer. Water supply was used as an entry point and then other services like PHC, sanitation, income generation, primary education etc were introduced later. For providing Primary Health Care two categories of workers were trained (1) community Health and Nutrition Worker (CHNWs) and (2) TBAs. The following strategy was used:

A Project Committee was formed in each village with subcommittees for each component of CBS. The CHNWs, most of them literate males, were selected by the Village Project Committee (VPC). A large number CHNWs were dispensers, teachers or village volunteers. 196 CHNWs were trained by the project against a requirement of 150. They received Rs.100/- per day during training but after training were volunteers. The VPC decided what compensation, if any they would receive. Some CHNWs, not all, received medical kits upon completion of training. They provided primary health care, nutrition education and first aid in their communities and acted as referral agents for those needing special attention. Referrals were made to the nearest government health facility or to the Aga Khan Health Services Minor Medical Units.

TBAs were selected with the help of the VPC and the criteria for selection were that they be married, middle aged and have some experience with delivering babies.

150 TBAs were trained in 3 phases over 5 years. Training was conducted in Gilgit according to the curriculum developed by the Population Welfare Division with slight modifications. Training was conducted in Urdu though interpreters had to be used frequently. TBAs were paid Rs.250/- and provided with safe accommodation during training. After training the TBAs received a TBA kit. They provided safe antenatal, natal and post natal care to the mother, provided health and nutrition education, advise about importance of ORS and immunization and recorded

births, deaths and referrals. She acted as a referral agent for those cases outside her area of competence. Many TBAs were absorbed by the government and Aga Khan health facilities upon completion of training.

Both the TBAs and the CHNWs were supervised by the LHV at the nearest AKHS MMU, the village project committee and the sub committee.

OBSERVATIONS

- A good project that was planned and implemented by dedicated people. A lot was achieved both in terms of quantitative and qualitative results.
- The TBA training component was very successful. Post training evaluation showed the TBAs to be satisfactorily practising all they had learnt. Initially problems had been faced while selecting TBAs since in the Northern areas the concept of a village dai does not exist as older women conduct deliveries in their own families. Also, since the training was going to be outside their villages, many were reluctant to leave them. The first problem was overcome by the Village Project Committee selecting any woman who was respected in the community to receive training while other criteria of being middle aged and having experience with deliveries were ignored. The second problem was solved by allowing a 'guardian' to come with one woman during training and paying him expenses for his travel and accommodation.
- All TBAs, who have not been employed in a Government or AKHS facility, are dissatisfied with their volunteer status. They do not receive any compensation for their services from the community.
- Some TBAs have learnt how to give injections from the LHV at the MMU and now have a regular medical practice.
- TBAs expressed a desire to receive further medical training. So that they could prescribe drugs and treat patients.
- The whole concept of a CHNW, though very much active on paper, seems to be unclear. They seem to be functioning in isolation without a defined support structure. Even the project management seemed more clear about the role of TBAs than that of the CHNW. No evaluation of the training was done, as was the case with TBAs, to assess their performance. There was a high attrition rate since many CHNWs who were government employees like dispensers, teachers etc. were transferred in the middle of the project.

-There were a lot of problems with monitoring and evaluation. There was no transport available for a long time so the monitoring and evaluation teams had to rely on indirect reports to assess project performance.

-The relationship of the project with the local government is very interesting. The President of the Village Project Committee was the Union Council member. The President of the District Council was made the project director for his district and was responsible for working of each VPC in his district.

RECOMMENDATIONS AND OBSERVATIONS BY THE PROJECT STAFF

-Supervision and monitoring is the key to success of any project. Results of the project would have been better had facilities for supervision and monitoring been regularly available.

-The CHNWs were not adequately compensated for their services. Patients did not want to buy medicines from the CHNW, even at a subsidized cost, when they could get them free at a government dispensary not too far away.

-The TBAs are the best resource to utilize for providing primary health care since her services are already recognized in the community.

RECOMMENDATIONS BY THE TEAM

-The role of TBA as a CHW and the possibility of integrating the two roles at a national scale should be explored.

-The relationship of the project with the local government is also worth exploring. This kind of a relationship is necessary to ensure proper working of a project.

BALUCHISTAN INTEGRATED AREA DEVELOPMENT PROGRAM (BIAD)

IMPLEMENTING ORGANIZATION

Government of Baluchistan

PROJECT SUMMARY

This program was started by the Government of Baluchistan in 1982 with the UNICEF as the major donor. Other donors were EEC, CIDA and the Government of Netherlands. The aim of the project was to raise the standard of living of the rural population of Baluchistan. For this project, water was used as an entry point. The idea was that once a felt need of a community was addressed then acceptance for the other services offered, namely PHC, sanitation, adult literacy and income generation, would be easier. The project was to be completed in four phase over a five year period with each phase covering four districts i.e. 1 district per division. A total of 140 clusters were to be covered by this project (1 cluster = about 5 villages and about 40 villages = 1 district). A pilot project with all components was started in 1982 and it was to be followed by yearly implementation of one phase. As it turned out, due to planning and management difficulties, only one phase had been implemented till 1985. So at that point, the objectives, targets and strategies were modified, changes made in the administrative and management structure of BIAD & activities restarted. The following description pertains to the current project activities.

A cluster committee is made in each cluster, with an average population of 4,000-5,000. Those villages are selected that are approachable by road and electrified in order to facilitate transport and use of heavy equipment for installing water supply. In addition, preference is given to clusters in which the villages are closed together and the community is willing to cooperate. Each cluster committee nominates one CHW per village. Usually these

workers are women who are intelligent, motivated and respected in their communities. At times TBAs are selected since they have easy access to most homes in the village. Once selected the CHWs are trained for about 6 months to provide primary health care. They are supervised by a female medical technician or an LHV of the mobile team. The mobile team consists of an LHV/female MT, a male MT, a lady teacher, a sanitarian and a driver. The various members of the team attend to their related components during their field visits.

After training the CHW performs the same role as the CHW in the GOP PHC project. Many TBAs receive TBA training in addition to the CHW training. The CHWs are supplied with CHW kits which are replenished by the project during and for six months after training. After this period the CHWs replenish the kits by selling the medicines at rates specified by the project. This practice is strictly supervised by the cluster committee.

OBSERVATIONS

-Considering the difficulties faced at the beginning of the project, considerable success has been achieved since the whole project was reassessed in 1985. All the modified targets have been met in 1988 in spite of the problems being faced constantly, eg mobile teams become grounded for weeks at times because of non clearance of POL funds for the vehicles from the government.

-This project is a perfect example of short sightedness on the part of the planners. If a pilot project had been completed as it should be i.e before the start of project activities, then the problems would have been defined and addressed in time. As it turned out, the pilot project and Phase I of the project were started simultaneously thus defeating the purpose of a pilot project.

-The CHWs that were interviewed were working well in their situations. They seem sure of their knowledge and are highly motivated. The need for a strong support system, however, is acutely felt. The visits of the mobile team are not very regular and the chain of referral with other government health facilities is not very clear. Also the credibility of the CHW goes down in the eyes of the community if there is no regular link with the service providers.

-Most CHWs are dissatisfied with their volunteer status and insist on being paid. They are willing to work in the GOP project if the pay is good.

RECOMMENDATIONS AND OBSERVATIONS BY THE STAFF

-The Project Director of BIAD feels that paying CHWs would defeat the spirit of volunteerism. Instead of using payment as a means to ensure proper performance, a strong support system should be developed. This would not only ensure quality of performance but will also be cost effective.

-The role of CHW in BIAD and in the PHC program is similar as far as training is concerned but beyond that only the CHW in BIAD is working effectively. The main reason for this is the strong supervision in the BIAD program.

-Disincentives may have to be used in some cases to maintain quality of work. eg in BIAD, kits were taken back from some CHWs when it was seen that their performance was not upto standard. In another instance the BIAD provided water supply was temporarily suspended when the cluster committee, after having initially agreed to immunization, backed out at the time of the immunization team's visit. The cluster committee then agreed to immunization in their village and the water supply was resumed.

-Supervision has to be strong if the tendency towards quackery is to be curbed among CHWs.

RECOMMENDATIONS BY THE TEAM

-Baluchistan is a difficult province to plan project for since the villages are culturally and geographically isolated. Innovative approaches will have to be developed if primary health care is to be provided to the whole province. e.g as the level of literacy among women is low special training methodologies will have to be designed to train these woman to become CHWs.

-Considering the poverty and the hardship conditions prevailing in Baluchistan's villages, payment is a must for CHWs if, they are to function effectively.

PLACES VISITED AND PEOPLE INTERVIEWED

PRIMARY HEALTH CARE PROJECT

PUNJAB

1. Mrs. Mehmooda Tariq Training Specialist
- District Hospital, Gujrat
 Dr. Zahid Zaheer PTO, MT training school
 Mr. Chaudhry MT Tutor
 Ms. Bushra MT Tutor
- Village Pang Dhera
 Ms. Rukhsana CHW
 Mr. Inayat CHW
- BHU Hajiwala
 Mr. Anwar MT, Incharge BHU Sehna
 Dr. Ashraf MO, Insharge
 MT
 2 HT students
- RHC Chak 48 SB
 3 MOs
 2 HT Students
- RHC Farooka
 Dr. Inayat ullah MO Incharge
 Dr. Iqbal MO
 Mr. Ubaidullah 2 MTs, 3 FMTs,
 Mr. Ghulam Malik CHW
 CHW
- District Hospital, Sargodha
 Dr. Bajwa PTO, MT Training School
 Mr. Shabbir MT Tutor
 Ms. Rajab Khatoon MT Tutor
- II. Mrs. Mehmooda Nasreen Training Specialist
- RHC Narangmandi
 Dr. Janjua MO, Incharge
 Mrs. Bushra Iqbal FMT
 Mrs. Zohra Saleem FMT
 Dr. Najam MO, BHU Jandiala
 Mr. Shareef Nawaz Chairman, Jandiala Union
 Council

Village Ashraf Ka Dhera
Mrs. Mango CHW
Mrs. Inayat Bibi CHW

Village Akbar Pura
Mr. Nazeer Maseeh CHW

Village Adhlian
Ms. Najma Ehsan FMT
Mr. Mustana CHW

SIND

Mrs. Shahnaz Iman Training Specialist
Dr. Memon Project Director, PHC
Dr. Ghulam Mohd. Memon DHO, Mirpurkhas

RHC Pithoro
Dr. Abdul Qadir Rajput MO, Incharge
Mr. Subhan MT Supervisor
Ms. Naz FMT
Ms. Yasim FMT
Mr. LAllah Jorio CHW

Village Noor Basti
Mr. Chaudhry CHW

MT Training School, Mirpurkhas
Dr. Arain PTO
Mr. Dogar MT Tutor

BHU Shadi Palli
Dr. Imtiaz MO, Incharge
Ms. Shahida FMT

NWFP

Mrs. Naseem Akhtar Wahab

Mansehra
Dr. Nadir Khan DDH
Dr. Lodhi DHO, Mansehra
Dr. Rafique ADHO, Mansehra
Dr. Gul Mohd. MO, THQ Bagnotar

RHC Havelian
Dr. Juma Khan MO, Incharge
Mr. Muhtaj Mohd. MT Supervisor
Ms. Akhtar FMT
Ms. Tanweer CHW
Mr. Masood Akhtar CHW
Dr. Aftab Jamal FSMO, Abbotabad

Chamba Village
Ms. Irshad Bibi
Mr. Nawaz

CHW
CHW

RHC Chawki
Dr. Shoaib
Mr. Riaz
Mr. Mamoon
Mr. Ansar

MO Incharge
MT
MT
EPI Technician

BHU Bagnetar
Dr. Sajjawal
Mr. Sajjad

MO Incharge
MT

BALUCHISTAN

Ms. Tasneem Paracha
Dr. Aslam Gichchi

Training Specialist
DHO, Pishin Dist.

BHU Karbela
Dr. Akhtar
Ms. Naseem Iqbal
Mr. Mohd Arshad
Mr. Agha LRazzak
Mr. Niamat

MO Incharge
FMT
MT
CHW
CHW

MT Training School, Quetta
Ms. Shaefta Durrani
Ms. Naseem Mir Afzal
Ms. Zahida
Ms. Shahida

MT Tutor
MT tutor
HT Student
HT Student

PLACES VISITED AND PEOPLE INTERVIEWED IN PUNJAB

1. ADULT BASIC EDUCATION PROJECT

Mr. Vincent David	Director, ABES,
Mr. Maqbool	Gujranwala
Mr. Bhatti	Supervisor
	FP Supervisor

Village Fatah Luma	
Ms. Fayaz Fatima	Asst. FP Supervisor
Ms. Kaneez Fatima	CHW
Mr. Nazar Mohd.	CHW

Village Keeranwala	
Ms. Anwar Begum	CHW
Ms. Akhtar	TBA

2. VILLAGE HEALTH EDUCATOR PROJECT

Dr. Nasreen Ilahi	Project Coordinator,
	UNICEF
Ms. Nadira Saeed	Ex-Dist. Nutritionist

3. CPHC PROJECT, SALVATION ARMY

Capt. Burrows	Social Secretary, SA
Mrs. King	Administrator
Ms. Elizabeth	GOBI Field Supervisor
Ms. Magdalene	Physically Handicapped
	Technician
Ms. Gloria	Field Supervisor
Capt. Irene	Nurse for the physically
	handicapped

4. INTEGRATED URBAN MCH PROJECT

Dr. Naheed Awan	Executive Director, MCWA
Dr. Asghari Awan	President, MCWA
Dr. A.H. Awan	Vice President, MCWA

Urban MCH Complex	
Dr. Mehmooda Mubasshir	Project Director
Dr. Surraya Munir	Medical Director
Ms. Imrana Shaukat	Nursing Director
Ms. Ghazala Butt	TBA
	3 LHVs

PLACES VISITED AND PEOPLE INTERVIEWED IN SIND

1. HOHE SCHOOL TEACHERS PRIMARY HEALTH CARE PROGRAM

Dr. Qurat-ul-Ain	Acting Director, BASTI
HSTWA Health Centre	
Ms. Samina Qasim	CHW & Home School Teacher
Ms. Qasim	CHW & Home School Teacher
Dr. Nighat	Technical Advisor, PHC

2. JOKHIO WELFARE ASSOCIATION PROJECTS

Mazar Khan Jokhio Village	
Mr. Mohd Khan Jokhio	President JWA, Coordinator
Mr. Rashid Jokhio	Co-Coordinator
Mrs. Dilshad	LHV, Family Welfare Centre
Mrs. Karima	Motivator
Dr. Yasmeen	Incharge MO, Outlet support Team
Mrs. Mubarika	Health Educator, Outlet Support Team
Mr. Amanullah	Male Motivator
Ms. Shahida	CHW, CBD Project
Ms. Shareefan	CHW, CBD Project

PLACES VISITED AND PEOPLE INTERVIEWED IN NWFP

1. ARI PROJECT, ABBOTTABAD

Dr. Jehangir

Principal, PMRC, Ayub
Medical College,
Abbottabad

BHU Bagnota

Dr. Sajjawal

Mr. Sajjad

MO, Incharge
MT

2. AFGHAN REFUGEE PROJECT, HARIPUR

Mr. Andrew Ruck

Save The Children Fund/UK

BHU No.5, Refugee Camp, Haripur

Mr. Niaz Mohd.

CHS

Camp No.3, Refugee Camp, Haripur

CHW

PLACES VISITED AND PEOPLE INTERVIEWED IN NORTHERN AREAS

1. FAMILY PLANNING THROUGH HEALTH GUARDS

FPAP Zonal Office, Islamabad Mr. Ashraf Chatha	Project Director
FPAP Model Clinic, Gilgit Dr. Ijaz Tahseen Dr. Hafeeza Ms. Saleema Gill Mr. Nayyat karim Mr. Bashir Ahmed Mr. Abdul Jalil Mr. Bulbul Mr. Shannawaz	Project Consultant MO, Model Clinic LHV, Model Clinic Field Officer Field Officer Health Guard Health Guard

2. COMMUNITY BASIC SERVICES

AKF Office, Gilgit Mr. Ali Dad Khan Ms. Parveen Zafar	Coordinator, AKF Coordinator, Women's Development Programs
AKF, Karachi Mr. Hakim Ferrasta	Chief Executive
AKU, Karachi Ms. Kausar S.K.	Senior Lecturer
FPAP, Islamabad Dr. Atiqa	Evaluator, CBS TBA Training Program
AKHS, Karachi Sister Nota	Ex-Trainer of TBAs, CBS

PLACES VISITED AND PEOPLE INTERVIEWED IN BALUCHISTAN

1. BIAD PROJECT

Quetta

Dr. Aslam But
Ms. Shahida

Project Director
FMT

Village Daringer

Ms. Begum

CHW

Killi Mohd Shai, Cluster
Mustung Road

Ms. Jan Bai

TBA and CHW

OTHER PEOPLE INTERVIEWED

Mr. Raymond Martin	Chief HPN, USAID, Islamabad
Dr. Heather Goldman	Project Officer, PHC Project USAID, Islamabad
Mrs. Enid Spielman	NGO Coordinator, USAID, Islamabad,
Dr. Rushna Ravji	Public Health Physician, USAID, Islamabad
Dr. Akram Bhatti	Public Health Physician, USAID, Islamabad
Dr. M. Zafar Ahmed	Deputy Director General Health, BHS, Islamabad
Dr. Tara Opretti	Training Advisor, BHS, Islamabad
Mr. Abdul Sattar Chaudhr,	Health Education Advisor, BHS, Islamabad
Dr. David Nicholas	PRICOR Consultant to USAID
Mr. Julian Lambert	Program Officer, UNICEF, Islamabad
Dr. Ilyas	Ex Principal, Sind Medical College, Karachi
Mrs. Intiaz Kamal	Country Representative Pathfinder Fund
Mrs. Zeba Zubair	Chairperson, NGOCC
Mrs. Amna Gani	Director of Programs, NGOCC
Mr. Barkat Rizvi	Chief Executive, NGOCC
Mr. Sajid Jafri	Program Officer, NGOCC
Dr. Noor Mohd. Abbasi	Advisor, AKHS
Dr. Reenie D'Souza	Preceptor, CHS Department, AKU
Dr. Jack Bryant	Chairman CHS Department, AKU.

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