

Series on Democracy and Health

Democracy and Health: Implications for MOH Policies

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Introduction

Democracy has been defined as “government by the people” or “a form of government in which the supreme power is vested in the people and exercised directly by them or by their elected agents under a free electoral system.” Another version of the definition describes democracy as “a state of society characterized by formal equality of rights and privileges;” and yet another definition describes democracy as “political and social equity.” (Random House)

Two concepts appear to be at the core of any of these definitions: community participation and accountability to the electorate. Furthermore, there are the social implications of decision-making at the community level, a decentralized power base, freedom of choice, social justice, and a lack of centralized controls. Given these core concepts and social implications of the state of existence termed democracy, what would be the implications for the health sector of applying these principles to its service delivery systems?

The first section of this paper reviews the current characteristics of the health sector common in much of the developing world. The second section proposes seven principles (most of which have already been identified as sequels to the Alma Ata Declaration) as key to the evolution of policies necessary for the democratization of health services: District Health Systems, Integrated Service Delivery Systems, Community Participation, Human Rights and Reproductive Rights, Cost Effectiveness, Equity of Access, and Sustainability. The third section reviews the factors that inhibit as well as those that facilitate the adoption of policies based on these seven principles and hence influence democratization of the health sector.

The Health Sector

From its inception, the health sector has been readily accepted as a system and resource for healing at a time of ill-health; the practice of using the health sector for the purposes of preventing ill-health has yet to be maximally operationalized. As a result, national health systems worldwide (traditional and modern) are biased toward curative care; public health remains for the majority of practitioners an unattractive option; and politicians are slow to divert resources from curative to preventive health programs. (Cichon and Gillion, 1993)

Arising out of the resource constrained 1970's, the 1978 Alma Ata Declaration of Primary Health Care was based on analysis of health care expenditures, client utilization patterns and morbidity data: 80% of all illness in developing countries was shown to be preventable at a fraction of the cost of curative care. The Primary Health Care Strategy was designed to rectify the situation. It identified the interventions necessary to prevent the majority of ill-health through inter-sectoral action, community participation and appropriate technology that was affordable, culturally appropriate and equitably accessible.

The Alma Ata Declaration, in effect, was the charter that laid down the blueprint for the democratization of the health sector: for communities to participate, it became clear they needed to be informed and educated, thereby endorsing the universal human right to information and to education. For technology to be appropriate, individuals needed to be consulted to determine locally available expertise, materials and financial resources. The goal, "the attainment of all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life", underscored the principles of human dignity and equality, the right to health, an adequate standard of living, the right to work, and the special needs of mothers and children.

With the widespread ratification of the Declaration by most of the Third World, acceptance of Primary Health Care as the bedrock of the national health system became the order of the day in a great many developing countries. To move from rhetoric to implementation proved to require a major revolution in the structure, functioning and

financing of the health system. Tensions between curative and preventive health became explicit, and public and private sector divisions increased. Price differentials between the two sectors were high, as the private sector participated in curative care almost exclusively, and community participation in health service delivery was pursued in the public sector only. The number of nongovernmental organizations participating in health service delivery increased requiring the creation of new institutional arrangements with the public sector.

Since its inception, the issue of quality of care versus coverage has preoccupied health professionals and the public alike with regard to the Primary Health Care Program. Mobilizing resources to extend health services to the majority of the population within the time-frame indicated by the Alma Ata Declaration challenged the medical profession to rethink existing clinical protocols, to develop uniform criteria to define adequate standards of care and maintain their credibility in the community. The dimension of human resource development for adequate numbers of appropriately trained personnel; their relation to the Western style cadres of service providers and to traditional practitioners (birth attendants, healers etc.) and furthermore to their remuneration; and the development of sustainable health systems. Other aspects of rethinking inherent in the Alma Ata Declaration included:

Implementing the principle of community participation has seen the concept evolve from passive receipt of services through donation of time, money and labor to centrally planned projects to local initiatives involving community diagnosis, planning, resource mobilization and management; with the health sector struggling to meet community demands. Democratization processes in the political sphere, placing greater emphasis on decentralized local government, has greatly facilitated this evolution in the dynamics of community participation.

Maternal, Child Health and Family Planning (MCH/FP) services have formed one of the eight essential components of Primary Health Care package since its inception. Political democratization since the Women's Decade and the Convention on Elimination of All Forms of Discrimination Against Women recognizes the role and status of women as procreators, economic producers and family care providers as well as their political rights as human beings. Prominent among those rights is the right "to decide freely and without coercion, the number and spacing of their children and to have the information and the means to do so." (Mexico Declaration) With the growth of

measures to improve their status, women's perspectives are increasingly being sought in the evaluation and design of health services.

The political democratization process has been facilitated (or precipitated, depending on one's viewpoint) by the economic policies aimed at developing sustainable Third World economies. These have had the effect of "generating a growing awareness of the potentially productive role of local authorities to raise resources, provide services, strengthen rural-urban linkages, stimulate private investment and implement national policies." (Smoke, 1993) The role of the local authority in Primary Health Care was recognized from its inception, with the district health management team designated the local health authority. The health sector is therefore strategically poised to benefit from the supportive ideological and economic environment, provided appropriate policies can be developed.

Some proposals of health policies that might merit the description "appropriate" and the rationale for such optimism are made in the next section of this paper.

Policies for the Democratization of Health Services

In the face of the new scenario brought about by the Alma Ata Declaration, underscored by the political democratization process and complicated by economic recession, the health sector is challenged to devise structures and mechanisms to facilitate a bottom-up approach to management, community participation, a focus on the majority and the most vulnerable groups, accountability, cost containment and sustainability.

District Health Systems

The district level is the backbone of the primary health care system: it represents the interface between the community and the government and thereby allows for dialogue between the two factions and the democratic process of individual participation in government decision-making. In many developing countries, political authority is being established at the district level in the form of district assemblies, whose membership is made up of elected representatives of electoral units comprising up to 500 people. In some countries, a minority proportion of the membership is appointed by the central government or to representatives of mass organizations. Heads of government agencies are ex-officio members and the agencies function as technical support teams of the district assembly. Such a political system, it is envisaged, would allow for meaningful dialogue between communities, service agencies, interested parties and government. The assemblies would have the power to raise revenues, draw long-term development plans, approve projects and programs, approve construction work, and contract agencies for performance of required tasks (Freidman, 1981).

To be able to function effectively as technical consultants to the district assemblies, district health management teams will require in addition to their technical skills, management skills: planning, monitoring, problem-solving, supervision and evaluation; as well as communication skills. One of their prime technical functions will be the

supervision and monitoring of quality of care in order to meet community demands and respect the principle of equity, human rights and dignity. Some of the constraints health systems have faced in their efforts to strengthen district health management systems include inappropriate training curricula and methods; inadequate funds, transport and equipment; supplies and protocols for supervision; inadequate manpower and administrative support. Indeed, many district health team members are part-time, spending the major part of the schedule in service delivery rather than management functions. This situation is encouraged by the fact that many teams do not have office space and budgets.

As has been documented elsewhere (Newell, 1989) "a village-based tier of health services is acceptable only if it is both an integral part of the community it serves and intimately linked with the next tier of services above it. It cannot stand alone: there must be a support system". This realization has brought with it efforts to effect adequate support systems for traditional birth attendants (TBAs) in their role as MCH/FP extension workers: referral systems, supportive supervision and community support.

The role of the district hospital within the Primary Health Care system is becoming more clearly defined as tertiary level care, monitoring of preventable morbidity, in-service clinical training and maintenance of quality of care standards. Manpower, equipment, supplies, transport and financial arrangements within the district health system will have to be made to accommodate the functions of the district hospital in order to ensure quality appropriate health services.

This has implications for financing of Primary Health Care. Initial suppositions were that governments would redirect funding from hospitals and curative care to health centers and preventive outreach services. However, it is evident from the budgets of most developing countries that there has been little success in doing so and that Primary Health Care has needed relatively large amounts of additional funding to survive. (World Bank, 1993) Reviewing the role of the district hospital in part explains why it has been so hard. For example, in many parts of Ghana, the districts with optimally functioning primary health care services have been districts in which district hospitals have played this role. (The fact that many of them were mission hospitals with additional resources was also a strategic point.) Although all developing countries have recognized the importance of the district level in the delivery of Primary Health Care, this does not appear to be the case for many international supporters of Primary Health Care. The assumption is often that this area should

be the responsibility of national governments, many of whom are unable to shift resources away from the existing curative system or mobilize additional budgetary resources for primary health care. The priority of these supporters has been to reach the target group with services: unsuccessful or unsustainable without strengthening the district health system. (WHO, 1988)

The political democratization process promotes a policy of decentralized management. Within the health sector this will necessitate strengthening district health management systems whose backbone is the hospital. Strengthening district health systems will therefore constitute the basis for the democratization process in health and acceleration in the implementation of the Primary Health Care program.

The challenge to the health system is to develop adequate health manpower development programs to maintain adequate numbers of appropriately trained personnel at the district level; to develop supervisory and referral systems that maintain an optimal level of quality of care; and to develop appropriate mechanisms to manage resources and facilitate community input in health service planning, supervision and monitoring.

Ministry of Health policies will need to have the goal of strengthening district health management through appropriate district health systems and management by district health teams. Priority areas for intervention will be management training programs for district teams, development of supervisory guidelines and strengthening of referral systems.

It is clear that with increasing decentralization of functions and responsibilities to the district level, provincial and central levels of the Ministry of Health will also have to review their roles. Provincial levels will be key in supporting district level by providing technical backstopping and promoting equitable distribution of health services through appropriate monitoring and supervision. Central levels will focus on strategic planning, intersectoral coordination and resource mobilization.

Integrated Service Delivery Systems

Increasing appreciation of the importance of competent district health systems brings with it realization of the counter-productive impact of the vertical program approach on the evolution of sustainable primary health care. It is clear that Primary Health Care comprises a service

delivery system at the periphery (that is, at the level of the consumer), that is a mix of programs pertaining to the control of communicable diseases, maternal and child health and family planning, immunization, environmental sanitation, health education, treatment of common ailments and referral of major illness. As the year 2000 draws increasingly close, more and more developing countries are calling for better integration of donor support and donor recognition of the right of individuals in recipient countries to comprehensive health care even in the face of inadequate resources.

Dialogue with the community often reveals that health service needs, especially preventive health service needs (i.e., immunization, family planning, health education, etc.), are often not the priority needs expressed by community members. (Rifkin, 1990) Requests related to health service needs are more likely to be requests for hospitals or at least a clinic (with the secret ambition of upgrading the clinic to a hospital). The primary health care strategy attempts to meet community expectations to accessible curative health care in an affordable way by preventing preventable conditions and establishing an efficient referral system that enables each individual access to curative services.

The low-demand nature of preventive services highlights the need for an integrated service delivery system at the district level and outreach services. This strategy is also cost-effective both from the point of view of the client as well as for the health system itself: one journey accomplishes a number of tasks. Indeed, the vertical program approach promotes increased costs by requiring program specific personnel, equipment and supplies; and it makes increased demands on community participation especially with regard to productive hours lost.

Studies have shown that community members "see life and its problems whole", not divided into artificial "sectors" or "programs." (PAHO, 1984) Greater community involvement through the political democratization process will likely increase the demand for integrated service delivery systems. All levels of the health system will have to plan for integration and coordination of vertical programs in order to meet this demand.

Promoting a policy of integrated service delivery therefore forms part of the democratization process in the health sector since it contributes to equity in access to health services, enables the health system

to improve its accountability to the people through improved cost-effectiveness, and facilitates meeting the human rights requirement of health for all.

The need for a multi-purpose health worker at the district level with the necessary community interactive, self-monitoring, evaluation and decision-making skills is being fuelled by the political democratization process that encourages communities to take control of its functioning. The challenge to the health sector is to develop appropriate service delivery protocols that allow for the delivery of an integrated package of services in a single visit which requires revising service provider job descriptions to enable such service delivery to take place; re-fashioning health manpower development plans; re-training of all health personnel, especially their supervisors; and developing integrated management information services and transportation systems.

Community Participation

Community Participation has been defined as the “process by which individuals and families assume responsibility for their own health and for those of the community, and develop the capacity to contribute to their own and the community’s development.” (PAHO, 1984)

The process of community participation may be seen as either an end in itself (the democratic approach) or as a means to achieving a set goal, for example, health for all (the instrumental approach). (Vuori, 1984) As originally conceived within the context of Primary Health Care, community participation would ensure that individuals would participate in planning, instituting and maintaining health systems that met their needs. Village-level health committees would be inaugurated with locally elected or appointed community leaders, and would form the liaison between the health workers and the community.

The political democratization process has encouraged individuals to see themselves as part of a community that has the power to change lifestyles and to demand accountability from government. This has had a positive effect on community mobilization for health. Communities have built clinics and accommodations for health workers on their own initiative and with their own resources, for example. However, in many cases, the planning and implementation of these efforts have occurred without collaboration of the health sector because of the absence of appropriate structures for dialogue within the

health sector. In Ghana, the evolution of district assemblies as the local community participative mechanism has highlighted the fact that health workers are inadequately prepared to enter into dialogue: management information systems are weak, resulting in poor quality services that are under-utilized; management skills are weak; health education approaches are inappropriate; and community participatory skills underdeveloped or even, non-existent. In addition, the health sector is characterized by a reluctance to give the community an active role in managing activities and resources, and by an attitude that it is the community that needs changing and not the health sector.

As a facet of community participation, the roles of traditional practitioners, Non-Governmental Organizations (NGOs) and the private sector have been highlighted not only by the political democratization process but also by the process of economic reform requiring reduced public sector spending. Health sector planning has had to expand to incorporate the activities and contributions of alternative players and highlights the need for greater reliance on strategic planning, better co-ordination mechanisms and increased monitoring and evaluation skills. Health Planning Units have been established, registration systems for NGO's active in health are being instituted, standardized management protocols are being developed to include all types of service providers, mechanisms for inter-sectoral communication are evolving in the form of inter-sectoral committees at different levels of the administrative system, traditional birth attendants are being trained and midwifery roles being reviewed to accommodate their role, and training of private practitioners in priority health programs such as family planning is being undertaken.

With the political democratization process this arrangement has become formalized in the local government scenario already described and given community participation the articulation of a basic human right. Past experience has shown community participation to be highest where there is community consciousness of its rights and responsibilities with regard to development. The existence of an organizational structure for action, a history of successful community action and the identification of health as a priority need have been demonstrated to be the hallmarks of potential for community action in health. (PAHO, 1984) It is to be anticipated therefore that the process will increase the level of community participation in health as part of the development process. In addition, the participation of non-governmental organizations in development initiatives is being increasingly recognized in many developing countries. Both these

developments call for new health policies.

The first requires that the health sector recognize the community as a partner in the institution and management of health services and formulate appropriate strategies for that involvement. That recognition still needs to be solidified in many countries, partly as a result of longstanding attitudes and practices within the health sector and also community perceptions of the government and health sector roles in the development process. Health has long been considered the prerogative of experts and a responsibility of government. One of the pre-requisites to community involvement is, therefore, adequate information and education for informed decision-making. Without it community participation was rapidly revealed as constituting little more than passive compliance or at best, cooperation with health directives.

The health sector has been encouraged, therefore, not only by Primary Health Care but also by the political democratization process, to devise innovative ways to inform and educate the public using formal and non-formal channels of communication including advertising. True communication, however, requires listening as well as telling; it means providing needed information as well as general information. The health sector has yet to develop the listening skills it needs. Social sciences research methodology such as Focus Group Discussions, Knowledge, Attitude and Practice Surveys, Exit client interviews, and operations research to determine what serves the community best, are important tools to facilitate the process of listening to the community.

The relevance of listening to the community is highlighted by the example of women's health: one of the priority areas of the Women's Movement and embodied in the Nairobi, 1987 Forward Looking Strategies Agenda for Action. It has become increasingly clear that impaired access to health care, high contraceptives and immunization discontinuation rates, and low utilization of delivery services, reflect in large part the inappropriateness of health care delivery systems for women even though they were the intended direct beneficiaries of the service. To raise childhood immunization rates, it has been necessary not only to convince men and women of the importance of immunization (or family planning) but also to consult them as to the frequency and time scheduling of clinic sessions, the preferred type of service provider (Health Research Unit, MOH, Ghana, 1992), significant traditional practices, in order to fashion a health service that meets the needs of the community it was designated to serve. (Nichter, 1984)

With regard to women's involvement, it has been observed that empowerment of women can occur on at least two levels; the first being the solution of a practical problem (as for example in labor-saving devices) and the second being in the long-lasting manner of building up self-esteem and personal consciousness to enable women make decisions about their willingness to challenge existing gender relations. (Alsop, 1993) The health sector requires interventions on both these levels. Not only does it need to tailor services to reduce time wasted; but also to inform and educate women as well as men about their health choices. Maternal Child Health and Family Planning messages have traditionally been addressed to women. This needs to continue as part of their empowerment process: they need to know. But in addition, messages need to be directed to men in their capacity of key family decision-maker, in order to facilitate behavior change that will support appropriate health interventions.

The health system also needs to develop flexible, community-specific approaches to accommodate community participation. Strategies will vary depending on the social cohesion within communities, whether they are urban or rural, the level of leadership skills present, the recognition of health as a priority need and the political, economic and cultural characteristics. (PAHO, 1984) To develop this flexibility, health workers will require training to change negative attitudes and to participate in community mobilization. (Shoo, 1991)

One such strategy is for the health system to create institutional management committees with vacancies for community membership. The challenge is to identify community participation that is a true reflection of the spectrum of interests that constitute a community. Past experience has shown that it is all too easy to create an elitist group of community representatives who are unable to voice the needs of the most disadvantaged groups. It has been observed that community participation as a process has to be nurtured and participation skills developed in both parties: health staff and community members. (PAHO, 1984)

The relationship with traditional practitioners has been particularly intense with traditional birth attendants and cool to quite strained with traditional healers. Initial misgivings about competition between traditional birth attendants and midwives are being eliminated by the growing realization that Safe Motherhood will require the upgrading of midwifery skills in order to bring emergency obstetrics close enough to the majority of the population to save lives. Health sector attitudes to these non-formal private practitioners have had to recognize their skills, community standing and their contribution to maternal

health care, Health workers have had to adopt adult learning training techniques in order to communicate effectively with them, and the importance of traditional practices in maternity care has been re-discovered through the TBA training program.

The role of traditional healers has been documented as being the second support mechanism available and used by families in much of the Third World; the first being home remedies. However, health workers tend to have very negative perceptions of traditional practices and a great deal of mistrust, making communication between them difficult at best. China perhaps has had the most success in incorporating traditional medicine in the formal health care delivery system; but in many countries traditional medicine remains a parallel system. Efforts have been made to train traditional healers in the management of diarrhoea and use of oral rehydration solution (ORS), antimalarial treatment, management of malnutrition, the importance of childhood immunization and the performance of aseptic circumcision and scarification; but so far these efforts have been limited and evaluation of their efficacy limited.

Community mobilization and more positive health worker attitudes are required to improve referral systems and thereby access to emergency care. Strategies for supervising traditional birth attendant service need to be devised that retain the TBA's standing as a community member rather than as an "assistant" to the health system, as part of the health sector's role in maintaining quality of care standards.

The relationship with private health practitioners (doctors, nurse midwives, pharmacists) has been strengthened by the drive afforded by the goal of Primary Health Care to reach the majority of the population. Private practitioners in the developing world have remained clinic- and urban- based with the major emphasis on curative care. Efforts are being made to involve them, through training and the provision of supplies in EPI service delivery, the use of ORS and in family planning programs with some success. The major issue and constraint to better relations has been the price differential between the two sectors and the nature of public health programs. The private sector will not give access to all segments of society, only to those that can afford to pay; public health programs require the participation of the majority in order to control disease spread. Inputs to the private sector from scarce public sector resources is thus seen as a bad investment, given the limited reach of private sector. On the other hand, stimulating the private sector to accept responsibility for public health would mean that the private sector would in effect con-

tribute resources by serving those that can pay and releasing government funds for those that cannot pay.

Mechanisms for involving the private sector in health service delivery have highlighted the need to accommodate the very different approaches of the two sectors: public sector requires regular reporting of performance for accountability; private sector requires reporting for income tax declarations; private sector is independent; public sector is dependent on political forces and public interest groups; private sector is individualistic; public sector is altruistic emphasizing the public good; private sector is for profit; public sector until recently has been philanthropic, although with the economic crisis it has become cost conscious and is increasingly for cost recovery; private sector desires state-of-the-art technology; public sector desires appropriate technology.

Ministries of Health will need to adopt policies that have as their goal the total involvement of the community, and strategies that encourage the participation of the widest array of community groups whilst maintaining acceptable standards of health care for all. Priority should be given to integrating the non-formal sector with the formal sector and promoting the mutual compatibility of all service delivery systems.

Human Rights and Reproductive Rights

Whilst human rights underscored the evolution of Primary Health Care, the issue of reproductive rights had received special attention at the first Population Conference in Bucharest 1974, "inspired by desire for social justice towards women, children and those men who have the least on earth." (Johnson, 1987) Articulation of reproductive rights in the health sector is apparent in the inclusion of Maternal Child Health and Family Planning services as a component of Primary Health Care. Initially, MCH/FP services comprised care for women during pregnancy and delivery and preventive child health programs; by 1980, 52 developing countries supported the demographic rationale for family planning and 65 supported the health and human rights rationale for population policies and family planning programs. The Mexico Declaration on Population (1984) and the Amsterdam Declaration of 1989 serve to document the growing worldwide consensus on the health, human rights and demographic rationale for family planning services. The result is that family planning is today increasingly regarded as an integral part of maternal child health services, a means to improve the status of women and to alleviate

poverty, as well as an essential factor of socio-economic development plans aimed at improving standards of living.

The health sector is challenged to translate policy statements with regard to family planning into programs with substantial coverage and demographic impact especially in sub-Saharan Africa. (U.N., 1992) Demographic and Health Surveys have documented the large unmet need that exists in communities all around the world where women with no means of controlling their fertility have no choice but to bear children they do not have the ability to care for. (Dixon-Mueller and Germaine, 1992) It is to be anticipated that the democratization process occurring politically will require the evolution of services to meet this unmet need.

Strengthening of Maternal and Child Health services through the integration of family planning services is a major strategy for extending that right to each individual. However, Maternal and Child Health services attract by their nature, a defined target group: pregnant women and women with children under 5 years of age. Adolescents, men, premenopausal women who have completed childbearing, and unmarried women are all not reached by this service. In response to this situation, social marketing programs, community-based distribution programs, adolescent reproductive health programs, employer/work-place based programs are all examples of attempts by the health sector to protect the human and reproductive rights of individuals and couples to family planning information, education and services. Each of these approaches present the health sector with new challenges in management systems, manpower, materials and budget requirements.

In many instances in the effort to meet the challenges posed by this demand, it has not been possible for the health sector to maintain adequate quality of care standards, exposing the sector to accusations of infringement of human dignity and lack of informed choice. Women in particular have suffered from this situation: while it is possible to examine, immunize and treat children under trees, services for adults require more privacy, and services for adult women require the most privacy. Furthermore, the complexity of logistics systems for the provision of a full range of contraceptive methods coupled with service delivery systems manned by illiterate community-based workers, lay commercial distributors, or paramedical staff with little management expertise has deterred many family planning programs from offering their clients the full range of method choice. Studies are accumulating that show major dissatisfaction with available family planning services: discontinuation rates are high (WHO, 1988) and

Figure 1

Table 4.7

Costs and Health Benefits of Public Health Packages in Low-and Middle-Income Countries, 1990

Country Group and Component of Package	Annual Cost (Dollars)			Disease Burden Averted (percent)/a
	Per Participants	Per Capita	Per DALY	
<i>Low-income (income per capita = \$350)</i>				
EPI Plus	14.6	0.5	12-17	6.0
School health program	3.6	0.3	20-25	0.1
Other public health programs (including family planning, health, and nutrition information) b	2.4	1.4	-- c	-- c
Tobacco and alcohol control program	0.3	0.3	35-50	0.1 d
AIDS prevention program a	112.2	1.7	3-5	2.0
Total	--	4.2 (1.2)	--	8.2
<i>Middle-income (income per capita = \$2,500)</i>				
EPI Plus	28.6	0.8	25-30	1.0
School health program	6.5	0.6	38-43	0.4
Other public health programs (including family planning, health, and nutrition information) b	5.2	3.1	-- c	--c
Tobacco and alcohol control program	0.3	0.3	45-55	0.3 d
AIDS prevention program a	132.2	2.0	13-18	2.3
Total	--	6.8 (0.3)	--	4.0

Note: Numbers in parentheses refer to per capita cost as a percentage of income per capita.

a. Although costs are estimated for 100 percent coverage, the health benefits are based on 95 percent coverage for EPI Plus and 80 percent coverage for the school health, AIDS prevention, and tobacco and alcohol programs.

b. Includes information, communication, and education on selected risk factors and health behaviors, plus vector control and disease surveillance and monitoring.

c. The health benefits from information and communication and from disease surveillance are counted in the other public and clinical services in the health package. The health benefits from vector control are unknown.

d. Calculations of the potential disease burden averted through this program assumes no change in the prevalence of smoking and alcohol consumption; if such prevalence were to rise, the potential benefits would be larger.

e. Excludes treatment of STDs, which are in the clinical services package; see Table 5.3.

Source: Author's calculations.

Source: World Development Report, 1993: p. 106

clients are inadequately counselled. Contraceptive technology is biased toward female methods, contributing to lack of male involvement in family planning.

In spite of the problems faced by family planning service delivery systems, acceptance and use of contraceptives has increased worldwide. This, coupled with the increased attention generated by the focus on universal human rights and the role and status of women in society, has highlighted the need for expanding the focus of MCH/FP to include all reproductive health needs: prevention and management of sexually transmitted diseases, promotion of sexual health, and

prevention and management of genital and breast cancer.

The policy decision to safeguard human and reproductive rights in health service delivery will require the evolution of appropriate mechanisms for ensuring that this is done: regular in-service training and supervision, service delivery protocols, client-centered evaluation, sensitive management information systems, and ethical review bodies, for instance, would all assist in this endeavor. With an increasing demand for accountability fuelled by the political democratization process and the involvement of women in political decision making, such mechanisms are urgently required.

Cost-Effectiveness

With the increased emphasis on decentralized district management systems brought about mainly by the economic reforms required by almost all developing countries in the past decades; but also by the political democratization process which encourages local decision-making and budgetary control, the health sector will have to justify its financial requirements and performance to the community that pays for it : "value for money" will be the key question. The health sector will become more "people-driven". Although people will continue to have the tendency to rely on the judgement of health professionals, they will require more information and a more equal relationship in decision-making. It has been estimated that implementation of the twenty most cost-effective interventions would eliminate more than forty percent of the total burden of ill health and seventy-five percent of the health loss among children. (World Bank, 1993) Cost-effectiveness information also helps to protect the health sector against the pressure of self-interest power groups such as the urban elite. For all these reasons, it is envisaged that cost-effectiveness will become a major policy in the health sector and a force for its democratization process.

Analysis of health systems across the world have shown inefficiency in service delivery to be most pronounced in the public sector, which can be reduced through decentralized management, accountability and reinvestment of savings or income at the local level.

One of the key interventions to promote cost-effectiveness is competition (World Bank, 1993), which will increase client choice and satisfaction as well as increase efficiency of service providers and health systems. The health sector will need to institute management strategies that elicit competition amongst service providers and that im-

prove health outcomes without becoming counterproductive. Competition should be encouraged within the public sector, and between public, private and NGO sectors.

Many of the most cost-effective interventions can be performed outside hospitals and are preventive in nature. However, provided the referral system from the subdistrict units is working well (i.e., clinics and health posts treat most cases and refer only those requiring more sophisticated care), treating a small number of severe cases of disease, hospitals can improve health at a lower cost than lower-level facilities. (World Bank, 1993) Estimates of cost-effectiveness will therefore be able to determine the best mix of services the district hospital should offer in support of Primary Health Care.

The health system will need to strengthen its ability to gather data on expenditures and outcomes in order to be able to develop the cost-effectiveness information it will require from all sectors, public, private, traditional and NGO. This will require transcribing government budget format from line budget to program budget, detailing the nature of consultation visits made in order to identify the particular intervention offered at each visit, and quantifying health outcomes (World Bank, 1993).

As more data on cost-effectiveness becomes available, health systems will be able to adjust the mix between public, private, traditional and NGO to ensure the best use of national resources: the best value for money spent. The role of the public sector in health service delivery may well change. Indeed with decentralization and community participation in health service management, both resulting in health institution management boards and village health committees, government's role is being directed from the provision of health care to financing health care delivery by private, traditional and NGO sectors.

As indicated in the World Development Report 1993, it is crucial that the donor community also focus on ways to improve the effectiveness of assistance to the health sector. A key intervention in this regard would be in better coordination of their inputs. It is agreed that the responsibility for coordination lies with recipient governments; but it is also a pre-requisite of effective planning to consider the role of all other players in the field, prior to establishing one's own role. In this instance it would appear that competition, rather than breeding efficiency, breeds inefficiency and reduced cost-efficiency.

Also as stated in the World Development Report 1993, adopting the priority of assistance to ensure a minimum package of public health measures and essential clinical services while focussing on capacity building, research and appropriate health policy reform, would greatly increase the productivity of donor assistance.

Ministries of Health will have to develop policies that have as their goal the maximization of cost-effectiveness of health services using strategies that promote cost-effective analysis and healthy competition among service providers. One priority area will be the development of appropriate, affordable financial auditing mechanisms.

Equity of Access

Equity of access to health care for the total population has been one of the tenets of the Primary Health Care philosophy. The political democratization process highlights the principle and complicates it: with people's participation in decision making, the demand for expensive curative services is likely to increase especially from the politically more powerful groups. With limited budgets, such demands will result in a skewing of resources and services in favor of the higher income groups. The health sector will need to be able to define and justify a minimum package of services in order to ensure equal access nationwide, and to stimulate private, traditional and NGO providers to participate in the planning, provision and maintenance of standards of care.

In order to reach the poor, the health sector will need to find ways to target the poor and to avoid the situation of providing subsidized services to those that can afford to pay. One way of doing this would be to establish as one of the criteria for inclusion in the minimum package of services, services needed mainly by the poor. (World Bank, 1993)

As proposed by the World Bank's 1993 Development Report, the public sector will need to adopt a policy of supplying the minimum package of services only, leaving the provision of alternative health services to the private, traditional and NGO sectors. Selecting the services most needed to improve the health of the poor as the basic package acts as an automatic targeting device. (World Bank, 1993)

The question of women's access to health care also requires special attention. Intra-familial patterns of decision making, intra-familial patterns of income distribution, social customs with regard to male-female interactions, the biological patterns of disease evolution (in particular, the sexually transmitted diseases) have all been found to exert a negative effect on the accessibility of health services for women. Studies have shown that in some cultures, women cannot avail themselves of available health services without their husbands consent. In others cultures, unless a husband gives money for health care, a woman will not be able to receive care. In cultures that do not permit women to be seen unveiled or undressed by males other than their husbands, services predominantly offered by men are rendered inaccessible to women. Studies have also shown that early stages of sexually transmitted diseases are often silent and consequently not attended to in women. Gender sensitive operations research will be required to identify and address this aspect of equity of access to health care as part of the democratization process.

Ministry of Health policies will have to include the goal of offering equal access to health services, using the strategies of establishing a basic package of services, priority gender sensitive operations research, and adjusting the allocated health budget to support the service package.

Sustainability

Since the Amsterdam Declaration (1989) on Population Issues of the 1990's and beyond, sustainability has become the key criterion for the planning and evaluation of population and development programs. Communities have also had time to experience first hand the collapse of initiatives resulting from withdrawal of initial support (national or international) in the absence of local mechanisms for their continuation. Involvement of the community in health planning, as is resulting from the political democratization process, will underscore the need for new projects to be sustainable and will be the means of ensuring that they are, provided that community representatives are indeed representative of the communities they serve. To be sustainable, initiatives should: 1) answer a felt need of the community, 2) be culturally appropriate, 3) be planned, executed, financed and evaluated by community members, and 4) include opportunities for renewal: skills transfer, cost recovery and relevance.

Health skills transfer will need to be locally adapted to be culturally and socially relevant, locally based to be affordable, and will need to

include strategies for training needs assessment and supervision and teaching methodology in order to maintain quality of service. One concern of the training of trainers “cascade type training” has been possible dilution of training skills and content with each level of training. However, the approach has some critical spin-offs: it has introduced training into the supervisors’ job description; it has demonstrated the need for supervisors to conduct training needs assessments; and it has highlighted the role of the district hospital in clinical training for the district health system. Additionally, it is clear that this dilution in skills is limited to the start-up period only. After the requisite teaching skills have been attained at each level, the challenge will be to develop appropriate resource materials in sufficient quantities. Manpower development plans will need to include supervisors training at each level as a pre-requisite for supervisors, thereby preventing any subsequent fall off in skills down the system. Another approach used, under the strengthening district health systems (SDHS) effort, has been to develop a national team of facilitators trainers who conduct problem solving sessions with multi-disciplinary health teams for management training. The problem is to maintain the national cadres of facilitators and to make them available nationwide on a regular basis.

Cost recovery is as important an aspect of sustainability as skills transfer. Health services were initially instituted as a public service to be paid for through taxes, therefore by the consumer. In developing countries this meant the civil servant and urban consumer. It soon became clear that a “free” public health service was plagued by inefficient use of resources, a lack of accountability and was subject to misuse of its goods as well as its services. The situation was aggravated by the economic crisis of the seventies and eighties in which health budgets along with other sector budgets were reduced. The evolution of the political democratization process within the health sector will emphasize the need for cost efficiency as indicated

earlier and will also emphasize the need for accountability, which in turn will curtail the degree of misuse of goods and services whilst increasing their efficient use, thereby containing cost.

The introduction of user fees in the public sector is now a widespread phenomenon in much of sub-Saharan Africa, and it has been shown that provided they do not exceed 1% of annual household income, these do not affect the utilization of health services (World Bank, 1993). In Ghana, user fees were regulated in such a way as to allow retention of revenue generated for use at the institutional level; this resulted in improved quality of care, as demonstrated by the reduction in drug outages.

Insurance schemes, public and private, are alternative ways of raising money that the health sector will need to consider in their efforts to continue to finance a minimum public health package and meet the demands of the total population for varying health services. Experience from various countries has shown that governments will have to have to undertake measure to prevent the explosive rise in costs of health service once insurance schemes become operational.

Ministry of Health policies will need to include the goal of attaining national self-sustaining systems using the strategies of cost containment, cost recovery, user fees and as the economy improves, increased budgetary allocations to the public sector.

Determining Factors

A number of developing countries have formulated such policies similar to those described above in recent of years, and there is a growing body of knowledge (albeit incomplete) with regard to what works and does not work, and why.

A key determinant is political will. For policies to be accepted, they have to be seen as being politically justifiable. With an uninformed, non-involved citizenry, influencing the political climate may not be a major problem; with a democratic system and an informed electorate, failure to convince the political hierarchy of the value of an intervention spells disaster.

Another key determinant is the level of management skills and systems existing in the health systems: the lower the level, the greater the degree of centralization and the lack of accountability, and the higher the level of inefficiency (as measured by waste and outcome), even in the face of appropriate policy statements. The district health system depends on adequate management skills, as does the success of community participation and the efficiency of service delivery systems.

The organizational structure of a Ministry of Health may actually impede communication between key departments, resulting in inadequate information for decision making at all levels. The lack of built-in mechanisms for self-analysis or monitoring is a natural outcome of such a structure. The result will be the formulation of policies that are likely to be vague, inappropriate or unrealistic and may never be actually implemented since the system has no way of determining the required level of specificity, the relevance or the degree of implementation.

The degree of donor support, ironically, is a major factor in determining the success or otherwise of policy formulation and implementation. Ironically, because donor input, in many countries is 30% or less of total program costs and, in theory at any rate, is offered on the request of national governments. Its power lies in its innate characteristic of being vertical in nature: donor support usually does not

take a holistic approach to health service development. This is partially understandable in the sense that each primary health care program has had to develop an appropriate technology in order to move beyond the confines of the hospital. This process has taken time and concentration for each program area and is on-going. No attempt is made to design programs and develop technologies with specific attempts to ensure their complementarity and their integration; although each program appears with the justification that it constitutes an "entry point" for the rest. The result is to impede the process of appropriate policy formulation and program design.

A major constraint remains the issue of health care financing, which in turn is dependent on the gross national product and the GDP. Although the point has been made that developing countries do not allocate as much to health as could be expected from the past allocation patterns of the now developed countries, the fact also remains, that the poorer a country the less it will allocate to health and that proportionate increases in health budgets occur with rising national income. (Cichon and Gillion, 1993) Indeed the same is true at the level of the individual.

Policy implementation of democratic policies requires increased health sector spending for a great many countries, which in turn requires a restructuring of the international markets that will allow developing countries to earn a viable living.

Conclusion

This paper has attempted to describe policy changes that would parallel and potentiate the democratization process in the health sector, and has examined their rationale and the constraints to their success.

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