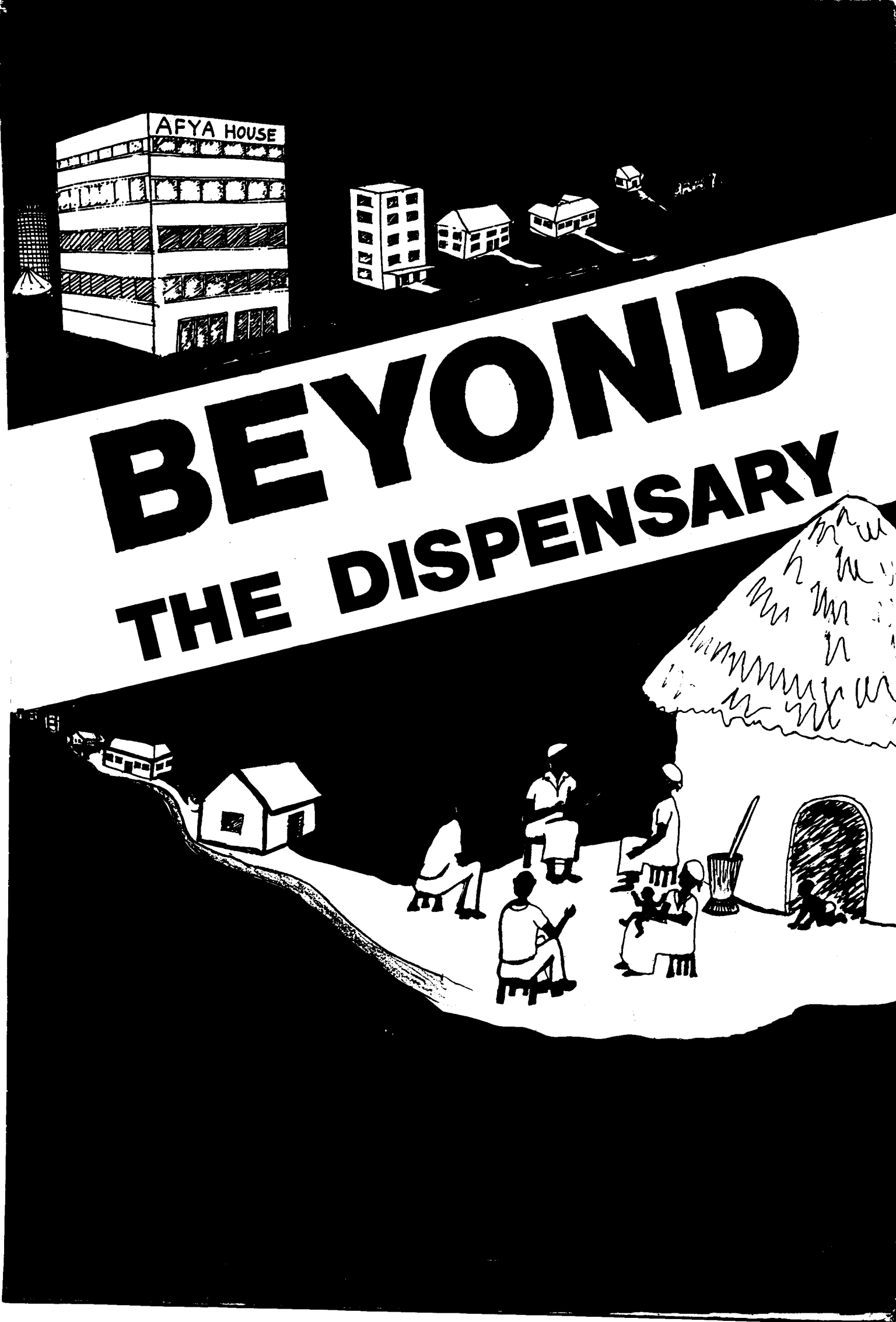


# BEYOND THE DISPENSARY

## AMREF

The African Medical and Research Foundation (AMREF) is an independent non-profit organisation which has been working for more than 25 years to improve the health of people in Eastern Africa, mostly in Kenya, Tanzania, Southern Sudan and Uganda. AMREF runs a wide variety of innovative projects with an emphasis on appropriate low-cost health care for people in rural areas. Project funds come from government and non-government aid agencies in Africa, Europe and North America as well as from private donors. AMREF is in official relations with the World Health Organisation.

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# BEYOND THE DISPENSARY

## (ON GIVING COMMUNITY BALANCE TO PRIMARY HEALTH CARE)

Roy Shaffer

Community Health Worker Support Unit
African Medical and Research Foundation

This brief work owes a lot to King, Werner, Morley and Bryan, writers whose personal-experience-based writings ushered in a new era of rationalization and de-mysticization of health service and motivated thousands of other community health workers, myself included.

The writing draws mainly upon the field experiences of many friends, particularly Geraldine, Janet, Gill, David, Penina, Mattie, Dan and Leda; colleagues who pioneered pathways of trust "beyond the dispensary".

Most important of all have been the CHWs themselves. When you consider their position you must agree that in most cases their endeavours are noble. Through their selfless service and example they are ushering in a new era of inspired health service by the people.

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# C O N T E N T S

APPENDICES

## SUMMARY

Public disenchantment and economic constraints related to health services have been approaching the intolerable in all countries of the world. Hence in 1978 WHO and UNICEF convened a conference at Alma Ata in Russia to re-think and rationalize health services. The resulting concensus thinking bore the label "Primary Health Care" (PHC). This paper considers the ramificatons of the PHC approach as it occurs "beyond the dispensary", as a Community-Based Health Care (CBHC) development.

CBHC is seen as a practicable way to narrow the widening gap between health needs and the resources to meet those needs. The key elements are voluntarism, motivation and prevention. The key human resource people are Health Committee members and Community Health Workers (CHWs). The CHW is primarily a catalyst of changed responsibilities, habits and conditions in her (most CHWs are women) neighbourhood. The CHW therefore must be permanent, mature, exemplary and a good communicator. Literacy is not a high priority. Voluntarism and popular selection are of the esssence as is community commitment to moral support of their CHW.

The CHW's primary focus is on her immediate neighbours. But she is also involved in a host of other human interrelationships, both vertical and horizontal. A CHW must be part of a network of reciprocal responsibilities which inter-relate facilities, cadres, philosophies (particularly the cure/prevention balance) and modes of approach to people.

The CBHC approach strives for more delegation of responsibility for health promotion, better balance between cure and prevention, more voluntaristic input into the system, increased awareness/ sensitization and better cross-disciplinary integration.

CBHC, as the title implies, should have been born in the minds and hearts of local people. It should crystalize around a self-help approach to specific preventable problems, not around a dispensary.

Traininig of CHWs generally takes place in the local community and does not last more than a week to start with. The curriculum should be felt by the CHW trainees to have emerged from their community's needs. The most suitable teaching method is the learner-centered-problem-posing method popularized by Paulo Freire.

A key feature of this method is the "starter" or "code" which poses the chosen problem in a sensitizing way.

The well trained CHW will be able to motivate her community towards changes in responsibility, habits and conditions involving motherhood, cleanliness, food and disease control. Evaluation of her impact on the community is still rudimentary. There are about thirty specific CHW-countable changes of habits and condition which are expectable as an outcome of the CHW's motivation of her neighbours. The CHW usually has an intuitive grasp of the state of these developments. The challenge is to devise survey and monitoring instruments which are meaningful and useful to her.

A number of uncertainties still cloud the CBHC scene. Will the CHW's individual reservoir of voluntarism last until she is rewarded by measureable changes in her neighbours' habits? Can communities (and doctors) be weaned off their fixation on a pill for every problem and a needle for every need? Can they be led to believe more confidently in "health without medicine"? Can part-time voluntarism, promoting prevention become a cultural "norm" and an option for closing the needs/resources gap?

Finally the paper points out that CBHC is more complementary to than competitive with formally trained clinicians. CBHC helps them to be EXPERTS rather than "NEXT-PERTS".

## BACKGROUND

Throughout the world there has recently been widespread and increasing disenchantment with health care in terms of its accessibility, and affordability. Developing countries in particular are being forced to re-evaluate their health systems in terms of cost and effectiveness.

In this connection, WHO and UNICEF in 1978 at Alma Ata (AA), Russia, launched a campaign to achieve "Health for All by the year 2000" through Primary Health Care (PHC). Prior to AA, "primary care" to most people meant first contact care, a limited use of the expression. The AA declaration broadened the use of the word "primary," putting greater emphasis in principle upon the community and its "participation, self-reliance and self-determination." Based on the phraseology of the declaration, Primary Health Care stands for essential care that is:

- accessible
- acceptable
- affordable
- all-inclusive (integral)
- all-together (participatory)
- at the centre (is the nucleus)and
- amenable to self-reliant initiatives

Furthermore, in the AA terms of reference, PHC renders the following types of service:

- promotive
- preventive
- curative and
- rehabilitative

and covers the following problem areas:

- nutrition
- water
- sanitation
- maternal/child health
- immunization
- endemic diseases
- education
- treatment.

The AA emphasis upon community involvement was not a new idea. Shattuck's Report of the Sanitary Commission of Massachusetts, 1850 emphasized community orientation and personal responsibility. But the personal and community emphasis Shattuck put forth in 1850 did not gain much ground then, for two reasons. First, an era of rapid development of large corporate water works was starting in Massachusetts.

The resulting reduction in prevalence of water-related diseases temporarily took the pressure off local community health services. Then, at the turn of the century great breakthroughs in bacteriology and immunization and, later, chemotherapy put great emphasis on "the men in white coats". There ensued both a popular and professional fixation on the institution-centered "pill for every problem and needle for every need" (PENN) approach to health. This (PPNN) expensive, curative-dominated approach became entrenched in the West, and it spread to the Third World. There its burgeoning costs began to hinder and even reverse progress towards better health in fledgling independent nations. By the mid 1970s it was obvious that something was going to have to change.

So at Alma Ata the former community orientation was revived, re-articulated and re-promoted as PHC, which was to become the nucleus of the health system. See Appendix A for core AA statement.

PHC is not a new system as much as it is a new emphasis and ordering of priorities, with the community becoming more central in the scheme of things. One could say the AA emphasis is upon making that first contact more peripheral, more participatory, more personal and more simple.

But the AA declaration did not define "primary". Neither did it give specific examples of the Where, Who, What, How, etc. of PHC. AA did, however, broaden the use of the word primary to include more than its prior meaning did, i.e. the new use meant more than just a sickness episode, a single point in time/place. Regarding the "Where", AA's geographical use of "primary" went in theory beyond the most peripheral establishment facility. It went right out to the village and the home.

Regarding the "Who", the title "primary worker" was transferred from the lowest and least formally trained establishment worker to the informally trained villager helping her neighbours.

In answering the question "What", AA tended to shift the balance of the emphasis slightly from sickness care to health care, i.e. from getting cured to staying healthier.

As to "How" PHC was to work, the emphasis in theory shifted towards the active (prevention, self-prophylaxis, self-referral) and away from the passive (being helped, being referred, being cured, being told).

A simplification of the above AA inferences might be this: "Primary Health Care refers to the first thing an ordinary villager does for him/herself right in the home to avoid getting sick."

But the official concept is not necessarily the popular concept. Misconceptions and mis-definitions have abounded. Establishment medical workers have often tended to regard PHC as just a strengthened dispensary programme.

Many so-called "Community Based" programmes are more tied up with "pills, preaching and per-diems" than with "people, prevention and problem-solving". On the other hand many villagers think of PHC as a box of medical "goodies" coming down the road to the village from the dispensary. Both these top-down interpretations are wrong and such mis-perceptions are resulting in much confusion and wastage of mental and monetary resources. Of a continental medical conference on PHC it was said, not altogether in jest, that there were 1,000 physicians there and 1,200 different definitions of PHC. One session was actually devoted to "The Role of the Specialist in Primary Health Care".

Three changes are needed:

- the people need to take their own capacities and responsibilities more seriously
- medical workers need to take the people more seriously
- both need to take prevention more seriously.

The word "radical" means root. CBHC should be a radical programme in that the people cut their own problems at the roots (by prevention).

The dispensary is not really primary geographically. Indeed, it is the community beyond the dispensary that is primary. So PHC should by definition have a local, community-based perspective. That perspective should complement and modify the traditional top-down medical establishment-based perspective. This paper attempts to fill in the details of the community-based perspective which will restore balance to PHC.

## COMMUNITY-BASED HEALTH CARE

The Community-Based Health Care (CBHC) movement is the "beyond-the-dispensary" part of the spectrum of PHC. It fosters and implements those recommendations of AA that are practicable beyond the dispensary. It addresses itself to encouraging and facilitating the peoples' own efforts to convert AA philosophy into practice right where they live. CBHC represents the geographically peripheral or outer half of PHC. It focuses on community-initiated activism. This activism is catalysed by Community Health Workers (CHWs). This programme of community activism should eventually be viable with or without outside influence or aid, whether from government or non-governmental organizsations. (Note Apx. J - 8 and 9)

This somewhat independent, bottom-up initiative is the heretofore "hidden" half of PHC. It can be considered the most important half of PHC, for if a PHC programme has no bottom-up initiative it is not in the AA sense "primary".

But "bottom-up" is not an altogether apt expression for this situation. If through lack of knowledge the people on the "bottom" do not really know which way is "up" they cannot be expected to initiate movement in the right direction. First they need awareness-raising as a form of orientation. ("Sensitizing" is too presumptuous a word.)

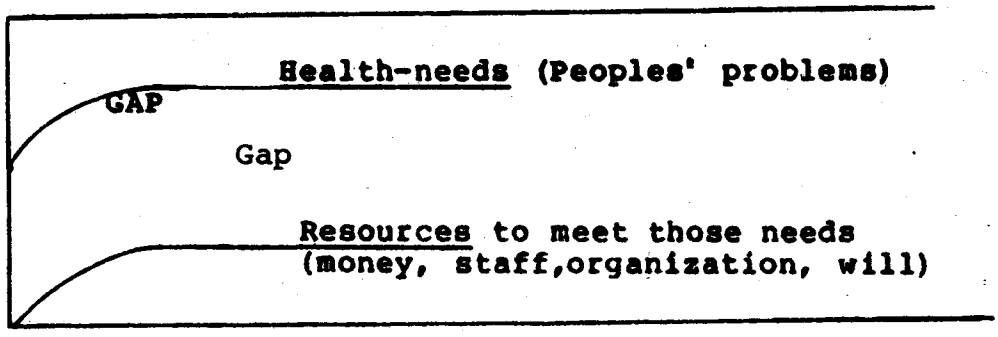
A common African proverb goes "It takes two fingers to kill a louse". And so, for faster progress in the race to attain better health for all by the year 2000, PHC will require a better balance between its two halves. Its traditional curative-centered top-down approach will have to be more evenly complemented by the prevention-centred bottom-up approach that starts beyond the dispensary. Furthermore, the top-down approach will have to involve more delegation of responsibility from formally trained health workers to CHWs. There is scope for such delegation in matters such as nutritional surveillance, immunization surveillance, malaria control, health motivation and TB/leprosy case-finding/holding. Through such delegation, the preventionists in the team can begin to get off the curative workers' "coat-tails".

In East Africa the modern revitalization of the philosophy of CBHC might be said to have first occurred recognizably at Nangina Hospital in the early '70s. In 1979 through the generosity and vision of World Neighbours, a Community Health Worker Support Unit was started at AMREF. This Unit co-ordinates Community-Based Health Care collaborations throughout East Africa between such organizations as Kenya Catholic Secretariat, Protestant Churches Medical Association, World Neighbours, etc. (Note Apx. J - 14)

Writings and discussions on PHC since AA have been preoccupied with the inner (or "top") half, i.e. from the hospital to the dispensary and its mobile extensions. This preoccupation with the establishment has been so strong and, conversly, practical outreach beyond the dispensary so poor that CBHC has remained relatively obscure. So we will attempt to clarify what CBHC is functionally through a series of questions. .

## WHY IS CBHC NEEDED?

CBHC is needed to fill the gap between health needs and health resources. The following figure illustrates this.




CBHC can reduce this gap or disparity in two ways: by lowering needs and/or by raising resources.

Needs can be lowered directly by preventing the illness that creates the immediate need. Needs can also be lowered indirectly over the long-term by preventing the birth of an overwhelming number of people (through better child spacing) and thereby minimizing the multiplication of need.

Raising resources is more difficult. Government and Mission institutions are already functioning at the limits of their money, staff and organizational capacity. This affects their philosophical will to make new commitments of staff and other resources, especially to that unknown territory beyond the dispensary walls.

So it may be many years before we begin to see a flow of staff and money that matches the flow of high-level rhetoric about "prevention" and "community". There will probably not be much more than a trickle going down the road beyond the dispensary for some time to come. Certainly, vague talk, at this point, of outside money for salaries for CHWs is unrealistic if not hypocritical or damaging.

So, while awaiting the evolution of philosophic and practical commitment at the centre, let us look at resources already existing peripherally, beyond the dispensary. Here we believe part-time voluntarism can raise the level of local resources and thereby narrow the health gap.

Part time voluntarism does not eliminate uncertainties about money, technical skill, organizational capability and will. But it does put those issues into manageable (local) dimensions. By putting some of the initiative into the hands of the people beyond the dispensary, CBHC voluntarism can produce a biblical "loaves and fishes" effect. A few local human resources blessed with a little training can "feed" (motivate) a multitude of their neighbours.

In summary, then, there exists today in most developing countries a large gap between health needs and resources. That gap cannot be filled by the present formal medical establishment programme alone. Prevention (reducing need) and voluntarism (raising resources) are also needed. These two can combine, like a pincer movement, to help narrow this health gap, i.e. the disparity between needs and resources.

## WHO IS INVOLVED IN CBHC?

CBHC may include any or all of the following personnel:

1. A nurse or equivalent medical person who provides technical guidance and, more importantly, moral support

2. Community leaders willing to lead towards commitment

3. Health committee members willing to be regularly, actively responsible for the administrative interests and morale of their CHWs

4. Community Health Workers willing and able to give a few hours a week to motivating their neighbours

5. Villagers willing to try changing their habits and conditions, both individually and as a community.

## THE HEALTH COMMITTEE

It is important that the bottom-up approach be a community phenomenon, not just one local individual's enthusiasm fuelled by some zealous outsider. So Health Committees (HCs) are desirable. They may be sub-committees of the District, Locational or Sub-Locational Development Committees. Their selection is usually by the administrative head, hopefully after sounding out the community.

The HC should be a major facilitator of that which CBHC is all about, i.e. community change. The HC's work is active advocacy of the CHW and active prompting of the community to respond to the CHW's motivations towards specific changes in habits and conditions.

The HC needs some preliminary training just as much as the CHW does, though for the HC it will be much briefer. The HC's first responsibility is to ponder questions such as the following:

1. Is there a need for change in people's personal habits and home conditions?

2. What sort of person would be most effective (as a CHW) in demonstrating, popularizing and promoting these simple changes among her/his neighbours?

3. Who could train these CHWs and who could provide them with on-going advocacy and moral support (administrative and medical)?

4. What is the chance of villager improving their personal habits and village conditions in response to the CHWs motivation?

5. Who will keep the CHWs themselves motivated? How?

6. What part, relatively, should chemotherapy (drugs) have in the CHW's role?

7. Approximately how much time per week would the average volunteer CHW be able to spare for this work? Thus, with how many families would she/he be able to keep in touch?

## WHAT IS A CHW?

The CHW may be either a man or a woman. However since most CBHC activity concerns Maternal/Child Health there tends to be a preponderance of women serving in the role. TBAs can be excellent CHWs (Note Apx. J-19). The ideal would be one of each sex for each community. The woman covering Maternal/Child Health (MCH) and the man cover environmental affairs.

The main function of the CHW is to be a catalyst of change in personal habits and environmental conditions in his or her immediate social neighbourhood (say 1,000 people or the area within a 2 mile radius or a 1 hour walk). Anything beyond that is not psychologically her community or neighbourhood.

Drugs need not be a pre-requisite to a CHW's acceptance and influence as a motivator. On the contrary, her drug dispensing can and often has weakened her primary message of "prevention". There are "drug-free" success stories and conversely there are cases where drugs have brought disaster to a programme.

The title CHW deserves some scrutiny because it is not altogether apt. Let us analyse the components of the title:

Community. The CHW must not only be in that community, but also "of" it in the sense that her work is a product of communal conception, momentum, management, funding, etc.

Health stands for total health, not just immunizations. It infers acculturated changes of habits and conditions.

Worker. The CHW is not a worker who "does" health for the people. The W should be turned upside down to become an M, standing for "Motivator".

**TO BE A GOOD COMMUNITY HEALTH WORKER ONE MUST FIRST OF ALL BE A GOOD COMMUNITY HEALTH MOTIVATOR**

She motivates a clean-up of the spring and the men are the workers. She motivates building of a dish rack and her neighbour does the work of building it.

Not listed in the above is the word EXAMPLE. Personal example is one of the CHW's most important influences on her neighbourhood.

**PERSONAL EXAMPLE IS THE CHW'S MOST IMPORTANT INFLUENCE**

So we could well change the title CHW to "CHEM" standing for Community Health Exemplary Motivator.
(Chemchem is the Swahili word for spring of water. The Swahili word "mchocheo", for incite or arouse is applicable to the role of the CHW).

The CHW is chosen with popular approval after the whole community has clearly understood the terms of reference. CHWs are, ideally, sponsored by a Health Committee and are usually trained by a nurse from a nearby static facility (most often a mission hospital). This trainer might have attended a CHW Support Unit Training of Trainers (TOT) course. Such courses provides special teaching skills designed for the CBHC situation.

The most widely emphasized personal characteristics desired in a CHW include the following (not in order of importance):

- a volunteer (as far as outside remuneration is concerned)
- permanent resident
- parent
- exemplary personal life
- good communicator
- respected activist in community
- has time to spare for this activity
- has approval of partner
- healthy
- fairly "average" person
- education suited to motivational role in that neighbourhood
- knows the community
- mature
- friendly

Literacy is not always a requirement. Some excellent CHWs are illiterate. Furthermore, a literacy requirement has led in some cases to selections which are bad on other counts.

The voluntaristic basis of the CHW's work is a troublesome issue which is discussed at length in a later section (P.35). But experience has shown that:

a. salary from outside may reduce the CHW's motivational role.
b. a gradual transfer of salary responsibility from outside sources to local sources does not work in practice.
c. no programme has yet come up with any consistent lasting local remuneration of CHWs (whether in money or in kind).
d. voluntarism is motivated mainly by religious impulses.

**VOLUNTARISM IS MOTIVATED MAINLY BY RELIGIOUS IMPULSES**

Communities are sensitive to the issue. Some localities have given one-time rewards such as a goat in Ekarakara or a prize radio in Maua. The Kisii CHWs are full-salaried (from Europe) workers so are not strictly within the terms of reference of this paper. Of far greater importance to the CHW than money or gifts is the remuneration or gratification of receiving moral support from the trainer/leader and response from the community in the form of changed habits.