PRIMARY HEALTH CARE

A joint WHO-UNICEF report presented at the International Conference on Primary Health Care held at Alma Ata (USSR) in 1978 invited governments to reconsider their health policies, with a view to enabling the communities to participate in the establishment of their own health priorities. Thus a certain autonomy would be created, in particular among third world populations, which have benefited but little from health care.

This approach, termed "primary health care", involves the mobilization of multiple sectors and fields of specialization: health, social assistance, education, agriculture, public works, transport and public information, which signifies a readjustment in the allocation of material, financial and human resources within development programmes.

The international seminar on primary health care held at Frunze (USSR) in May 1979 examined the practical implications for the Red Cross of this concept. The National Red Cross and Red Crescent Societies were invited to collaborate closely with the health services of their countries so as to achieve common and co-ordinated action, which would involve re-examination of current programmes in order to adapt them to local situations.

Since then, numerous resolutions adopted by International Conferences of the Red Cross and the statutory bodies of the League have confirmed the National Societies' commitment in this sector of activity.

With the aim of being able to offer the entire world population accessible and financially feasible health care, governments and non-governmental organizations are more and more interested in primary health care. The Review, *with the kind permission of the* International Nursing Review, *offers its readers an account of an experiment carried out in Kenya by the Maua Methodist Hospital, which is concerned with the health of the Maua Via Meru (Kenya) communities. The article, written by Ms. Mattie Tolley, ASN, MS, Nurse Adviser on Community Health, Maua Via Meru, seemed to us to be of interest for the National Societies, owing to the methods used to develop the communities' participation in their primary health care.*

Use of the Innovative Decision-making Process in Primary Health Care

In an effort to provide accessible and affordable health care to the populations of the world, governments and non-governmental organizations have turned to primary health care. The Maua Methodist Hospital in the community health Maua Via Meru, Kenya, gives us an example of such efforts.

As the Alma Ata Declaration (WHO, 1978) [1] has become a more widely accepted guideline for health care priorities greater emphasis and effort have been placed on providing primary health care. Training and use of paramedical community health workers are common in many developing countries. The ability of the non-professional community health worker to be of assistance as a health educator, motivator, and minor treatment provider has been demonstrated in a number of studies (Fournier, 1975;[2] Djukanovic, 1975,[3] Maru, 1983).[4] A means of developing a primary health care programme with a solid base in the community and in which the community health worker rather than the professional health care provider is recognized and supported by the community has been more difficult to accomplish (Skeet, 1985).[5]

Maua Methodist Hospital has been involved in searching for a workable community-based approach to primary health care since 1977.[6] Slowly

[1] World Health Organization, Alma Ata Conference on Primary Health Care. (1978). Declaration of Alma Ata, *WHO Chronicle*. Geneva, 1978.

[2] Fournier, G. & Djermaoye, I., "Village health teams in Niger (Maradi Department)". In K. Newell (ED), *Health by the people*, Geneva, World Health Organization, 1975, pp. 128-144.

[3] Djukanovic, V. & Mach, E. (eds.), *Alternative approaches to meeting basic health needs in developing countries*. Geneva, World Health Organization, 1975.

[4] Maru, R., "The community health volunteer scheme in India: an evaluation". *Social science of medicine*, 17(19), 1983, pp. 1477-1483.

[5] Skeet, M., "Community health workers: promoters or inhibitors of primary health care?" *International Nursing Review*, 32(2), 1985, pp. 55-58.

[6] United Nations International Education Fund for Children. (1982). *Evaluation of Maua hospital community-based health care project*. Report No. 20/82. 1982.

a model that appears to be workable has evolved. Analysis of the model reveals that the framework closely follows the collective innovative decision-making process described by Rogers (1971). Using this framework as an evaluation tool, it is easy to spot the weak areas in individual community programmes and to provide corrective education or motivation.

Rogers' framework, as applied to community-based primary health care, follows five steps which mid-level nurses have found no difficulty understanding. These steps have also been successfully communicated in a more familiar language style to community leaders and health workers of rural Kenyan communities.

Stimulation of the community is the first step of the process. This activity is not a time of telling the community its health needs or of giving solutions; rather it is a time of raising the awareness of the community to their health needs and problems through data-gathering questions and the presentation of the gathered data back to the community in a concise and creative way. Community mirroring activities are presented to established groups and meetings in that community using plays, songs, stories, games and drawings. The health provider who acts as the stimulator facilitator does not name the problem or suggest any solutions, but is content to trust the community members to identify their own problems and priorities, whether or not they coincide with her own assessment. Stimulation is complete when community leaders or groups recognize the need to make changes which will lead to the improved health of their community members.

Expansion of the need to change and the reason for change into the social consciousness of the total community is the second step, a step Rogers calls initiation. A specific plan of action is made by the community or its selected leaders to meet a particular health care need. Community organization and support for community designated leaders is essential to the success of this step. The role of the health care provider is to provide education and encourage organization of successful group activity. Planning and decision-making must be left to community members. Community initiators will be those people with some creativity and imagination and are often not the appointed or elected official leaders of the community. Commonly we have observed them among the educated: teachers, preachers, business persons, women's leaders and other service-minded literates. Community initiators in the Maua project have taken their concerns to grassroot organizations of their specific community, such as churches, cultural and self-help groups, and finally to full community meetings.

Many great ideas perished because of a bureaucratic veto; therefore, innovations must be approved by the community power structure. Rogers

calls this step legitimation. The initiators, who are engrained in the system of that community, will be better equipped than the health provider to get the necessary approval from the power structure. The initiators know exactly who among the government officials, institutional administrators, and power elite families can bless or kill an idea or action with their support or lack of same. Detailed knowledge of these powerful people also helps them to know how to overcome any blocking actions. In the Maua pilot community an obstructive government official was sidelined by making him "patron" of the committee, a position in which he gained community recognition and political credit for "leading" the committee but actually took no part in decision-making and action. He could not criticize a committee that was "his".

It is wise to have the most widespread community involvement that is possible in the next step: decisions to act. The health care provided may assist innovators to explore various methods of involving the community in the decision-making. That person may provide the technical assistance with any paperwork needed. The specific method should be decided by the innovators since it is important that the decisions be made in a way appropriate to the culture. In developing countries where illiteracy is high, verbal communication through community meetings or other public meetings is common. As our project has evolved, several methods of reaching community consensus and/or decisions have been used. Churches and women's groups have been channels for gathering or passing information. Major decision-making has been done at a "baraza", a total community meeting called by the area assistant chief. Health committees selected at the baraza carry out the decisions and oversee the progress of the work, including the work of the community health workers. Co-ordination and co-operation between communities and with the health care providers in areas such as fund-raising, training, and requests to the government have been worked out through the Igembe Health Council. The Council has representatives from each of the communities involved in primary health care in that governmental area regardless of which health care provider is assisting in the project. Presently, it appears that the Health Council will become a recognized part of the government structure for implementing primary health care, truly joining the efforts of the community and the formal health care providers. The Maua Community Health Department staff have trained health committees in the problem-solving process and act as consultants to the Igembe Health Council.

Only when the community has become deeply involved and committed is it time for the final step of the process: action. It is essential that action is carried out by community members. This is the time for community health workers to be selected and trained. The health care provider may assist the

community to identify characteristics which they want to have in their workers, but selection is made through the community process. The health care provider then takes the role of a trainer. In the Maua project, short-listing of community health workers is usually done by the health committee from a list of volunteers. Volunteers are often solicited through churches, women's groups, youth groups and the official political party. Final approval of the short-list of community health workers is done at a baraza. The health care provider then works with the community, or a group selected to represent the community, to identify priorities for a training programme. The provider facilitates a team to prepare the technical training which gives the community health workers the ability to deal with these priorities. At Maua, training is done by enrolled community nurses with assistance from student nurses. Specific resource persons are invited to aid with topics in their area of expertise.

Agriculturalists, health educators, experienced community health workers, public health officers, community development assistants, water development officers, and local elected officials have all been resource persons. After the initial preparation, a member of the training team becomes a consultant to the local health committee as well as a technical supervisor of the community health workers.

Whoever holds the pursestrings, holds the power; therefore, the community should be actively involved in financial and back-up services such as housing, food and training materials before training begins. Maua training is done in the community at facilities arranged by the health committee. The health committee also takes full responsability for food and lodging of the trainers as well as lunch and tea for the trainees. Trainees return home at night. Initial teaching materials are supplied by the training team but equipment or supplies left in the community must be paid for from community funds. Cost of transport for the training team to the community is negotiated, as well as transport for follow-up supervision visits and continuing education for community health workers.

Evaluations of the use of this framework demonstrates that over a five-year period the pilot community, which had no health services when the project began, developed well-used monthly maternal-child health services within a radius of 3-4 miles of most of the population.

Twenty-eight community health workers visited 5-8 families per week providing health education, encouraging use of health services, and screening for communicable diseases. Malnutrition dropped from 8% to 4% and bolderline malnutrition from 41% to 24%. Immunizations dramatically increased: numbers of children under 5 years immunized for measles increased by 37% and BCG by 46%. Fifty-three per cent of the children had completed primary immunizations. Environmental factors related to

health also improved. In 1977, 91% of the families had no toilets. By 1982, 55% had completed toilets, of which 37% were clean and in use (UNICEF, 1982). Presently fourteen communities are involved in the Maua project. Although not all have progressed as rapidly as the pilot community, similar trends are seen.

Using the collective innovative decision-making process as a framework has not made implementation of community involvement easier, but it has made identification of weak areas possible and facilitated planning of appropriate action. In the Maua project, we have learned that if we want the community to claim the project as their own, and sustain it, we must be thorough in building the foundation of community involvement before moving to the action stage. Results may be slower and less dramatic, but after 8 years, we believe we can say they are lasting because the community is committed and in control. Use of Rogers' framework has facilitated the development of a flexible model of primary health care which can be tailored to the specific cultural, social and economic circumstances of any community.