URBAN EXAMPLES

FOR BASIC SERVICES DEVELOPMENT IN CITIES
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URBAN PRIMARY HEALTH CARE -- HEALTH SERVICES FOR THE URBAN POOR, A PROCESS AND A PRODUCT

CONCEPTUALLY AND OPERATIONALLY THE PRIMARY HEALTH CARE APPROACH PRESENTLY BEING IMPLEMENTED AROUND THE WORLD IS FOR THE MOST PART A RURAL APPROACH BASED ON RURAL EPIDEMIOLOGY AND ON A RURAL ADMINISTRATIVE FRAMEWORK.

NONETHELESS, THERE ARE SOME EXAMPLES OF URBAN PRIMARY HEALTH CARE PROGRAMMES. EVEN FROM THE FEW REVIEWED HERE IT IS POSSIBLE TO UNDERSTAND URBAN PRIMARY HEALTH CARE BOTH AS A SET OF HEALTH AND NON-HEALTH ACTIVITIES (E.G., PREVENTIVE AND CURATIVE HEALTH, ENVIRONMENTAL IMPROVEMENTS, SANITATION, WATER, COMMUNICATION AND INCOME GENERATING ACTIVITIES) AND AS ONE ASPECT OF THE DYNAMIC PROCESS OF CONTINUAL IMPROVEMENT AND CHANGE TAKING PLACE IN POOR URBAN COMMUNITIES (COMMUNITY ORGANIZATION, COMMUNITY PLANNING, COMMUNITY IMPLEMENTATION).

THE PROJECTS REVIEWED HERE SHOW SEVEN EXAMPLES OF PRIMARY HEALTH CARE ACTIONS IN POOR URBAN AREAS IN LATIN AMERICA: FOUR IN COLOMBIA, ONE IN PERU, ONE IN BRAZIL AND ONE IN ECUADOR.

THESE EXAMPLES ARE ORGANIZED SO THAT YOU CAN READ THE BASIC FACTS ABOUT EACH PROJECT IN 30 SECONDS. THE SUMMARY IS FOLLOWED BY A TWO OR THREE PAGE REVIEW OF PROJECT DETAILS. THE CONCLUDING PARAGRAPH IDENTIFIES WHERE ADDITIONAL INFORMATION CAN BE OBTAINED.

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1) NAME OF PROJECT: Integrated Programme of Community Participation in Health and Education for Family Life--Cali, Colombia

2) TARGET POPULATION: Initially 100,000 inhabitants of Cali and at a later stage the entire city.

3) TIME FRAME: Programme was developed in 1979, became operational in 1980 and is ongoing.

4) EXECUTING AND CO-OPERATING AGENCIES: Municipal Secretariat of Health--Regional Health Unit, Cali, Colombian Institute of Family Welfare (ICBF), Universidad del Valle and National Food and Nutrition Plan (PAN).

5) COSTS: The total cost for 1980 amounted to 13,413,259 pesos (approx. US$204,160 at current rate). The two largest components were: personnel--7,632,231 pesos (approx. US$116,168) and subsidized food. Average annual cost per person covered was about $126 pesos (approx. US$2).

6) SOURCES OF FUNDS: The subsidized food was provided in full by the PAN. All other components were funded by the Regional Unit of Health and by the ICBF.

7) OBJECTIVES:

1. To offer integral care to the minor, the family and community groups in the most vulnerable population of Cali.
2. To extend the coverage of the services of the participating entities, rationalizing the system of service provision and implanting new methods for care.
3. To promote community participation, incorporating the home as a basic unit of service provision and stimulating the development of local community groups for the study, analysis, search and proposals for solutions to the needs of the child and family.

8) BRIEF DESCRIPTION: INTEGRATED PROGRAMME OF COMMUNITY PARTICIPATION IN HEALTH AND EDUCATION FOR FAMILY LIFE--CALI, COLOMBIA

Background

The primary health care programme for urban zones in Cali was initiated as a consequence of the work by the Universidad del Valle in Candelaria (Valle), where a new system for providing health services was developed. Its basic characteristics were integrated health care for the individual, the family and the community, extensive coverage, low cost, delegation of responsibilities, community participation, taking the home and the community as the basis of the health system. The objectives of the programme were to be met by decongesting the services at the level of the large hospitals, by increasing the facilities for access to health services and by establishing a staged system of care.

Health System--Stratification of Services

The overall zone covered by the programme is divided into Integrated Areas of Health that are defined as geographic zones, each with a population of approximately 250,000 people and with a Centre-Hospital serving as a seat for its Area, 7 or 8 Health Centres and 4 or 5 Health Posts.

The basis of the programme is a pyramidal system of care where the various institutions are classified into levels according to their degree of complexity and their capacity to provide medical attention. There are three levels of health care and patients are referred from one level to another according to their state of health.

The first level is subdivided into the following:

Home: The basic health services, especially the work of health promotion and the prevention of illness, are carried out in the home. These activities are undertaken primarily by the promoters who make periodic visits to the homes of families assigned to them.

Health Posts: These represent the first institutional links. The posts are of simple construction, consisting of a waiting room, consulting room, room for injections and a house for the nursing assistant or guard. At each health post there is an urban health promoter and a nursing assistant. This personnel is supervised by a General Nurse who is responsible for six Health Posts. Medical consultation at this level is undertaken as needed.

Health Centre: The activities carried out at this site are those of health promotion, prevention of illness, restitution of health, reduction in the risk of complications, acceleration of the process of recuperation and incorporation of the individual into the social and family nuclei.

Centre-Hospital: This is the most developed health institution of the Integrated Area of Health and, in addition to the foregoing links, it includes activities for the restoration of health at the professional, general and specialized levels in four divisions of medicine: internal medicine, obstetrics, surgery and pediatrics.

The second level consists of the General Hospital where activities are carried out by general and specialized doctors. Here, institutional beds are available for hospitalization services of a longer term nature.

The third level consists of the University Hospital which is one of the highest in complexity and technology. The Division of Health Sciences and the Faculty of Medicine are linked through formal agreements.

Programme Operation

The programme relies heavily on the principle of community participation as the foundation for social dynamics capable of creating positive change and guaranteeing the permanency of the programme. Activities focus on the identification of formal and informal community groups, and their orientation toward community work.

Risk is the basic criterion utilized to establish priorities, to define and assign activities and to establish the levels of care for individuals. By way of a questionnaire the urban health promoter classifies families according to 1) health risk and 2) family welfare risk. The work of the promoter and nurse assistant is done according to the family risk (defined according to specific variables). There are 5 visits/year for high risk families and 2 for low risk families.

Through community participation and the application of the risk criterion it is possible to develop an optimization of resources and to obtain in a short time an increase of coverage.

Personnel

The personnel assigned to the programme combines the human resources of the participating institutions. Based on the levels of care, the following personnel has been programmed for 100,000 persons:

1 nurse
1 social worker
30 health and family welfare promoters
4 nurse assistants
2 statistical assistants

In addition, personnel is required for cleaning and security in each one of the Health Posts.

The health and family welfare promoters carry out their activities in the homes, while the nurse assistants carry out their responsibilities alternatively in the home and in the health post.

The extension of coverage is guaranteed by the actions developed at this first level which, at the same time, determine the demand for services at the Health Centres and at the more specialized hospitals.

Information and Evaluation

A team of members from organizations participating in the programme has developed a system of information and evaluation of the programme. Such a system is intended to make possible the analysis of implementation activities and the planning of adjustments and revisions for future actions.

Based on the paper "Atencion Primaria en Salud y Bienestar Familiar" prepared by Marco Tulio Galarza et al. of the Secretaria Municipal de Cali which was presented at the International Seminar/Workshop on Urban Primary Health Care held in Popayan, Colombia on 5-9 July 1982.

(i) For a copy of the original document in Spanish or for the informal English translation write to UNICEF HQ Library, NY.

(ii) For any additional help or information write to UNICEF Regional Director, Bogotá, Colombia.

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1)	NAME OF PROJECT:	Integrated Local Programmes of Health and Welfare, Medillin, Colombia.
2)	TARGET POPULATION:	17 barrios (neighborhoods) with a total population of approximately 575,000.
3)	TIME FRAME:	--
4)	EXECUTING AND CO-OPERATING AGENCIES:	The Health Section Service, the Municipal Secretariat of Health, the Colombian Institute of Family Welfare, Cajanal, the Faculty of Medicine and the School of Public Health.
5)	COSTS:	--
6)	SOURCES OF FUNDS:	Costs are covered by the general budget of the Section for Health Education and by Community Participation.
7)	OBJECTIVES:	General: ---To comply with national and international policies that recommend community participation in activities intended for the promotion of health, and the recuperation and rehabilitation to health. ---To improve the health conditions through community participation. Specific: ---To achieve the integration of the institutional health system and the community. ---To train the institutional health team, community leaders and groups in order that they may work together as personnel and undertake actions leading to improvements in the state of the health of the community.

8) BRIEF DESCRIPTION: INTEGRATED LOCAL PROGRAMMES OF THE HEALTH AND WELFARE, MEDILLIN, COLOMBIA

Background

The Primary Health Care approach was adopted in reaction to the perceived limitations of the health-related activities which had been undertaken in Colombia.

The programme in Medillin represents an integrated effort to put into practice the strategy of Primary Health Care introduced by WHO in 1978 (Alma Alta Declaration) that stresses the participation of the community. The underlying idea is to involve the community and make it responsible within the formal system for the provision of health services. The system is oriented towards the needs detected in a health study undertaken by the community itself.

Programme Structure

In order to ensure co-ordination of health activities, the following hierarchical structure has been established:

1. Co-ordinating Committee (central level)
2. Regional Committee of Intermediate Units
3. Health Centre Committee
4. Local Health Committee (barrio or block)

Institutional health teams composed of interdisciplinary technical personnel (doctor, dentist, nurse, assistants, sanitation promoters and in some cases a nutritionist, social worker and sociologist) operate at the level of the Local Health Committee. At each of the levels there is representation by a Health Volunteer chosen by the community. This set-up is designed to ensure permanent contact between the Health Service and the community.

The key elements of the system are the members of the interdisciplinary health teams and the community leaders (volunteers) designated by the barrio, labor or school organization.

Activities

Health--is oriented towards the four traditional health promotion topics: prevention, promotion, recuperation and rehabilitation. The community and the institutional health team are responsible for integrating their reasoning and practice with the demands and needs of the community. Activities of the programme include services to individuals such as medical attention because of illness, preventive examinations and control (medical and epidemiological) of the higher risk groups, and immunizations.

Environment--includes effort in the field of basic sanitation and in detection of environmental and food contamination.

Community participation--includes identifying and establishing contact with existing community organizations, and organizing meetings between these and the members of the health team in order to discuss health conditions, possible approaches, and training for community leaders.

Health Volunteers

A goal of the programme is to train a volunteer for each block. In order to do this, individuals who wish to participate in the programme are enrolled through grassroots organizations, the Health Centre or by motivational efforts of other volunteers. The stages of training consist of: induction and theoretical information, theoretical-practical stages in health activities, and information about the various programmes of the Health Centres. At the end of the training, the volunteer is given a certificate. Of the community members who enroll, about 50% complete the training course and become active participants in the programme. There are various reasons why the other half drop out. They include: change of residence or civil status, false expectations, "machismo" criteria regarding the work of women, and employment in formal work.

As part of the training process, the volunteer has to complete a form which asks for information on the state of health of the community. This is important in the context of primary health care insofar as it represents a first step in drawing together the formal health system and the actual interests of the community. At a later stage, the volunteers are expected to undertake a more complete analysis of the health situation and, on this basis, be able to focus health activities.

Limitations

The major set of limitations of the programme are to be found in the community participation aspect. Because of inadequate conceptualization of the importance of primary health care, the Institutional Health Team has not incorporated the general guidelines of the community participation strategy into its work. Moreover, because the team's working hours do not correspond to the availability of the community, the team has had difficulty making contact with the community. Also, the development of the programme has been sectoral, without a campaign that would indirectly induce the community itself to offer its services. Finally, volunteers have not been given a real opportunity to participate in the formation of the committees and teams, as the programme structure plans.

Based on the paper "Experiencia de la Secretaria de la Salud Publica y Bienestar Social de Medillin" by Lic. Marta Ligia Echeverry et al. which was presented at the International Seminar/Workshop on Urban Primary Health Care held in Popayan, Colombia on 5-9 July 1982.

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1) NAME OF PROJECT: The Peripheral Centres--La Asuncion, Manizales, Colombia

2) TARGET POPULATION: The inhabitants of the La Asuncion barrio (neighborhoods). Total population covered in 1982 numbered 15,675.

3) TIME FRAME --

4) EXECUTING AND CO-OPERATING AGENCIES: Project was developed and advanced with the help of Zonta International, through UNICEF.

5) COSTS:

Construction:	2,655,206 pesos (65 pesos = US$ 1)
Stock:	44,200 pesos
Training :	28,000 pesos/promoter
Operating cost :	2,153,893 pesos/year

6) SOURCE OF FUNDS: The most important was the Zonta International Organization. Others are the Health Service of Caldas and the University Hospital of Caldas.

7) OBJECTIVES:

1. Organization of out-patient care through the Satellite Centres.
2. Provision of health care with a team sufficient for meeting the demand in each area.
3. Broadening the field of practice of the University, making it possible for the student to be exposed to more common illnesses.
4. Decrease in the cost of care for those in need.

8) BRIEF DESCRIPTION: THE PERIPHERAL CENTRES--LA ASUNCION, MANIZALES, COLOMBIA

Background

A study carried out in 1971 showed that the health sector was not meeting the demand for services, notwithstanding the increase in medical hours of attention that had been organized by the health care institutions of the city (University Hospital, Children's Pilot Centre). Moreover, it pointed out the existence of various welfare and religious institutions that were attending out-patients in dispensaries in all the barrios (neighborhoods).

The Peripheral Centres project was structured with the intent of establishing a more far-reaching and efficient health care system.

This was to be achieved by:

1. Bringing the health activities directly to the home
2. Educating the community on health matters
3. Increasing coverage through the primary health care activities of the promoters at the level of the home, and by the nursing assistant in the Centre, under the supervision of the nurse and the doctor.

Organization of Health Activities

The project consists of a series of Health Centres. Each covers a population that varies between 15,000 and 20,000 persons and constitutes an administrative unit in co-ordination with the Hospital.

Each Centre has a doctor, two nursing assistants and one aide for various services. In addition, there are a number of promoters and in some centres there is a dentist.

The physical facilities consist of two consultation rooms, an emergency and injections room, a dental consultation room, a pharmacy, a waiting room, area for information and files and a consultation room for the functions related to nursing.

Laboratory samples are taken in each Centre and sent to the Hospital in a vehicle that comes for this purpose in the mornings. If special examinations are required, the patient is referred to the Hospital, as is also done for inter-consultation, in which case one can request the appointment by telephone.

If a patient has been hospitalized, he/she returns to the Centre with a hospital record that includes the dismissal diagnosis and recommendations to the referral doctor for follow-up. This record bears the same number as that assigned to the patient in the Hospital.

Services provided in the Health Centre

In each Health Centre the following services are offered:

--- General medical consultation
--- Mother-child and family planning consultation
--- Anti-tubercular programme and campaign
--- Programme and campaign against cancer
--- Programme and campaign against venereal diseases
--- Injections and simple cures
--- Minor surgery
--- Supplementary food programme
--- Immunizations
--- Health education
--- Pharmacy and dental services
--- Activities delegated to the nursing assistant (control of low risk pregnancy, hypertension, bacillus examinations, and the control of the growth and development of the child under five years of age.)

Health Promoters

The health promoters carry out the activities of primary health care at the home level, with emphasis on the promotional and informational activities regarding services offered by the Centre. In addition, they refer family members to the different programmes, apply simple treatments and provide health education. They are also integrated into the Health Committee of the Health Board (Junta) of Community Action of their barrio.

There is an 18 week training programme that all health promoters must attend. The programme which has both theoretical and practical components is conducted partly in the School of Nursing Auxiliaries and partly in the community to be assisted.

In order to improve the quality of their performance and maintain their continued effectiveness, promoters participate regularly in continuous education programmes developed by the School of Nursing Auxiliaries. They attend a monthly meeting which is held in the Health Centre, in which the entire team directed by the doctor and nurse co-ordinator participates. During these meetings the activities are planned and evaluated, supplies are provided to the promoter, problems are analyzed and educational information is made available.

Conclusions

Because of this project it has been possible to improve the level of health, to increase coverage and to render the services more efficient. In an eight hour work day, the doctor is able to attend patients who merit immediate medical care and those referred by the promoters. The activities of the promoters and nursing assistants permit the doctor to use his/her time more efficiently.

The improvement in health care is reflected in the decrease in illness and death caused by diarrhoea, malnutrition and diseases prevented by immunization.

Some difficulties were encountered in the implementation of the project. One was the interference of interested parties, often the community leaders themselves, either for personal or political reasons. This interference took place especially during the selection of promoters. Second, because of economic difficulties in the Health Institutions, the number of promoters that could be financed was inadequate for full coverage. Finally, limitations stemming from the need to provide more or less tight supervision, occurred particularly during the initial phases.

An important lesson to be learned from the experience is that the proper functioning of a project of this nature depends upon a basic infrastructure, like the Health Center, which serves as support to the promoter and, at the same time, serves as a link with the Hospital.

Based on the paper "Programa de Atencion Primaria La Asuncion" by Dr. Jorge Isaac Garcia et al. of the Hospital Universitario de Caldas which was presented at the International Seminar/Workshop on Urban Primary Health Care held in Popayan, Colombia on 5-9 July 1982.

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1) NAME OF PROJECT:	Integrated Health Care for the Child and Family in the poor areas of the Southern Zone of Metropolitan Lima, Peru.
2) TARGET POPULATION:	46 neighborhoods with a population of approximately 550,000 characterized by low-incomes, unemployment and limited provision of services.
3) TIME FRAME	Initially 1978--1982. Being extended for period 1982--1985.
4) EXECUTING AND CO-OPERATING AGENCIES:	Ministries of Health and Education, UNICEF
5) COSTS:	For the period 1978--1982 the average yearly cost was approximately US$ 914,000.
6) SOURCES OF FUNDS:	Major support came from UNICEF and the community--other funds came from the Ministries of Health and Education.
7) OBJECTIVES:	To promote integrated health care for the child and family and at the primary level, through co-ordinated action of the sectors and institutions and through the active and conscious participation of the organized community.

8) BRIEF DESCRIPTION: INTEGRATED HEALTH CARE FOR THE CHILD AND FAMILY IN THE POOR AREAS OF THE SOUTHERN ZONE OF METROPOLITAN LIMA, PERU.

General characteristics

The key unit of the programme is the integrated service centre. It is approximately 225 square meters in site with 75 square meters for direct health purposes and 150 square meters for the non-formal initial education (pre-school) programmes, kitchen and food storage.

In the integrated service centres efforts are made to implement, through the sub-programmes, the services for health, food and nutrition, environmental sanitation, early stimulation and non-formal initial education for approximately 100,000 children between the ages of birth and 5 years. In addition, improvement in the education and working qualifications of women is sought with the purpose of increasing their role in the care and formation of the children and of increasing their family income.

Through a system of communication and diffusion of information (communication workshops), efforts are made to support the population to gain awareness of its situation, using the existing resources for seeking more adequate solutions, and training the people for the various activities of the project.

Community participation is the basis of the programme as can be seen in its training activities.

Activities

Health Services--The project has brought about a substantial expansion of health services which has had, above all, important effects on mother-child care. The goal of the project was to establish 100 integrated service centres by 1982. Seventy of these centers have been completed and the rest of the construction is to take place in the second phase of the programme. Where the centres have not been built, temporary medical care posts have been established thereby fulfilling the goal of 100.

A census was carried out for 9,000 families (approximately 50,000 persons). Some 1,080 block delegates or monitors who were trained in 29 courses participated in this exercise. The operation of this system of family information, undertaken with the participation of the population itself, makes it possible to obtain data of considerable value for the programming of health and education activities.

There has been registration and health control of 1,400 infants of less than one year of age and 400 pregnancies, covering thereby a total population of appoximately 110,000. The population has also participated in an organized fashion in the immunization programmes conducted at the integrated service centres. As a result of various campaigns, over 20,000 children and 3,000 infants have been vaccinated. In the latter case, this has been with anti-tetanus vaccine.

As part of the health activities a large number of people were trained: 166 health promotors, 64 traditional midwives and 50 nursing assistants. The midwives and the health promoters are volunteers selected by the population. The nursing assistants are personnel assigned to the project by the Ministry of Health.

Nutrition--Control tests for measuring nutritional status were given to 6,500 children. Talks and various efforts on nutritional education have been directed towards 500 mothers. Supplementary support activities using food provided by various agencies were organized and some experiments in the implementation of family gardens and in the operation of communal kitchens were undertaken.

Environmental Sanitation--Activities included: control of 86 water supply trucks and of 10 water wells, disinfection of 600 water tanks in houses, fumigation of 1,500 non-residential buildings and houses, vaccination of 35,000 dogs (2,500 destroyed) and eradication of rats in 350 locations, and 48 garbage clean-up campaigns. Currently, a study is underway on means to encourage community participation in the permanent eradication of garbage. For this, demonstration models of urban sanitation are being designed for the outdoor spaces surrounding the facilities of the integrated service centers.

Formal and non-formal education

a. Early stimulation--Play workshops have been initiated in two centres. These workshops, which are essentially for the training of parents of children between 0 and 3 years of age, are undergoing further development.

b. Non-formal initial education programmes--Some 234 programmes have been implemented for approximately 25 percent of the children from 3 to 5 years of age.

For programme operation, 806 activators were selected and trained. These were volunteers, selected by the population. Their activities are supervised and assisted by co-ordinators (26 in total), personnel of the Education Sector, selected and trained by the project.

Teaching material support has been provided to the 234 programmes in operation and 5 communal workshops have been established to create this material. Based on their experience, the extension of these workshops to other integrated centres has been proposed.

c. Employment training for women: Under the Basic Work Education Programme (PEBAL), 1,000 adults have been trained in 9 non-formal programmes and 3,849 have been trained in formal programmes.

Some 3,000 participants have undergone skill training in 14 workshops of the clothing, shoe, restaurant, food processing, carpentry and electricity industries.

Finally, a study on the participation of women in economic activities was carried out. It establishes possible productive activities in the project area.

Based on the paper "Atencion Integral al Niño y su Familia en los Pueblos Jovenes del Cono sur de Lima Metropolitana" prepared by Dr. Julio Herrera Dávila of UNICEF, Peru, which was presented at the International Seminar/Workshop on Urban Primary Health Care held in Popayan, Colombia on 5-9 July 1982.

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1)	NAME OF PROJECT:	Primary Health Care in the Slum Areas of Guayaquil, Ecuador.
2)	TARGET POPULATIONS:	The population of "Barrio Cisne II" which numbers approximately 75,000. In August there were 46,000 beneficiaries.
3)	TIME FRAME:	1980--1983
4)	EXECUTING AND CO-OPERATING AGENCIES:	The Ministry of Health, the Ministry of Social Welfare and Popular Promotion, the "Jefactura Provincial de Salud del Guayas" which is the main health unit at the provincial level, and UNICEF.
5)	COSTS:	--
6)	SOURCES OF FUNDS:	Government of Ecuador and UNICEF.
7)	OBJECTIVES:	1. To provide improved health services to the marginal urban areas through primary health care. 2. To raise the levels of health and community welfare through activities in the fields of environmental sanitation, immunization, mother-child care, health education, family planning and first aid.

8) BRIEF DESCRIPTION PRIMARY HEALTH CARE IN THE SLUM AREAS OF GUAYAQUIL, ECUADOR.

Background

Cisne II is one of the low-income areas (barrio) of Guayaquil, the largest city of Ecuador. The barrio has an inadequate supply of potable water, no sewage system and insufficient health services. There is a low degree of immunization, 90 percent of the population is affected by gastro-intestinal diseases, and infant and childhood mortality are high. The major causes of death for children under 5 years of age are gastro-enteritis, respiratory diseases and other diseases that could be prevented by immunization.

Programme Activities

The operational design of the programme includes the following activities:

1. detection of pregnant women for pre- and post-natal control activities
2. mother-child care
3. evaluation of nutritional status of children
4. systematic immunization of children
5. deworming of children and adults
6. identification and referral of the ill to the local health centers and hospitals
7. first-aid
8. promotion of education on health and nutrition
9. responsible parenthood
10. diffusion of simple methods of environmental sanitation
11. promotion of community participation in problems of health, environmental sanitation, morbidity and sanitary education

Organization of programme

The geographical area of the programme was divided into 16 portions. For each, a promoter was chosen jointly by the members of the community and the health authorities, and a Módulo was established. The average number of families assigned to each promoter was 320, about 2,000 individuals. The division of the area into Módulos has made a positive contribution towards improving coverage, monitoring and supervision.

The services of the programme are provided by a technical team composed of a physician, who is the director of both the project and of an important health center in the area, a second physician in charge of field work, two nurses, a health educator, a statistician and 16 health promoters.

The responsibility for the planning, supervision and evaluation of the programme falls to the administrative group comprising the Chief and the Technical Director of the "Jefactura Provincial de Salud del Guayas", the Director of the "Maternidad Santa Marianita" and a field co-ordinator who serves as advisor to the members of the technical team and to the health promoters. He also serves as the link between the technical team and the administrative group.

Activities of Promoters

The promoters are always residents of the neighborhood in which they work. In exchange for their services they receive a small payment from the community organization. The promoters are full time health workers. Their time is divided among three main functions: family visits, which should take place four times per year, first-aid activities in the health post and compilation of the information system.

The promoters keep statistical information on the state of health of the population in their area. They record this information on a set of cards with the headings: the family, children from one month to 5 years, children between 6 and 14 years old, adults, pregnant women, family planning, post-partum control and new born, annual population census, and annual assessment of the conditions of the population. The information system was designed as a means of monitoring the promoters' activities and to provide a basis for programme decisions. The data system makes it possible to relate the various categories such as new-borns, children, pregnant women, etc., to their condition with respect to nutritional status, deworming, immunization, morbidity, referrals for medical attention and family planning.

Training of Promoters

The training of promoters consisted of a three week course which alternated theory and practice using a set of manuals prepared for this purpose. The manuals were revisions of ones that had already been used for similar PHC approaches in rural areas of Ecuador and Colombia. They include topics such as: working with the community, most frequent diseases, environmental sanitation, first-aid, emergency childbirth and an information system and its management. The manuals are not only intended to serve as training materials but are to be used as guides and reference material in the day-to-day work of the promoter.

Based on the "Evaluacion del Program de Atencion Primaria Urbana Cisne II, Guayaquil, Ecuador" prepared by Lic. Piedad S. Portilla, UNICEF.

(i) For a copy of the original document in Spanish write to UNICEF HQ Library, NY.

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1)	NAME OF PROJECT:	Co-Clube. An Urban Community Health Programme in Coque, Recife, Brazil.
2)	TARGET POPULATIONS:	Inhabitants of Coque, the largest and oldest low income area in Recife, numbering about 20,000.
3)	TIME FRAME:	--
4)	EXECUTING AND CO-OPERATING AGENCIES:	The "Brothers of Men" (a French NGO) and the Municipal Government through the Secretary of Health.
5)	COSTS:	A total of Cr.148,000/month of which Cr. 90,000 for six doctors, Cr.36,000 for twelve attendants and Cr.22,000 for medicines (in June 1981 Cr.80=US$1). Supplies, water and light are covered by the receipts from services.
6)	SOURCES OF FUNDS:	The City of Recife, "Brothers of Men" and the nominal fees charged for services.
7)	OBJECTIVES:	To maintain a high degree of organized and systematic community participation in the planning, inplementation and evaluation of health care activities in order to encourage changes in attitudes and behavior.

8) BRIEF DESCRIPTION CO-CLUBE. AN URBAN COMMUNITY HEALTH PROGRAMME IN COQUE, RECIFE, BRAZIL.

Background

Coque is located near the center of the city of Recife, on the banks of the Capibaribe River. Population density varies from 105 to 628 people per hectare. Only ten percent of the houses have piped water. There is no sanitary waste system and liquid waste is disposed of in the streets or directly into the ocean. Natural drainage channels have become clogged with trash, provoking local flooding during heavy rains. Trash is collected daily in areas where the streets are wide enough. Insects and rodents are prevalent in vacant lots and in waterways where trash is disposed of.

Health statistics for Coque are not available. It can be concluded, however, that the situation is below the average for Pernambuco which, in turn, is below the average for Brazil. For the country, the infant mortality rate is 123 for 1000 live births, for Pernambuco it is 138 per 1000. The five principal causes for death among infants age 0--1 are: enteritis, diarrhea, complications at delivery, pneumonia and congenital diseases. In the 1--4 year old range the principal causes of death are pneumonia, enteritis, diarrhea, measles, meningitis and vitamin deficiency.

History of Co-Clube

Co-Clube was founded in 1966 by a Catholic order of monks. The original building was used by people brought in by the monks from rural areas while they awaited hospital treatment in Recife. Shortly thereafter, the activities were expanded to include education. There were 15 rooms, seven of which were used as classrooms for preschool, primary school and typing classes.

In 1970 a private, non-profit French aid organization, "Brothers of Men", began to offer its support and broaden activities to include medicine. Two medical students gave consultations, made home visits and showed films and slides about health. The organization started a mother-child feeding programme and renovated the school building to house the consulting rooms as well as the school. Preventive health care activities increased again after a serious flood affected the area in 1974. Parents of students were organized and street meetings were held.

Present Activities

Health--The main objective of the health post is to provide ambulatory and laboratory services and to promote vaccination campaigns. It also performs a role in mainaining community involvement insofar as individuals who receive medical attention are encouraged to participate in other neighborhood activities.

Three doctors, a laboratory technician, eleven attendants and a watchman were chosen by the community to work in the health post and participate in health education activities. The medical personnel also participates in the planning, implementation and evaluation of sub-projects. Their salaries are paid out of contributions from "Brothers of Men". The Municipal Government provides a gynecologist, a psychiatrist, a general practitioner and a dentist whose work is confined to consultations.

There are two medical consultation rooms and the six doctors work alternate shifts so that at least one is always on duty during the day. More than 100 consultations are held per week and vaccinations are given. A very small fee is charged for each consultation. All patients are invited to participate in a seminar on current health issues at the end of the week.

The on-site laboratory conducts feces, urine, blood and pregnancy exams for a small fee. The receipts are used to maintain the laboratory. It is staffed by residents of the community who have completed special courses in laboratory technology.

Education--The objective of the education component of Co-Clube is to strengthen community organization and, at the same time, raise the level of understanding and consciousness about health problems. The health attendants go to classes given by the doctors that deal with local health problems such as parasites, tuberculosis and environmental sanitation. They are then responsible for the education of the rest of the community. They fulfill this responsibility by holding classes and health discussions in the streets of Coque. As a result of these meetings, groups have been formed on each street to carry out the activities in the areas discussed.

There is a training program that all those aspiring to become health attendants must follow. Students come from Coque as well as from other neighborhoods. The emphasis of the training program is on the technical aspects of health rather than on the community development aspects since it is assumed that, coming from low-income areas, the trainees are already sensitive to the needs of their clientele.

Extension of activities

Given the difficulties in attending a community the size of Coque with one small health post, two others are being started by a neighborhood youth group that is working closely with Co-Clube.

The managers of Co-Clube are currently preparing a proposal that calls for an expansion of the ambulatory activities, a greater emphasis on home visits and an increase in the use of audio-visual material for education purposes.

Based on the paper "Co-Clube: an Urban Community Health Program in Coque, Recife, Brazil" prepared by Marilyn Dawson, UNICEF Project Officer, Recife.

(i) For a copy of the original document write to UNICEF HQ Library, NY.

(ii) For any further help or information, write to John J. Donohue, Senior Urban Policy Specialist, UNICEF, New York.

1) NAME OF PROJECT: Primary Health Care in Marginal Areas of the City of Popayan, Colombia--Barrio La Mario Occidente

2) TARGET POPULAION: Population of Barrio de Mario Occidente numbering approximately 10,000 which respresents 1,600 families.

3) TIME FRAME: 1981--82

4) EXECUTING AND CO-OPERATING AGENCIES: Ministry of Health, Cauca Section Health Service, UNICEF, School of Nursing Assistants in Popayan.

5) COSTS: Investment and operation costs for both years totalled 6,194,232 pesos (approx. US$ 94,300 at current exchange rate).

6) SOURCE OF FUNDS: The main financial support came from Zonta International and UNICEF.

7) OBJECTIVES:

1. To expand the coverage of the health services to the communities in the urban marginal areas of Popayan by using the primary health care strategy.
2. To construct and provision a Primary Health Care Unit which will serve as the basic unit of health care.
3. To train the health promoters on the basis of a modular and theoretical/ practical system that will allow for adjustments based on actual facts.
4. To stimulate and incorporate into the process the active participation of the community, in both the implementation and in the follow-up and evaluation.
5. To apply the results of this experience in other marginal areas with similar conditions, making the necessary adaptations for each case.

8) BRIEF DESCRIPTION: PRIMARY HEALTH CARE IN MARGINAL AREAS OF THE CITY OF POPAYAN,COLOMBIA--BARRIO LA MARIA OCCIDENTE

Background

The primary health care project in the city of Popayan, "Barrio La Maria Occidente", was conceived as a demonstration model of primary health care.

The overall objectives were to achieve the highest degree of health compatible with the level of community development, to increase services giving preference to marginal groups and to organize the community in order to ensure its active participation. It was also considered necessary to decentralize the social investment so that the various regions could gradually assume control and responsibility for execution of the project and adjust the efforts undertaken to the actual problems and needs of each region. It was therefore felt that the participation of the community should be conscious, active, deliberate and continuous.

Project Phases

Selection of the area--The "Barrio La Maria Occidente" was chosen after taking into consideration a set of criteria which included: present lack of health services, accessibility and population.

Construction of a primary health unit--This involved locating the site, legally clearing its title and transferring it to the Cauca Section Health Service, obtaining a permit and undertaking the construction. The health unit is composed of: a consultation room for individual attention, a consultation room for oral health attention, a room for emergency treatment, a room for vaccinations, a pharmacy, a room for administration, a multiple-use room (conference, meetings, etc.), a waiting room and restrooms. The health unit also has an ambulance and a garage.

Promoters--These were selected according to specific criteria that included: education to the first year of high school, age between 18 and 35, habitual residence in the barrio of La Maria Occidente, and approval by examination and interview.

Once selected the promoters went through a training programme that covered the following areas:

a. Community
b. Health care for women
c. Health care for the child up to the age of 15 years
d. Health education
e. Accident prevention and emergency care
f. Basic sanitation
g. Information sub-system

As part of the training programme, actual practice in the respective area of coverage was undertaken by promoters. Once they completed their formal training, their first activity was to undertake a health study of the community.

The activities of the urban promoters are similar to those of rural promoters; the former, however, have additional activities such as house-to-house vaccination, assessment of visual acuteness in school children, teaching the family the care of the bed-ridden patient. Moreover, the urban promoters also have the crucial role of motivator of the community for the formation and functioning of committees. They should be leaders in the community and be prepared to participate in all the programmes for community organization and education, fulfilling those activities that are delegated to them in this respect.

Plan of Action

The Section Health Service of Cauca, the School of Nursing Assistants, the Directorate of Medical Care of the Ministry of Health and UNICEF jointly determined the plan of action. It reads as follows:

--- To make study tours to similar programmes before initiating the process of training.
--- To have project follow-up meetings with the participation of the Ministry of Health and UNICEF.
--- To request technical support as necessary.
--- To construct the primary health care unit.
--- To present progress reports on the construction and training.
--- To present financial reports.
--- To present a final project report.
--- To develop the mechanisms for the recruitment and selection of promoters.
--- To develop the necessary teaching material.
--- To train 10 urban health promoters during 1981 and 8 during 1982.
--- To motivate the community to cooperate with the promoters in the development of their work.
--- To develop a methodology and tools for follow-up and evaluation.
--- To prepare a report that documents the development of the programme and the results achieved.
--- To develop a means for the interchange of information and support for projects with similar practices.

The portion of the work-plan dealing with activities related to implementation, follow-up and control includes:

--- To observe and to reach conclusions on the degree to which the established objectives have been fulfilled and to make the corresponding adjustments in the Plan of Action and Implementation.
--- To exchange actual experiences of the Services in the implementation of the programmes according to the conditions of work, with the purpose of enriching and accomplishing the corresponding adjustments.
--- To hold quarterly meetings for follow-up and operational control. Adequate programming and accomplishment of these meetings are necessary conditions within the programme.

The information system for urban promoters, which was designed in the programme, made it possible to develop evaluation mechanisms, both quantitative and qualitative. By using these mechanisms it was possible to evaluate the direct effects of actions on the community. The community-based approach ensured that the community participated in the study of health conditions, received information on the results of the study, suggested plans of action based on the findings and participated in actions undertaken.

Limitations and Conclusions

Some limitations were due to situations created prior to the introduction of the project. Some were physical, for example the type of housing construction and layout of the barrio made some sanitation efforts more difficult. Other limitations were of a social nature and prevented the inhabitants from participating in some activities. Yet another limitation was that at times the community ignored the importance of the preventive health programme, giving more importance to secondary care.

It was felt that this type of programme could be implemented in communities that have an infrastructure similar to the barrio "La Maria Occidente" once the implementation and evaluation of the current project is finalized.

Based on the paper "Proyecto de Atencion Primaria de Salud en Areas Marginadas Urbanas en la Cuidad de Popayan: Barrio La Maria Occidente" prepared by the Ministero de Salud et al. which was presented at the International Seminar/Workshop on Urban Primary Health Care held in Popayan, Colombia on 5-9 July 1982.

(i) For a copy of the original document in Spanish or for the informal English translation write to UNICEF HQ Library, NY.

(ii) For any additional help or information write to UNICEF Regional Director, Bogotá, Colombia.

(iii) For any further help or information, write to John J. Donohue, Senior Urban Policy Specialist, UNICEF, New York.