

People and Health

Juan Gervas

Rediscovering lost vocations

A small group of health professionals in Madrid has built up a research and advisory organization whose objective is to help doctors, nurses, pharmacists and others to achieve greater job satisfaction by turning away from unthinking, routine approaches to their work and meeting the needs of the community more directly, not least through preventive measures.

Many doctors, nurses and pharmacists in Spain and elsewhere feel more like clerks than health professionals because of the way health care has developed. In Spain a plan for the reform of primary health care is intended to change the working conditions of staff and the way in which care is delivered to the population. Progress has been made but as yet only 30% of the structure has been modified. Many physicians and nurses in the social security system have lost their self-esteem and it is hard to get them to believe that things really can be altered. The same is true of the pharmacists, who, even if they are in private business, depend almost entirely on sales to the social security system.

The Spanish public health system has developed from the social security system, which delivers health services directly to the population. The National Institute of Health, a social security agency that provides

medical care for over 95% of the population, has its own network of primary care centres with family doctors, paediatricians, nurses and auxiliary personnel. Patients are seen for an average of three minutes each and very little preventive care is given. Many consultations consist simply in making out a prescription or referring a patient to a specialist.

The Ministry of Health provides most preventive services. With the present move towards regionalization this responsibility is being taken over by the Autonomous Communities. The reform of primary care, which began in 1984, is based on new health centres and involves substantial investment. The process is going forward slowly.

"What are we doing?"

In 1982 the present author and two other family doctors in the social security system asked ourselves what was really happening at our consultations. The daily round of work hardly left us with time to think.

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We decided to record data on patients and their treatment. After six months we had information relating to 90 working days and almost 1500 patients. With the help of a statistician and an epidemiologist, we established a data base in a computer at the Ramon y Cajal Hospital in Madrid. We found, among other things, that age was positively correlated with attendance at the surgery and the number of health problems; that cardiovascular disorders ranked first among the chronic diseases; and that more than a quarter of the patients left without prescriptions. A study was conducted on the use made of consultations, and another was performed on the financial costs of the care delivered. These investigations led us to consider patients', as opposed to doctors', opinions. We interviewed patients after consultation, and used the same form to record doctors' and patients' opinions. Sometimes doctor and patient were perfect strangers to one another and conducted a dialogue that reflected this.

Teamwork

The statistician modified an analytical programme to facilitate our investigations and we were soon joined by additional colleagues. All analysis is done outside working hours. Meetings are nearly always held at our homes or in a cafeteria. We have no office and no legal existence! We are just a group of friends who work in different parts of Madrid and belong to various public and private organizations. The first analysis showed that we did hardly any preventive work, that we scarcely saw any psychological, social or family problems (or at least did not record them), that the clinical histories we took down were inadequate, and that we had registered and coded incorrectly.

We needed financial backing and an identity. The group had been growing and

now comprised about two dozen persons (general practitioners, nurses, pharmacists, a schoolteacher, a psychiatrist, a psychologist, a sociologist and a statistician). We requested and received help from the Social Security Research Fund so that we could study the "correlation between input and output at the outpatient clinic". The acronym of this phrase in Spanish (CESCA) was adopted as the name of our team.

The nurses and doctors among us designed a new clinical history form, which was problem-orientated and geared to facilitating preventive work. At two of our surgeries the nurses ceased to work alongside the physicians and transferred to offices that were free during consulting hours. The testing and introduction of the clinical history and the nursing consultation faced us with unforeseen issues, some of them with ethical implications. But now the nurses do preventive work and conduct check-ups in chronic cases, allowing the physicians to devote more time to treating patients and to dealing with complications of chronic cases.

As we did not know whether patients bought the drugs we prescribed, we obtained lists of the pharmacies that had dispensed our prescriptions in 1984. Some of the

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dispensing pharmacies cooperated with us in an investigation into this matter.

The difficulty of coding the diagnoses made in our consultations took us into the field of classification. The present author has

become a member of the Committee on Classification of the World Organization of National Colleges and Academies of General Practitioners and Family Physicians. We are at present taking part in a European multicentre study to test the International Classification of Primary Care.

By 1986 the team felt ready to begin teaching. Our courses on record-keeping, information systems, and research into general practice have been well received. We have developed a primary health care network which has over 400 members throughout Spain; these physicians, pharmacists and nurses are developing joint studies and cooperating with the European Community in various primary health care research projects.

We receive considerable amounts of correspondence, all of which we answer as best we can. We have a regular section on primary health care in a journal (*Clínica rural*) circulating among country physicians, in which we try to demonstrate that it is possible to change things for the better.

In 1988 we organized a scientific committee and an economic board to optimize our activities. The Social Security Research Fund has renewed its assistance. Our research for

the next three years will be on "Minimum data in primary health care: their coding and exploitation in an information system". We shall continue to teach and shall bring in new subjects, such as the applications of microcomputers in primary health care, evaluation, and quality control. We aim to be professional, enthusiastic about our work, and capable of improving matters with as little outside help as possible.

Reorientation

Professionals who feel that they are clerks rather than doctors, nurses and so on are likely to be despondent and bored in their daily work; they may believe that scientific studies can only be done somewhere else; they may suffer a loss of self-esteem; and they may have no expectation of improvement. In order to emerge from this "condition", they have firstly to recognize it. The possibility then exists of showing them how to tackle it by referring to instances where a "cure" has already been achieved.

The situation arises because the training of health professionals is often irrelevant to the sufferings and problems of the community. Clearly, therefore, it is necessary for the affected people to undergo a measure of retraining. □

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Towards the measurement of community participation

A description is given of the initial stages in the development of a methodology for assessing community participation in health schemes. A study in Nepal indicates that the approach adopted will be useful to planners who wish to evaluate involvement in primary care programmes.

Planners have often demonstrated the existence of community participation by looking at activities rather than processes (1). For instance, they have reported the presence of community health workers or community health committees, have attended meetings, or have measured community contributions in money or kind. However, for planners in many countries, information is required about the processes that influence change.

A methodology is being developed in order to answer this need. At the request of WHO and UNICEF, 200 case studies were reviewed and factors influencing community participation were identified (2, 3). They included needs assessment, leadership, organization, resource mobilization, and management. These indicators can be made

to facilitate assessment of participation in a given programme:

- at different times;
- by different planners;
- by different participants.

What is community participation?

In the literature, the word "community" has been given the following principal meanings:

- a group of people living in the same area and sharing the same basic values and organization;
- a group of people sharing the same basic interests at any given time;
- a group of people targeted for interventions.

In primary health care, with the goals of equity, effectiveness and efficiency, it is important to identify the people in greatest need and to make realistic judgements about how changes can be achieved.

With regard to "participation", it is clear from the literature that it should be active and involve potentially effective choice.

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We therefore suggest that community participation is a social process in which specific groups with shared needs living in a defined geographical area actively pursue

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identification of their needs and take decisions and establish mechanisms to meet them (2).

Assessing the breadth of participation

It is possible to ask a series of questions designed to reveal the breadth of participation in specific health care programmes. Examples are given below of the sorts of question which may be put.

In the case of needs assessment, questions are asked which will help to show whether professionals and/or community members have been involved:

- How were needs identified?
- Did identification relate only to health service needs?
- Was the community involved in needs identification and assessment?
- Did the assessment strengthen the role of a broad range of community members?

The questions about leadership investigate whether community leaders represent narrow interest groups or a broad range of socioeconomic interests:

- Which groups does the leadership represent and how does it do so?
- Is the leadership paternalistic and/or dictatorial, limiting the prospects of wider participation for various groups in the community?
- How does the leadership respond to the needs of poor and marginalized people?
- Have most decisions by the leadership resulted in improvements for the majority of the people, for elites only, or for the poor only?

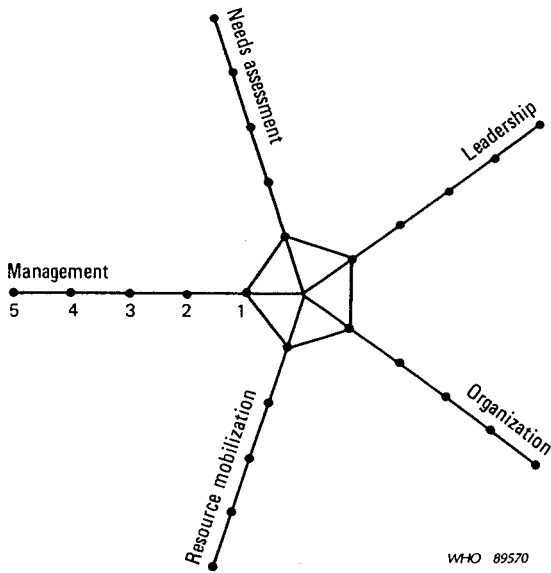
Questions about organization focus on whether planners attempt to create new structures or to integrate health programmes into existing structures:

- Have new organizations been created to meet defined needs or have the existing ones been used?
- Are the organizations flexible and able to respond to change or are they rigid, fearing change in control?
- What changes have taken place in the organizations since the introduction of health programmes and do the changes benefit professionals or community members?

Concerning resource mobilization, questions need to determine the extents to which programmes are supported by outside funds and community contributions:

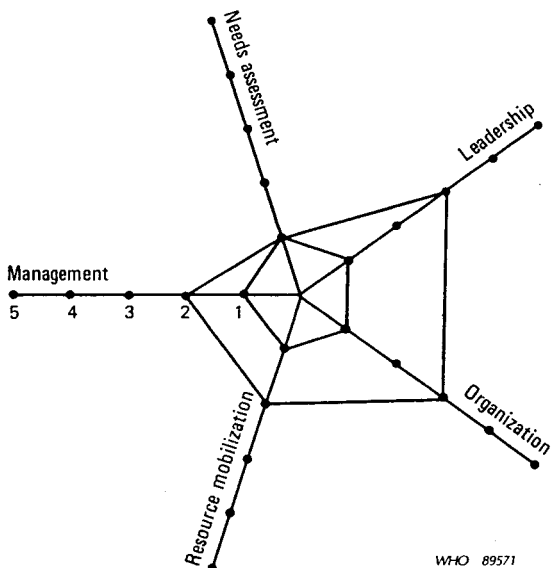
- What has the community contributed and what percentage is this of the total programme costs?
- Have resources from the community been allocated for the support of parts of the programme which in other circumstances would be covered by government allocations?
- Whose interests are served by both the mobilization and allocation of resources?

Fig. 1. Diagram for assessing community participation



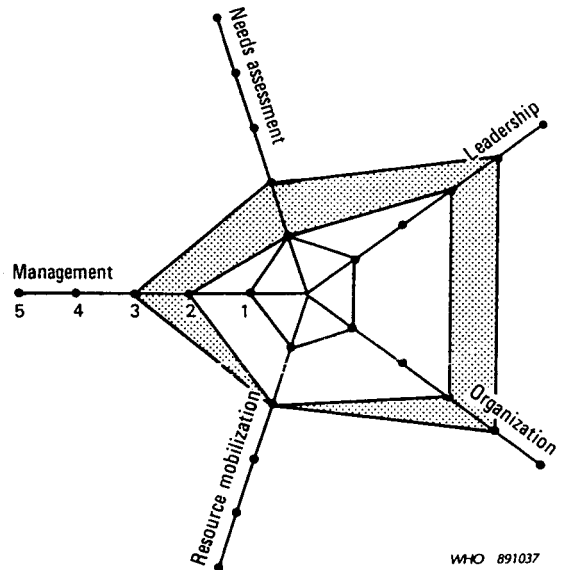
To assess management it is necessary to determine whether responsibility and accountability rest with professionals or whether community members become involved in decision-making:

Fig. 2. Baseline assessment of health programme



- Are decisions solely in the hands of professionals or are they made jointly with community members?
- Have the decision-making structures changed to favour certain groups, and, if so, which groups?
- Have management structures expanded to broaden the decision-making groups?
- Has it been possible to integrate non-health needs?

Fig. 3. Changes between first and second assessments



When answers to these questions have been analysed, a decision is made as to where to place a mark on each of several continuous lines that separately represent different factors (Fig. 1). The lines are arranged in a spoke-like configuration to show their inter-relationships and the marks indicate whether participation, in respect of the factors, is wide or narrow. Fig. 2 shows how marks might be placed as a baseline for a sample hypothetical programme: they go near the centre if participation is narrow and near the end if it is wide; they cannot be placed at the very centre because there is always at

least some participation. Fig. 3 represents a comparison between the baseline and an assessment done at a later time.

The indicators are descriptive. They do not tell planners whether participation is good or bad. The judgement made depends on the planners' goals. It is intended that the indicators should allow planners to describe change and define processes taking place. They are based on the principles of primary health care and on case studies suggesting that health improves with broad participation in a wide range of activities.

A study in Nepal

In Nepal, government planners require information on the extent of community participation in their health programmes. In order to assess this, the methodology described above was tested with the help of district health managers (5). Modern health services of the Western type have been evolving slowly. In the 1950s, several poorly coordinated vertical programmes were set up. They, and the involvement of numerous foreign donor agencies with various policies, characterized the health system for some

Ways should be explored whereby community participation can be assessed by district management teams.

twenty years. The Nepal Country Health Programming Exercise chose a countrywide system of locally recruited, government-employed village health workers during the period 1980-85. The system was to be supplemented, a few years later, by

voluntary community health leaders and traditional birth attendants.

Today the national health system is designed according to the district health care approach, but there are still organizational differences between districts. However, there is now a strong commitment to national coordination and to an integrated public health system. The Decentralization Act of 1982 provides for the decentralization of government structures and planning capacities and is a major support for the new district health policy. Within the health sector, committees have been created at all administrative levels in order to allow for community involvement. These committees are of special importance at the levels of the health posts and *panchayats* (the basic administrative units of the communities), where they are supposed to coordinate their activities with those of the local health personnel.

Initially we discussed the situation with various people, ranging from district managers to community representatives, using the kinds of question described above. A protocol for interviews was then developed and a ranking scale was devised for the answers (see table). Decisions as to where to place the marks on the spoke diagram were made. The district health managers were thus provided with a description of community participation in their programme and a basis for planning was laid down.

After assessment of the factors, the diagram was drawn. This gave the district health managers a description of community participation in their programme and provided a basis for planning.

The study helped planners to achieve a better understanding of the process of participation, and they found the methodology quite useful.

Ranking scale for process indicators of community participation

Indicator	Ranks				
	1. Narrow	2. Restricted	3. Mean	4. Open	5. Wide
Needs assessment	Imposed from outside with medical, professional point of view (CHL, village health worker, health post staff); or: Latrine building programme imposed on community.	Medical point of view dominated an 'educational' approach. Community interests are also considered.	CHL is active representative of community views and assesses the needs.	WHC is actively representing community views and assesses the needs.	Community members in general are involved in needs assessments.
Leadership	One-sided, i.e., wealthy minority; imposing wardchairman; health staff assumes leadership; or: no heterogeneous WHC ^a .	WHC not functioning, but CHL ^b works independently of social interest groups.	WHC functioning under the leadership of an independent CHL.	Active WHC, taking initiative.	WHC fully represents variety of interests in community and controls CHL activities.
Organization	WHC imposed by health services and inactive.	WHC imposed by health services, but developed some activities.	WHC imposed by health services, but became fully active.	WHC actively cooperating with other community organizations.	Existing community organizations have been involved in creating WHC.
Resource mobilization	Small amount of resources raised by community. No fees for services. WHC does not decide on any resource allocation.	Fees for services. WHC has no control over utilization of money collected.	Community fund-raising involvement in control of expenditure.	Community fund-raising periodically and WHC controls utilization of funds.	Considerable amount of resources raised by fees or otherwise. WHC allocates the money collected.
Management	Induced by health services. CHL ^b only supervised by health staff.	CHL manages independently with some involvement of WHC. Supervision only by health staff.	WHC self-managed without control of CHL's activities.	WHC self-managed and involved in supervision of CHL.	CHL responsible to WHC and actively supervised by WHC.

^a Ward health committee.

^b Community health leader.

It had been expected that it would be possible to use the assessment to describe changes in participation from the beginning of the programme. However, interviewees could not recall the previous period. Thus a first assessment should serve as a baseline rather than as a means of judging change.

Different groups of people had different perceptions about community participation. For instance, the members of the district management team perceived participation quite differently from service recipients. The methodology, therefore, may even be used to crystallize differing perceptions, with a view to improving health programmes through better mutual understanding.

It should be noted that the assessment was carried out by one person, whereas a key aim of the method is to provoke discussion in order to achieve group agreement for future plans. Given this objective, ways should be explored whereby community participation can be assessed by district management teams that organize their own interviews and data analysis.

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The purpose of the approach outlined above is to help managers to understand the process of community participation in health programmes. It seeks to describe change by assessing how broad or narrow participation is at a given time and comparing it with that at another time or with that perceived

by another group. It is concerned with the process of change rather than with the achievement of a standard. It is a participatory way of assessing community participation and may be used for involving the district health team as well as community groups in evaluating their own programmes.

This approach is at a very early stage of development. It should be employed by various kinds of planner and adjusted to meet their objectives. However, its first experimental use in Nepal suggests that it will be valuable to planners wishing to evaluate participation in primary health care programmes. □

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Quentin Reilly

More power to the people

The problems and benefits associated with health service decentralization in Papua New Guinea are outlined below.

Over the past decade there has been a strong tendency to decentralize health services in many developing countries. One of the principal motivating factors has been the encouragement given by UNICEF and WHO. However, community participation is not easily achieved where there is relatively little input of ideas from outside and where the people have been accustomed to fairly autocratic government, as in most developing countries that have recently become independent.

In Papua New Guinea it has been found that the required changes in attitude take a considerable time to occur. The National Health Plan for 1974–78 set out the principles of a widely available service, and that for 1986–90 reaffirmed them. The country's decentralized health system was based on the type of administration that existed in the Department of Health. Further moves towards decentralization were associated with the acquisition of provincial autonomy in the mid-1970s, and the process was brought to completion under a health minister who firmly believed that decentralized decision-making could produce substantial benefits.

At the 1980 meeting of provincial health officers, the Secretary for the Department of

Western Highlands reported that the shortage of skilled manpower was seriously hindering the improvement of services. He considered that political interference, the attitudes of national departments, and the disintegration of national unity, were major problems associated with decentralization, and pointed out that one consequence of the process was increased political influence on decision-making by provincial public servants. It was often difficult to decide whether a politician was exercising his rights or interfering in the independence of the public service.

Resistance

The Secretary reported that he had encountered the following attitudes among national staff.

- Fearing a loss of control and a decline in their own status, they opposed decentralization and refused to delegate decisions.
- They totally ignored decentralization in the belief that it was only a passing phase.
- They politely remembered to ask the provinces their opinions about some matters but merely informed them of decisions on others.
- They refused to make decisions, passing on all responsibility to the provincial governments.

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At the same meeting, the Secretary for the Department of Decentralization suggested that the disciplinary process should be broadened to include the people actually affected, so as to reduce confrontation. As an example of what he envisaged, he

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mentioned that village health committees might decide what action to take. This view was adopted some years later in the Department of Health's primary health care policy.

Another important factor that affected relationships between the central and provincial authorities was that many provincial health officers were overseas contract workers, whereas the headquarters staff were nationals of Papua New Guinea. Some of the provincial health officers were knowledgeable and forthright, and this appeared threatening to the headquarters staff whose authority had been eroded by decentralization.

Unfortunately, on graduating, national medical officers sought clinical posts for the most part, rather than ones of an administrative or public health nature. The move to appoint nationals of Papua New Guinea as provincial health officers in some provinces led to posts being filled by health extension officers. They had received three years of training in general health, preventive and clinical medicine, and administrative matters, and had then worked as rural doctors. They were able to deal with

a high proportion of the medical problems encountered in rural areas. At a later stage they were given the opportunity to take specialist courses in administration, health programme management, and some clinical fields, e.g., anaesthetics.

It is interesting to observe that certain arguments against decentralization deployed by officials of the Papua New Guinea Department of Health in 1980 closely resembled the following ones previously offered by staff in the New York City Health Department, which had decided to decentralize in the mid-1970s (1).

- The authority of the functional bureaux should not be weakened, as the accomplishments of the Department are the products of specialized bureaux.
- The technical surveillance of the Department would suffer if there were an increase in the authority of district health officers, who lack the specialized knowledge of bureau chiefs and their staffs.
- A bureau chief cannot assume responsibility for quality of service if it is provided under the direction of another officer.
- The problem of coordinating a large number of health districts is just as great as that of coordinating the field services offered by bureaux.
- A decentralized district system is disruptive of the pattern of professional and personal relationships at all levels, the quality of which is critical to the effectiveness of the Department.

New roles and attitudes

The efficiency of the Health Department's headquarters deteriorated for a time after decentralization because senior staff were

unwilling or unable to take on their new roles. Only in late 1982 did the situation start to improve, following drastic changes in the Department's personnel and structure. Attempts by some headquarters staff to retain the full extent of their influence after decentralization not only caused confusion among peripheral staff but also reduced their efficiency, demoralized some, and eventually frustrated and demoralized the senior individuals concerned.

In the provinces the most obvious effect of decentralization was that all health workers began to see themselves as members of a single team, rather than of isolated sections, relating through the provincial health officer to Health Department headquarters in the capital. As most problems were dealt with more quickly at provincial level than nationally, staff morale improved. Cooperation and the sharing of resources occurred more readily in respect of both transport and finance.

Health extension officers are vitally important in Papua New Guinea. They are not just substitutes for doctors but have a very important role of their own, organizing and running the rural health services.

On decentralization of the health services, the former provincial health officers became Assistant Secretaries (Health) for the provincial departments. Not only were administrative responsibilities increased, but there were also new political tasks in relation to the provincial governments.

Prior to decentralization, all provincial health officers were medically qualified, whereas at the beginning of 1984 nine of the 20 Assistant Secretary positions were held by health extension officers, and by 1988 there were 12 such officers. Initially, they took up these posts because national medical officers were not interested in them

and suitably qualified foreign medical officers were difficult to recruit.

Subsequently, some foreign officers taught the senior health extension officers working with them how to fulfil the requirements of the posts. A course in community health was introduced at the University of Papua New Guinea, and obtainment of the diploma on offer is now essential for people wishing to hold the senior provincial health positions. It has been shown that these health workers can do the job at least as well as medical officers. Likewise, at Department of Health headquarters, medical officers held all the Assistant Secretary positions prior to decentralization, whereas by 1984 some senior paramedical workers were working alongside senior medical officers as Assistant Secretaries. These changes have resulted in an improvement in the standard and coordination of activities in the Department of Health.

Improvements in services

Statistics derived from the 1971 and 1980 censuses show that substantial improvements in the health of the population occurred in the intervening period. This evidently

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resulted, to a considerable degree, from the decentralized primary health care approach. Infant mortality decreased from 134/1000 live births in 1971 to 72/1000 in 1980, while childhood mortality decreased from 79/1000 to 42/1000. Life expectancy at

birth rose from 47.4 years to 49.6 years. Maternal mortality seemed to remain high, although only estimates were available. The results of a comparison of health facilities reflected the policy of giving priority to the expansion of basic health services. Between

The coverage of disease control programmes improved when primary health care was introduced.

1973 and 1984 the number of aid posts increased by 44%, while that of health centres and subcentres increased by 40%. The number of hospitals fell because of the closure of some long-stay establishments for tuberculosis and leprosy patients. However, there was an increase of 7% in the number of beds in health centres and hospitals.

These infrastructural changes gave the population improved access to health services. In 1973 some 86% of the population were believed to be within a two-hour journey of a health service facility, whereas in 1980 and 1985 the corresponding figures were 93% and 96%. The average number of people covered by each aid post decreased from 1666 in 1973 to 1466 in 1984.

During 1975 about US\$ 31 million were spent on health, equal to 8.7% of government expenditure and 2.6% of the gross domestic product. From 1975 to 1984 the proportion of government expenditure going to health remained relatively constant and the proportion of the gross domestic

product doing so increased consistently. By 1985, expenditure on health had increased to \$ 79 million, which was 8.8% of government expenditure and 3.7% of the gross domestic product. Expenditure per capita on health in 1988 was \$ 24.3. The ratio of expenditure on primary health services to that on hospitals was 55:45 in 1984, little changed since 1973.

The coverage of disease control programmes improved when primary health care was introduced. Vaccinations were generally done by community health nurses who travelled to various maternal and child health clinics. In one province, aid posts were used with great success to improve vaccination coverage. In 1983 the coverages, as measured by third doses of triple antigen, Sabin, and pigbel (enteritis necroticans) were 27%, 27% and 30% respectively, and in 1986 the corresponding values were 47%, 42% and 69%. BCG vaccination over the same period improved from 58% to 75%.

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The basic purpose of decentralization is to give more power and responsibility to the people in the determination of their health and development. This should not only be seen as a human right but also as the only way to increase the people's appreciation and utilization of health services, raise health status, and improve the quality of life. □

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