EVALUATION REPORT 1988

PRIMARY HEALTH CARE

NETHERLANDS DEVELOPMENT COOPERATION

Ministerie van Buitenlandse Zaken

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in de Nederlandse ontwikkelingssamenwerking vanaf 1975)

Het rapport is thans in de Engelse taal verschenen.

Een exemplaar gaat U hierbij toe.

DEN HAAG, JUNI 1989

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PRIMARY HEALTH CARE

EVALUATION OF DUTCH-SUPPORTED ACTIVITIES IN THE FIELD OF EXTRAMURAL HEALTH CARE SINCE 1975

Operations Review Unit
October 1988, 243

Cooperation with developing countries to improve public health has been an important aspect of Dutch development policy from the outset. The motivation for this was partly humanitarian and partly that health is regarded as a prerequisite for economic development. Several years ago, the Development Cooperation Section of the Dutch Ministry of Foreign Affairs began to feel the need for an evaluation of the activities undertaken in this area and everything it had achieved since 1975. This resulted in 1987 in an evaluation report on activities in the field of hospital-based health care, i.e. intramural health care.

This report concerns Dutch experiences in extramural health care projects and programmes, i.e. care which is provided mainly outside hospitals. Together these two reports cover most of the sector.

The present report consists of four parts. The first part describes in brief the context in which extramural care is carried out. Chapter one focuses on the relations between socioeconomic development and health and on the main causes for the low standard of health in developing countries. It summarises the action taken by governments and donororganizations to improve health in developing countries since World War II and gives a brief review of Dutch development cooperation policy in relation to health care.

The second part contains the main evaluation results of 33 projects carried out since 1975. These findings are preceded by a chapter 2 which describes the methodology of this study and by a financial survey in chapter 3 of Dutch bilateral aid in the field of health care from 1975 to 1987. The main findings are presented in chapters 4, 5 and 6. Chapter 4 analyses the project activities in terms of their objectives. Were the activities supported or initiated by the Dutch government geared to improving the health of as many people as possible in the periphery? Chapter 5 evaluates the extent to which the main principles of the primary health care approach were taken into consideration in the implementation of the selected projects. Chapter 6 presents the main project results, i.e. what was achieved during the project or programme period.

The third part presents a brief assessment of the Dutch-supported activities in the field of extramural health care that were examined and concludes with recommendations for future action. The last part contains the appendices.

CONTEXT

HEALTH AND HEALTH CARE IN DEVELOPING COUNTRIES

1. Health situation

The average level of health of the population in low income countries is considerably lower than in high income countries as is illustrated time and again by the statistics of organizations such as WHO, UNICEF and the World Bank. There is a clear correlation between the Gross National Product (GNP) and the level of health and health care. The Table below lists a number of important indicators and determining factors for health which are linked to the level of development.

Table 1. Health indicators and determinants in countries with different income levels

Indicators and determinants	National income level		
	Low	Medium	High
1. GNP per capita in $	200	1.270	12.960
2. Births per 1.000	43	31	13
3. Deaths per 1.000	16	10	10
4. Average life expectancy			
male	52	61	73
female	54	65	79
5. Infant mortality per 1.000 live births	106	65	24
6. Maternal mortality per 100.000 live births	607	381	11
7. Drinking water (% of population with access)	33[1])	56[1])	94[1])
8. Calories (daily supply per capita)	2.100	2.719	3.357
9. Literacy %	28	55	93
10. Population per physician	17.670	4.940	550
Nursing staff	7.130	1.400	180

The correlation between poverty and poor health is understandable, since poverty usually goes hand in hand with malnutrition (sometimes severe), unsafe drinking water, inadequate sanitation, poor housing, a rapid succession of pregnancies, and in many cases poorly paid, 'dangerous work' - all factors which increase the risk of disease (including chronic disease) and premature

Source: World development report, 1988
1) Social Indicators of development, 1987

death. Widespread infectious diseases which have not yet been brought under control, e.g. malaria, tuberculosis and bilharzia, are not in themselves poverty-related although they present an additional threat to the poor.

A low GNP, however, does not always mean unfavourable scores for health indicators. Some countries with a low GNP, such as Sri Lanka, China and Cuba, score relatively well on indicators such as life expectancy at birth and infant mortality. This is because it is not only the GNP but also factors such as environment, the way in which people live and, in particular the way in which the national income is distributed among the population which determine the average level of health of the population.

Distribution

The highest mortality rate is found among young children, particularly in the first year of life. The main cause lies in the complex of malnutrition, worm infestation, anaemia and frequent infections. Particularly common are acute gastrointestinal and bronchial infections, the former often being complicated by dehydration, which can rapidly prove fatal.

From time to time whole areas are afflicted with measles or whooping cough in a manner reminiscent of the plagues of medieval Europe. Tetanus in newborn infants (the people themselves call it the 'disease of the seventh day') is one the first ten causes of death in areas where hygiene at childbirth is inadequate.

Both men and women are affected by the major infectious diseases mentioned above. Many men are exposed to additional risks at work, e.g. accidents and insecticide poisoning. Women are particularly affected by diseases related to the reproductive cycle: miscarriages and even normal births are dangerous if there is no expert assistance available. Physical weakness due to the dual workload on women both in the home and outside coupled with frequently recurring periods of pregnancy and breast-feeding, although not included in the statistics as diagnoses, are in many instances the main cause of chronic infection and premature death.

In many if not all societies inequality in opportunities for health runs parallel to, and forms part of, social inequality in other fields such as employment, income and education. The form the inequality takes may differ according to class, sex and race, and even between urban and rural areas. Health facilities are few and far between in many rural areas. Levels of health and patterns of disease similar to those in the rich countries can be found among the better-off in towns and cities. In many of the rapidly growing slums around them, on the other hand, the level of health is very poor, similar to that in rural areas. For example, in the various regions in Kenya, infant mortality ranges between 75

and 145 per thousand live births, and in Ghana, between 65 and 235 per thousand live births. In the slums of Third World Cities and in certain conditions such as those in the tea plantations of Sri Lanka, the situation is worse than elsewhere in the country.

Causes

The medical/biological view is that health and disease are determined by biological factors, and scientific medical care plays the most important role in fighting disease and reducing the death rate.

In many cultures the main causes of disease are sought in a complex of non-material forces outside the individual. Cures include not only magic but also traditional forms of health care.

A third approach attributes disease mainly to social causes. It exists in several variants and does not exclude elements of the other two approaches. Proponents of this approach regard disease as being caused almost entirely by economic circumstances, especially poverty, and are therefore most interested in the economic and social distribution of disease. In their view health cannot be improved without first relieving poverty.

Historical studies in this area (e.g. McKeown, 1979) reveal that the opportunities for health in the industrialized world have indeed improved more as a result of socioeconomic development than the development of medical technology, which came later. This finding has brought about an international revolution in thinking on disease, its causes and ways of fighting it. It is now recognized that the medical approach alone cannot solve the health problem. Some people even believe that socioeconomic factors are responsible for 70% of health problems (Cumper and Lee, 1983).

Others, conversely, have demonstrated the effectiveness of a purely medical approach to certain diseases, e.g. tuberculosis among the black population of New York (McDermott, 1978). Unicef also seems to favour this approach as demonstrated by its vigorous campaign mounted in 1983 to fight infant and child mortality.

It is not possible to give a precise ratio of specifically medical to socioeconomic causes of disease, although there are indications that the worse the health situation (e.g. in terms of infant mortality) the greater the part played by socioeconomic factors (Prescot, 1975). It can be demonstrated, moreover, that some types of disease are more poverty-related than others, and it is these that are the worst killers in the Third World.

Patterns of disease and mortality in developing countries differ considerably from those in the industrialized countries. In developing countries infectious diseases predominate and are accompanied by malnutrition and high birth rates. In the industrialized countries infectious diseases and malnutrition are no longer a serious threat to public health. The birth rate is low, and chronic degenerative diseases such as cardiovascular disease and cancer as well as accidents dominate the pattern of disease and infirmity. This difference in patterns of disease has highly significant consequences for the formulation of an effective development cooperation policy with regard to the specific health problems in developing countries and such policy must necessarily be very different from the policies adopted for the prevailing situation in industrialized countries. The following table from a World Bank report is indicative of the different patterns of disease.

Table 2. Patterns of diseases in countries with low and high levels of social and economic development

Disease or infirmity	Low socioeconomic development	High socio economic development
infectious diseases	44%	11%
cancer	4%	15%
cardiovascular diseases	15%	32%
accidents	4%	7%
other	34%	35%

Source: Health, Sector Policy Paper, World Bank, 1980.

Health care system

Health care in most developing countries can be divided into a number of subsystems. In many communities traditional methods of healing are used and retain their own position and status, separate from modern or scientific health care. In some places their status is officially recognized and included in the national plans to promote health. In any event, traditional methods, whether officially recognized or not, play a major role in large parts of Africa, Asia and Latin America. As far as organization is concerned, 'modern' health care has developed into two sectors, public and private. The public sector is directed by and from a Ministry of Health, in medical and employment legislation and in programmes implemented accordingly. The private sector comprises a large number of activities designed to promote health. First there are the private doctors and hospitals for whom profitmaking is a subsidiary or principal objective. Then there are charitable institutions, e.g. missionary organizations, which make a major contribution to health care in many developing countries.

The 'modern' health care system consists of functional units such as hospitals, health centres and stations, doctors' practices (private of otherwise) and paramedical assistants. There are considerable differences in the size and technological capacities of these units. The most common classification is by level of medical care: primary, secondary and tertiary. Ideally they should make up a network of facilities interlinked by a referral system. They may be defined as follows:

1. Primary (extramural) health care covers all the activities and bodies at village or community level; this includes health centres without beds.
2. Secondary health care comprises hospitals with general medical facilities but without specialist care, at both district and provincial level.

3. Tertiary health care comprises hospitals with specialist facilities, e.g. regional hospitals and those with a national function, including teaching hospitals and specialist hospitals.

Rough calculations indicate that developing countries spend 2-6% of their annual GNP on health care, 75% of which goes to the private sector (World Bank, Investing in Development, 1985).

The Government Health Care Budget moreover is mainly devoted to tertiary provisions which benefit only a minority of the population. An example which is illustrative of the situation in most developing countries is cited in a report by the Irish Advisory Council in Development Cooperation (1984): in Ghana, 40% of the Goverments' Health Care Budget is spent on tertiary provisions which reach only 10% of the population. Only 15% of the budget was devoted to primary health care benefiting 90% of the population. 45% was used for secondary care taken up 9% of the population.

2. Strategies

At the outset the emphasis was mainly on hospitals. In many countries a large part of the health budget was and is spent on building, equipping and operating large metropolitan and provincial hospitals. The "periphery", which includes the slums in large cities as well as the rural areas, is often neglected. It has, however, gradually become apparent that hospitals contribute little to improving the level of health of the population in developing countries.

Since the Second World War a number of strategies have been developed to raise the level of health of the population. It is possible to determine, albeit somewhat artificially, a number of overlapping phases in these efforts to improve health.

Vertical campaigns

Since the 1950s many countries have conducted campaigns against epidemics of tuberculosis, malaria, river blindness, whooping cough etc. These campaigns were organized independently of and outside the hospital system. Although results were sometimes effective in the short term, they were frequently random and transitory and insufficiently rooted in a long-term structural approach.

Basic health services (BHS)

When confronted with the necessity of making a choice between good health care for a small section of the population or reasonable health care for all, governments of developing countries, encouraged by international fora, began to formulate plans in terms of multi-stage, technically less ambitious health care

networks which would cover the entire country. In concrete terms, the choice was between one large hospital or a number of smaller hospitals, health centres and health posts.

Epidemiological research revealed moreover that people suffering from the major diseases could usually be treated as outpatients in health centres, often by paramedical staff trained for that purpose. Many countries therefore opted for decentralized facilities.

The aim of this BHS strategy was to use "polyvalent health centres" to reach more people closer to their homes and to provide them with essential drugs, maternal and child care, basic dental care, first aid and information on elementary matters such as nutrition, general hygiene, the use of safe drinking water, sanitation and waste disposal. The introduction of BHS was a major step forwards.

The health care network thus developed was a centrally devised and organized system. In practice it put additional financial and organizational pressure on national and local health services. Services in many countries were ill-equipped, for example in terms of finance and manpower, to take on this extra responsibility. In countries where consistent efforts were made to set up a BHS system it was often apparent that many people from the periphery either could not or did not wish to make use of basic health care facilities for various reasons including mistrust, the distance involved, the cost and the low standard of services.

Health for All by the Year 2000

In the 1970s dissatisfaction with a situation that had still not improved led to international reconsideration of the strategies which had been followed until then.

At the same time, significant progress had been achieved in certain places in the world by means of a number of innovative alternative approaches such as the barefoot doctors in China. It appeared that what these approaches had in common was that activities designed to improve health were based on the current social and economic situation of the people for whom they were devised. A more conscious effort was made to place poor or good health in the context of poor or adequate nutrition and safe drinking water, good or bad housing, literacy or illiteracy and, in particular, local culture and the knowledge and technical skills of the local population. A second characteristic of the alternative approaches was that they were concerned not only with what central health services could or should do but also with what the people concerned and their leaders thought of their health, their own ideas of possible solutions for existing ills and what contribution they could make towards improving the situation.

WHO and UNICEF came to call this approach primary health care (PHC) and at the WHO/UNICEF congress in Alma Ata in 1978 it was decided that it was the ideal means of achieving the goal of "Health for All by the Year 2000".

Since 1978 this goal and the PHC approach it involves have been gradually integrated into the policy of various governments and of international and bilateral development organizations. This strategy has also influenced Dutch development policy. In 1986 the HFA/2000 principles were explicitly included in Dutch health policy.

The Alma Ata declaration describes PHC as follows:
"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self- reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health as close as possible to where people live and work, and constitutes the first element of a continuing health care process."

Publications at the time of the Alma Ata congress emphasized that PHC is based on the local socioeconomic situation. It is directed at the most important health problems in the community and includes activities and services aimed at the promotion of health, the prevention of disease and at cure and rehabilitation. PHC therefore provides at least the following:

a. information on health;
b. improvement of the food supply and good nutrition;
c. supply of proper drinking water and sanitation;
d. maternal and child care and family planning;
e. vaccination against the major infectious diseases;
f. prevention and control of epidemics;
g. appropriate treatment of common diseases and provision of first aid;
h. provision of essential drugs.

The above points also fit in with the original BHS approach: good health centres and health posts carry out more or less the same tasks although there are a number of important differences between the two approaches.

- One of the differences between professional health workers working for the health service and PHC is that with the latter a large degree of involvement and activity on the part of individual people and the community as a whole is assumed and encouraged. People are expected to assist not only

in building facilities but also in identifying the most urgent problems, in planning, setting up, implementing and evaluating activities and in sustaining them independently. The idea behind this is that health care is more than simply providing services or medical treatment. As it was so concisely put by international organizations, it is "health by the people" instead of "health for the people".

- In PHC it is assumed that health care is provided using national and local resources. This includes manpower (for example village or neighbourhood health workers), organization and management, and finance (self-reliance and responsibililty).

- In order to increase the chance of success, activities undertaken within the framework of PHC will be closer to local tradition and respect local taboos. They will, however, have to be technically sound considering the finance and the technical means (appropriate technology) available.

- More than is the case with BHS, the point of departure for planning and activities in PHC is that disease and premature death are caused mainly by factors such as inadequate nutrition, unsafe water and poor housing which by tradition belonged to other social sectors. This is the reason for many apparently non-medical activities being part of PHC.

The following procedures are more or less typical of a consistent PHC approach:

a. The health situation is determined in consultation with village or neighbourhood representatives. The initiative may be taken by professional health workers or by the community itself through an existing or an ad hoc committee.

b. The neighbourhood or village elects from among its own numbers men and women who will receive practical training as health workers. Traditional midwives are given refresher courses. Their tasks are determined in consultation with the community.

c. The people from the village or neighbourhood concerned supervise the provision of the facilities which the elected health workers need to carry out their work.

d. The health service supports health workers by providing technical advice and training, and possibly seeing to supplies. Daily supervision of the work of the health workers is, in the first instance, in the hands of village inhabitants, through an elected health committee. These committees are partly responsible for the monitoring and evaluation of the health activities implemented.

e. Apart from treatment, which is usually the first need to be perceived, other preventive activities are important, such as the improvement of drinking water supplies, waste disposal, sanitation and the improvement of latrines, prenatal care, maternal and child care, vaccination and information on health.

f. In time, the elected health workers and committees exert a certain amount of pressure on government organizations (the bottom-up approach). In PHC people request medical care (BHS, vaccinations and medicines) as well as attention from other sectors such as agriculture and water services.

Successfully implementing the "Health for All" strategy requires more than developing and implementing the PHC concept. Central to the "Health for All" strategy is the goal of providing everyone with equal opportunities for health. If this goal is to be realized through the PHC approach the following changes should be set in motion.

- Accessibility should be improved in keeping with the most important goal which is equal opportunities for health for all. This is the case particularly in backward rural areas, slums and for certain sections of the population such as women. A consequence of this is that it is necessary to reallocate national resources.

- The role and requirements of the various categories of professional health workers are not the same as in BHS. Whereas in the past these workers were mainly responsible for providing care, in the "Health for All" strategy they take on the role of supervisors and supporters of PHC workers. For this purpose they need a change in orientation and additional skills, for example in management, in communications and in training village health workers who are often illiterate.

- The organization of health services and the training of medical staff should be properly harmonized and attuned to the principles of "Health for All" and PHC. Referral and re-referral of patients can only take place if there is cooperation between every level from the lowest to the highest, on the basis of a manageable system of services geared to local and national possibilities and means.

3. Dutch health policy

Annual Explanatory Memoranda and the four major policy documents on bilateral aid published since 1974 (1976, 1979, 1980 and 1984) contain broad policy statements on health care. Efforts in this area implicitly follow developments in overall Dutch development policy.

At the Ministry's request a Medical Working Group on Technical Assistance (a group of external experts) submitted a report in 1975 containing general principles for a health policy as part of the Dutch development programme. It stressed the need to shift the emphasis from hospital-based care to primary health care by helping to achieve an "affordable package of facilities" for the rural and, in some cases, peripheral urban population. The traditional distinction between prevention and cure is not really relevant in this connection. The package should include a drinking water supply, health education, simple medical services (not necessarily performed by "expensive" doctors), mother and child care, campaigns against endemic diseases and vaccination programmes. The creation of "multi-purpose centres" at local level should be part of a national health care system as it should be possible to obtain more specialized types of treatment where necessary.

In fact the group made a plea for an integrated approach to health problems in which the lowest level of medical/social services would be strengthened and given a broad reach, local expertise would be mobilized and popular participation in health activities would be encouraged. The development of Dutch expertise in this direction was also mentioned as a subsidiary goal of future development policy.

These general principles were developed in the Policy Memorandum on Bilateral Aid (1976) and later official Memoranda. The 1984 Memorandum "Review of Bilateral Cooperation Policy" again gave priority to "simple, affordable health care with maximum spread, brought about with the participation of the population", to be approached in an integrated manner and coordinated with other activities. Local financing of running costs were to be given higher priority than in the past so as to ensure continuity.

The general direction set out in the 1984 Memorandum was developed in the Policy Memorandum on Health Care of 1986, which concentrates on the phenomenon of 'diseases of poverty', and infectious diseases at the centre. Health care should be seen as part of the general socioeconomic development process. The document supports the objective of Health for All by the Year 2000.

This cannot be achieved unless good progress is made with the time-consuming process of reorganizing health services. The reallocation of funds in favour of decentralization and strengthening of preventive care will form central issues in this process. The emphasis should be more on the public health approach to fighting disease and on high-risk groups than on the treatment of individual patients.

The promotion of primary health care is central to the health component of the policy. Primary care will be largely devoted to sectoral and intersectoral preventive measures, basic therapy, mother and child care and improving the

health status of women. This is all focussed on local communities and carried out by the local people themselves with the support of professional staff with a minimum of training.

The policy document makes the following points on the function of hospitals. Secondary curative care has lower priority and will only be considered under particular circumstances. Reinforcement of the second curative level seems worthwhile in countries which already enjoy a reasonable standard of health, and where the referral system from primary health care is probably operational. Tertiary curative care will not in principle be considered for assistance.

Subject to certain conditions, special programmes, fully or partially implemented on vertical lines, may form an element in the health sector. Examples of such programmes are: public health programmes to combat important endemic diseases, the supply of essential drugs, the WHO-programme to combat diarrhoea and the Expanded Programme on Immunization.

In the educational field, policy is to continue on its previous course, which is directed towards increasing the capacity of developing countries to solve their own specific problems. Education for health workers will focus on primary health care and public health. Priority areas are: management, systematic campaigns against important endemic diseases, nutrition and population problems.

Research will be devoted primarily to optimalizing the health services of developing countries. Research assistance will be channelled into operational and applied research in primary health care and public health.

Dutch policy finally attaches great importance to the coordinating role of UN organizations such as WHO, UNICEF and UNFPA in the health sector.

4. Conclusion

Many developing countries have a fast-growing, young population with a low average level of health. Traditional medical, curative health care is expensive and reaches only a relatively small section of the population. Generally speaking the rural population and slum dwellers belong to a periphery which receives insufficient medical care or none at all. Women and children are among the most vulnerable groups in this respect.

The pattern of disease in developing countries is largely determined by poverty which is apparent in malnutrition, insufficient drinking water and sanitation facilities and extremely bad housing, particularly in urban slums. Combating these problems requires as much attention as strictly medical care.

A number of strategies have been proposed and applied in the search for poli-

cy and implementation mechanisms for structural improvement of health. There are "vertical" programmes to fight particular epidemic diseases, BHS facilities which are, in principle, spread over the whole country and, finally, PHC.

The element these three approaches have in common is that their activities are primarily extramural and, in the first instance, directed more at the periphery than those of hospitals concentrated in large cities.

While vertical programmes are selective about the diseases they aim to fight, the BHS approach is more integrated medically. In PHC, participation of the local population, intersectoral influences on health and a wide geographical spread of health care are far more important than was the case in former approaches such as BHS.

A country which opts for the "Health for All" strategy in which PHC is the main ingredient is opting for a multi-faceted approach to the health problem which increases the chance of a gradual but genuine improvement in the health of each member of the population. If this strategy is to be successfully implemented, the following points should be examined in further detail:

- reallocation of available national resources;
- retraining of professional health workers in knowledge and skills which are essential to PHC;
- streamlining of the organizational and coordination structure between the various levels of the health service and with other sectors.

In accordance with WHO policy, primary health care within the strategy of Health for All by the Year 2000, is the cornerstone of Dutch efforts in development cooperation policy on health. Attention focuses on basic therapy, mother and child care - including nutrition, vaccination and family planning - health education, drinking water and sanitation, and on the sectoral and intersectoral contexts.

FINDINGS

METHODOLOGY

1. Selection

The findings summarized here are the result of 47 evaluation reports on 33 extramural health projects and programmes in 20 countries implemented since 1975 with the support of the Dutch Development Cooperation authorities. In this context "extramural" means that the prime focus of the projects and programmes was not and is not on improving high-technology curative medical care and treatment concentrated mainly in urban hospitals, but on improving outward-looking, easily accessible care which contains certain BHS aspects or campaigns to combat epidemics, the training of paramedical staff and the provision of essential drugs, ideally in a PHC context.

The Dutch contribution to the activities evaluated amounted to commmitments of Fl. 187 million. The smallest Dutch contribution (a single contribution to a small embassy project in Tanzania) was Fl. 5,000 while the largest (the training of medical assistants in Bangladesh) was over Fl. 38 million (see Appendix for more details).

In the ten-year period studied (1975 to 1984) over Fl. 12 billion was allocated in the categories Ia (target countries), IIIa (balance-of-payments support) and IIIc (socioeconomic emergency situations), 7.3% (Fl. 900 million) of which went to the health sector where 60% (Fl. 540 million) was spent on extramural health care (see appendices 2, 3 and 4).

The selected projects for this evaluation study represent about one third of all bilateral activities which have received Dutch support for extra-mural health care during the period between 1975 and 1984. The primary health care projects cover as many as three quarter of all activities financed in this subsector over the past ten years.

2. Types of evaluation

Of the 47 evaluations, 24 were conducted on the instructions of the Evaluation Unit (IOV). The remaining 23 were conducted by or on the instructions of the operational unit of the Directorate-General for International Cooperation or by a Dutch non-governmental organization.

A number of projects and programmes had been systematically evaluated every year or every second year so that the reports showed the progress of the project. Others were visited once by an evaluation team. These were mainly interim evaluations and in some cases they were ex-post evaluations.

The evaluation teams varied in composition and approach. The IOV missions conducted "external" evaluations or evaluations which were "independent"

of those carrying out the projects and the recipient country. Sometimes the country desks had an evaluation conducted by a team which they had assembled and briefed themselves and in a number of cases a joint evaluation was conducted by a group of experts from the Netherlands and the recipient country. In the latter case the terms of reference for the evaluation study were drawn up in consultation between the Netherlands and the recipient country.

3. Comparability of evaluation results

A summary such as this inevitably presents a number of methodological problems, one of which results from the great variety of activities evaluated. The question is what homogeneous evaluation criteria should be used for matters as varied as material support at health posts, supplying of essential drugs, training of paramedical staff or the development of PHC models in countries which are very different from one another.

A second methodological problem which only exacerbates the first is that the evaluations differ in timing, scope and the issues dealt with, and they were drawn up for various reasons. The ideal situation would have been for all the evaluation reports to have provided unambiguous answers to the same analytical questions. Apart from the fact that there are a variety of changing views on health care in development cooperation, this could hardly be expected in projects and programmes implemented in radically different situations by various implementers and policy-makers in the Netherlands and abroad.

It is difficult to assess the impact that the Dutch contribution has had on the health of the target groups, as most projects had not been completed at the time of the evaluation or inspection. Moreover, the registration of the state of health of the population had not yet been properly developed and no base line study had been conducted at the outset of the projects.

Even where there were more or less reliable statistics available, for example on the decline in the mortality rate or the incidence of disease, change cannot be ascribed solely to the impact of certain projects or parts thereof as there are so many other, non-medical factors involved, such as drought, revolution and economic crisis or good harvests, food aid and a higher level of education. In many cases other (donor) organizations contributed to the same programmes in the same country or region.

There is usually more information available on input and output and the direct results of certain aspects of activities on which a qualitative assessment of progress, stagnation or decline in health care can often be based. For example, if a project involves refresher courses for traditional midwives, it is possible to determine how many of them have been trained during a certain period and at what cost and how many of them still use the newly-acquired methods after a

certain length of time. This measuring of effect by means of output studies is internationally advocated (World Bank Staff Working Paper 546).

On balance, these evaluation reports do give a reasonably clear picture of the work undertaken with Dutch support. They provide evidence of progress and improvements being made, but also of accidental and fundamental problems occurring along the way.

DUTCH HEALTH SECTOR COMMITMENTS

The total Dutch bilateral aid to the Health Sector since 1975 amounts to almost 2 billion guilders. This averages out to approximately 5.5% per annum of total bilateral ODA. The percentages varied considerably from one year to another, as Table 3 shows.

Table 3. Bilateral commitments in the health sector as reported to the DAC 1975-1987

Year	Amounts (f million)	% of total bilateral aid
1975	65	5.7
1976	343	14.1
1977	142	6.4
1978	158	5.7
1979	147	5.5
1980	124	3.9
1981	151	5.7
1982	142	5.7
1983	121	4.7
1984	87	3.0
1985	126	5.2
1986	143	4.5
1987	113	3.3
	1.862	Average % 5.5

About a fifth of Dutch bilateral aid to the health sector consists of technical assistance. Thousands of Dutch doctors have been employed in developing countries through private and government channels during the last decades (see Appendix 5). In recent years there has been a continuing presence of about 250 Dutch doctors in developing countries. Non-governmental organizations play an important role in the implementation of activities in the health sector. Approximately a quarter of all the bilateral funds for this sector are channelled through these organizations.

OBJECTIVES AND PROJECT DESIGN

1. Introduction

The promotion of health, particularly among people in the periphery, was the ultimate, overall goal of all the projects evaluated. Projects agreed after 1978 usually state that they subscribe to the views on health care propagated at Alma Ata.

The way in which the various countries have translated this policy into concrete project objectives has led to rather wide variations in approach. Sometimes a country chooses as a matter of principle a broad and integrated PHC approach, although it is more common for a more selective approach including a limited number of components to be adopted. This means the approach geared to the integration of diverse activities fades into the background.

No immediate assessment of project aims can be given. The choice of "all" or "only a part" is rightly determined by other factors as well as what the Dutch Development Cooperation authorities advocate. National and local points of departure and policy priorities also have a significant influence as does what is considered feasible and opportune both on a national and a local level in the short and the long term.

2. Project goals

The 33 projects dealt with in this report can be categorized roughly as follows in terms of goal and approach:

a. Projects and programmes with a consistent PHC aim. Examples worthy of note are: Colombia (no. 11) where the Dutch Development Cooporation authorities insisted on varied activities in four remote areas; Liberia (no. 19) where activities took place in a number of sectors in one province; a programme in Guinea Bissau (no. 32) on a more or less national level; the introduction of Dutch support in a national UNICEF programme in Nicaragua and a combined PHC/BHS programme in the Western Province (W.P.) of Zambia (no. 28).

b. Projects which include PHC elements (such as the introduction of village health workers and drinking water supplies), but where views on cooperation or integration with other sectors appear to be limited. Examples are India (no. 2), Nepal (nos. 5, 6 and 7), Niger (no. 17), Senegal (no. 18), Cameroon (no. 20), Mali (no.21), Rwanda (nos. 29 and 30) and the two small embassy projects in Peru (nos. 15 and 16).

c. Other projects which aim to expand and/or improve BHS facilities (in many cases health posts or mother and child care clinics). Sometimes ser-

vices are directed from a hospital or health centre in the form of an "outreach" programme. Examples are India (no. 2), Nepal (nos. 5 and 6), Yemen Arab Republic (no. 8), Pakistan (no. 9), Sudan (no. 22), Zambia (nos. 27 and 28) and the four small embassy projects in Tanzania (nos. 23-26).

d. Projects which aim to train semi-professional staff to work in health centres or health posts in a certain area (India, no. 2) or on a national level, such as in the multidonor Medical Assistants Training Programme in Bangladesh (no. 1).

e. Examples of support in the production, delivery and distribution of essential drugs are to be found in Nicaragua (no. 12) and Mozambique (no. 31). In both countries the essential drugs were intended for PHC or BHS use, i.e. primarily outside established city hospitals.

f. The last project and the only one of its kind is a vaccination campaign in the Philippines (no. 10), implemented largely by UNICEF and co- financed by the Netherlands (partly in the form of vaccine supplies).

It may be concluded that all the above mentioned activities were focused mainly on the periphery. This may be considered as an important improvement compared with hospital-based health care as was dealt with in the previous evaluation report.

With the exception of programmes in Colombia, Nicaragua, Senegal, Liberia and Zambia the majority of the activities did not, however, follow the integral

or comprehensive approach. These project activities werd focused on components of centrally controlled basic health services or elements of PHC. In itself this would have been acceptable if this selection had been based on an analysis of the local situation.

3. Project design and planning

In theory, the initiative should be taken by the developing country. In practice, however, the Netherlands strongly advocates that the health care project proposals place sufficient emphasis on extramural activities, preferably of a PHC nature.

Aid to Colombia, Liberia, Nepal, Zambia (W.P.) and Senegal are examples of mainly Dutch initiative. In some cases initiative was taken by non-governmental and international organizations such as WHO and UNICEF.

In retrospect, both responding to requests and insisting on certain projects being implemented may be viewed as valuable and realistic. Responding to a request from a government or non-governmental organization - an approach often adopted by the Dutch NGOs - can mean that proposals result in action more quickly. However, PHC initiatives by the Dutch Development Cooperation authorities have proved opportune for basic policy reasons in countries where the periphery had been neglected for various reasons.

Because of the diversity of motives among those taking the initiative, the formulation of aims was usually unsatisfactory and unrealistic. People wanted to do too many things at once, with the result that aims were not selected stringently enough. Evaluation reports sometimes stated openly, and often implied, that the fact that aims had not been defined was partly the result of inadequate knowledge of the needs, problems and possibilities of the target group. This shortcoming applied not only to Dutch development organizations, but frequently also to government agencies in the country with which the Netherlands was cooperating.

One way of overcoming this lack of insight into the problem is to conduct a serious (and probably time-consuming) study and analysis of the situation before a project commences. Another possibility is to formulate interim goals gradually, in the course of implementation. This is known as the flexible approach. Good examples of this are provided by projects in Colombia, Liberia and Bangladesh.

In conclusion it should be noted that where project results are negative, this may sometimes be ascribed to the fact that the formulation of PHC policy and the manner of implementation had not been detailed or tested enough during the research phase.

4. Situational analysis

The initiative for activities and the formulation of project proposals should be based on a knowledge of the socioeconomic situation in the project area and an understanding of local health problems. For this reason it is necessary to answer the following questions:

- How does national health policy stand as regards PHC? What progress is being made towards decentralization of policy-making and the implementation of PHC?
- To what extent is the poor state of health of the population determined by poverty in the form of malnutrition, poor nutrition, contaminated water and unhealthy housing? To what extent will medical care provide a solution?
- What is already being done locally in accordance with traditional and non-traditional views by government agencies or social organizations? What is the capacity of local and central government organizations and the target group to incorporate change? What contribution are they willing and able to make?
- What is the position of women? Are there women's organizations? What role can women play in PHC? Are there traditional midwives?
- What can the Netherlands do? What is needed most urgently: buildings, equipment, management, information, mobilization, formal training from scratch or refresher courses?
- Which other donors are involved and in which sectors?

Answering such questions, which amounts in effect to carrying out a base line study, may ensure that any projects undertaken are appropriate in the existing situation. Knowledge of the situation at the outset of a project is also essential for the effective monitoring and evaluation of results.

It is noticeable that very little attention is given in project documents and evaluation reports to the place of PHC in a national context. It would appear that most emphasis was placed on the application of PHC at local level. Questions about the need for management skills at a national level in order to be able to implement PHC, about mechanisms which could lead to the reallocation of resources, and about the retraining required for the reorientation of the professional health workers were hardly raised.

IMPLEMENTATION

1. Introduction

Implementation of the main principles of primary health care will be examined from the following angles: approach to health care (curative versus preventive); manpower development; strengthening local health institutions,

in particular the role of village health workers; involvement or participation of the target group; adaptation to their living conditions; integration with primarily non-medical aspects or sectors of daily life in villages or urban areas; and costs and financing. This selection of angles from which to approach the subject is determined partly by the desire to focus attention simultaneously on the factors which are important in ensuring a lasting effect even after the donor (in this case the Netherlands) has withdrawn, or in international jargon: "the factors of sustainability".

2. Preventive activities

Despite the fact that a great deal of importance is attached to preventing disease and to stimulating policy aimed at achieving this, the kind of activities which the Netherlands supported were very much concentrated on the traditional curative care.

This applied not only to activities previously labelled as BHS, but also to programmes whose content and approach were based on PHC. It was even the main activity of health centres and health posts set up by the central authorities. Staff, whether doctors, medical assistants, nurses or auxiliary nurses, spent most of their time on treatment. In so doing they were responding very much to the demands of the population. Village health workers (known by different names in different countries), usually assisted at births, worked to combat epidemics, treated recurrent outbreaks of diarrhoea and respiratory infection, and provided first aid for accident injuries. Naturally, treatment was the main aim in supplying drugs for BHS and/or PHC.

A focus on healing did not mean that no attention was paid to prevention. Projects in this category combine curative care, preventive medicine and health education activities. This type of approach assumes the availability of essential drugs, insight on the part of the health worker into the relationship between prevention and cure and, naturally, a minimum of knowledge and the skill and willingness to provide information at an appropriate level, in the language of the people concerned and with a certain amount of knowledge of local customs. The amount of time, attention and money devoted to improving the quality of drinking water is extremely important. If water supplies were consistently considered as part of PHC the picture of preventive health care would improve everywhere. As the water supply is considered as a separate sector in many countries, it is mentioned here only if it is officially part of PHC, as is the case in Colombia, Liberia and Zambia (Western Province) for example.

Prevention includes the organization and implementation of vaccination campaigns, preferably as part of a regular system of primary care. This was attempted (with some success) in a number of projects such as those in Liberia, Colombia and Niger. Good results were achieved in Senegal and Nicaragua. In

the above-mentioned programme in the Philippines, Dutch input was limited to providing DPT vaccine in an extended programme of immunization (EPI) set up and and implemented by the WHO, UNICEF and the Filipino government. The relevant evaluation report noted that because vaccines were supplied over such a long period it jeopardized the independent local production of vaccine, which had been the objective.

Evaluation reports repeatedly refer to health education sometimes in the context of "transfer of knowledge" and sometimes in combination with "increasing public awareness" and "community development". The underlying idea is that health is only partly dependent on health services and facilities in the strict medical sense and that the way the population lives and takes care of itself is equally important.

The picture which springs to mind when one hears the term health education is one of a person or team setting out with either modern or simple audio and/or visual material. The projects differ considerably in their degree of sophistication. In some places only blackboard and chalk are available along with sheets for film screens and silent films, while in others there are colour films with soundtracks, slides, video programmes and sometimes television programmes. If this form of health education is provided consistently over a long period of time, preferably on a national level, with a clear and recurrent message, it can certainly be effective. One example of this was the "Jornadas Populares" project in Nicaragua in which the message was simple, appropriate and clear.

A less spectacular way of providing information, but in many cases the only way possible, is to hold village or neighbourhood discussions on an appropriate level on common health problems and possible steps to improve the situation. Detailing and cautiously trying out these proposed, modest, affordable and technically attainable improvements within the framework of the village, neighbourhood or family is often the only way to set change in motion. Much time and effort has gone into this in Colombia, Liberia, Cameroon and Niger. Health education sessions organised by VHWs can, however, run aground because, after a while, people are no longer interested in hearing the same message time and time again. In cases where VHWs were also responsible for treating patients, or had access to funds for community action, health education was successful.

It is extremely difficult to measure the effects of extramural health care and even more so to measure the impact of health education. Generally speaking, the evaluation reports are optimistic but vague on this point. People make the best job they can of providing information, and that in itself is considered an important input. Sometimes output is defined in terms of numbers of organized health education sessions and the numbers of people who have attended

them. Apart from stating that it is difficult to measure effect, it would appear that the attention and skill required to do so are not usually present either at the implementation or the evaluation stage.

3. Training

Almost all the evaluation reports devoted attention to training or refresher courses for paramedical staff, a category which does not usually include nursing staff, analysts or laboratory assistants in hospitals, but refers to staff charged with the promotion of community health within the framework of BHS or PHC.

BHS usually employs professional staff who depend, in theory, on the official health services for training, supervision, salaries and supplies. These include the medical assistants in countries like Bangladesh and Tanzania (who are known by different names in different countries), fully- trained community health nurses, e.g. in Indonesia, and professional midwives.

Village representatives with scant previous training play a crucial role in rural projects with a definite PHC approach. If they perform general duties they are called VHWs, Secouristes, Promotores de Salud or Agents Sanitaires de Base. If they are specialized in midwifery and antenatal and postnatal care they are known as traditional birth attendants (TBAs), Matrones, Parteras Empiricas or Dhais. Careful consideration should be given to their deployment and working methods, which can be influenced in a number of areas.

This process starts with selection. Is the final decision in the hands of the community or does it lie with the established health system? Do the authorities select workers as is the case in Sudan and the Yemen Arab Republic or does the community choose them as is the case in Nicaragua, Liberia, Senegal and Niger? In some countries both parties influence the choice although ultimate responsibility lies with the authorities or, as in Colombia, with the authorities and the project leaders. Are there formal and informal requirements with respect to such matters as leadership, background (being locally born and bred), schooling (primary school for example) and training?

The way in which selection takes place is extremely important for the continuity of service of the trained member of staff. Does someone want to be trained as a volunteer (training takes between 10 days and 9 months) while he/she already has work at home or elsewhere or does he/she see health work as a source of income? It is important that there is clarity in this respect in the selection and training process and that any financing has been properly arranged. In the latter case in particular the continuity of project aid or incorporation into a well operating and financially sound BHS or PHC system is essential for the person in question and for the village as a whole. At present, experiments with incentives for VHWs are taking place in the Western Province of Zambia.

Furthermore the way in which training is planned and organized is crucial. A short period of training, as in Nicaragua, is acceptable, but in such cases periodic refresher courses are more important than they would normally be. Where training or refresher courses take place in a hospital, as is the case in Rwanda, the health worker is all too easily exploited as a doctor's "helper". Whether the course is run by people working in the field or by professionals with a more academic approach makes all the difference. The place where trainees complete their period of work experience is also important; is it a small health post or a large health centre where tasks are clearly defined and there are clear specialisations, as in Bangladesh.

In Niger training often takes place in the nearest health centre. The advantage of this system is that training is carried out by the same nurse who will later be responsible for supervision. However, one problem with this method (in effect a design fault) is that the nurse may not have been trained to teach other people or indeed have mastered all aspects of treatment, and is thus partly responsible for mistakes being passed on to trainees.

In Sudan a school complex was built for a nine-month course for VHWs. Although there was very little tradition in BHS, let alone PHC with its elements of participation and integration with other sectors, both the consultant taken on by the Dutch Development Cooperation authorities and the Sudanese government thought - mistakenly as it transpired - that as long as the physical infrastructure was provided, the rest would follow automatically.

The proposed or existing training curriculum for health workers is sometimes remarkable. The little information on this provided in the reports reveals that in a number of projects, rigid attempts are made to run semi-literate village representatives or TBAs through the curriculum of a medical student in a few weeks or months. The textbooks used for this purpose in Colombia, Niger and Nicaragua, for example were indicative of the futility of the operation. Information provided at a later date showed that many projects in these countries had improved in time.

4. Village health workers

In many projects where steps were taken to introduce PHC and employ VHWs it appeared that expectations were too high. It was thought that everything that a normal health service does or should do could be achieved. This was an unrealistic demand. A more realistic alternative is for the VHW to do initially what he is best at and then to branch out into activities which the village considers important. The ideal situation is a combination of the two. It would appear that VHWs are often expected to perform tasks set out by the health service without the requisite resources being provided.

In some cases the VHW does more than he is actually allowed to do. In certain places, Uraba in Colombia for example, the VHW may not treat illnesses because powerful local doctors' organizations prevent this. In Rwanda and India VHWs are not allowed to issue medicines. In certain projects, however, in Senegal, Liberia, Niger and Sudan, for example, treatment is one of their main tasks. A VHW who may not carry out any curative work as in Zambia W.P., is placed in a very difficult position. In isolated rural areas with an infant mortality rate of 150 per 1,000, curative work is sorely needed and much in demand. A VHW who can only refer patients may find that people have no confidence in him or the information he can provide. On the other hand, his training has not properly equipped him to treat any but the most elementary cases.

In the ideal situation the basis for a VHW's role in preventive care lies in an analysis, however basic, of the local health situation. The VHW and his supervisor or a teacher will draw a map of the village, fill in the names of the families in it and visit them, noting cases which present a special risk, such as children who have not been vaccinated, pregnant women and old people. Regular house visits help the VHW to "monitor" the state of health of the individuals in the village and of the village as a whole.

Where the VHW does not enjoy the necessary status or have the required skills or means to vaccinate children and adults, he will assist in centrally organized campaigns by registering children and assembling them on vaccination day (e.g. in Senegal, Liberia and Niger). Sometimes he will assist in vaccination campaigns carried out by mobile vaccination units (e.g. in Rwanda, Niger and Zambia).

Resources

All reports agree that a prerequisite for successful BHS and/or PHC is the availability of certain minimum resources: a basic package of essential drugs, materials such as dressings and medical instruments, and a simple office.

In very large districts, transport is usually the most expensive item on the budget. It is extremely helpful if the health service can take on this expense. How-

ever, the required funds and organization for this purpose are sometimes lacking, and at any rate it is not always given priority. Having the community pay for these items often proves difficult. The development and introduction of an effective system of financing appears to be a long- term process.

Where the local population has to pay for everything including materials, the salaries of the VHWs and even the cost of supervision (e.g. Mali and Benin), the work of the VHW is strongly dependent on the continued goodwill of the population, the achievement of short-term results and whether other problems, such as war (in Sudan) and famine (in Niger), which sometimes threaten the very survival of the population take precedence. The reports suggest that the costs of materials can be only partly covered by contributions from the village communities, that the organization of such a system requires careful planning and its implementation takes a long time.

In some cases the situation was quite the reverse and VHWs were so swamped with material that their "practices" came to resemble small hospitals. These were naturally white elephants as either no one had the skills to operate the equipment or there was not enough money to ensure continuity.

Technically, there is no reason why acute shortages or surpluses should occur, as international "mini packages" geared to the less well-trained VHW have been developed. In Colombia (Choco) a "mini-puesto de salud" was used. This is a convenient case containing essential drugs and dressings, a number of instruments and a small filing system. In Niger and Liberia too, VHWs have no more than a medicine kit. In places like India, Niger and Liberia, retrained traditional midwives or newly-trained midwives are provided with a UNICEF kit containing basic instruments.

Support and supervision

In the light of what the evaluation reports say about supervision and support of health workers, it would appear that on paper, at least, reasonable provision is always made for supervision in centrally-run BHS systems. This does not mean in practice that supervision from the higher levels of the BHS system takes place regularly or is of an adequate standard. Supervisors in many developing countries are often not provided with the necessary training, manpower and transport to carry out the tasks for which they are formally responsible. Where this does take place, a visit from an inspector is often no more than a formal check based on standard checklists. Reports on PHC projects also mention this problem. Developing and testing an appropriate and realistic PHC supervision model is not a simple matter. Shifting the emphasis in health care from treatment to prevention and organizing supervision are two particularly difficult areas. One should not lose sight of the fact that adding supervision to the tasks of professional health service staff means extra work. There is often not enough extra pay to compensate for the work, and transport and adminis-

trative back-up are inadequate, which reduces motivation. India, Senegal and Colombia are good examples of the success which can be achieved by a combination of retraining sessions and adequate supplies.

Supervision by village councils of the VHWs they have chosen seems to have a positive effect on the way in which and the diligence with which the latter carry out their work.

With certain exceptions, it would appear that the key to the success of the VHWs in the long run lies not so much in the nature and frequency of supervision but in the material and moral support they receive.

The main problem in PHC is the willingness and ability of institutional health services to provide extra attention and funds for the periphery. It is extremely difficult to get the existing system to do anything for the benefit of people who are a long way away and have low social and economic status. Long-term support from abroad (in this case the Netherlands) and debate between the local population and the national authorities through the intermediary of the donor country can work as a lever (e.g. in Senegal, Niger, Liberia and 4 regions in Colombia).

5. Adaptation, participation and intersectoral activities

Adaptation

There is general agreement in debates on development cooperation that the more these activities fit in with what the local population sees as its needs and its cultural, social, financial and technical possibilities, the greater their chance of success. The work of the Netherlands in contributing to primary health care should be seen against this background.

Within the international definition of PHC this work should conform to the Alma Ata criteria of "health care based on practical, scientifically sound and socially acceptable methods and technology (...) at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."

What is immediately noticeable when examining projects in the light of these criteria is how much they differ according to the country or even the region in which they were implemented. In some countries painstaking work at village level by experts and/or volunteers seemed to be required (e.g. the Netherlands Development Organization's work in East Cameroon), while in others, such as Bangladesh, it seemed sensible to contribute generously to an ambitious building programme for the training of medical assistants. Circumstances vary considerably from place to place and this was obviously taken into account.

This does not change the fact that adaptation to local circumstances was not always what it might have been. The health plan developed for Sudan did not allow the regional authorities enough scope. In many cases neither the authorities in the host country nor the Dutch Development Cooperation Department knew enough about the local situation to plan an appropriate form of PHC. In projects in Mali, Colombia and Liberia, the projects were adapted during implementation.

A great advantage of health projects was that tangible, concrete activities almost always fulfilled at least one of the perceived needs. The activities undertaken were usually scientifically sound even if the material input was sometimes greater than could be processed or used at that particular moment. The building and equipping of health centres in Sudan and schools in Bangladesh were probably the most striking examples of this.

One of the most trying problems is still how to make the financial input a temporary contribution without eroding the "spirit of self-reliance and self- determination". The evaluations show that the problem was not usually Dutch "extravagance" but often that foreign (i.e. Dutch) funds rather than funds from local and national budgets were used for longer than was prudent or had been agreed. Once a project or programme had been set up with the help of Dutch money its continuation became too dependent on that support.

Participation

Adaptation can be properly achieved only if the beneficiaries participate in the development activity.

In development cooperation in general and certainly in PHC, the term "participation" covers at least the following two concepts (Muller, 1981): participation in the form of the mobilization of people and their scarce resources and participation in the form of people having a say in their own future. In practice, the first meaning is more commonly used, and mostly in terms of money. The government or project leaders feel that the "target group" should participate in the development of projects, i.e. by contributing money and labour (preferably unpaid). This is most apparent in the French-speaking West African countries such as Niger and Senegal where in practice participation simply means making a financial contribution.

Although participation is a key PHC concept it is difficult to give it substance. This applies particularly to situations in which local or central government authorities are open to influences from the grassroots in word only. However, the great diversity in cultures, class and status within individual countries is also a serious impediment. Generally speaking, participation is measured in terms of what people can afford. There are, however, at least two dangers in this narrowing of the concept. In the first place, the poor spend a surprising

amount of money and energy on their own health. In developing countries this often takes the form of paying for the services of traditional healers, long journeys on foot to health posts and, increasingly, the purchase of all kinds of Western drugs. In the second place, these are situations in which the poorest sections of the population are being expected to contribute to projects whose value still has to be demonstrated, while the authorities continue to gear the existing health system to the urban population. For reasons of equality (equal opportunities for health for each individual) this policy should be replaced by a PHC approach. It is therefore hardly surprising that participation in this sense does not quite live up to expectations.

Participation in its other sense refers to the involvement of people in more ways than one. Ideally, people gain more control over their own lives. They are given the opportunity to analyse their own situation and they search for solutions to those problems they consider most pressing. The development project will play a role in possible solutions but it is not a cure-all. Ideally the local population should make a contribution to the planning, implementation and supervision of the project. That this can be more than a mere ideal is shown in reports on activities in countries as different from one another as Nicaragua, Colombia and Liberia.

In Liberia village committees made proposals for village development. In cooperation with the staff of the VHW project and other sectors, priorities were set and the planning and implementation of small projects for schools, small village plantations, concrete bridges, village stores and the improvement of marketplaces were undertaken. Their participation allowed the village inhabitants to experience what the effect of their own priorities (which were not shared by the project) could be.

In Choco, Colombia, village health analyses were linked to historical studies of village development in general. This led to problem-solving strategies which spanned more sectors than health alone. Something similar has been done in Uraba and Guaviare, where villages with their own organizations invited authorities from all sectors to participate in a dialogue in which they explained how they saw their problems and linked their request for specific government support to undertakings as to what they were prepared to do.

If PHC is to be successful and sustainable it is vital to improve the organizational and management skills of the community concerned. When projects are further advanced the communities are better able to carry out improvements, or at least solve some of their problems and find their way to organizations which provide additional aid or will listen to well-founded protest. These developments seem to protect the progress which communities have achieved from external threats.

Project aid from donors is by definition provided for a limited length of time, while governments sometimes adjust their priorities. Village communities, however, are relatively stable, which makes them a suitable framework for long-term development. Participation by the local population can therefore make a significant contribution to the sustainability of PHC cooperation projects.

However, not all experiences with village committees were an unqualified success. Sometimes the local or the Dutch project leaders did not know enough about the traditions of the target group and this led to the formation of health committees which were out of tune with the network of status and power relationships within the community. Such committees tend to collapse in the course of time; the evaluation reports cite examples in Senegal, Niger and Colombia (early stages of the project in Choco).

Participation models of a different order, but whose effect is nevertheless analogous, are those introduced in a somewhat artificial way, sometimes because of a national development philosophy. It would appear that the local population did not always heed the call to participate as readily as political leaders had assumed they would. The MCH clinics in Tanzania and PHC strategy in the Western Province of Zambia are examples of this.

Generally speaking it is probably true to say that people, wherever they may be, are prepared to be involved in developments (including projects) and that they are prepared to make sacrifices on condition that they soon see concrete results which have more than just a short-term effect. Simply including the word "participation" in a development plan does not necessarily guarantee that it will indeed take place. If participation is to be achieved, expertise must be applied to develop an approach which is appropriate for the local situation and a favourable general political and social climate should either already exist or actively be promoted.

Intersectoral activities

The reason that the PHC approach places such strong emphasis on integration or at least cooperation with other sectors is that experience has shown that there is only a tenuous link between medical care in the strict sense and the level of health of the population. The greater the poverty, the less the effect of medical care on the level of health. Other aspects such as housing, nutrition, education and whether people work in agriculture or in industry also play an important role. Conversely, rural development is not possible without medical care. A reasonable state of health is required for participation in economic activities and it is also one of the basic needs of people wherever they may be.

The RUHSA project in India provides a good example of the inter-relationship of different sectors. The idea there was that the project would provide medical

services, and the confidence this inspired in the local population could be exploited to organize them more effectively so that they would press for more attention and better facilities in other areas. Not only the health sector but banks (with loans of up to fl. 500), cooperatives (which increased in number) and social organizations for women and young people were successfully encouraged and supported in stepping up and improving their activities.

The situation in Liberia was quite different. The government provided very few services in the villages. Thanks to the initiative for primary health care, a process of intersectoral community development was initiated; regular consultation with village elders took place, the planning and management capacity of health committees was reinforced, traditional midwives were given refresher courses, drinking water supplies were provided, more practical training was introduced and gradually small improvements in agricultural techniques were brought in. This process of community development created new structures within the villages. This drew the attention of UNDP which set up a multi-sectoral project directed at village activities which was implemented through the new structures.

The first report on cooperation in Niger complained of the lack of contact with other sectors. A later evaluation indicated that some improvement in this area had taken place, although the emphasis was still very much on drugs and treatment, and vaccination campaigns were still carried out "vertically" without a great deal of consultation with other services. It appeared that people's attitudes began to change gradually with the prospect of improvement. At their own request a project for the introduction of energy-saving stoves had been linked with some success to a health education campaign for women.

6. Cost and financing

The issue here is inextricably linked to one aspect of sustainability, i.e. who will pay what when foreign aid is withdrawn?

In theory health care in developing countries can be financed in a number of ways: directly by the people who use the services, indirectly by means of taxes from national or regional public funds or by means of funds from other countries. Foreign aid must in general be regarded as temporary. Even the "Health for All by the Year 2000" strategy is based on the assumption that PHC will, after an initial period, be financed by means of national or local funds. The question is to what extent and at what stage of development is this possible? In many cases the recipient country does not have enough money to continue all the projects independently. The only course of action then is for the government to shift priorities in its total budget. In order to asssess whether such an option is realistic, it is necessary to have an understanding of the current spending pattern.

Information on expenditure in the health sector in terms of a percentage of GNP or national budgets is often available. It is more difficult to determine in absolute figures or as a percentage of the total health budget how much is spent on PHC, if only because various countries define it in different ways. There are a number of reasons for the lack of clarity in this area, such as technical and administrative shortcomings among the bureaucracies, and reluctance to make full reports even to international organizations such as the WHO. Even if it is more or less known how much is spent from public funds, in most countries it is not clear how much is donated privately.

In 1987 the WHO concluded on the basis of the figures available that there is some evidence that developing countries in which spending on health as a percentage of GNP has declined since 1977 outnumber those in which it has increased. The reasons for this decline are obvious. In times of economic stagnation or recession the social services are the first to be affected by austerity measures, whether or not these are imposed by the IMF, the World Bank and/or bilateral donors.

In countries where social programmes such as those in education and health care had enjoyed relatively high priority for a long time, the allocations were maintained in theory and even on paper, but government services (and even genuine possibilities for self-reliance) declined drastically. Importation of essential drugs (or raw materials and machinery for local production), instruments, maintenance and transport came to a standstill.

Cost of PHC

Publications on PHC often suggest that PHC is relatively cheap and that it can and should be financed from national and local funds.

There is only limited information available on cost, some of the sources being projects and programmes set up with foreign support. It is difficult to make a comparison of costs as there is no unanimity about the components of the package of facilities or back-up which fall into the category of PHC. Although it is claimed that PHC programmes can be carried out for about $1 per person annually (Kasongo project 1984), this is often refuted.

In 1981 the WHO estimated the investment costs of the most important components of PHC at about $20 per person per year. Drinking water facilities and sanitation came to about $48, vaccinations $3, eradication of malaria $0.75, essential drugs $5 and construction and training about $15. Spread over 4 years, these initial costs came to $20 per person annually. On the basis of the same sort of estimate the operating costs of PHC programmes came to $10 per person annually.

The little information available in the reports summarized here provides occasional details to amplify this vague general picture. In Senegal the initial costs of PHC elements in the programme were about Fl. 4 per person above the normal cost of health care in the region. In India (RUHSA) this amount was Fl. 10. In neither of the above two cases was any money invested in drinking water supplies. On the other hand costs in Kolar (India) came to only Fl. 3.

Costs in Colombia during the initial stages came to Fl. 100 per person, including drinking water for about 25% of the target group. Operating costs came to about Fl. 25 per year. This too was over and above the normal, usually low cost of health care.

Contributions by the local population

Only scant information on contributions by the local population is provided in Dutch development cooperation projects. Agreements made while projects were being planned were often delayed or could only be partly implemented.

There are indirect indications that national governments are gradually contributing more to PHC. The number of staff in rural areas is increasing and the part of the operating costs not paid by the Netherlands, such as transport and drugs, is growing. It is true that in some cases a large percentage comes from other donors e.g. transport provided by USAID in Nigeria, transport and storage of drugs, the "cold chain", by Unicef and drugs supplied by bilateral donors, or from loans from the World Bank, for example.

There have been numerous initiatives to encourage self-financing in the past. In India the local organization involved in implementing projects and the Dutch Non-Governmental Organization contributed to a capital fund. The interest on the capital was used to cover operating costs.

In Niger, Benin, Senegal and later in Liberia, the population has had to make considerable financial contributions to setting up and maintaining PHC programmes. This may take the form of money and labour for the building of a "case de santé" and the salary of the VHW (either in the form of payment for each visit made or a lump sum for each member of the community or for drugs provided). This last approach enables VHWs to make some profit on drugs so that they can supplement their incomes which are usually low. With the exception of the operating costs in a research project which is still in progress in Benin, it has not been demonstrated anywhere that a village or neighbourhood community can bear any more than a small part of the cost of an extensive programme.

In the first instance it would appear to be obvious and useful that people should make some contribution towards costs. The following questions

should, however, be asked: what services should be paid for, how much should be paid and what percentage of the total costs should this be? At what stage does the cost become an impediment to the poorest sections of the population with the worst health? At times when people's health is most at risk, for example during famine, they will scarcely be able to pay anything at all. In the relatively more developed parts of the country where the regular health service is better organized anyway, it is sometimes free.

While the poorest sections of the population contribute to regular health care by means of individual taxation, they benefit relatively less. In places where the population has to make large contributions the government has no financial involvement in PHC (or virtually none) and can continue to treat health care issues as it always has done.

Donor contributions

The material aspect plays an important role in Dutch input in extramural health care projects. In Bangladesh, for example, the building of clinics, training facilities, staff accommodation and student dormitories and the supply of equipment and instruments accounted for a significant share of total spending. This is true of a number of other projects too. In the programme in Senegal, 50% of the project funds went towards infrastructure and in Sudan over 70% of the budget was spent on construction.

The Netherlands did not decide on these priorities for expenditure unilaterally. Many official health institutions in the partner countries often preferred to receive a building rather than a foreign expert, drugs rather than information on drugs and a mobile film unit rather than a course on visual media.

The Ministry responsible for Development Cooperation itself, the non- governmental organizations and the Netherlands Development Organization often provided staff as well as material support as described above. This took place at all levels. Someone could, for example, be assigned to or temporarily replace a District Health Officer whose job it was to organize primary health care in his district with usually extremely limited resources. Other people were appointed to teach local middle-grade staff or VHWs, sometimes as an advisor but more often as a trouble shooter or someone to set activities in motion.

In a number of projects the Dutch expert was given the job of "broker" either between the Netherlands and the partner country or between the indigenous field workers and their own official health service. In a significant number of cases (e.g. in Colombia, Mali, Liberia and the Western Province of Zambia), the Dutch project advisor had a relationship based on mutual trust with both the authorities and the local population and was able to play a positive role as an intermediary. As a significant percentage of funds usually comes from

abroad, the expert usually has more influence on health authorities than the local field worker. Although Dutch experts are usually the first to recognize the essential weaknesses of such a situation in terms of sustainability, they often have little choice. No target group will be impressed by a project if there are no visible signs of activity. This applies in particular to situations in which people have for years been bombarded with information on a healthy diet, safe drinking water, hygiene and a healthy way of life. Tangible activities require persuasion and the actual acquisition of the drugs and transport which have been promised.

The evaluations reveal that, particularly in the initial stages of a project, it is not only the start-up costs, including investments in infrastructure, extra supervision and research, which are mainly paid by the Netherlands, but also the largest part of the operating costs. An exception in this respect is Colombia, where after 5 years the national contribution to local financing was higher than that of the Netherlands.

What is important in the first place for the financing of PHC is cost control and the redistribution of funds in the health sector as a whole. Donor countries must continue to press for this in policy dialogue with recipient countries. The desirability of cost recovery at project level through private contributions should be investigated with care.

RESULTS

1. Introduction

The simplest and most common question which people ask about development cooperation and extramural health care is: has it done any good? Are the people for whom it was intended any better off than they were before? In short, has the health of the population improved?

It is not a simple matter to demonstrate the effects on the health of the population of the 33 activities evaluated. Where the evaluation reports have made assessments, they are usually limited to the output of an activity.

It is not easy in technical terms to assess the impact of an activity on health and it would not be entirely credible for at least two reasons. First there were very few places where there were reliable baseline data available, and second, where changes in health are measurable, they are often the result of factors other than the development project in question. A period of severe drought in Niger, the price of cotton in Tanzania or of jute in Bangladesh can have a more significant effect on health than any project.

According to the WHO, there are at any rate few countries which have developed reliable methods and procedures for systematically determining the impact of factors influencing health. Although such factors as unemployment and poor housing are generally believed to influence health, it is not at all clear how this takes place and to what degree.

In discussing the results of the projects, the point of departure here is therefore the output achieved in the most important areas of attention mentioned above.

2. Coverage of health care activities

On the basis of the evaluation reports it is possible to conclude that in general the availability of health care and its use by the population did increase directly or indirectly in one way or another as a result of the projects in question.

In some places coverage was increased more than in others. In India (RUHSA), for example, the project was benefiting about 35,000 people within several years. They were all living within a radius of about 30 kilometres in a "development block" and were easy to reach. In Colombia, where the PHC programme was implemented in 4 regions, people live very far apart and the area is not easily accessible. Nevertheless some 50,000 people are still reaping the benefits of the programme in some way.

In Niger, at the time of the evaluation in 1986, several hundred thousand people had access to basic first aid closer to home than had previously been the

The evaluation places the large number of trained VHWs in Niger into perspective by saying that the standard of their work is not particularly high and that they are usually no more than itinerant drug dispensers. On the other hand, traditional midwives who have had refresher courses appear to achieve good results by providing simple information and better, more hygienic assistance at deliveries. They seem to be more effective than young, "midwives" trained on an ad hoc basis.

Periodic refresher courses and the inclusion of such training in regular supervision, if possible in villages and carried out by the staff of the regular health service, is recommended in almost every evaluation report as it may improve both the balance between prevention and cure and raise the standard of the VHWs' work.

4. Village health workers

The essence of PHC often lies in the work of briefly trained VHWs, traditional midwives who have taken refresher courses and village health committees. They are either employed or assisted by the health service and provide the impetus for simple, basic health care in villages. Their work involves treating the most common diseases, providing first aid, essential drugs, health education, drinking water and sanitation and combating malnutrition and poor nutrition.

Activities involving VHWs were given top priority in PHC programmes co-financed by the Netherlands. Dutch support of VHWs was geared to training, providing resources and supervision.

In conclusion it may be said that the Netherlands has made a significant contribution to introducing village health care, to improving the standard of work of VHWs and to enlisting the required support of the national health services for their work.

It is evident that the support of the regular health service for village health care is essential. Although this was given a good deal of attention in almost all projects, not enough support was achieved in many cases. Despite training, the motivation of professional health service staff for carrying out these additional tasks does not come about of its own accord. An even more urgent problem is supplying the resources for carrying out this supervision, such as transport and drugs for VHWs.

A joint programme evaluation report on Tanzania by the Dutch Ministry, Cebemo, (the Central Agency for Joint Financing of Development Programmes) and ICCO (the Inter-Church Coordination Committee for Development Projects) praises the fact that thousands of VHWs have been trained since 1969, but adds that in 1981 there were nevertheless relatively few vil-

lages which had a VHW. Lack of continued central support resulting in inadequate supervision and, particularly, in a lack of drugs and other aids had caused many VHWs to seek alternative employment.

It would appear that efforts to obtain these resources from the national health service and possibly to supplement them with resources obtained from the villages tend to improve gradually during the course of projects in places such as Colombia, Niger, Liberia, Mali and Benin.

5. Adaptation, participation and intersectoral activities

Adaptation

Adaptation was not as good as it might have been, at least during the initial stages of the projects which usually coincided with the first steps towards PHC in the developing country concerned. In village health care this was evident from the selection of village workers, teaching aids and training methods. In some cases aspects of the support system of the regular health service, such as buildings, were excessively lavish.

Harmonization and cooperation with the traditional health service was difficult and possibly did not receive enough attention. A number of projects did, however, manage to forge links with traditional midwives. The quality and sustainability of their work was assessed more favourably. Neither the national authorities nor the Dutch experts knew enough about local conditions at the outset of many projects. Adaptation to local conditions took place gradually and in a satisfactory manner during the course of a number of projects.

Participation

It is difficult to give form to "participation", a key concept in PHC, particularly if local or central governments are open to influences from the grassroots in theory only and if the Dutch Development authorities and the experts and volunteers do not have a sound knowledge of the social and cultural organization of the communities in question. If the field staff is mainly indigenous, the latter problem is easier to solve but, even then, the great diversity in culture, class and status in most countries will be evident in the relationship between the staff and the target group.

In places where participation is limited to a financial contribution from the local population, its success is largely dependent on the product on offer. In these projects the emphasis is very much on treatment. In places where participation includes being involved in analyzing problems and the planning, implementation and monitoring of activities other than curative work, interesting developments took place in a number of projects. Improving organization in villages, and initiatives involving other sectors, such as drinking water faci-

lities, are examples of this. However, these changes did not always have a lasting effect.

The evaluation reports describe in general terms how the local population is involved in the development process. As no monitoring or evaluation of participation in projects takes place, only a certain amount of general information is provided on how and why the local population takes part in planning, implementing and evaluating project activities. In a number of projects, such as those in Senegal and Mali, the local population participates in implementing activities and/or makes a financial contribution. Attempts to set up village health committees sometimes encounter opposition from local authorities. In Zambia, Liberia, Colombia and Bangladesh village committees were permitted while in Nicaragua, public health councils at local, district and national level were involved in stages in the development of PHC. In the RUHSA project in India and in Colombia intensive efforts were made to develop models to bring about participation.

The main aim of participation is to reinforce village organization so that after a while people can work together to carry out health care activities and activities in other areas which are considered important. Villages which are well organized are able to make more forceful demands on the authorities. This approach resulted in a continual increase in the number of villages involved in the project.

There has been a growing realization in recent years that women play an extremely important role in increasing the effectiveness and efficiency of development activities in general and programmes such as PHC in particular. This is because women are the linchpin of daily activities such as the preparation of food and child care and take prime responsibility for family planning. Women should also be treated as an important target group for health care activities because of the extra health risks they run as a result of childbearing and their disadvantaged social and economic position.

In most of the projects examined, the role of women was neglected, particularly at the outset of activities. Recently approved or extended activities show that the intention is to correct this state of affairs. In Bangladesh, for example, policy is that as many women as men are to be trained.

Giving women a more central place sometimes meets with social and cultural opposition. Taking on women as VHWs has proved a problem in Zambia, Mali, Niger and Yemen. A good example of women participating in health care is Nicaragua, and there it is due in part to government policy.

Intersectoral activities

The integration of activities into various sectors such as community develop-

ment, water, food production, industry and ecology, is, in theory, an unquestionably sound strategy. However, the projects and programmes described here provide little or no indication of how this is best achieved. This is hardly surprising in view of the way in which government services are organized with clearly defined areas of responsibility and the resulting disputes over jurisdiction. The evaluations suggest that in many cases intersectoral cooperation is considered too difficult and is regarded as a luxury for which there is no time in the course of daily work. The reports nevertheless advocate grasping every opportunity for intersectoral activities which presents itself. Initiatives for improving drinking water supplies are often the most suitable for such an approach in the first instance.

The projects evaluated reflect a variety of activities and approaches connected to intersectoral work. The little experience gained with this aspect of PHC to date suggests that the main problem is the institutional barriers which are difficult to break down and which slow down the development of integrated intersectoral activities. In some regions where the Netherlands supported development projects in agriculture, horticulture and cattle farming there were different target groups (Mali, the Yemen Arab Republic and Zambia), and in many others there were no formal consultative bodies.

Improving the water supply sometimes constitutes a modest start. A number of projects are noteworthy in terms of intersectoral activities. In India, the Christian Medical College Hospital set up a private organization RUHSA to stimulate integrated development in the region. Attention was devoted to health care, social development, agriculture, cattle farming and research and training in health care.

Government policy in Nicaragua and Tanzania stimulates projects which foster integrated development in health care, education and agriculture. Nicaraguan health campaigns are supported by the work of trade unions, farmers' unions, neighbourhood organizations, cooperatives and women's organizations. A number of intersectoral activities have begun in the PHC project in Liberia. Encouraged by this, the UNDP set up a multisectoral project which greatly expanded these activities.

Finance

As most projects had not been in progress for very long at the time of evaluation, it is not possible to give a final assessment of the sustainability of the changes instituted. The analyses indicate that a longer period of cooperation between the developing country and the Netherlands will be needed to reach self-reliance.

The financing of the operating costs of village health care and the use of national and local resources to subsidize them is a major problem which is far

from having been solved in the vast majority of projects. The economic situation in a number of countries such as Zambia, Nepal, Nicaragua and Mozambique means that it will not be possible to hand over activities within the near future. Favourable developments in this respect have taken place in Colombia. Although the population of the host country is gradually starting to share in the financing of projects in Mali, Niger and Liberia, no more than a part of the total costs can be generated in this way. There was excessive donor investment in Sudan, Bangladesh and Nepal.

Furthermore efforts which make services and basic drug programmes more efficient at a national level will help solve this problem.

6. Policy dialogue

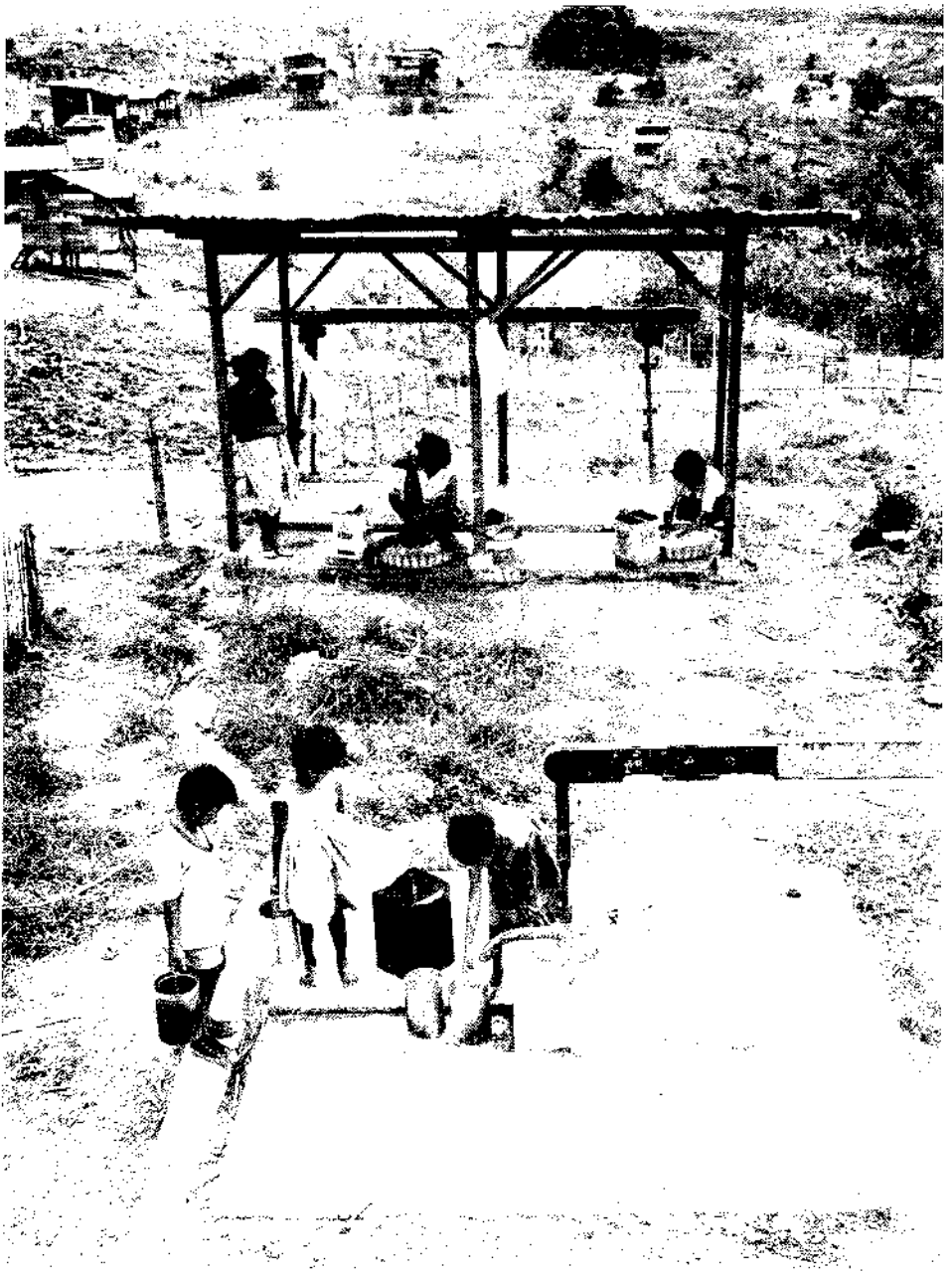
The evaluation reports give very little explicit information on the effects of Dutch activities on the views and policies of the medical profession and the national and local authorities in the partner countries. It is difficult to quantify these effects. It is even more difficult to establish a causal relationship with Dutch contributions as, in theory at least, BHS and PHC have become "common property" through activities and campaigns carried out by various national and international groups. There are, however, a number of clear exceptions. In projects in Colombia and the Yemen Arab Republic, the form taken by the PHC concept in the projects supported by the Netherlands appear to influence national PHC activities, and in Liberia the methodology developed was selected as a national model.

The reports provide clear indications of the useful but sometimes difficult processes involved in influencing policy. The negative attitude towards PHC held by the more conservative section of the medical profession is one explanation for the latter. Disappointing results and the attitude of the local population reinforce this negative view.

On the other hand, in almost all the extramural projects and programmes supported by the Netherlands it was possible to find local doctors and paramedical staff who worked extremely hard on their own and with support from the Netherlands in areas such as treatment, prevention, information and integration with other sectors.

It appears that the long-term presence of motivated foreign (including Dutch) experts helps to convince national and local authorities not only of the need for and inevitability of the promotion of health within the framework of PHC, but also of its advantages. Examples of this include Liberia, Nicaragua, the Yemen Arab Republic, Colombia, Tanzania and Guinea Bissau.

COMMENTARY AND ASSESSMENT



SUMMARY

In the past, the emphasis in health care was primarily placed on hospitals. Many countries still spend the largest part of their health budgets on hospital care, often neglecting rural areas (the periphery). It has gradually become apparent, however, that hospitals contribute little to improving the health of the population.

Since the Second World War a number of new strategies to enable health care to benefit larger sections of the population have been developed and applied: examples include campaigns to combat epidemic diseases, basic health services (BHS) and primary health care (PHC).

For the purposes of this report, these strategies will be referred to as "extramural care". BHS strategy aims to set up networks of small health centres. The work in these clinics is often carried out by auxiliary nurses or other middle-grade medical staff. The essence of PHC is to provide as many people as possible with health care by using health workers who have undergone a brief period of training. One of the main principles of PHC is to involve the population in implementation, planning and monitoring.

A number of years ago the Dutch Development Cooperation authorities felt the need to evaluate what the Netherlands has undertaken in the field of health care since 1975 and what has been achieved. This resulted in a report published in 1987 evaluating achievements in health care in hospitals. The present report covers Dutch health care projects and programmes conducted mainly outside hospitals, so-called extramural health care. Together these two reports cover the major part of this sector.

This report brings together and analyses 47 evaluations previously carried out on 33 projects and programmes supported by the Netherlands. Together these projects represent about one third of all bilateral projects in the field which receive support from the Netherlands.

These evaluations reveal that the Netherlands has been involved in extramural health care for some time now. The intention to devote more attention to extramural health care set out in the 1970s and the main features of the policy have remained unchanged, although the policy has been adapted to fit in with new international guidelines (Health for All by the Year 2000). In 1986, the Health Care Memorandum emphasized once again that primary health care has high priority in Dutch aid policy.

The shift in emphasis is also demonstrated by the funds for health care pledged by the Netherlands. Most of the funds destined for the health sector are used for extramural activities. It should, however, be noted that the total amount spent on health care has, relatively speaking, declined in recent years.

In terms of aim and approach the projects evaluated may be categorized as follows:

- projects and programmes with consistent PHC aims such as those in Colombia, Liberia, Guinea Bissau, Nicaragua and Zambia;
- projects aimed at certain aspects of PHC. Examples are to be found in India, Nepal, Niger, Senegal, Cameroon, Mali, Rwanda and the Small Embassy Projects in Peru;
- projects whose purpose is to expand or improve BHS premises, e.g. in India, Nepal, the Yemen Arab Republik, Pakistan, Sudan, Zambia and the Small Embassy Projects in Tanzania;
- projects aimed at training semi-professional staff for health centres or health posts in places like India and Bangladesh;
- support in the production, supply and distribution of essential drugs for use in PHC or BHS. Examples are Mozambique and Nicaragua;
- support for vaccination programmes such as those in the Philippines.

Since 1978 emphasis has come to lie increasingly on the PHC approach in order to extend the coverage of health care and to increase its sustainability. In the PHC approach special attention is given to certain principal elements in detailing project aims and plans. These are discussed below, together with the Netherlands' experience in these areas as reflected in the evaluation reports.

Preventive care

In the PHC approach emphasis is placed not only on curing disease but also on preventing it. Information campaigns are important in this respect. The principle behind this is that while medical care and medical facilities do play a part in public health, the way people live and look after their own health is equally important.

Almost all reports mention that care has remained primarily curative and that there is relatively little preventive care. This not only applies to activities formerly classified as BHS; curative care continued to play a significant role even in programmes set up along PHC lines and with a PHC approach. Health care centres and posts concentrated on this aspect in particular, and their staff - doctors, medical assistants, nurses and auxiliaries - spent the most time on treating patients. In doing so, they were fulfilling an important need. Village health workers assisted at births, and provided primary care in fighting epidemics, treating the most common illnesses such as gastroenteritis and respiratory infections and assisting accident victims. Curing patients was naturally the main aim in supplying medicines for BHS and/or PHC.

Adaptation

The more activities fit in with the needs of the local population and with their cultural, social, financial and technical possibilities, the greater their chance of long-term success. The PHC approach assumes that health care will be adapted to these possibilities and that it will be brought about as far as possible by using the population's own resources.

In the early stages of the projects, which often coincided with the beginning of PHC in the developing countries concerned, this adaptation was not as good as it might have been. This was apparent in the choice of village health workers, teaching aids and training methods. In some cases certain components of the regular health care support system, such as buildings, were unnecessarily lavish.

Harmonization and cooperation with traditional health services were also difficult and often did not receive enough attention. A number of projects for setting up cooperation with traditional midwives were successful. In a number of projects, for example those in Mali, Colombia and Liberia, harmonization came about gradually during the course of a project.

Participation

Adaptation can only take place properly if the people themselves are involved in activities. More than was the case in previous strategies, the PHC approach assumes and encourages a high level of involvement and work on the part of individuals and the community. This means that the community assists not only in building facilities but also in defining the most urgent problems, in planning, setting up and implementing activities, and in evaluating and sustaining activities independently. There has been a graving realization in recent years that women play an extremely important role in increasing the effectiveness and efficiency of development activities in general and programmes such as PHC in particular. This is because women are the linchpin of daily activities such as the preparation of food, and child care and take prime responsibility for family planning.

Although participation is a key concept in PHC, in practice it is difficult to achieve. It is dependent upon local and central government authorities being open to influences from the grassroots. Experts posted to developing countries should possess a thorough knowledge of social and cultural practices in the communities in question and good communication skills.

Involving the local population in the development process is dealt with only in broad outline in the evaluation reports. One common form of participation is providing a financial contribution. In Zambia, Liberia and Colombia village committees played a major role in decision-making. In India and Colombia strenuous efforts were made to develop models for ensuring participation.

In most of the projects examined, the role of women has not received enough attention. This applies particularly to the initial phases of the projects evaluated. Recently approved or extended activities are showing signs of improvement in this respect although there are sometimes social and cultural impediments. The appointment of women as village health workers (VHWs), for example, causes problems in countries such as Zambia, Mali, Niger and Yemen. Nicaragua, on the other hand, provides a good example of the participation of women in health care, partly as a result of government policy.

Intersectoral action

The point of departure for planning and action in PHC is that disease is caused by factors such as inadequate nutrition, unsafe water and poor housing which are traditionnally regarded as separate sectors. For this reason cooperation with many of these sectors is being sought.
Although intersectoral cooperation and the intersectoral promotion of health has been successfully introduced in a number of projects, this element was the least developed in the projects evaluated.

Intersectoral activity is seen as a "luxury" for which there is, unfortunately, no time. The fact that it requires the cooperation of a number of different ministries and organizations is a complicating factor. The evaluations provide few indications of how best to achieve interaction between the various sectors. The absence of an intersectoral approach can severely limit the effects of health care projects.

Health workers

Village health workers play a crucial role in carrying out PHC activities. The village usually chooses one person from its midst to receive practical training as a health worker. The official health service provides this person with support in the form of technical advice, training and refresher courses and, where necessary, supplies. The village is responsible for the day-to-day supervision of the VHW's work through an elected health committee. An important requirement for the success of PHC is that there is a regular minimum supply of aids such as essential drugs.

In a number of cases where there were initiatives for PHC and the use of VHWs in the projects, it was apparent that expectations had been too high: they were expected to do everything a normal health service does or is supposed to do, which is an impossible demand. A realistic alternative is for the VHW to do what he or she thinks is best in the first place, with particular emphasis on activities which the village considers important, in consultation with the health service. In practice, however, VHWs regularly have to perform activities specified by the health service but for which the means are lacking.

Experience has shown that the support of the regular health service for village health care is extremely important. Although a great deal of attention was devoted to this aspect in almost all of the projects, adequate support was not always forthcoming. Despite training, the professional health service staff are not always motivated to carry out these additional duties. One of the main problems is providing the means for this supervision such as transport and a supply of drugs for VHWs.

It would appear that efforts to secure such items from the national health service, possibly supplemented by resources from the villages themselves, are becoming more effective in projects with a long-term donor commitment (for example in Colombia, Niger, Liberia and Mali).

Finance

The view that people should meet at least part of the costs of health care themselves is generally accepted. Although self-financing should be aimed at, rural poverty will make supplementary central or local government financing for the implementation of PHC programmes necessary for a longer period. The major part of the cost of supervision by the regular health services will certainly have to come from national budgets. This will require reallocation of available national funds.

In a relatively large number of projects the financing of recurring costs in PHC remains an acute problem. The continuation in the long term of donor contributions for the financing of running costs which are often not even coordinated, is not a realistic solution. Co-financing by the recipients is an obvious solution which should be worked out in more detail. There are, however, clear indications that in many of the poorer countries the principle of cost recovery can cover only a small part of the costs without raising the threshhold for health care so as to make it inaccessible to the poorest sections of the population who have the worst health. Increasing the efficiency of health services, determining national requirements and examining the possibility of shifting resources to the periphery are strategies which donor countries will have to continue to advocate.

Conclusion

The aims of many PHC projects, particularly those set up at the outset, were formulated too vaguely and were not sufficiently realistic. Lack of insight into local potential and requirements often resulted in a standard approach which resembled a blueprint rather than taking into account the many variations in actual situations. Joint study and analysis of the situation at national and local level is a prerequisite for tackling these problems. In countries such as Zambia, Liberia and Colombia where the approach was more systematic, results were better.

On the basis of the evaluation studies it may be concluded that, generally speaking, the availability of health care and its use by the population were clearly increased in the projects in question. The beneficiaries of these activities were mainly those in the periphery.

Apart from realistic planning, adequate detailing of adaptation, participation and intersectoral action in implementation, institutional development and the possibility of financing projects from national and local sources appear in particular to determine the sustainability of the PHC projects studied.

The reports moreover demonstrate that only long-term cooperation produces lasting results. Regular dialogue and good donor coordination will enhance the quality and sustainability of results.

CONCLUSIONS AND RECOMMENDATIONS

1. Assuming a structural policy of fighting poverty and in view of the fact that the promotion of health does not in the first instance begin in hospital, the Dutch Development Cooperation authorities would be well advised to continue trying to improve public health through extramural care in which the PHC approach is central.

2. The 1986 Health Care Memorandum provides a good framework for Dutch aid efforts in extramural care. The findings of the evaluation studies support the reasoning of the Memorandum. The main objectives are clear: care should be provided for as many people as possible and fighting the causes of disease is at least as important as treatment and short-term prevention.

3. The introduction and implementation of primary health care is an essential part of the long-term strategy of change within the existing health care systems ("Health for All by the Year 2000"). For reasons of sustainability the Netherlands should support primary health care projects for a longer period of time.

4. It is important to hold regular discussions on policy with the recipient country and other donors in order to ensure that a favourable policy framework for developing PHC is set up on a national level. The emphasis in discussions on policy should be on decentralization, efficiency, cost control and the reallocation of funds in favour of PHC.

5. National programmes for the rational use of drugs (Essential Drugs Programmes) form a significant contribution to cost control and the saving of foreign currency. Dutch support in this area is to be recommended. Cost recovery mechanisms at project level should be reviewed in a local and national perspective taking into account the purchasing power of the poorest users.

6. The focus of extramural care should lie on preventive measures and simple treatment combined with information. These activities should be directed at the most common illnesses as well as new diseases such as AIDS.

7. The role of village health workers in PHC is essential. The selection, training and remuneration of VHWs requires special attention. The VHW should have access to at least a minimum of means. It is also important that health care services ensure adequate and motivating guidance and supervision. Special attention should be given to institutional development and the reorientation of these services.

APPENDICES

APPENDIX I

PROJECTS/PROGRAMMES INSPECTED AND EVALUATED

	Title	Administration	Country	Dutch contribution x Fl. 1000
1.	Medical assistants training programme	DGIS	Bangladesh	38.302
2.	Ellen Thoburn Hospital	NGO/ICCO	India	66
3.	Rural unit (RUHSA)	NGO/ICCO	India	194
4.	Schieffelin Centre	NGO/ICCO	India	577
5.	Coronation gift	DGIS	Nepal	3.350
6.	NLRA, Joint programme BHS	NGO	Nepal	3.400
7.	Integrated community health services	DGIS	Nepal	1.536
8.	MCH Clinic Radaa	DGIS	Yemen Arab Republic	1.900
9.	Rural health care	NGO/ICCO	Pakistan	1.764
10.	Vaccine supplies	DGIS	Philippines	2.450
11.	Primary health care	DGIS	Colombia	15.297
12.	Raw materials pharmaceutical industry	DGIS	Nicaragua	32.854
13.	Primary health care	DGIS/UNICEF	Nicaragua	3.850
14.	Jornadas Populares	DGIS	Nicaragua	540
15.	KAP, Posta Medica Arequipa	DGIS	Peru	5
16.	KAP, Posta Medica Lima	DGIS	Peru	8
17.	Medical team	DGIS	Niger	11.800
18.	Standard health care project	DGIS	Senegal	1.500
19.	Standard health care project	DGIS	Liberia	2.400
20.	Health care Eastern Province	SNV	Cameroon	1.800
21.	Soins de santé primaires	SNV/KIT	Mali	1.350
22.	Primary health care Jonglei	DGIS	Sudan	9.500
23.	KAP Kubengu Juu	DGIS	Tanzania	15
24.	KAP Mtombozi	DGIS	Tanzania	15
25.	KAP Bwakira Juu	DGIS	Tanzania	15
26.	KAP Kolero	DGIS	Tanzania	5
27.	Sichili Rural Hospital	NGO/CEBEMO	Zambia	94
28.	PHC Western Province	DGIS	Zambia	10.000
29.	BUFMAR	NGO/ICCO	Rwanda	972
30.	Medical activities	NGO/ICCO	Rwanda	1.324
31.	Drug supplies	DGIS	Mozambique	7.600
32.	Soins de santé primaires	DGIS/SNV	Guinea Bissau	2.100
33.	Mother and child care	NGO/ICCO/ CEBEMO	Tanzania	31.000
			TOTAL:	**187.583**

APPENDIX 2

DISTRIBUTION OF HEALTH CARE ACTIVITIES BY SUBSECTOR IN THE PERIOD 1975-1984 FOR THE REGULAR BILATERAL AID PROGRAMME

	1975			*1976-78*			*1979-1981*			*1982-84*			*total*		
Sub-sector	No.	*f* 1,000	%	No.	*f* 1,000	%	No.	*f* 1,000	%	No.	*f* 1,000	%	No.	*f* 1,000	%
1	9	6,239.40	5.10	10	16,948.2	9.5	14	10,910.0	6.6	11	37,162.7	35.4	44	71,260.30	12.500
2	21	71,066.35	58.50	50	133,046.9	74.7	42	95,448.3	58.1	23	35,005.1	33.4	136	334,566.65	58.800
3	9	6,501.30	5.40	19	13,288.1	7.5	15	30,012.0	18.3	5	7,340.0	7.0	48	57,141.40	10.000
4	5	23,132.80	19.00	4	3,142.0	1.8	2	400.0	0.2	1	80.0	0.1	12	26,754.80	4.700
5.1	6	12,447.70	10.20	2	1,350.0	0.8	5	14,500.0	8.8	2	11,500.0	11.0	15	39,797.70	7.000
5.2	4	1,660.40	1.40	6	880.0	0.5	–	–	–	–	–	–	10	2,540.40	0.400
5.3	4	132.50	0.10	7	477.5	0.3	5	778.8	0.5	–	–	–	16	1,388.80	0.200
5.4	2	284.10	0.20	6	3.210.6	1.8	4	4,960.0	3.0	7	12,800.1	12.2	19	21,254.80	3.700
5.5	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
5.6	2	17.35	0.01	–	–	–	–	–	–	–	–	–	2	17.35	0.003
6	–	–	–	6	5,690.0	3.2	7	7,250.0	4.4	1	1,000.0	1.0	14	13,940.00	2.500
Total	62	121,481.90	100.–	110	178,033.3	100.–	94	164,259.1	100.–	50	104,887.9	100.–	316	568,662.20	100.–

Subsectors 1-6

1. Primary health care
2. Hospital Care
3. Medical training
4. Medical research
5. Other activities:
   - 5.1 Family planning
   - 5.2 Health planning
   - 5.3 Identification/evaluation
   - 5.4 Pharmaceutical industry
   - 5.5 Health insurance
   - 5.6 Conferences/workshops
6. Campaigns against endemic diseases

APPENDIX 3

DISTRIBUTION OF HEALTH CARE ACTIVITIES BY SUBSECTOR IN THE PERIOD 1975-1984 FOR THE RURAL DEVELOPMENT PROGRAMME

Sub-sector	*1975*		*1976-78*		*1979-81*		*1982-84*		*total*	
	f 1,000	%	*f* 1,000	%	*f* 1,000	%	*f* 1,000	%	*f* 1,000	%
1	5,060	44.7	15,829.10	42.5	34,158.90	46.7	17,252.80	42.4	72,300.8	44.5
2	5,255	46.4	10,188.20	27.4	9,081.85	12.4	2,896.43	7.1	27,421.5	16.9
3	–	–	1,584.30	4.3	1,759.80	2.4	2,432.10	6.0	5,776.2	3.6
4	405	3.6	–	–	–	–	–	–	405.0	0.2
5.1	–	–	–	–	1,100.00	1.5	5,250.00	12.9	635.0	3.9
5.2	–	–	–	–	1,540.10	2.1	–	–	1,540.1	0.9
5.3	–	–	–	–	–	–	–	–	–	–
5.4	600	5.3	6,787.62	18.2	6,334.30	8.7	416.00	1.0	14,137.9	8.7
5.5	–	–	–	–	–	–	–	–	–	–
5.6	–	–	–	–	–	–	–	–	–	–
6	–	–	2,820.10	7.6	19,145.00	26.2	12,411.30	30.5	34,376.4	21.2
Total	11,320	100.0	37,209.32	100.0	73,119.95	100.0	40,658.63	100.0	162,307.9	100.0

Subsectors: 1-6

1. Primary health care
2. Hospital care
3. Medical training
4. Medical research
5. Other activities:
   - 5.1 Family planning
   - 5.2 Health planning
   - 5.3 Identification/evaluation
   - 5.4 Pharmaceutical industry
   - 5.5 Health insurance
   - 5.6 Conferences/workshops
6. Campaigns against endemic diseases

APPENDIX 4

DISTRIBUTION OF HEALTH CARE ACTIVITIES BY SUBSECTOR IN THE PERIOD 1975-1984 FOR THE SOCIAL AND ECONOMIC EMERGENCY PROGRAMME

	1975		*1976-78*		*1979-81*		*1982-84*		*total*	
Sub-sector	*f* 1,000	%	*f* 1,000	%	*f* 1,000	%	*f* 1,000	%	*f* 1,000	%
1	–	–	4,298.2	8.20	4,590.0	7.40	10,443.4	22.20	19,331.6	11.80
2	–	–	22,104.5	42.00	2,970.1	4.80	6,948.1	14.80	32,022.7	19.50
3	–	–	10,027.5	19.00	3,635.0	5.80	–	–	13,662.5	8.30
4	–	–	–	–	–	–	–	–	–	–
5.1	–	–	–	–	–	–	–	–	–	–
5.2	–	–	–	–	–	–	–	–	–	–
5.3	17.6	0.7	21.6	0.04	27.–	0.04	26.–	0.06	92.2	0.06
5.4	2,650.0	99.3	16,197.7	30.80	26,621.6	42.90	29,545.1	63.90	75,014.4	45.60
5.5	–	–	–	–	–	–	–	–	–	–
5.6	–	–	–	–	–	–	–	–	–	–
6	–	–	–	–	24,250.–	39.10	–	–	24,250.–	14.80
Total	2,667.6	100.00	52,649.5	100.00	62,093.7	100.00	46,962.6	100.00	164,373.4	100.00

Subsectors 1-6

1. Primary health care
2. Hospital care
3. Medical training
4. Medical research
5. Other activities:
   - 5.1 Family planning
   - 5.2 Health planning
   - 5.3 Identification/evaluation
   - 5.4 Pharmaceutical industry
   - 5.5 Health insurance
   - 5.6 Conferences/workshops
6. Campaigns against endemic diseases

APPENDIX 5

DUTCH HEALTH WORKERS IN THE THIRD WORLD 1975-1984

	No. of postings
Supplementation experts	303
Dutch-funded supplementation doctors*	177
Bilateral experts	201
PITDCG+doctors	487
Associate experts	32
SNV volunteers	482
	1.682**

* Known as 'SANO doctors' until 1978
\+ Private Initiative Tropical Doctors Consultative Group
** 78 to Latin America, 1.525 to Africa and 79 to Asia

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