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Community-Based Health Care

Lessons from Bangladesh to Boston

edited by Jon Rohde and John Wyon

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MANAGEMENT SCIENCES *for* HEALTH
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in collaboration with the Harvard School of Public Health

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Foreword

The importance of this book drawn from the Symposium on Community-Based Health Care: Lessons from Bangladesh to Boston, and of the meeting itself, is to lay to rest the notion that we have little to learn from societies very different from our own, that our systems and experience are so narrowly constrained by our culture and economic status as to be irrelevant to those in very different material circumstances or with different histories.

What these lessons teach us is that Boston *should* understand Bangladesh, *not solely for intellectual purposes,* nor so that it can assist Bangladesh, but to better understand itself and its own programs, and to see models and ideas that will have relevance for Boston's work. Policymakers in the wealthy nations can learn much about community education for behavior change, about outreach to disempowered and marginalized populations, about the use of community workers and ancillary personnel, and about relating health and other sectors in a great variety of settings.

These lessons show us that Bangladesh has something to learn from Boston that it can *use,* not merely a fantasy system of care beyond the reach of all but the richest societies. Program directors in the developing world can learn much about community empowerment and control, about the use of data and evaluation, and about management and information systems. Both the symposium itself in November 2000 and this compilation and analysis demonstrate the utility of learning from each other, even when the lesson learned is "Don't do what we did!"

We have much to learn from one another, and what we learn is not always what we have started out to study. Often an examination of teaching and communication materials leads to an understanding of cultural diversity and sensitivity and its utility in improving health by making services more appropriate as well as more accessible. Often a look at using paraprofessional and community workers as a cost-saving

device leads to an understanding of the improved outcomes produced by peer educators and leaders. Similarly, a study of data can lead us to better understand and identify proxies when hard data are not available; and frequently a search for explanations and causes leads to better understanding of the relationship between health and economic status, or education, or environment, or housing, or violence.

We have too often assumed that models of health care, delivery systems, financing, and community-based approaches could only be studied—or used—in similar situations, in peer societies, with similar material means and economic or political systems. What we have learned, and what the symposium furthers, is that very dissimilar societies, with very different constraints, can benefit from understanding how others work and what can be used in organizing societies to improve health.

In Boston, arguably the medical center of the United States, health status in poor neighborhoods was improved more by adopting the community health center model of South Africa than by the presence of a multitude of world-class research institutions. The infant mortality initiatives of Costa Rica, the system of community health workers in Jamaica, and the outreach to young fathers in Kenya have all informed and shaped programs in Boston's neighborhoods. As Commissioner of Health and Hospitals in Boston 10 years ago, I looked as much to communities in the southern hemisphere for ideas and models as I did to those in other big American cities. Healthy Boston, like the healthy communities movement worldwide, benefits from this sharing of information, ideas, and approaches. Lessons Without Borders, a project of the US Agency for International Development, adapted this approach and examined the programs it funded or designed in the developing world. It returned those to the United States that would improve both inner city and remote rural health.

At the same time, we found that our colleagues from those countries from whom we had borrowed ideas or programs were equally interested in the transformation that occurred to them in our society and often regarded them as improvements or evolutions of the original model, and adopted our adaptations.

This process of sharing, shaping, and redesigning occurs only where there is openness of spirit as well as of mind. But increasingly, both

occur. These lessons also broaden our understanding of the determinants of health and the barriers to care. When we examine other societies who have resources we do not, or barriers we have overcome, and still see health and access disparities, we have greater understanding and purpose.

From Boston to Bangladesh, from Haiti to Hamburg, there is much to learn, much to excite us about the possibilities of communities' role in their own health; when we look through a window, we often see our own reflection.

—Judith Kurland
Regional Director, US Department of Health and Human Services

Preface

The gathering of health ministers from around the world at Alma-Ata, Kazakhstan, in 1978 was arguably the most influential meeting of its kind in the history of public health. The Declaration of Alma-Ata remains one of the most influential yet debated documents in the field of health, with its call for meaningful involvement of communities in the design and control of affordable health services. Can it work for the billions of poor today? Or is it simply an ideal?

The symposium on which this book is based was held in November 2000, sponsored by the Harvard School of Public Health, Management Sciences for Health, and the Rockefeller Foundation. The meeting was an opportunity both for those who were involved in the Alma-Ata conference and for those who have been practitioners of its recommendations to share experiences, debate the principles, and attempt once again to interpret the lessons of primary health care (PHC) in an effort to reach "health for all." The symposium, and the book that emerged from it, reached back to the antecedents of PHC in the mid-19th century, considered the technological advances following World War II, and looked to see how experiences since Alma-Ata have influenced health and health services in countries as poor as Bangladesh and as rich as the United States.

Can it work? Surely yes! Many projects have amply proven this: Jamkhed in India has reduced infant mortality from 160 to 18 or less, endemic malnutrition has virtually disappeared, and fertility has fallen to under 3 children per family in a poor rural area with a population of 200,000. (See the bibliography for sources on this and other projects.) The Narangwal Project in the Punjab proved the success of the Bhore Commission model of family planning and essential care provided by health auxiliaries in rural villages. Piaxtla in Mexico demonstrated the power of an activated community to provide care for itself. Sidney Kark, before he was driven by apartheid from his home country of South Africa, demonstrated the power of social medicine by treating

families in a community context and addressing the cultural-behavioral determinants of health. This book presents examples from Bangladesh, Bolivia, Germany, Haiti, Nepal, Peru, Tibet, the United States, and Vietnam. All of these had a common factor: visionary leaders to drive the process. While all involved the community in some way, it was the vision and energy of dedicated leaders that made the projects work. Indeed, often the results did not outlast the presence of the founding leader. Alma-Ata was silent on this crucial element.

Can community-based PHC reach large populations? Again yes! But with caveats. Barefoot Doctors, a national extension of the Ting Hsien model of John Grant and Jimmy Yen of the 1930s, surely reached most of China in a sustainable fashion. Top-down in policy and organization, it was grounded and paid for by each work group, each community. Accountability was entirely local. Yet this remarkably effective, equitable, and affordable system folded with the collapse of the centrally directed economic system, which left communities prey to the uncertainties of the marketplace. A fee-for-service system replaced work points, and with it both preventive medicine and equity were largely lost. One wonders whether market forces can support an equitable health system.

Indonesia has pioneered a system of village initiatives to make health for all affordable. The Dana Sehat scheme, initiated in Solo with small monthly payments by each family into a common pool to pay for medicines, had shared benefits that helped the poorest gain some access to care. But significant health payments exceeded the savings and bankrupted many village schemes. Indonesia's *posyandus* (village health posts) are run entirely by volunteer women who work only one or two days a month, a sustainable level of effort in a community where service is recognized by public approval. These posts started only to weigh children monthly and for mothers to share advice on child rearing. Later they added oral rehydration packets for the most common illness, diarrheal disease, and periodic vitamin A supplements. Then the Indonesian Family Planning Program saw these posts as an easy and reliable way to resupply contraceptive pills. Still later, health outreach workers added immunization services to improve coverage of infants. More recently, some posts have added treatment of minor ailments, and a few are monitoring chronic ailments like arthritis and

hypertension in older patients. There are now some 250,000 posts in 65,000 villages, all run by volunteers. The services are of very mixed quality and limited in scope, but the phased approach, embedded in the village tradition of a monthly women's meeting called *arisan,* made this a viable and sustainable large-scale activity reaching most of the country.

These experiences led James Grant of UNICEF to champion GOBI (growth promotion, oral rehydration, breastfeeding, and immunization)—a few things for everyone, needed by rich and poor alike. No doubt the idea was very top-down, but UNICEF chose just a few interventions aimed to be relevant to all children in all nations that would support and strengthen health systems of any design. All too often GOBI became target driven and not built into any system, so it was not sustained. Where it was embraced by a health system, it has lasted and contributed substantially to declining infant and childhood deaths. Where carried out in campaigns, its benefits rapidly faded.

Is community-based PHC affordable? Who pays for it and for how long? As the world swings to the tune of the market economy, we have seen many programs wither and die. Social-sector budgets are early targets of the International Monetary Fund—communities are asked to pick up the tab for health services, and equity is lost. The governments of Sri Lanka and Costa Rica made the unusual decision to give priority to village-based health posts manned by midwives, even at the expense of hospitals. Both those countries have seen their rewards in sustained reduction in mortality and fertility, although their high levels of female education have probably contributed as least as much to this result as the health care system.

A more usual response is seen in Bangladesh, where the government has provided a few essential services and encouraged NGOs to work with communities through a large array of approaches to provide responsive health and development initiatives. BRAC has covered this country of 110 million people with house-to-house demonstrations of oral rehydration therapy and achieved a high rate of TB cure with trained community workers paid largely through sale of a few inexpensive drugs. BRAC's annual budget is US$132 million, of which 74% is generated within Bangladesh from BRAC's own activities and programs. NGOs immunized the country and distribute vitamin A twice

annually. This book explores some of those approaches and finds the results impressive (see chapters 4 and 5). Meanwhile, the government has concentrated on family planning, modifying its approach with a strong element of continuous operational field research, achieving the most dramatic fall in fertility of any poor nation. Affordability may mean learning what you can pay for and staying within those limits, leaving the communities to set their own priorities with their own resources. In Bangladesh, many have found it necessary to *exclude* those who can best afford to pay, as they tend to take over the system, be it health, credit, or education. This inverts the standard wisdom of cross-subsidy often applied to social insurance schemes.

Is community-based PHC sustainable? Here the record falters. Often projects do not outlast their founding leaders. Overambitious expansion in both population served and range of services can exceed financial resources and management capacity. Especially vulnerable is the voice of the community, which these studies show to be critical to success. Chapters describe issues of financing (chapter 10); choice and adaptation of technologies (chapter 7); and various levels of community involvement and tradeoffs between scale and comprehensiveness (chapter 6). While large government systems run by tax revenues have the scale, they rarely have the responsiveness to or ownership by the people they serve and are thereby less effective, even in health outcomes.

No discussion of PHC can be considered comprehensive today in the absence of strategies to deal with the HIV epidemic. Some 45 million infections worldwide are estimated to date, with 25 million deaths, and in many countries the curve continues to rise. In contrast to many infections, HIV is often shrouded in secrecy, shame, and recrimination, the victims blamed for their fate. Yet this epidemic underscores the failure of the very fundamentals of PHC, for it can *only* be prevented, not cured, and *only* through knowledge, social action, and culturally sensitive measures taken by the people themselves. While the power of science has found means to ameliorate and defer the devastating clinical effects of this infection, social inequities between nations deny the majority of sufferers the respite these advances could offer. The inequities exposed by this epidemic challenge the very principles of global public health. The symposium regrettably did not grapple with this important issue.

The second part of this collection discusses recent experiences in the United States and Germany, uncovering a remarkable parallel with poorer countries. We are reminded that the antecedents of the community health center movement in this country lay in South Africa, India, and postwar Europe. The principles developed and applied at Many Farms (Arizona), Columbia Point (Boston), Lexington (Kentucky), and more recently Watts (Los Angeles) and Roxbury (Boston) emphasize social determinants of health, teamwork, and a strong role for the community. Linking such grounded programs with academic centers, to ensure that graduates have a pragmatic appreciation for social issues and the ability and inclination to work with community representatives, is an ongoing challenge. John Knowles pointed out years ago that 80 percent of the advance in life expectancy since World War II has been due to social factors and behavioral change; medical technology plays a steadily decreasing role. Yet when budget cuts come, it is the social services, the poverty reduction strategies, the home visits, and health education that go first.

Whether we are considering rural Nepal or the Mayo Clinic, good health information plays a central role in enabling planners to design appropriate interventions as well as to share with communities an understanding of the epidemiology. From an initial situation analysis to design of service mix and choice of technologies to research on better approaches to health care, to monitoring and reporting on progress, a robust health information system is a critical part of reaching health for all. It is also a critical tool in motivating communities, donors, and governments to provide needed funds. Nothing speaks like the facts, whether in Bangladesh or Boston!

The following questions may help the reader explore the diverse lessons of this book:

- What is the role of the community in this approach? How is it involved?
- Who should choose the priorities for implementation and how?
- What is the role of measurement in planning? Implementation?
- What is the mix of technologies chosen? And the modifications to suit cultures?

- Is it sustainable? How? How cost-effective is it compared to other approaches?
- What is the role of charismatic leadership? Can the approach outlast the leader?
- What political considerations contributed to the success or difficulties faced by the community-based PHC program?
- How does one avoid being taken over by vested interests and the rich?
- What is the role of women and how does this approach empower or liberate them?
- Is there evidence to support the belief that female education is an important determinant of health, perhaps even more than health care?
- How important are health technology and specific antidisease programs, in contrast to health behavior and healthy lifestyles?
- What is the relationship between community-based health services run by the community and government health services?
- What is the optimal mix of professional capacity and ratios of different levels of workers in a large-scale community program?
- How does one address the fundamental problem of poverty as a prime determinant of health among the poor?
- What should a health program do about nutrition and food?
- What are the distinct roles of international, national, and local voluntary and professional agencies?
- What are the crucial roles of universities in poor and in rich countries?

The discussions at the symposium often addressed these questions, which will be raised again in the conclusion.

—Jon Rohde

Acknowledgments

This book is based on a symposium held on November 11 and 12, 2000, at the Harvard School of Public Health in Boston. More than 100 people experienced in primary health care, in poor and wealthy countries, met to explore developments since 1978, the year of the meeting of health ministers at Alma-Ata. This symposium was designed to exemplify the main stages of this evolution up to the year 2000, derive their common principles for application elsewhere, and encourage the creation of approaches and methods to improve the health of communities of people.

The symposium had its roots in the Working Group on Community-Based Primary Health Care, a committee of the International Health Section of the American Public Health Association. Many of the contributors have participated in this working group. As the group was planning an event to celebrate the new millennium at APHA's annual meeting in Boston, they learned that the Alumni Council of the Harvard School of Public Health was developing a symposium to showcase models of community-based health care, with a focus on the United States. Its purpose was not only to establish principles for community-based health services but also to produce materials for physicians and others preparing to work as public health and preventive medicine specialists. With the support of Dean Barry Bloom of the Harvard School of Public Health, these two groups, led by Drs. John Wyon and Joan Altekruse (president of the HSPH Alumni Council), joined forces to plan the symposium. The symposium thus expanded to focus on community-based health care in both international and domestic settings.

The planning committee also drew upon Professor John O. Field, retired from Tufts University; Dr. Eliot Putnam, Jr., the former Director of the National Council on International Health (now the Global Health Council); and Ms. Gail Price, the current president of the HSPH Alumni Council and a Senior Program Associate at Management Sciences for Health. MSH is a nonprofit organization, with head-

quarters in Boston, that has worked in more than 100 countries to improve health systems and services. Dr. Ron O'Connor, MSH's Chief Executive Officer, championed this book, and Ms. Catherine Crone-Coburn, MSH's President, provided support for its development.

The HSPH's Office of Alumni Programs provided extensive assistance for the symposium. The Assistant Dean for Students and Alumni, Dr. Robin Worth, and the staff of that office, principally Ms. Catherine Fratiani, organized the event. We are deeply indebted to HSPH for managing and hosting the symposium. Participants from universities, hospitals, and public and private health institutions in a dozen countries attended. Many MSH staff members participated in the symposium, which MSH also supported.

Dr. Jon Rohde, Senior Advisor to MSH's EQUITY Project in South Africa, was a key participant in the symposium and served as the lead technical editor of this book. Jon Rohde, with assistance from his colleague Dr. Barbara Timmons at MSH, assembled and edited the chapters in this book. Ms. Ceallaigh Reddy copyedited many of the chapters. John Wyon was active in reviewing them, suggesting improvements, and following up; some were entirely rewritten. Five new chapters were written especially for this book.

Ms. Judith Kurland composed an inspiring foreword, while Drs. Hugh Fulmer and Anthony Adams contributed the introduction to Part II. Dr. Robert Northrup of Project Hope assisted Dr. Joseph Valadez with the revision of his chapter. Mr. John Pollock of MSH reviewed several chapters and made helpful suggestions. Dr. Paul Farmer of Partners in Health and Brigham and Women's Hospital provided some background materials on HIV/ AIDS. We are grateful to all these people for giving generous amounts of their time so that this book could become more than the proceedings of a conference.

We extend special appreciation to the Rockefeller Foundation for partial funding of the symposium and this book and to the James M. and Cathleen D. Stone Foundation for its contribution to the publication costs.